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# Access to Healthcare for Women Experiencing Homelessness

Simon Community Report 2024

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**Acknowledgment -**

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# Contents

## Introduction

**We believe that health is a human right, a belief that is supported by the World Health Organisation (WHO, 1946). This research considers improving access to healthcare for women experiencing homelessness in Northern Ireland (NI), with the hope that this will lead to better health outcomes and therefore better social outcomes, with the larger scale hope that this will result in reduced length of time homeless.**

People experiencing homelessness have poorer health than people in the general population. They have higher rates of long-term health conditions, like cancers and lung disease (Rogans-Watson et al., 2020), mental health diagnoses, such as depression and self-harm (Clements et al., 2022) and they are more likely to die at a younger age (Ivers et al., 2019). Women experiencing homelessness face challenges and barriers that may differ from men (Milaney et al., 2020). The number of women experiencing homelessness in NI is growing, they face greater inequalities, and their voices are underrepresented in research (Pleace, 2016, Bretherton, 2017).

This report considers how access to healthcare can be improved for women experiencing homelessness. It includes the voices of women experiencing homelessness and those who are involved in supporting and advocating for them.

## Simon Community

Simon Community is Northern Ireland's leading homeless charity established in 1971 and has a clear vision of creating a society where everyone has a place to call home. Their mission is simple, to end homelessness. Operating throughout Northern Ireland, the organisation provides temporary accommodation alongside specialised support services designed to address the unique challenges faced by individuals experiencing homelessness. Their aim is not only to provide immediate assistance but also to support a long-term solution and end the cycle of homelessness.

## Our Study

The aim of the study was to find out what access to healthcare looks like for women experiencing homelessness in NI and how it could be improved. We spoke to women experiencing homelessness and other stakeholders to find out about their experience of access to healthcare.

The research had two phases: interviews and workshops. First, we interviewed ten women experiencing homelessness living in Simon Community NI hostels, six Simon Community NI staff and three healthcare staff involved with women experiencing homelessness in NI. We then hosted two workshops. The first with 13 participants who were involved with developing and undertaking policy and healthcare educators, and the second workshop had 21 participants who were mostly practitioners and working in service delivery.

# Understanding The Issue

## Understanding Homelessness in Northern Ireland

**Homelessness can be difficult to define, and there isn't an agreed global definition. It can include people sleeping on the street, people in emergency accommodation, people staying with friends and family, and people in temporary accommodation.**

In NI, homelessness is defined by the Housing Order (NI) of 1988, the legal definition of homelessness in NI is:

> *A person is homeless if he or she has no accommodation available for his or her occupation in the United Kingdom or elsewhere.*

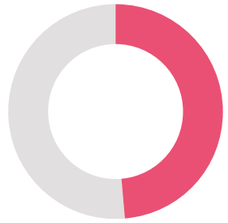
The Housing Order (NI) was amended in 2003, introducing the requirement that the NI Housing Executive assess applicants before awarding Full Duty Applicant status to those who meet the criteria. Full Duty Applicant criteria include determining whether the applicant is homeless or threatened with homelessness, eligible for homelessness assistance, in priority need for shelter and assistance, and if they are intentionally or unintentionally homeless.

Temporary accommodation is arranged by the NI Housing Executive for households in priority need awaiting assessment and for those who have been accepted as Full Duty Applicants but awaiting permanent offer of housing. As of July 2023, 4,204 households were living in temporary accommodation in NI - a number which has nearly doubled since 2018 (NISRA, 2018, NISRA, 2023). Temporary accommodation includes placements in settings such as B&Bs, private lets and voluntary sector hostels such as those run by Simon Community NI.

The percentage of women experiencing homelessness being accepted as FDA in Northern Ireland has remained somewhat consistent in the NI Homelessness Bulletins since their inception in 2018. This percentage is higher than the percentage of male presenters being accepted as homeless. In the year April 2022 to March 2023, 5,251 single males presented as homeless to NI Housing Executive, with 48.7% being accepted, while 2,690 single females presented and 66.1% were accepted.

### Single Males

- Percentage Accepted



### Single Females

- Percentage Accepted

# UNDERSTANDING HOMELESSNESS FOR WOMEN

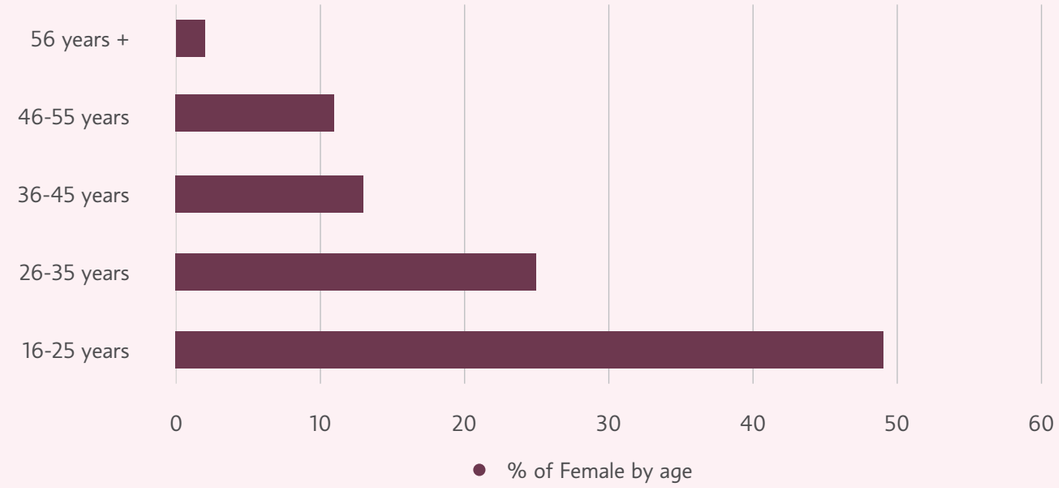
Pathways into and experience of homelessness may look different for women. They are more likely to have experienced domestic violence, abuse and trauma (Phipps et al., 2019). This includes high rates of childhood sexual abuse (Weinrich et al., 2016) and adult sexual and physical abuse (Hudson et al., 2010). omen experiencing homelessness have worse mental health than men experiencing homelessness and are more likely to have mental health diagnoses (Cherner et al., 2018). Women experiencing homelessness are more likely to have exhausted informal supports before accessing support services and therefore may be more vulnerable when they eventually get there (Bretherton, 2017).

Women experiencing homelessness are also more likely to have had children taken away and living separately from them. Having children taken away is a source of distress for mothers experiencing homelessness, this can impact upon their identity and mental health (Mayock et al., 2015). Although this is not an exclusively female experience, it is more common among women experiencing homelessness.

Chronic homelessness among women has been growing in NI and services such as the Belfast Inclusion Health Service and Extern have reported higher numbers of women attending in recent years (Boyle, 2021).

Simon Community have also noted a growing number of women using their services. During 2020-2021, 301 females were supported in Simon Community NI accommodation projects. 48% of were under 25 years of age.

**Breakdown of Age for Female Clients**




**204** women presented to Simon Community NI with complex needs equating to 68% of the female population in accommodation services.

- **82%** with a mental health issue, of those, 80% had a condition or illness likely to last more than 12 months.
- **51%** presented with a drug issue.
- **49%** with an alcohol issue
- **24%** with issues pertaining to their physical wellbeing (for example mobility issues, COVID, serious illness)

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## Understanding Health and Homelessness

People who are experiencing homelessness are more likely to have physical and mental health needs (Rogans-Watson et al., 2020), they are also at higher risk for addiction or substance misuse (Yoo et al., 2022). Sadly, they are also more likely to die younger (Ivers et al., 2019), and are more likely to have experienced trauma within their lives (Robinson, 2023).

For women who are experiencing homelessness, these difficulties are more extreme (Aldridge et al., 2018). They are more likely to have diagnosed mental health issues, suicidal thoughts and childhood trauma than men experiencing homelessness (Milaney et al., 2020).

> *"The availability of good medical care tends to vary with the need for it in the population served."*
>
> **Tudor Hart,** 1971

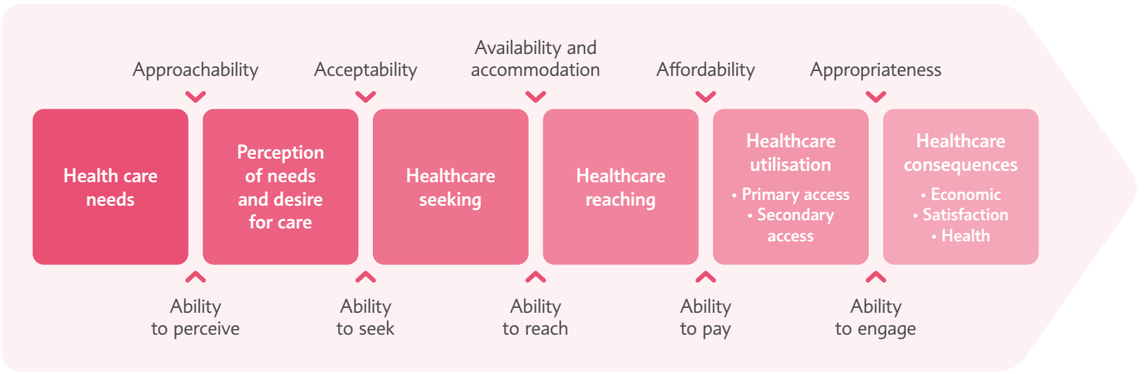
## Understanding Access to Healthcare

The 'Inverse Care Law' tells us that people who need health care most are more likely to struggle with accessing health services (Tudor Hart, 1971). This same link between increased health needs and difficulty in accessing services was shown again in recent research from Canada and Australia (Haggerty et al., 2020).

This link between health need and accessibility deeply affects people experiencing homelessness. We know that health needs are multiple and complex and difficulty with access is also shown to be greater for people experiencing homelessness (McNeill et al., 2022). This includes difficulty in registering with general practitioner services and high attendance at Emergency Departments (ED) (Ingram et al., 2023, Ni Cheallaigh et al., 2017).

Understanding what 'access to health services' means is complex. To help us, we used a framework- the Levesque Access Framework. This shows us how healthcare access is a two-sided relationship, with both service user and service provider (Figure 1). Using this framework encouraged us to look at how access can be impacted both by service users and the service providers.

**Figure 1 – Part of Levesque's Access Framework (Levesque et al., 2013)**




If we think about this framework, we learn that improving access to healthcare for women experiencing homelessness in NI requires us to look at all sides and aspects of access, not just changing how services are delivered. This framework was used to design interview questions to ensure all aspects of access were considered in the data.

# Research Aims and Question

The main aim of the study was to provide suggestions that could improve access to healthcare for women experiencing homelessness in NI. Improving access to services could lead to better health outcomes and potentially reduce length of time experiencing homelessness.

## Our research question was:

**'What is the nature of access to healthcare for women experiencing homelessness in Northern Ireland and how can it be improved?'**

## Our objectives were:

1. Gain an in-depth understanding of how women experiencing homelessness in NI access and use healthcare;
2. Identify demand and supply barriers to women experiencing homelessness in NI accessing healthcare;
3. Investigate how the experience of women experiencing homelessness in NI contributes to improved service planning; and
4. Identify ways of improving access and provision of healthcare for women experiencing homelessness in NI.

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# Voices of women experiencing homelessness and service providers

**To understand the experience of healthcare access for women experiencing homelessness, we chose to focus on women living in single adult hostels. We spoke to both women experiencing homelessness and the staff who support them.**

## Who did we speak to?

We interviewed 10 women experiencing homelessness living across Northern Ireland.

These women were all living in single adult Simon Community NI hostels. They were recruited from hostels in Belfast (6) Coleraine (2), Lisburn (1) and Armagh (1), and their ages ranged from 19 to 38. Sixty percent of participants had experience living in other temporary accommodation before their current hostel, four mentioned sleeping on sofas at homes of family or friends and one had experience of sleeping on the street. Five participants described experiencing abuse and five had diagnosed addiction support needs. Two participants had experience of being in the care system and three participants had children in care.

We spoke to three healthcare professionals.

To keep their identity protected, the exact details of profession and location will not be shared. Our healthcare professionals were a dentist and two nurses, based in Belfast, Derry/Londonderry, and NI Prison Service. Their time in role varied from two years to over 20 years with a range of experience in relation to women experiencing homelessness.

We interviewed six Simon Community NI hostel managers.

They represented hostels in each health and social care trust, each with more than 10 years of experience working with people experiencing homelessness.

All service managers and healthcare staff participants were female. This was not aimed for during sampling and recruitment, but these sectors are known to have larger numbers of women represented in the workforce, with a recent NI report showing 68% of the homelessness sector workforce is female (Orr and O'Hara, 2022). While NHS England statistics suggest that 76.7% of their 1.3 million NHS employees are women (NHS, 2021).

# Input from further stakeholders

Two workshops were hosted following the interviews to provide input from further stakeholders. The first workshop was hosted in Queen's University Belfast and invited participants who were involved in developing or undertaking policy and healthcare education. The second workshop was hosted in the University of Limerick and involved practitioners from across the Republic of Ireland (ROI). Results from the interviews were presented at these workshops, followed by opportunities to respond and comment on issues, solutions and actions that were raised in interviews. Data was recorded through participants written comments and field notes taken by researchers during discussion. The second workshop also made use of the online tool 'Mentimeter' to record comments.

# Results

**Data was analysed using reflexive thematic analysis (RTA) (Braun and Clarke, 2022). The following results section will present six topics that we heard about from the voices of women experiencing homelessness and staff who support them.**

## 1.0 Complex needs and Trauma

Women experiencing homelessness often have complex health and social care needs. This includes both physical and mental health needs, as well as experiences and impacts of trauma. Trauma can include abuse, the trauma of homelessness or the trauma of having children taken away. They may also struggle with drug or alcohol addiction and could have other additional needs such as learning disabilities.

The physical health of women experiencing homelessness is poor and there may be physical symptoms that have not been assessed or diagnosed.

*Um, well I've got asthma. I have BPD [borderline personality disorder] and depression and anxiety. Probably have diabetes too.*
**(Woman experiencing homelessness 6)**

*just recently diagnosed with paranoid schizophrenic and psychotic and depression and anxiety.*
**(Woman experiencing homelessness 9)**

Women experiencing homelessness often have higher mental health needs that may outweigh physical health concerns. Some participants described the negative impact that the experience of homelessness and living in a hostel had on their mental health.

*if you don't have mental health problems and all going into hostels, you will have them when you come out of them… Just because of all the things that you're denied, there's no security, no stability. There's nothing like that, and so it does affect people's mental health.*
**(Woman experiencing homelessness 3)**

*It seems, their physical health… their trauma and their mental health sometimes nearly supersedes that, you know.* **(Hostel Staff 1)**

Both women experiencing homelessness and staff told us about the high prevalence of trauma for this population. Examples of trauma included abuse and having children removed, as well as the experience of homelessness.

*I was living with this dickhead. Sorry for my cursing. But eh, he assaulted me and stuff, so he did.*
**(Woman experiencing homelessness 8)**

*So I came from an abusive relationship, and was made homeless from it.* **(Woman experiencing homelessness 4)**

*They've the trauma of maybe having children removed and then having to revisit that trauma if they have a subsequent pregnancy and the child's taken into care again. So you have all that undealt with trauma that they're dealing with.* **(Hostel Staff 1)**

The experience of homelessness and constantly moving from place to place could also be described as trauma (Robinson, 2023). Homelessness may mean that women are moving to new areas regularly, meaning they don't know about services in the area and are always meeting new healthcare staff. Moving around also makes it difficult for new healthcare staff to get medical notes, or for women to receive appointment letters to the correct address.

*Being somewhere you don't know as well…Not knowing where you are, or where to go, or what, where's the best place to go or, you've no idea.*
**(Woman experiencing homelessness 9)**

*Depending on where the client's been before and have they moved GPs or do you know, if they've moved round loads of different GPs trying to, that trail to be followed up. 'Cause they'll want the last known GP and stuff like that, it can be a nightmare actually, at times.*
**(Hostel Staff 5)**

### How does trauma affect women experiencing homelessness?

Trauma can make things even harder for women experiencing homelessness. The impacts of trauma are complex and can be difficult to identify. Impacts of trauma can be split into four types:

1. **Physical (how we feel physically),**
2. **Emotional (how we feel emotionally),**
3. **Cognitive (how we think) and,**
4. **Behavioural (what we do).**

Women experiencing homelessness and staff described various examples of these impacts.

#### *Physical Impacts*

As already described, women experiencing homelessness are likely to have poor physical health. Therefore, it may be difficult to figure out if their physical health is linked to or caused by trauma. Alongside chronic physical health conditions, other physical impacts could include sleep disturbances, flashbacks or hallucinations.

One woman told us that she struggled with sleep and sometimes needed medication from her doctor.

*I've only ever asked him for sleepers like twice because I will not ask for them, unless I genuinely need them.*
**(Woman experiencing homelessness 3)**

Staff told us about the possibility that people may be hearing voices, which could be an example of flashbacks or hallucination. This may lead to the woman reacting in an angry manner because of what she may be hearing or seeing. Staff told us that this may lead to the women not receiving care and being asked to leave.

*they may be hearing something different, they may be hearing voices and they might be feeling under threat. So then they act out, they may become aggressive and abusive when they don't mean to, and then they're asked to leave.* **(Health care staff 3)**

The physical impacts of trauma may be difficult to identify for this population, as they may already have physical health needs. The complex links between homelessness, trauma and health needs make it difficult to know the source of need, but we do know that women experiencing homelessness are more likely to have experienced trauma and have greater health needs.

#### *Emotional Impacts*

Emotional impacts of trauma can create feelings of anger, fear, sadness or shame. People may have difficulty identifying or managing their emotions or they may react by numbing their feeling.

Some women experiencing homelessness told us about how their fear limited where they could go.

*I hardly go out that door, so I don't…Just basically, family reasons, just sends my anxiety through the roof. And that's why I don't go down the town.*
**(Woman experiencing homelessness 10)**

Staff gave other examples of how women may be fearful and under threat.

*They might be fearful from threats. They might have made decisions that they wouldn't normally make, to survive. So they might have, they're very vulnerable and can be used, I don't know how to say this, they can get involved in a sexual relationship for the wrong reasons. Maybe that be a roof over their head or money to provide food or something like that there.* **(Healthcare Staff 3)**

Staff also told us about how some women may be afraid of how healthcare staff could reduce their access to their children.

*If a young female has children who, that are maybe with family or in care, they feel sometimes if they go to the doctor and say how are they feeling, you know, that can be used against them.* **(Hostel Staff 4)**

For some, this could be linked to shame they might feel around treatment for health needs such as Hepatitis C, and fear of how this could be perceived by staff.

*But you know, she was telling me about, you know, she didn't come here to collect, she's a hep C treatment, she didn't come to collect her treatment that morning because she said [name], they'd be asking you where you were and didn't wanna say I was coming here, getting treatment.* **(Healthcare Staff 2)**

For some women, shame was part of why they chose not to access domestic abuse shelters. As they did not want others to see them and know about their experience.

*But you don't wanna be seen living, coming out of Women's Aid, people's gonna know you've been battered or something. And I just don't like that feeling.*
**(Woman experiencing homelessness 7)**

The emotional impacts of trauma are wider than those examples provided here. And the findings may be limited due to difficulty identifying emotions. Some women experiencing homelessness may struggle to describe exactly how they are feeling, or they may be numbing how they are feeling, which may not be described in interviews.

### *Cognitive Impacts*

Cognitive impacts are the impacts to how people think. This may be how they think about themselves, how they think about others, how they think about the future or how safe they feel their environment is.

Some women told us that they had low self-esteem and feelings of worthlessness, and that they felt their health didn't matter, or that they didn't want to waste other peoples' time.

*there's an aspect of me that be's like well what, does it really matter, like? Trying, maybe links back to low self-esteem where I'm just kinda like is there any point in doing it?* **(Woman experiencing homelessness 6)**

*I don't know, I think I just end up getting frustrated at myself and then being like I'm wasting these people's times, doing this to myself and stuff like that like…Just don't wanna stay.* **(Woman experiencing homelessness 6)**

*It was just, like it was horrible to feel like no one cared about me and like no one noticed. Like, you know, like I was just not there, like I just didn't matter to anyone. Like it, it felt like I was a burden more than I was like, a person* **(Woman experiencing homelessness 5)**

The women experiencing homelessness we spoke to told us about the difficulty they found with trusting other people, this was both within friendships and with health and support staff.

Some talked about the importance of having trusted peers and friendships within hostels. However, these friendships could leave women feeling devastated and let down if their friends struggled with addictions or other vulnerabilities.

*The night she got kicked out she kept begging me for drink…And it, it threw me off the- like it really did throw me off everything like I was so devastated that I thought someone that was my friend in here and then they just ended up being like, the same as everyone else.*
**(Woman experiencing homelessness 5)**

One woman we spoke to told us about the perspectives of people around her. She told us about people who couldn't see a future beyond the hostel.

*I feel like being here, it's all about your perspective, like, the people that are doing good here are the ones that don't spend a lot of time here, they get out they do things. They're, this is a steppingstone to them. The ones that aren't doing so well are the ones that can't see beyond here, they don't see a future.*
**(Woman experiencing homelessness 2)**

The cognitive impacts of trauma mainly affect how someone might view themselves and how they might feel about how safe the world around them is. Their experiences may lead to them feeling a sense of worthlessness and they may not easily trust others or feel safe in new environments. Experience of trauma can also heighten feelings of judgement (Alunni-Menichini et al., 2020). Therefore, staff must be aware that women experiencing homelessness may expect judgement and will have to ensure that they create a non-judgemental and safe environment.

### *Behavioural Impacts*

Trauma will likely cause women to seek coping strategies that may be beneficial or add to their vulnerability. This may be to help forget painful and unwanted memories or emotions. During our interviews, we heard about some high-risk and self-destructive behaviours, which add to the vulnerability of women experiencing homelessness.

For example, women experiencing homelessness told us about engagement in substance misuse.

*I used to take a load of tablets, I don't do that anymore. I only smoke grass and drink, that's it. But, well I've took coke before like.* **(Woman experiencing homelessness 7)**

Both healthcare and hostel staff also told us about substance use and addictions becoming the main priority for some women, meaning that accessing healthcare gets pushed down the priority list.

*Mental health is a big issue for our females, there's addiction, whether it be through prescription medication or alcohol and or both. Do you know what I mean? There could be illegal drugs as well.* **(Hostel Staff 1)**

*And then I do think then there is that bit that they've other competing priorities. You know, if you're addicted, your competing priority is not your health and not your appointment, but it's where you get your next drugs that you're seeking.* **(Healthcare Staff 2)**

Substance misuse is not exclusively linked with homelessness, but it is a struggle for some people experiencing homelessness. It is likely linked to coping with trauma and increases vulnerability.

Staff also told us about the exceptionally vulnerable state of women experiencing homelessness. They told us that women may sometimes get involved in sex-work or may be exploited in relationships.

*We certainly have saw huge increase in our women who are injecting drugs. And also, women who would sex work, now they'll not admit to that. But we know from anecdotal evidence that they with sex work to get money to feed their drug habit.* **(Healthcare Staff 2)**

*There is definitely a shortage in like specific women-only hostels…their partnerships and relationships are not always conducive to good health, and they can become quite vulnerable.* **(Healthcare Staff 2)**

Another coping strategy for trauma could be avoiding certain people, places or situations. This means that women may avoid experiences that may trigger unwanted memories or emotions.

For some women, this may mean they can struggle to acknowledge things that have happened to them. Staff told us about women who couldn't recognise sexual assault, this could be an example of trauma where the coping strategy is to avoid talking about or acknowledging the severity of their experience.

*There's women who don't even realise they're being sexually abused. They don't realise that that has happened, that it was sexual assault, and they tell you something so flippantly.* **(Hostel Staff 1)**

Another example could be avoiding finding out about health needs. A staff member told us about a woman who was 'blasé' about getting a breast lump checked. This could be a self-protection strategy to help avoid unwanted experiences or emotions.

*Like, we'd an older woman here, who had a lump in her breast and was red flagged. That had been missed because she was transient, ended up here, came in and she was so blasé about it, but, you know.* **(Hostel Staff 1)**

The real-life consequences of trauma for this already vulnerable group are complex and interconnected. Their experience of trauma causes physical, emotional, cognitive and behavioural impacts that affect their ability to engage with health services.

# 2.0 Support from friends, family and staff

## Lacking support from friends and family

We found that women may also have limited support from friends and family. For many of the women we spoke to, this was because of conflict or relationship breakdown.

*I don't speak to any of my family.* **(Woman experiencing homelessness 3)**

*Sofa surfed between two friends and then basically we sort of fell out and that's when I came here.*
**(Woman experiencing homelessness 10)**

*I lived with my mom and dad up until I was about 15/16 and then my mum kicked me out. Em, like at the very start of the pandemic we just, we were all trapped in the house together and wasn't allowed like to leave. And it created a lot of tension and she ended up cussing me out and then kicking me and my dad out of the house.* **( Woman experiencing homelessness 5)**

The women we spoke to told us that not having friends and family to help them left them feeling alone and unsupported when using health services. One woman described an experience of attending an Emergency Department and then having to go home in the dirty clothes she arrived in because she didn't have anyone to call to bring her fresh clothing.

*I didn't have even someone else to bring me clothes to the hospital. So I was like, I was with the same clothes that I had, like vomiting blood. And I was like, ok, now I need to take a shower. But I didn't, I didn't have clothes to change*
**(Woman experiencing homelessness 1)**

## Relationships with support staff

Women told us that the positive relationships they had with staff were really important to them.

Women experiencing homelessness told us they felt they could trust their support staff and go to them if they needed help. They told us that they felt like staff knew them really well and felt able to go to appointments when staff came with them. These staff included hostel support staff and individual community nurses who took time to offer healthcare support.

*I can always say to [support worker] if I can't get enough help.* **(Woman experiencing homelessness 7)**

*They know more about what I want to talk about because they know me better than I even know myself.*
**(Woman experiencing homelessness 7)**

*There's one in there, fuck yeah, she's brilliant. She'll go, she'll go to all my appointments with me, so she would. Because I would always phone her and ask her would she go…Just can't face them on my own.*
**(Woman experiencing homelessness 9)**

Hostel staff also told us about advocating for women experiencing homelessness outside of appointments. Staff felt this advocacy was an important part of their role.

*I've had to attend a couple of meetings within the practice over the years to, you know, to fight our case basically and say like these people are as much deserving as anybody else that's coming in as a new client or a new patient or whatever, and deserve every, you know, every bit of respect like.* **(Hostel Staff 2)**

The women experiencing homelessness also told us about the importance of trust and support from healthcare staff, such as GPs. Some women we spoke to said they would feel more confident in female healthcare staff.

*I don't know he's just, he listens to me. Any other doctor just be's like oh, she's just another junkie looking this or that. No he actually listens to me. But he also takes no bullshit as well. And if I'm being unreasonable in what I'm asking or what I'm saying he'll tell me. He'll be like well, no, I can't do this but we can meet in the middle we can do this [name]. So that's, he's just, I just think he's 100%.*
**(Woman experiencing homelessness 3)**

*I saw a lady doctor and she was the sweetest and most loveliest doctor ever…I think from a woman as well. I'm not saying the men are bad, but I think with more women's issues like, period and like weight…But like, I think you need to have that confidence with the person, and like especially with a woman as well*
**(Woman experiencing homelessness 5)**

Women experiencing homelessness are likely to have limited social support, as research tells they are likely to have used all available informal supports before coming hostel settings (Bretherton, 2017). This means that the relationships with staff may be even more important. Positive and trusting relationships with hostel and healthcare staff are facilitators for access to healthcare. These trusting relationships can be nurtured through seeing the same doctor each time you visit a GP, staff listening and offering longer appointments. These are examples of trauma-informed approaches to healthcare provision.

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# 3.0 Simple, flexible service design

Women experiencing homelessness told us about their difficulties in navigating services. Hostel and healthcare staff agreed with this.

Some examples of barriers to access within service design were location of services, long wait times, appointment mechanisms and rigid thresholds.

The experience of homelessness creates a transient lifestyle, where women may have to move regularly. Therefore, location of services can become a barrier. One woman had been told she might have diabetes but chose not to go to her GP because it was far away. Other women talked about difficulties getting medication.

*Won't go to a doctor, because it's really far away and it's a hassle to phone up and stuff. I just haven't got round to doing it…With the lack of family support, it would be pretty hard like…It'd be 2 buses really.*
**(Woman experiencing homelessness 6)**

*Yeah, and like my doctors is over in north. Em, and there's not really any chemists that, round here that would go and get them. One, because it's too far, it's out of their area, and two, because it's a controlled substance…And I couldn't be walking to, travelling to North to get my meds.*
**(Woman experiencing homelessness 3)**

The process to get an appointment was criticised, both due to the phone system to initially get an appointment, and then the wait times that followed to actually see the doctor. For some, wait times in Emergency Departments were too long to wait to be seen.

*Every time I rang up the doctors, you must have to ring about 14, 15 times to get through. And then whenever you get through, they're telling you have to wait 2 or 3 weeks for an appointment.* **(Woman experiencing homelessness 8)**

*Not everyone's gonna want to go sit in A&E for 12 hours just to get a mental health assessment done.*
**(Woman experiencing homelessness 3)**

Women experiencing homelessness also told us they were discouraged by the complex system that followed, and felt like there were too many steps in the process before receiving help.

*It's just you need to wait on this and then you'll need to wait another two weeks… It, it creates this like, I don't know it, it creates confusion and it, it, it just seems like it's been pushed off and pushed off and pushed off and nothing really done about the actual issue.*
**(Woman experiencing homelessness 5)**

Women also told us that they sometimes felt there were too many professionals involved. This made them feel like they wanted to disengage with services.

*I feel like sometimes you can overwhelm yourself with too many professionals and you kinda want to disengage.*
**(Woman experiencing homelessness 2)**

Issues around thresholds included issues with accessing addiction services. Hostel staff told us that for women to access addiction services they had to prove they had used certain substances.

*Even accessing alcohol programs and addiction programs are quite difficult… even for our opiate users… you wanna be clean but if you wanna get on the program, you have to have used… they have to test you to have used opiates and then you only get on the program then.* **(Hostel Staff 6)**

Another threshold issue is the difference in thresholds between prison and community health services.This sometimes meant that women would receive some support in prison but this support would not continue once they left prison.

*We may have someone who has come and they met the threshold to be supported within our team… But then as they leave, their need is not considered great enough to meet the threshold of the mental health community providers, and so the person's care just stops.*
**(Healthcare Staff)**

Tailoring services to suit the needs of women experiencing homelessness was also described as a facilitator for access, where services could be trauma and gender informed and provide a safe option for women to use.

*You know maybe they need to be bespoke services for women where you can have gender specific support and gender specific training, and you can identify the issues that they have and kind of work it and tailor it to woman services…Because women, seldom do have very safe options* **(Hostel Staff 1)**

*They understand the homeless population, they understand clients, they take it at the client's pace. They're fantastic actually, I couldn't fault the hub at all.*
**(Hostel Staff 5)**

Part of tailoring services is providing services that come to hostels to deliver healthcare where women are, rather than asking them to seek it out. One woman told us this made access easier for her because she could seek healthcare privately without people knowing she was going somewhere.

*It makes it easier, yeah, because you're not having to go to the place, and people know what you're going there for.* **(Woman experiencing homelessness 9)**

Increasing flexibility and simplicity of systems could improve access for women experiencing homelessness, this could be implemented both in tailored services and within specific services, where possible.

## 'The Hub'

The Belfast Inclusion Health Service, sometimes known locally as 'the hub', is a Nurse-led multi-disciplinary team that offers a drop-in service for healthcare advice, support and treatment options for people experiencing homelessness. Their services include;

- GP Registration / Appointments
- BBV testing, referral and treatment
- Vaccinations
- Mental Health Issues including addiction support
- Social Work Services including housing / benefits support
- Needle Exchange Service
- Naloxone supply and education
- Other health care needs

## 4.0 Coordination within and across Healthcare Services

Both hostel and healthcare staff told criticised the lack of connect between health services and across systems.

One healthcare staff member told us that she felt services were designed in silo, meaning that they are all designed separately, without thinking about each other.

*I think services are designed in a silo they're designed, not thinking how do they connect and what are the needs of the service user. And so if you are a service user trying to cross lots of paths with very little resource, nigh impossible* **(Healthcare Staff 1)**

Coordination issues include pathways between services and across Health Trusts. Staff told us that there are no clear pathways for women when they move Health Trust or are discharged from an institution such as hospital or prison. Record sharing is difficult during these times of transition because records are kept on different systems.

*I think we probably will have to look at maybe hospital admissions and probably good, planned discharge from hospital as well because, does the hospital services really understand homeless services and, you know, what homelessness services look like?* **(Healthcare Staff 1)**

*Because you know mental health records and substance addictions records are not known. You know you cannot access those on a regional basis. They're all kept separately. Trusts use different records.* **(Healthcare Staff 1)**

Dual diagnosis is an example of when disconnect in design impacts negatively on the service user. This is when someone may require both addiction services and mental health input but cannot access each service until the other issue is resolved.

*because if you're saying to someone, well, you know I'll, I'll treat you for your mental health, but you need to get some help with your addiction. And they're going, but the only way that I feel I can get out of bed in the morning is if I take that hit or if I take that drink.* **(Hostel Staff 4)**

Staff told us that inclusion health nurses and good working relationships between hostels and local GP surgeries could improve access to healthcare for women experiencing homelessness.

*But I would link in with Belfast. So if I know that the person has moved to Belfast and they have a health need, I contact [staff from Belfast hub] or [staff from Belfast hub] or whoever is there and they will follow them up down there.* **(Healthcare Staff)**

*So some of the GP surgeries are happy to work alongside us with the written documentation that we give, which is really good.* **(Hostel Staff 2)**

Increased coordination and connect between services could improve access to healthcare by creating clear pathways for women experiencing homelessness. People who attended our workshops added that coordination needed to include a unified governmental approach to ensure that holistic care could be delivered on the ground.

## 5.0 Education for Healthcare Staff

Women experiencing homelessness recommended that healthcare staff should be educated to reduce judgement.

*Maybe a wee bit more information on just how to deal with homeless people* **(Woman experiencing homelessness 2)**

*I think they need continuous training, even if it's once a year or once in six months. But like, to remember how to treat the clients, share experiences between them…How to speak with people how like to not discriminate.* **(Woman experiencing homelessness 1)**

As previously mentioned, women experiencing homelessness may often experience judgement and stigma from healthcare staff and the general public. These attitudes could be challenged and improved by educating healthcare staff about homelessness. Women told us about how they felt judged by both the public and more specifically by healthcare staff.

*When people think of the homeless community and think of like health care, they just think, oh, it's just a bunch of junkies on the street looking clean needles. It's not.* **(Woman experiencing homelessness 3)**

*It depends on the person it depends on their like, willingness to see you as a person and not just another person coming in and out like not just a number you know?* **(Woman experiencing homelessness 5)**

*It's like they look down their nose at you, it's the way they word things, their tone. It's almost, and then trying to explain things, it's like they're trying to explain things to a toddler.* **(Woman experiencing homelessness 3)**

During our workshops, stakeholders added to this by suggesting that training and education should take place in undergraduate, postgraduate and professional education for healthcare staff and for hostel staff. It was suggested that this education could reduce stigma and improve attitudes. Therefore, relationships between healthcare or hostel staff and women experiencing homelessness could be improved.

## 6.0 Involve People with Lived Experience of Homelessness

Involving people with lived experience of homelessness in service design and delivery was mentioned both in interviews and highlighted more explicitly as a priority during the workshops.

*I think as we design new services that we really need to firstly have lived experiences involved in the design of services but also understanding the impact beyond how many people we treat and how many whatever.* **(Healthcare Staff 1)**

Hostel staff, healthcare staff and additional stakeholders from the workshops also described the benefit of involving people with lived experience of homelessness in service delivery. This included peer support roles to answer questions or to accompany women experiencing homelessness to appointments.

*I really do think it's about navigation and it's the peer mentors and it's supporting people and that could be through health care providers or charities or whoever runs the thing but, who have a specific role as advocates to support people to enable them to, to make appointments and to attend appointments and to support them in the follow up or whatever is needed.* **(Healthcare Staff 1)**

Discussion from the workshops followed on from this idea and stakeholders said that providing peer support could lead to a more educated and sensitive approach to providing healthcare for women experiencing homelessness. Workshop participants also suggested having peer advocates at forums to be the voice of women experiencing homelessness during decision making processes.

# Discussion

**This research highlighted barriers and facilitators for women experiencing homelessness when trying to access healthcare. Much of this is linked to experience of trauma and suggestions linked to trauma-informed practice. Most of the following discussion will focus on facilitators for improving access.**

## Barriers

The barriers mentioned throughout this report are varied and can be linked to both service provision and service user abilities, as described in Levesque's Access Framework on page 3 (Levesque et al., 2013).

Barriers that are linked to service provision include the complexity of systems, disconnect across services and between services and users, stigma from staff, lengthy wait times and appropriate services and professionals being located distantly from those who need them (Schmidt et al., 2023).

The ability to perceive health needs or engage with health services may be hindered by complex needs and experiences that impact upon priorities (Kennedy et al., 2014), self-worth, empowerment and feeling safe (Allen and Vottero, 2020, Rizzo et al., 2022). Some of these may be linked to trauma responses (Milaney et al., 2020, Rodriguez-Moreno et al., 2021, Torchalla et al., 2014). Transience may also limit awareness of available services or ability to get to services.

## Facilitators

The findings from this research include the close links between trauma and homelessness. This link has been previously examined (Robinson, 2023, Tsai et al., 2020), and trauma informed care has been recommended for use with PEH in other settings (Kohler et al., 2021, Guarino, 2014). While speaking to women experiencing homelessness and the staff who support them, suggestions often included the principles of trauma-informed practice. These are; safety, trust, choice, collaboration, empowerment and cultural consideration (NHS, 2022). Therefore, many of the suggestions to improve access to healthcare for women experiencing homelessness are similar to trauma-informed practice, and so this theory could be a useful approach to apply in settings where women experiencing homelessness are accessing health services.

Suggestions for improving access are summarised in five themes that are contained within the acronym INvEST. The principles are Invest, Network, Educate, Support and Tailor. These findings are supported by other global literature, which provides solid justification for the implementation of the five INvEST principles to improve access to healthcare for WEH in NI. The following discussion will consider this literature, followed by specific recommendations for Northern Ireland.

## Prioritise involvement

Involving people with lived experience of homelessness to remove barriers and increase access to services was noted as a key priority in a UK-wide review (Luchenski et al., 2018). Co-design and co-delivery of services is also recommended in the National Institute for Health and Care Excellence (NICE) guidelines for all populations. Peer support is also more specifically mentioned in the NICE guidelines on integrated health and social care for people experiencing homelessness (NICE, 2022). This involvement of people with lived experience of homelessness is also part of Trauma-Informed Practice principle of 'collaboration' (NHS, 2022). Peer support can improve substance use outcomes, housing outcomes and quality of life (Barker and Maguire, 2017), as it provides non-judgemental support from someone with shared experience (Parr, 2023).

## Improve connectedness

Addressing homelessness requires input from multiple sectors and therefore requires a coordinated response (Lee and Ferguson, 2019). Connectedness between services starts with shared agendas from government level and agreed action plans to ensure pathways are clear and defined. The connectedness and communication at a grassroots level can improve access, where GPs and hostels work together to facilitate GP registration and sharing of information. One example in practice of increased communication between services is the 'Complex Lives' model, which is based on the Doncaster model (Team Doncaster, 2017). This model is being developed by Belfast City Council and the NI Homelessness Strategy for 2022-2027 plans to evaluate and extend the complex lives model in NI (NIHE, 2022). Further work could include evaluating this model in a NI context.

## Provide education

Education could improve awareness of services, both for staff who can signpost and help women experiencing homelessness navigate the system, and for women experiencing homelessness if moving to a new area (Paisi et al., 2019). Education for staff can also reduce stigma and increase awareness of the needs of women experiencing homelessness (O'Carroll and O'Reilly, 2019, Luchenski et al., 2018). This has been recommended for both undergraduate (Sharman et al., 2021, Reeve et al., 2017) and specific training for professional or frontline staff (Gunner et al., 2019). Education for women experiencing homelessness may be more nuanced and empowerment based (Paisi et al., 2020), with the focus of removing fear, following the principles of TIP (Kohler et al., 2021).

## Offer holistic support

Supporting women experiencing homelessness by treating them holistically and addressing basic needs such as safety, shelter and sustenance before considering health will improve the effectiveness of access to healthcare services (Weber, 2019, Armstrong et al., 2021). Models like 'Housing First' address shelter before other needs and have been found to improve housing outcomes (Greenwood et al., 2020, Baxter et al., 2019). Support also includes nurturing trusting relationships between WEH and both hostel and healthcare staff (Armstrong et al., 2021). Trust is included as a principle of trauma-informed practice and these positive relationships are foundational to good quality care (Asmoredjo et al., 2016).

## Ensure flexibility

There are various ways to tailor services to suit the needs of women experiencing homelessness, and various approaches that can be taken. Providing targeted, tailored services is recommended in other literature for both hospital (Gallaher et al., 2020, Hewett et al., 2016), and community settings (Ungpakorn and Rae, 2020). Increasing flexibility within systems (Andermann et al., 2020), providing outreach services (Armstrong et al., 2021, Johnson et al., 2023) and co-located services (McGuire et al., 2009) are all examples of tailoring services that can improve access to healthcare for women experiencing homelessness. Service provision approaches may also be tailored, for example, services targeted to women have shown reductions in psychological distress, health-care use, and drug and alcohol use, and improvements in self-esteem (Speirs et al., 2013).

# INvEST

## A recommended model for practice

**The ways to improve access that have been identified through this work are captured within the acronym INvEST. The five principles to improve access are INVolve, Network, Educate, Support and Tailor. These principles could be used to guide actions across Northern Ireland, depending on the specific needs within the area.**

### 1.0 Involve

Involving people with lived experience of homelessness is the key principle for improving access to healthcare for women experiencing homelessness in NI. This involvement should take place on several levels. People with lived experience of homelessness should be involved in service planning, commissioning, delivery and evaluation. Efforts should be made that this is meaningful involvement rather than tokenistic. Examples include involving people with lived experience of homelessness at decision making levels, as well as being involved in peer/buddy support.

### 2.0 Network

Improving coordination and connectedness within health and social care services and across health and hostel settings will improve access to healthcare. Improving communication within health and social care settings via models such as the 'Complex Lives' model, which brings together multi-disciplinary teams to discuss and resolve single cases from a holistic perspective. It could also include data sharing systems such as the PASS system in ROI (DRHE, 2023). This is a shared database that contains information on every homeless hostel bed space used, meaning that services can access notes and information about individuals as needed so that care is connected and not unnecessarily replicated and people experiencing homelessness are not required to tell their story regularly and risk re-traumatisation. Also included within 'Network' is the need for clearer, defined pathways and handovers between institutions and the homeless sector, this could include discharge from hospital, release from prison or leaving the care system. Coordination issues also span upstream to governmental strategic level, where interdepartmental agendas and shared action plans can facilitate holistic downstream working.

### 3.0 Educate

Education for both homeless and healthcare sectors could improve access to healthcare for women experiencing homelessness in NI. This could include introducing the complexities and issues of homelessness and health into education at undergraduate and postgraduate level as well as during continuing professional development. Education could also include raising awareness about available services, perhaps including an online or physical service map that displays available services, made available for both staff and women experiencing homelessness. Education should also be provided for administrative staff on specific issues such as registering patients with a GP without ID address. The aim would be that this education for hostel and healthcare staff would reduce stigma.

Women experiencing homelessness should have information that enable and empowers them. This could include access to a resource showing available services and perhaps also providing induction visits to health services such as local pharmacies or GP when first moving to a new area. Peer/buddy systems may also facilitate opportunities for learning as they can ask questions of someone who already has experience of the systems.

### 4.0 Support

Support should be trauma-informed. It should include addressing basic needs such as shelter, food and safety before addressing health concerns. This could include the use of 'Housing First' models that prioritise shelter before addressing further needs. Important support for women experiencing homelessness comes from relationships with both hostel and healthcare staff. Hostel staff can support women experiencing homelessness by encouraging and providing reminders or company for appointments, although staff shortages can make this more challenging for hostel staff. Hostel and healthcare staff should advocate for the rights and health needs of women experiencing homelessness and trusting relationships should be nurtured, perhaps through consistency of contact with the same person and through longer appointment times.

### 5.0 Tailor

Services and systems should be tailored so that they are more easily accessible to women experiencing homelessness. The key consideration within this principle is to increase flexibility within systems. This includes GP registration, appointment mechanisms, thresholds for services and in funding systems. Providing specific tailored services such as the Belfast Inclusion Health Service allows for services to provide opportunistic and flexible healthcare targeted to the needs of women experiencing homelessness. However, mainstream services could improve access by increasing flexibility and following the trauma-informed principles of safety, trust, choice, collaboration, empowerment and cultural consideration for women experiencing homelessness.

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