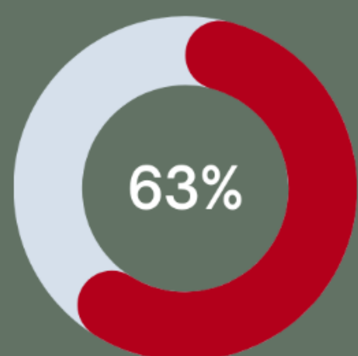
Barriers and facilitators to health care access for women experiencing homelessness in Northern Ireland

Background

People experiencing homelessness have poorer physical and mental health than the general population and tend to struggle more with accessing healthcare, despite their greater need for it (Aldridge et al., 2018, McNeill et al., 2022a).

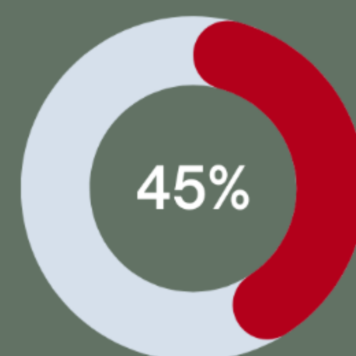
There is a growing number of women experiencing homelessness in Northern Ireland (NI) and greater inequalities in health outcomes.

People Experiencing Homelessness: Long-term illness, disability or infirmity

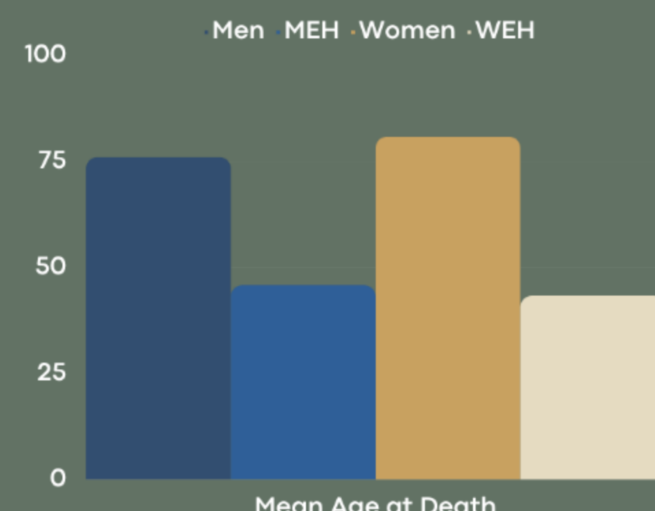


Compared to 22% in general population

People Experiencing Homelessness: Mental Health Diagnosis



Compared to 25% in general population



Northern Ireland

Deprivation in NI is noticeably worse than in other parts of the UK, with 37% of the population living in the lowest 20% of deprivation (Abel et al., 2016). It is well documented that deprivation leads to poorer health outcomes, with the example of mental health and suicide being noticeably disproportionate in NI as compared to the rest of the UK. One out of five adults in Northern Ireland have a mental health problem at any one time (Betts and Thompson, 2017).

Within the UK, suicide rates are highest in Northern Ireland (14.3 per 100,000), followed by Scotland (14 per 100,000) and then England and Wales (10.5 per 100,000) (NISRA, 2022). These high rates of suicide and poor mental health have been linked with exposure to the conflict (O'Neill and O'Connor, 2020, O'Reilly and Stevenson, 2003), showing the critical impact that the conflict has had directly on health.

The nature of the violence during the Troubles mostly involved paramilitary groups, and despite an agreed ceasefire in 1994, resulted in a death toll of around 3600 people between 1969 and 2000 (Tonge, 2002). For some people in NI, conflict continues to infringe upon their daily lives, and for society as a whole, the instability, intergenerational trauma, and post-conflict consequences impact upon deprivation and welfare for the general population (McNeill et al., 2022b).

Research Question

What is the nature of accses to healthcare for women experiencing homelessness in Nothern Ireland and how can it be improved?

Findings

There are both supply and demand side barriers for access to healthcare for WEH in NI, i.e. both the service provision and the service user abilities impact upon access.

WEH are vulnerable and experience a variety of complex health and social care needs. Their awareness of these needs may be limited as well as their knowledge of services available to them. All service design and delivery should include people with lived experience (PLE) of homelessness, to ensure that they are appropriate and effective. The approach to homelessness must be unified from government level to individual service level, with a holistic understanding that health is one part of this picture. Hostel and healthcare staff and commissioners should be educated to understand the vulnerability and deprivation of WEH and how to design simple and flexible services that are sensitive to their complex needs. Relationships between WEH and hostel and healthcare staff should be nurtured, and funding decisions should be made with creativity and understanding of the needs of the population, ensuring that imagination and willingness are harnessed to improve access to healthcare for WEH in NI.

Five principles were constructed containing action points that could be implemented to improve access to healthcare for WEH in NI. These are summarised under the acronym **INvEST.**

Methodology

Semi-structured interviews were conducted with women experiencing homelessness, hostel staff and healthcare staff spanning across Northern Ireland. Following the interviews, two stakeholder workshops were hosted to gather views from stakeholders in practice policy, planning and healthcare education.

Workshops
2
34 Participants

Interviews
19
10 WEH
6 Hostel Staff
3 Healthcare Staff

'We, we aren't just a number... We are people and like, we are human as well... it's nice to get that recognition for it sometimes.'
WEH5

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.
WEH3

I — Involve

Involving PLE in service design, commissioning, delivery and evaluation is a key action in improving access to healthcare for WEH in NI. These voices must be heard at all stages of decision making and implementation, ensuring their presence is not tokenistic. This could be done by including PLE at board level or on steering groups as well as recruiting Expert's by Experience for advocacy and peer support roles.

N — Network

Communication between services can be improved through models such as 'Complex Lives' (Team Doncaster, 2017) and shared information databases, such as the PASS system in Dublin (DRHE, 2023). Continuation and engagement with the interdepartmental homelessness action plans will promote unified approach from the government. Producing a shared agenda, aims and funding may also contribute to the feeling of a shared approach.

v

E — Educate

Education and training could be provided for health and hostel staff on the needs of WEH with the aim of improving understanding and reducing stigma. This training could be implemented at all levels; undergraduate, postgraduate or professional level. Staff should also be educated in available services and pathways so that they can help signpost and navigate systems for WEH.

S — Support

Support can be provided in various areas. The 'Housing First' model is an example of case management that provides support to meet basic shelter needs before addressing health and other social care needs (Greenwood et al., 2020). This model is currently in place in NI but could be rolled out to wider areas. Focus should also be given to dual diagnosis services, so that having multiple needs doesn't exclude WEH from any one service.

T — Tailor

Finally, the principle of tailoring services has multiple action points that are relevant to improve access to healthcare for WEH in NI. This is a practical application of Michael Marmot's proportionate universalism (PU), where services are targeted and tailored to those who need them most (Francis-Oliviero et al., 2020, Marmot, 2010). The key message within the 'Tailor' principle is to increase flexibility in appointment mechanisms, in GP registration, in thresholds and in funding.

Authors Miss Sarah McNeill
Professor Diarmuid O'Donovan
Professor Nigel Hart

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