Homelessness

This chapter should be read in conjunction with the full homelessness health needs assessment for Hampshire.

Summary

The rate of statutory homelessness in Hampshire was 0.81 people per 1000 households in 2011-12, with the highest levels in Gosport, Havant and East Hampshire.

Non statutory homelessness is difficult to measure but can be estimated from Supported Housing panel data. These show the highest numbers of applications amongst people with mental ill health, young people and people living in Fareham and Gosport, Basingstoke and Deane, the New Forest and Winchester.

Gosport has had the highest number of households accepted as homeless and in priority need in Hampshire annually for the last 4 years with a rate of statutory homelessness in 2011-12 of 3.32 per 1000 households, higher than both the South East and England. Most people eligible for assistance in Gosport during this time were households with dependent children. The main reasons included parents or relatives no longer willing or able to accommodate people and a loss of rented or tied accommodation.

Basingstoke and Deane Borough Council has seen a rise in statutory homelessness from 2 to 11 acceptances from 2011-12 to 2012-13.

People who are sleeping, have slept rough and/or are living in hostels and night shelters have significantly higher levels of premature mortality, mental and physical ill health than the general population.

Recommendations

- Strategic and coordinated work on the wider determinants of health including increasing levels of education, training and employment, identifying and working with vulnerable people early.
- Access to flexible primary care (including dental) services, located according to need across the county.
- Improved engagement, early identification and intervention with homeless people.
- Improved access to diagnosis and management of substance misuse and mental ill health, increasing access to support for low level mental health issues and removing barriers.

1. Introduction

People who are sleeping, have slept rough and/or are living in hostels and night shelters have significantly higher levels of premature mortality, mental and physical ill health than the general population. They often present with a "tri morbidity of physical illness, mental health problems and substance misuse", which may be both a cause and consequence of their homelessness[1]. Research into the mortality of single homeless people[2,3] found that the average life expectancy of a homeless person is 47 years for men and 43 years for women. This compares to 78.6 years for men and 82.6 years for women in the England general population[4]. The same report found that drug and alcohol misuse accounted for just over a third of all deaths and homeless people are over 9 times more likely to commit suicide than the general population.

Risk factors for becoming homeless include poverty, unemployment, sexual or physical abuse, family disputes and breakdown, drug and alcohol misuse, school exclusion and poor mental or physical health[5]. There is emerging evidence that psychological disorders strongly predict homelessness, including Personality Disorder, Post Traumatic Stress Disorder, complex trauma and/or conduct disorders in children[6]. Research of 16-17 year olds accepted as homeless found that they were more likely to have been excluded from school, have parents who suffered from mental health problems and experienced sexual abuse[7].

2. Level of need in the population

2.1 Different types of homelessness

Lower tier local authorities have a statutory duty to provide suitable accommodation for people who are eligible for assistance; homeless through no fault of their own and who fall in to a priority need group[8]. Groups in priority need include:

- pregnant women;
- people with dependent children;
- 16-17 year olds;

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[1] Department of Health Office of the Chief Analyst (2010) Healthcare for Single Homeless People. http://www.dhcarenetworks.org.uk/_library/Resources/Housing/Support_materials/Other_reports_and_guidance/Healthcare_for_single_homeless_people.pdf

[2] Connelly, J. & Crown, J (eds) (1994) Report of a working party of the Royal College of Physicians. Homelessness and ill health, Royal College of Physicians: London

[3] Crisis (2011) Homelessness: A silent killer. A report into the mortality of single homeless people http://www.crisis.org.uk/data/files/publications/Homelessness%20-%20a%20silent%20killer.pdf

[4] ONS Annual Death Extract & ONS LSOA mid year population estimates. Comparators from ONS Life Expectancy Tables.

[5] Fitzpatrick, S., Kemp, P. and Klinker, S. (2000) Single homelessness: An overview of research in Britain, The Policy Press: Bristol

[6] Maguire, N.J., Johnson, R., Vostanis, P., Keats, H. and Remington, R.E. 2009 Homelessness and complex trauma: a review of the literature. University of Southampton: Southampton

[7] Department for Communities and Local Government, 2008. Statutory Homelessness in England: the experience of families and 16-17 year olds. Homelessness Research Summary Number 7 http://dera.ioe.ac.uk/7314/1/researchsummaryseven.pdf

[8] Housing Act (1996) http://www.legislation.gov.uk/ukpga/1996/52/part/VII/crossheading/homelessness-and-threatened-homelessness

- people aged 18-20 who have been previously looked after;
- people aged 21 years old and over who are vulnerable as a result of having been looked after; and
- vulnerable people, such as older people, those with mental ill health and mental and physical disabilities[9].

People who fulfil these criteria are defined as falling into the group of 'statutory' homelessness. If someone is not entitled to housing through the homelessness legislation, this is often labelled as 'non-statutory' homelessness[10]. This group mostly comprises single adults or couples without children and may consist of rough sleepers, people living in hostels, squats, friends' floors or in other forms of temporary accommodation such as bed and breakfasts. Some of these people may live outside mainstream housing and homeless provision and may therefore be 'hidden' as they are not known to services or counted in homeless statistics[11].

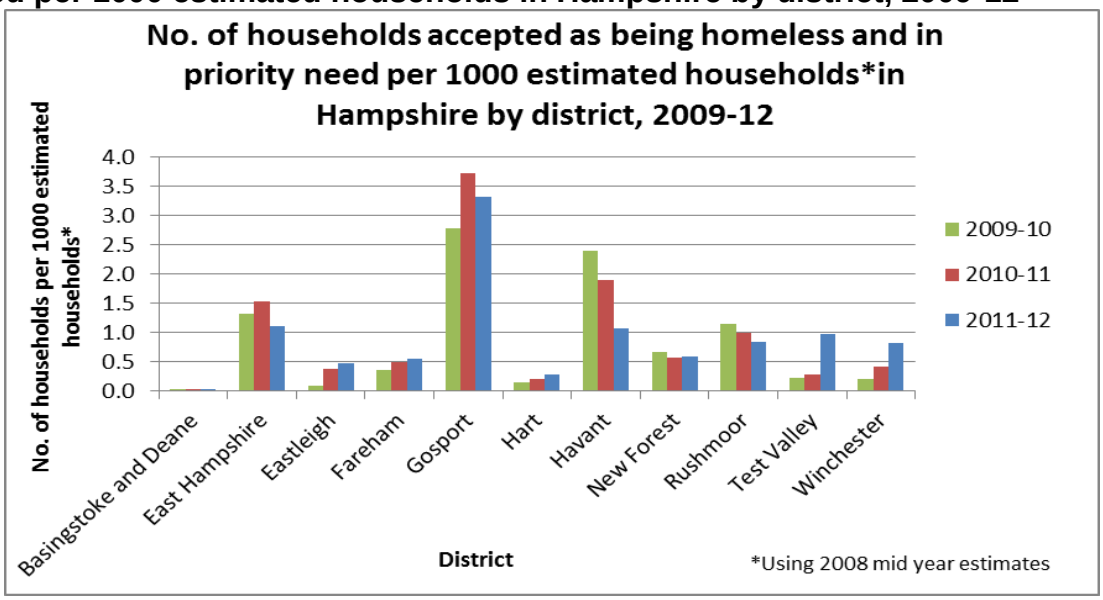
2.1.1 Statutory homelessness in Hampshire

The rate of statutory homelessness in Hampshire was 0.81 people per 1000 households in 2011-12. Gosport has had the highest number of households accepted as homeless and in priority need in Hampshire each year from 2009-12. In 2011-12, the rate of statutory homelessness in Gosport was 3.32 per 1000 households, which was higher than both the South East and England. The majority of applicants eligible for assistance in Gosport during this time were households with dependent children. The main reasons for the loss of the last settled home included parents or relatives no longer willing or able to accommodate people and a loss of rented or tied accommodation[12].

Lower tier local authorities are also responsible for homelessness prevention, assisting people with the means to address their housing and other needs to avoid homelessness. In 2011-12, 3,738 households were assisted with homelessness prevention and relief in Hampshire[13]. The low levels of statutory homelessness in Basingstoke and Deane shown in figure 1 are due to focused interventions to prevent homelessness, including work with the private sector to help individuals to secure accommodation.

[9] Homelessness Act (2002) http://www.legislation.gov.uk/ukpga/2002/7/contents
[10] Homeless Link (2012) About Homelessness. http://homeless.org.uk/about-homelessness
[11] Crisis (2011) The hidden truth about homelessness. Experiences of single homelessness in England. *Centre for Regional Economic and Social Research.* http://www.crisis.org.uk/data/files/publications/HiddenTruthAboutHomelessness_web.pdf
[12] Department for Communities and Local Government (2012) Statutory Homelessness: January to March 2012 and 2011/12, England https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/6804/2160776.pdf
[13] Department for Communities and Local Government (2012) Statistical data set. Live tables on homelessness https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness

Figure 1: Number of households accepted as being homeless and in priority need per 1000 estimated households in Hampshire by district, 2009-12



Source: DCLG, 2012

2.1.2 Non statutory homelessness in Hampshire

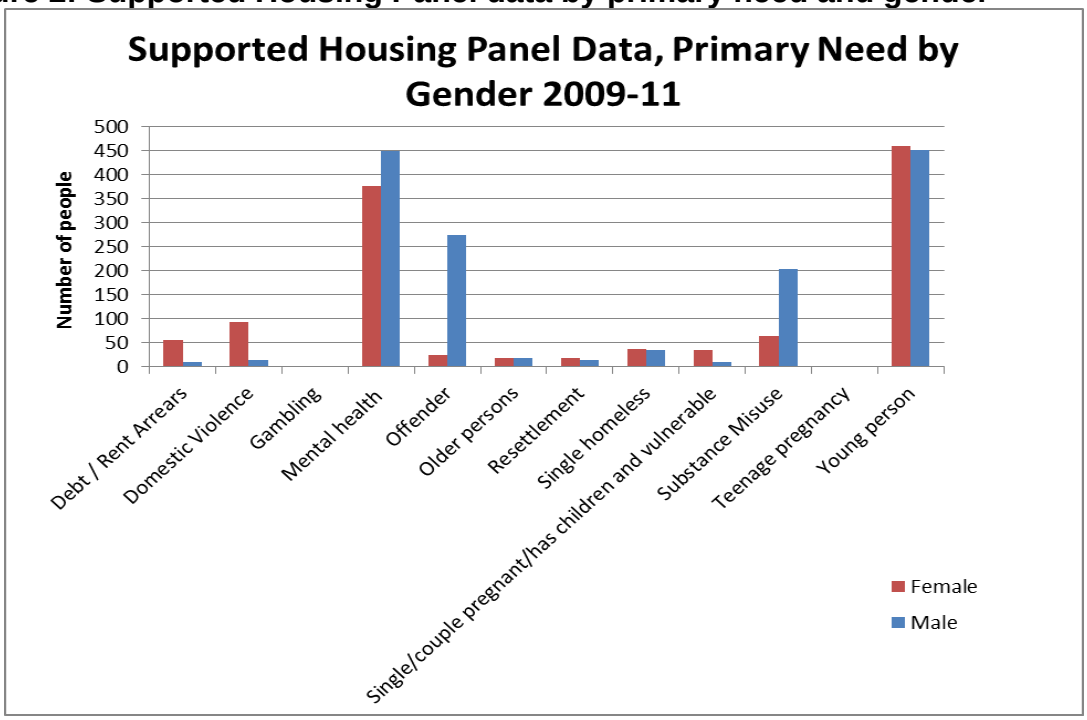
Non statutory homelessness is very difficult to measure due to the transient nature, extent of 'hidden' homelessness and different methods used to count homelessness[14]. Supporting People provides services for people over the age of 16 years old who are vulnerable, have a defined housing related support need and require support to live more independently or to gain access to appropriate accomodation.

The majority of applications for Supporting People are referred to local level Supported Housing Panels. These panels deal with individuals with a variety of needs, not all of whom fit the definition of non statutory homelessness. Applications can give an indication of the level of housing need for vulnerable people. In 2009-11, there were 2,637 applications for housing related support made through Supported Housing Panels. Figure 2 shows that more applications were from men than women and the majority of these were due to mental health or for young people. Data available on applications between April and June 2010 shows that the highest numbers of applications were in Fareham and Gosport (79 applications), Basingstoke and Deane (62), the New Forest (52) and Winchester (48)[15].

A count of the number of rough sleepers in Hampshire in autumn 2012 found 39 rough sleepers across the county, with the highest numbers in Winchester, Basingstoke and Deane and the Test Valley. The way these data are collected means these figures should be used with caution.[16,17]

[14] Homeless Link (2012) About Homelessness. http://homeless.org.uk/about-homelessness
[15] Hampshire County Council (2012) Supporting People Services http://www3.hants.gov.uk/adult-services/supporting-people/sp-service-users/sp-services.htm
[16] Rough sleeping counts involve counting the number of people sleeping, about to bed down or actually bedded down in places not designed for habitation. They are carried out by district level local authorities on a single night of the year within a defined time period. Local authorities can decide to

Figure 2: Supported Housing Panel data by primary need and gender



Source: DCLG, 2012

2.2 Health needs of homeless people in Hampshire

A health needs audit was carried out in December 2012, surveying 142 people in touch with homelessness services in Hampshire. The aim of this was to provide a snapshot of health need across a range of issues applicable to someone who is homeless in Hampshire. Findings are presented in Table 1 and have been compared with a national audit, which was carried out with 724 homeless people across the country[18,19].

either carry out a count or an estimate of the number of people sleeping rough in their area based upon their assessment of whether the local problem justifies counting.

[17] Department for Communities and Local Government (2012) Rough sleeping Statistics, Autumn 2011. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/7381/20936571.pdf

[18] Homeless Link (2010) The health and wellbeing of people who are homeless. Results from the National Audit http://homeless.org.uk/sites/default/files/Health%20Audit%20Findings_National%20evidence_0.pdf

[19] Homeless Link (2012) The Health Needs of Homeless People. Comparisons with the General Population. http://homeless.org.uk/sites/default/files/R9_2ComparativeHealthStats.pdf

Table 1: Results of Hampshire homeless health needs audit

Health need	Hampshire audit (%)	National audit (%)	Detail (Hampshire findings)
One or more physical health need	72 (102 people)	82	Common physical complaints: joint aches or problems with bones and muscles, chest pains and breathing problems and dental/teeth problems. Only 33 people (23%) responded that they were seeking support or treatment for their physical health problems and that this help was meeting their needs.
One or more mental health need	82 (116 people)	72	Common responses included stress (103 people, 73%), difficulty sleeping (85 people, 60%) and anxiety (83 people, 58%). 58 people (40%) said they used drugs or alcohol to deal with their mental health problem. Only 54 people (38%) said that they had a mental health need or condition which had been diagnosed by a doctor or health professional and 30 people (21%) said they were receiving support for their mental health condition which met their needs.
Long term condition	15 (21 people)	No data available	45 people (32%) said that they thought their health stopped them being able to undertake any training, volunteering or employment that they wanted to do
Learning disability	11 (16 people)	No data available	This is higher than levels in the general population (1-2%).
Taking drugs or recovering from a drug problem	37 (52 people)	52	Cannabis was the most common form of drug use. 16 people (11%) said they were receiving support for their drug use which met their needs.
Drinking alcohol more than four times a week	18 (25 people)	20	14 people (10%) said they were drinking every day, which is lower than the national audit. 26 people (18%) said they drunk 10 or more units on a typical drinking day. 16 people (11%) were receiving support for their alcohol consumption that met their needs.
Vaccination	Hepatitis A – 14 Hepatitis B – 23	Hepatitis A – 24 Hepatitis B - 30	Relatively low vaccination levels compared to the national audit. Screening for HIV (24%) and Hepatitis C (20%) and TB (16%) were also low compared to the national audit.
Sexual health check in the past 12 months	36 (52 people)	26	115 people (80%) said they knew where to go to access contraception or support for sexual health.
Smoking	83 (117 people)	77	38 people (27%) said they wanted to stop smoking and 42 people (30%) said they had not been offered smoking cessation advice.
Eat at least 2 meals a day	59 (84 people)	70	Despite low levels eating 2 meals a day, 95 people (67%) said they eat at least one piece of fruit and vegetables a day and 30 people (21%) had 3 or more a day. This may be due to local homelessness services negotiating access to fruit and vegetables with local shops.

3. Projected service use and outcome in 3-5 years and 5-10 years

Levels of homelessness in England have been increasing since 2009-10 and are projected to increase further in coming years. During the 2011-12 financial year, local authorities acceptances for statutory homelessness increased by 14% from the previous year. In addition, the single night rough sleeper snapshot in Autumn 2011 estimated that there were 23% more rough sleepers than the previous year in the UK[20]. Policy research has attributed some of this change to the impact of the economic recession[21].

These increases have also been accompanied by a reduction in available support services for homeless people across the country. A survey of needs and provision (SNAP) conducted by Homeless Link showed a 3.6% reduction in the number of beds in direct access hostels and second stage accommodation in England in 2010-11 compared to the previous year[22].

Figure 1 shows data on statutory homelessness in Hampshire, with mixed trends at district level. Some of this difference can be attributed to the different strategies for preventing homelessness in each district. For example, Basingstoke and Deane Borough Council, which has had low levels of homelessness through work with the private sector. Recent data show that statutory homelessness in the area rose from 2 to 11 acceptances from 2011-12 to 2012-13. Given the national picture, it will be important to continue to monitor trends in homelessness across Hampshire.

4. Current services in relation to need

Evidence shows that homeless people use proportionately more unplanned health care services than the general population. Hospital Episode Statistics (HES) coded 'No Fixed Abode' (NFA)[23] in 2007-08 year showed that homeless people in England use four times more acute hospital services than the general population, costing at least £85 million per year, with eight times more inpatient costs than the general population and an average length of stay of almost three times the average for the

[20] Department for Communities and Local Government (2012) Rough sleeping Statistics, Autumn 2011.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/7381/20936571.pdf
[21] Homeless Link, St. Mungos, Crisis & Shelter (2010) Homelessness: trends and projections.
http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=2&sqi=2&ved=0CEwQFjAB&url=http%3A%2F%2Fwww.mungos.org%2Fdocuments%2F4651.pdf&ei=Y8SLUd935vzRBZD5gZAL&usg=AFQjCNGEbeb7O3fRpeSUhKw5Uzg4_6dxbg&sig2=3qPNUXsxCBa4t1CAGwoVbw&bvm=bv.46226182,bs.1,d.d2k
[22] Homeless Link (2012) Homeless Watch. Survey of Needs and Provision 2012 (SNAP) Homelessness Services for Single People and Couples without dependents in England.
http://homeless.org.uk/sites/default/files/SNAP2012%20fullreport.pdf
[23] No Fixed Abode coding is used for homeless patients who cannot provide an address when they present to hospital. This coding may not provide an accurate picture, as it depends on the information provided by individual patients and will exclude those who may provide an address for their hostel or short term accommodation. It may also include some people who are not homeless but do not want to give their address (DH, 2010)

general population aged 16-64 years old. The most common reasons for hospital admissions were toxicity, alcohol or drugs and mental health problems[24]. The total cost of homelessness across all public services was estimated to be around £24,000 to £30,000 per person[25].

4.1 Primary care

Homeless people have the same right to access NHS services as everyone else. Only three Hampshire GP surgeries are commissioned to provide improved access to primary care services for homeless people in Aldershot, Winchester and Andover. The rest of the county relies on local informal arrangements to ensure access to services for homeless people.

The homeless health audit found high levels of registration with GPs (108 people, 75%) but fewer registrations (56 people, 40%) with a dentist. 115 people (80%) had visited their GP at least once in the last six months and 39 people (27%) had done so over 5 times. 8 people had been refused registration by a GP practice and 4 people were refused access to a dentist in the last 12 months (8%). Reasons included missed appointments, alcohol and dentists either being full or too expensive.

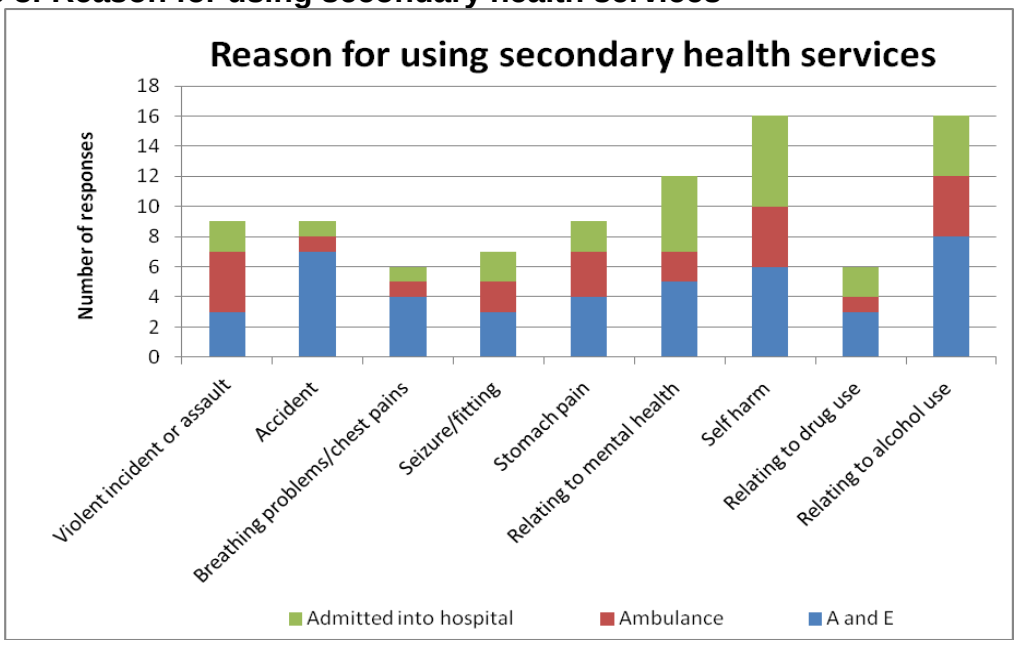
4.2 Acute hospital use

Hospital use was similar to the national audit data. Up to 39% of respondents had visited A & E, used an ambulance or been admitted to hospital at least once in the last six months. Common reasons included alcohol, accidents and mental health, including self harm (Figure 3). 26 people (18%) said that the hospital made sure they had somewhere to go when they were discharged and 15 people (11%) said that the hospital did not ensure they had somewhere to stay on discharge. This is lower than the results from the national audit, which found that 27% of clients had help with their housing before they were discharged.

[24] Department of Health Office of the Chief Analyst (2010) Healthcare for Single Homeless People. http://www.dhcarenetworks.org.uk/_library/Resources/Housing/Support_materials/Other_reports_and_guidance/Healthcare_for_single_homeless_people.pdf

[25] Department for Communities and Local Government (2012) Evidence review of the costs of homelessness. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/7596/2200485.pdf

Figure 3: Reason for using secondary health services



From 2006-12:

- 75% of 'No Fixed Abode' admissions in Hampshire were for men, compared to 44% in the general Hampshire population.
- 71% were aged 20-54 years old. The majority of general Hampshire population admissions were for people aged 0-4 years old or over 60 years old. This may represent the different age structure and lower life expectancy of the homeless population compared to the general population.
- 75% were for emergencies, compared to 34% in the general Hampshire population.
- The most common admissions were for injury and poisoning, mental and behavioural disorder and digestive diseases.
- 36% did not stay in hospital and 18.6% stayed for 10 or more nights.

5. User and provider views

Ten semi structured interviews, two focus groups and a provider workshop were carried out in Hampshire during autumn 2012 to collect the views of service providers and service users on the health issues and services available for homeless people in Hampshire. This section summarises the findings from this research.

5.1 Clients with complex needs

There are a growing number of people with complex needs, in particular a combination of learning disabilities, mental health and substance misuse which are difficult to disentangle. Service provision for this group was identified as insufficient, leaving vulnerable people under supported.

5.2 Barriers to accessing mental health and substance misuse services

Common themes included delayed diagnosis, lack of understanding of mental health needs within primary care, strict eligibility criteria, long waiting times and inflexible

mental health services. Improvements in the availability of long term solutions and community based care for lower level mental health issues were also identified. Substance misuse services provided a flexible service but with long waiting times for rehabilitation and poor planning for discharge from detoxification.

5.3 Hospital discharge

Issues included a lack of planning around the housing needs of individuals when they leave hospital, a lack of understanding by healthcare staff of the needs of homeless people and the circumstances which lead them to seek care.

5.4 Dental health

Poor access to dental health and barriers to accessing dental services included a lack of available NHS dentists, long waiting times and inflexible appointment structure.

5.5 Barriers to accessing mainstream service

These included distance to services, cost of transport, inflexible appointment structures, communication difficulties, low literacy levels, transient lifestyles, a lack of engagement and willingness to engage and the influence of wider determinants such as income, family circumstances and housing related issues.

5.6 Specific issues are experienced by young people who are homeless

Examples are teenage pregnancy, access to money, poor eating habits, anger management and a lack of engagement with health services.

5.7 Challenges associated with the transition of care and housing across the Surrey/Hampshire border

These include communication across teams and consistency of care and medication during transition between areas and on discharge from hospital and prison.

6. Evidence of what works

The following are examples of initiatives which have demonstrated impact at a local level in different areas of the country in addressing the health needs of homeless people.

6.1 Advocacy and peer support

Advocacy plays an important role in building bridges between people and services. It can be used to support homeless people in navigating mainstream services, gaining advice on health and welfare, attending appointments and during times of transition such as hospital discharge and moving between accommodations. Combining advocacy with peer support and education has been shown to break down barriers to access and raise awareness within services of the issues homeless people experience, encouraging them to be more flexible and responsive to their needs. It can also provide a pathway for homeless people to gain skills, enter into volunteering and gain meaningful employment in the longer term[26]).

[26] Homeless Link and Groundswell (2012) Homelessness and Health. Resources to Support Peer Activity http://homeless.org.uk/sites/default/files/HomelessHealth_PeerActivityToolkit_0.pdf

6.2 Working with adults with complex needs

A combination of strategic engagement and individual, intensive support is required to work with people facing multiple needs and exclusions to help them to engage and navigate existing services, improve their wellbeing and reduce the intensity of their service use. Pilot programmes in Cambridgeshire, Derby and Somerset using this model and supported by a coalition of national charities under the initiative 'Making Every Adult Matter' (MEAM) have showed improvements in health, wellbeing and a reduction in the burden on the criminal justice system[27].

6.3 Hospital discharge

Homeless Link and St. Mungos[28] have highlighted a number of case studies where improved coordination between hospitals, local authorities and the local voluntary sector has led to improved patient experience and planned hospital discharge. Interventions recommended include improved identification of homeless patients at an early stage, engagement of relevant support agencies, protocols which ensure patients are fit for discharge and ongoing care and treatment following transition back into the community.

7. Recommendations

A full set of recommendations can be found in the homelessness health needs assessment. Key recommendations include:

- Strategic and coordinated work on the wider determinants of health including increasing levels of education, training and employment, identifying and working with vulnerable people early.
- Access to flexible primary care (including dental) services, located according to need across the county.
- Improved engagement, early identification and intervention with homeless people.
- Improved access to diagnosis and management of substance misuse and mental ill health, increasing access to support for low level mental health issues and removing barriers.

[27] Battrick, T. et al (2012) Evaluation of the MEAM pilots. An interim report by FTI Consulting and Compass Lexecon for Making Every Adult Matter (MEAM). FT Consulting: London

[28] Homeless Link & St. Mungos (2012) Improving hospital admission and discharge for people who are homeless http://homeless.org.uk/sites/default/files/HOSPITAL_ADMISSION_AND_DISCHARGE._REPORTdoc.pdf