Director of Public Health Report 2018

Central Bedfordshire

great lifestyles

Homelessness and health: improving the health and wellbeing of those without safe and stable housing in Central Bedfordshire

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Foreword

The Director of Public Health Report is an independent report focused on improving the health of the people of Central Bedfordshire. This year my report focuses on the important topic of homelessness and health. It aims to highlight issues, present evidence and make recommendations to address the public health challenges of homelessness, in order to improve outcomes among homeless people and those at risk of homelessness.

Ill health can be both a cause and consequence of homelessness. Being homeless is associated with extremely poor health outcomes relative to those of the general population. In 2012 the average age of death of homeless people was 47 years for men and 43 years for women, compared to 77 years for the general population (74 for men, 80 for women).

Homeless people are more likely to have poor physical and mental health, and people with physical and mental health problems are more vulnerable to becoming homeless. As with other risks
to public health, prevention and early intervention can help to keep people housed appropriately, stopping the escalation of issues that can lead to losing stable accommodation and worsening health.

The Homelessness Reduction Act 2017 represents a unique opportunity to strengthen collaboration between local government, health services and voluntary sector partners, focusing on what we can do together to better prevent and relieve homelessness and to improve the health of homeless people in Central Bedfordshire. To contribute to this effort, we draw on national and local evidence to describe key challenges for homeless people, focusing on the health impacts of homelessness for a number of vulnerable groups.

The report highlights a small number of targeted areas for focus that collectively aim to improve health and prevent homelessness among vulnerable groups, and to improve health outcomes for homeless people. The associated recommendations are intended to be achievable, evidence-based and with potential to positively impact population health.

I hope this report will raise awareness of the relationship between homelessness and health locally and serve as a call to action to improve outcomes for local homeless people. My vision for Central Bedfordshire is that local partners strengthen their collaboration and collective leadership in order to:

- Better identify the overlapping vulnerabilities that put people at risk of homelessness and its health impacts, to prevent homelessness where possible by intervening early.
- Improve health and mitigate risks to health among people who experience homelessness, including people living in temporary accommodation and rough sleepers.
- Strive to reduce health inequalities among vulnerable populations who experience homelessness.

Muriel Scott
Director of Public Health

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Understanding homelessness

English law defines somebody as homeless if they have no accommodation, or when the accommodation they have is not reasonable for them to continue to occupy (National Audit Office, 2017). According to Shelter, this includes people living and sleeping rough on the streets but also people who are staying temporarily with family or friends; staying in a hostel, night shelter or bed & breakfast; squatting or may be living in unsuitable accommodation (Shelter, 2018b).

Rough sleepers can be understood to represent the 'tip of the iceberg' of homelessness in society and are the most visible group affected. However, a much larger group are affected by hidden forms of homelessness and a lack of safe and stable housing. The homelessness charity 'Crisis' defines the 'core' and 'wider' groups affected by homelessness (Bramley, 2017).

Core homelessness: those experiencing the most acute forms of homelessness	Wider homelessness: a broader group of those experiencing insecure or poor housing
• Rough sleepers. • Sleeping in cars, tents, public transport. • Squatting (unlicensed, insecure accommodation). • Hostel residents. • Users of night/winter shelters. • Domestic abuse victims, e.g. living in refuges. • Living in unsuitable temporary accommodation (e.g. bed and breakfast). • Staying with others (not close family) in crowded conditions (e.g. sofa surfers).	• Long term staying with friends/relatives. • Eviction/under notice to quit (and unable to afford rent/deposit). • Asked to leave by friends/relatives. • In intermediate temporary accommodation and receiving support. • In other temporary accommodation (e.g. social housing, private rented sector). • Discharged from prison, hospital (other state institutions) without permanent housing.

Further, in Central Bedfordshire the core homeless includes households less able to cope and whose vulnerabilities can make the health impact of homelessness more severe. Those core homeless living in overcrowded and/or concealed households and poor quality/unsafe households are also a particular issue, for whom alternative options maybe very limited. The local definition of wider homeless would also include households at risk of homelessness, particularly those living in unaffordable accommodation for whom homelessness is just a matter of time due to rent arrears and/or debt for example.

Homelessness in England

The pyramid on page 5 illustrates best available estimates of numbers of households in England who experienced different forms of homelessness in 2016/17, as defined by the homeless charity 'Crisis' (Bramley, 2017).

- In England, there is strong evidence that homelessness has increased significantly in recent years. Between 2010 and 2016 rough sleeping increased by 134%, whilst homelessness 'acceptances' by local authorities increased by 33% during the same period.
- The number of households in temporary accommodation increased by approximately 60% from 48,240 in 2010/11 to 77,230 in 2016/17. Family homelessness increased by approximately 20% from 36,773 families in 2011 to 43,919 in 2017.

UK Government targets related to homelessness policy include:

- To halve rough sleeping in England by 2022
- To eliminate rough sleeping in England by 2027.

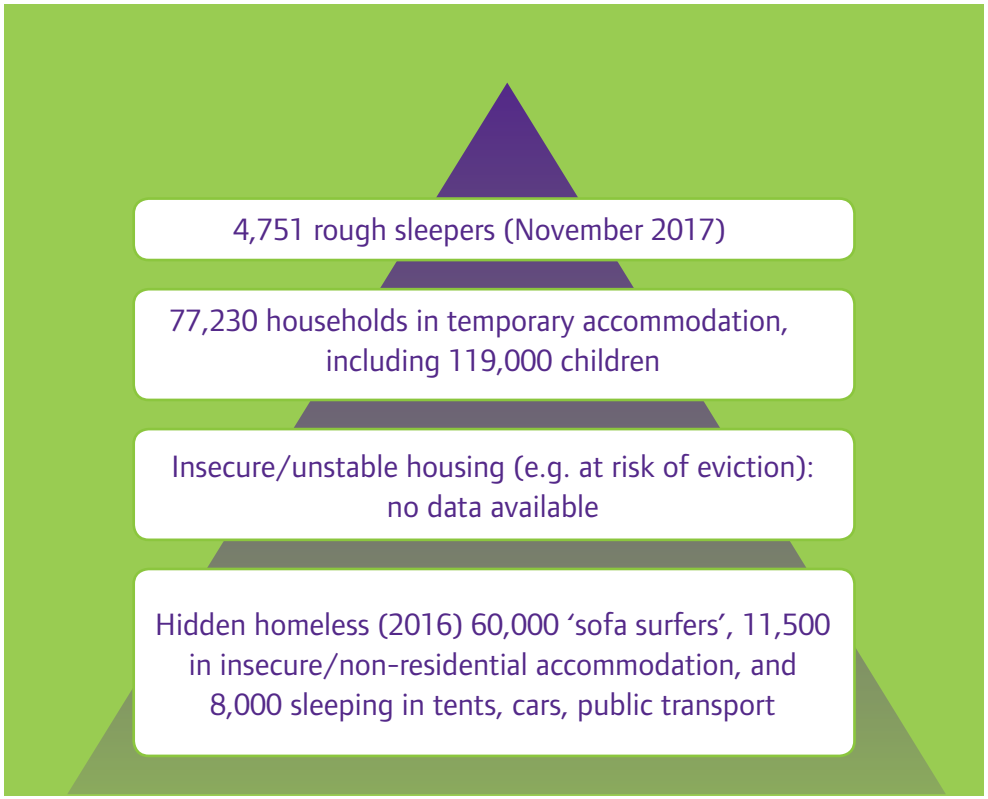


Figure: Pyramid of homelessness in England, 2016/17
(Source: statutory data and Bramley, 2017)

The Homelessness Reduction Act (2017): the new duty to refer and the impact on local authorities

The Homelessness Reduction Act aims to encourage local authorities to focus on prevention and early intervention, improve quality of advice and assistance provided, improve protection for single homeless people and promote joined up services. It amends existing homelessness protection in five important ways:

1. Improved advice and information about homelessness and the prevention of homelessness. A review of prior homelessness legislation found that information and advice provided to single homeless people needed to be much more effective (Crisis, 2015). Under the Homelessness Reduction Act, local authorities are required to work with other relevant statutory and non-statutory services to identify at-risk groups and to develop high quality information and advice.

2. Extension of the defined period of "threatened with homelessness". Under prior legislation, an applicant was only assessed as threatened with homelessness if they are likely to become homeless within 28 days. Under the Homelessness Reduction Act, the period "threatened with homelessness" was extended to 56 days.

3. New duties to prevent and relieve homelessness for all eligible people, regardless of priority need and intentionality. Under the Homelessness Reduction Act, all eligible people who are found to be homeless or threatened with homelessness are entitled to more tailored support from the housing authority, regardless of priority need status, intentionality, and local connection. All people found to be homeless and in priority need will be provided with temporary accommodation, and assessment of priority need status will increasingly require multi-agency working.

4. Introduction of assessments and personalised housing plans. Under the Homelessness Reduction Act local authorities are required to conduct an assessment with all eligible applicants who are homeless or threatened with homelessness. The aim of the assessment is to develop a personalised housing plan that sets out actions local authorities and applicants will take to secure accommodation.

5. The duty to refer. Since 1 October 2018, the Homelessness Reduction Act places a duty upon public bodies to work together to prevent and relieve homelessness through a 'duty to refer'. Under the new legislation, public bodies in England will have a new duty to refer service users (with consent) who may be homeless or threatened with homelessness, to a local housing authority. This requires the development of *"effective referral arrangements and accommodation pathways that involve all relevant agencies to provide appropriate jointly planned help and support to prevent homelessness"*

The Homelessness Reduction Act has significantly reformed England's homelessness legislation, placing new duties on local authorities to intervene earlier to prevent homelessness in their areas. The new legislation places significant additional pressures on local authorities to meet growing demand for housing in the context of an ongoing national shortage of both affordable housing and temporary accommodation.

Snapshot of Homelessness in Central Bedfordshire and current trends

The 'pyramid of homelessness' illustrates the size of the issue in Central Bedfordshire, using recent estimates of the numbers of households who experience different forms of homelessness, as defined by Crisis (Bramley 2017). The 'hidden homeless' and households at risk of homelessness are gaps for which there is no reliable local data available.

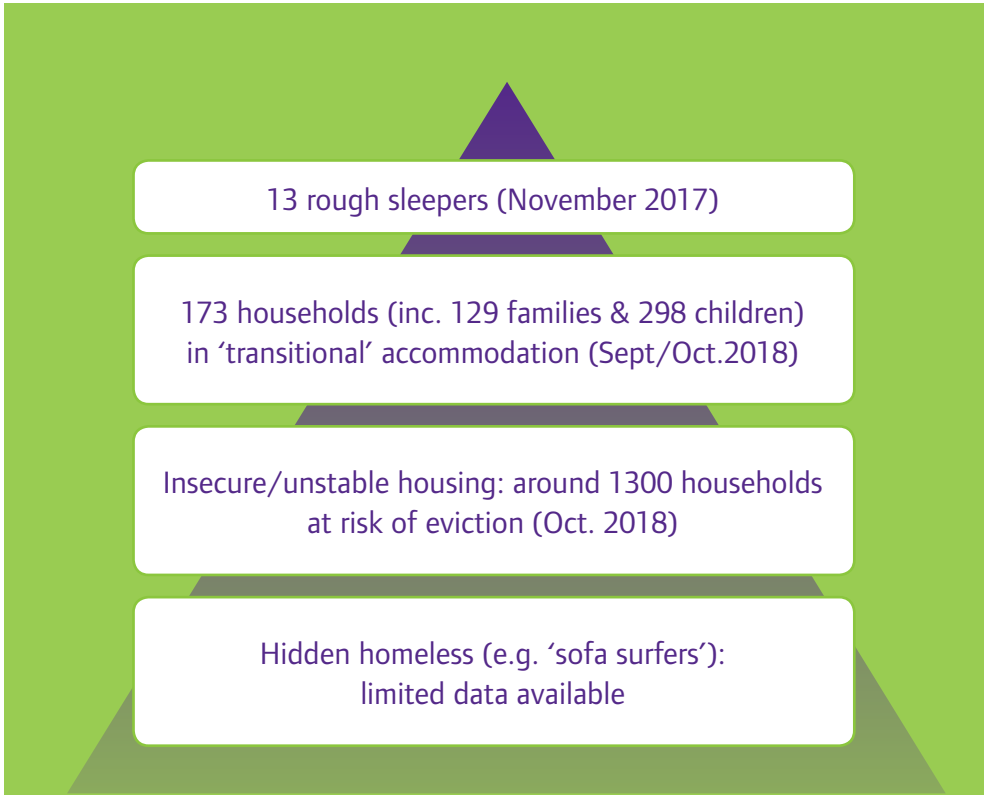


Figure: Pyramid of homelessness in Central Bedfordshire 2017-18.

In Central Bedfordshire rates of homelessness have largely remained below national statutory homeless measures due to its relative affluence and substantial investment in tenancy sustainment, supported housing and homelessness prevention. However, several measures of homelessness have increased since 2010/11. For example rough sleeping has increased significantly, but then reduced in 2017/18 for reasons including the regional Rough-sleeper Partnership (see Appendix). Since 2015 the number of households in temporary accommodation has risen, though rates of family homelessness and overall statutory homelessness since 2011-12 have experienced less fluctuation and remain markedly below national levels.

- There has been an overall increase in rough sleeping with an estimated 13 rough sleepers in November 2017 compared to 5 in 2010. However, 13 is less than the peak of 19 in November 2016.
- The rate of households in temporary accommodation in Central Bedfordshire remains below the national rate, but the numbers (see page 9) have risen significantly in recent years, peaking at 207 in December 2017 but reducing to 173 (October 2018).

Statutory homelessness measures

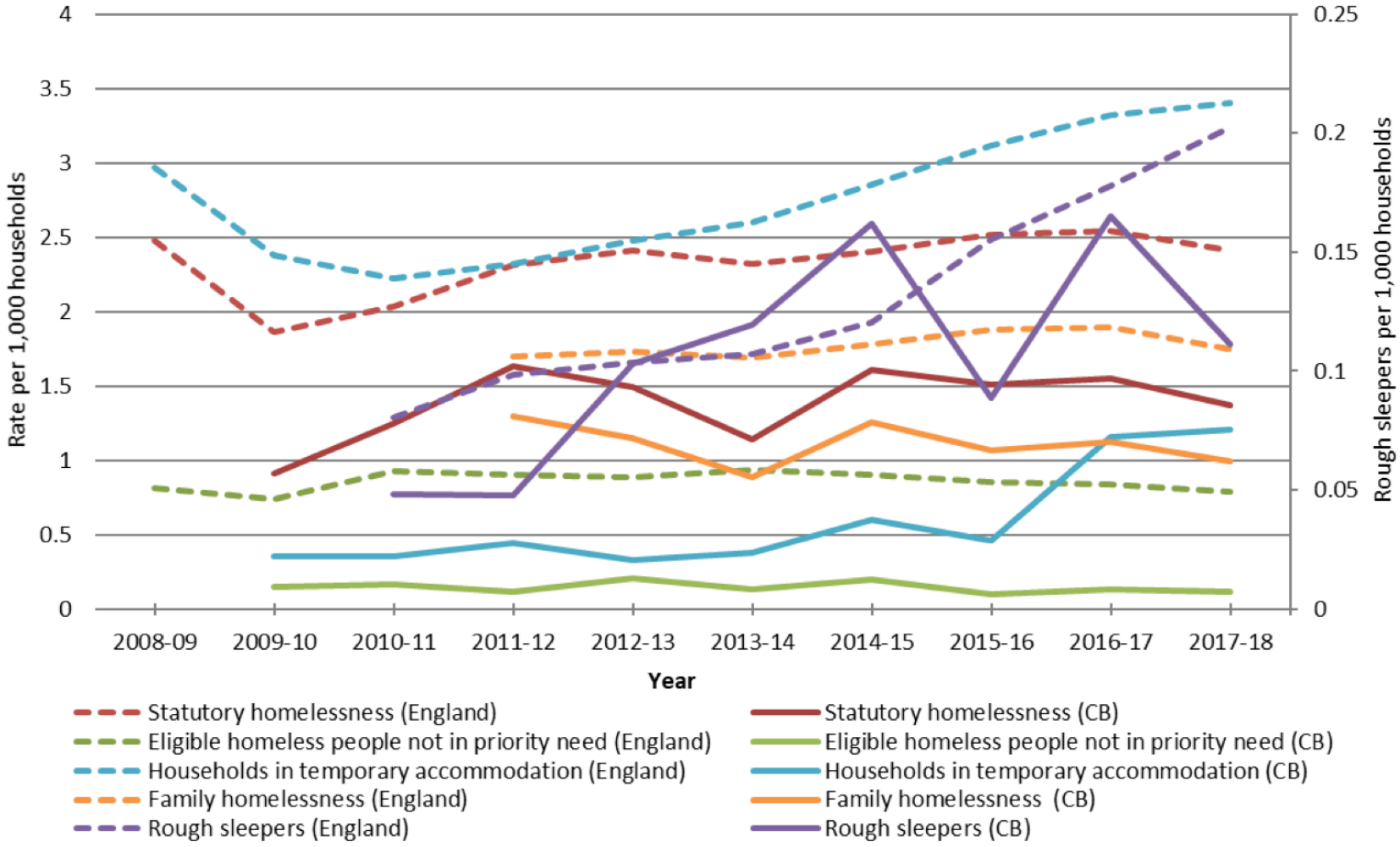


Figure: Statutory homelessness and rough sleeping trends - Central Bedfordshire and England
(Source: Ministry of Housing, Communities & Local Government)

Rough sleeping

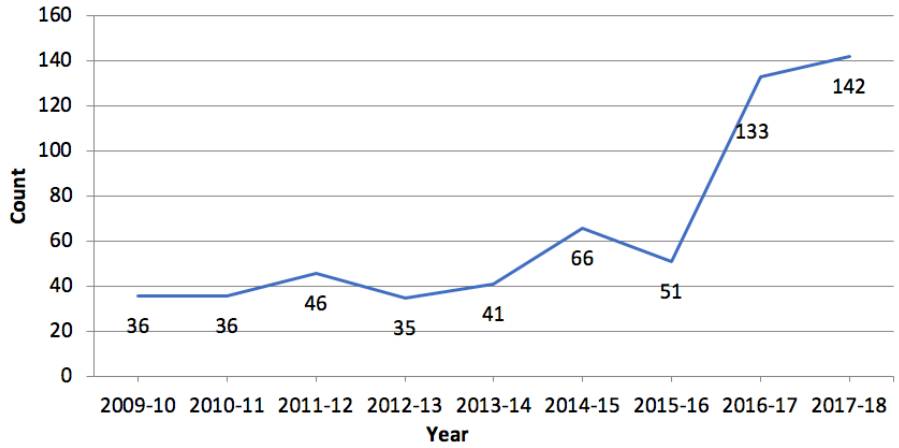
At the November 2017 national rough sleeper count, there were an estimated 13 people sleeping rough in Central Bedfordshire but this national snapshot could be concealing a larger picture. For example, from August 2016-May 2017 the NOAH (New Opportunities and Horizons across Bedfordshire) street outreach team engaged with 42 rough sleepers. From June 2017-May 2018 the SMART service engaged with 65 rough sleepers, of whom:

- Around 20% have mental health issues.
- Nearly half have alcohol issues.
- Around one third have drug issues.
- Most have been rough sleeping for 1 to 6 months.
- 70% have local connection to Central Bedfordshire.
- The main reasons for rough sleeping were eviction from private rented sector and friends/family asking them to leave.
- Settled accommodation solutions have been found for around half.

(Source: Housing Service, Central Bedfordshire Council)

Temporary/transitional accommodation

The number of households living in temporary or transitional accommodation has rapidly increased since 2014, the latter term preferred by Central Bedfordshire to include other housing types (e.g. supported housing for rehabilitation) and reflect the role of this accommodation in supporting households towards securing permanent accommodation as a progression model towards regaining life-skills and being able to maintain a tenancy without being at risk of revolving door homelessness. Reflecting the trend in temporary accommodation demand, up to 2014 there were 30-40 households in transitional accommodation but this peaked at 208 households in December 2017, reducing to 173 households in October 2018. Further, a number of households benefit from floating support to sustain a tenancy, whilst around 130 households are living in supported accommodation for reasons including domestic abuse.



(Source: Ministry of Housing, Communities and Local Government)

Local patterns in the use of transitional accommodation are also changing:

- Central Bedfordshire aims to improve system resilience by moving households out of private transitional accommodation and into CBC owned accommodation, to ensure the time living in transitional accommodation is as short as possible. The current average for households becoming homeless is circa 22 weeks living in transitional accommodation.
- In August 2018 75 households were in private transitional accommodation/nightly lets in Central Bedfordshire, 96 in CBC owned transitional accommodation.
- From spring 2019, once the use of private transitional accommodation has been further reduced, Central Bedfordshire plans to focus on reducing the total numbers of households in transitional accommodation. This will be delivered though Council investment to create new supply of transitional accommodation and successful implementation of the Homelessness Reduction Act 2017.
- Accommodation for larger households (4+ beds) across Central Bedfordshire is a challenge, however remodelling and extending properties is increasing the supply of larger properties to prevent these households requiring transitional accommodation.

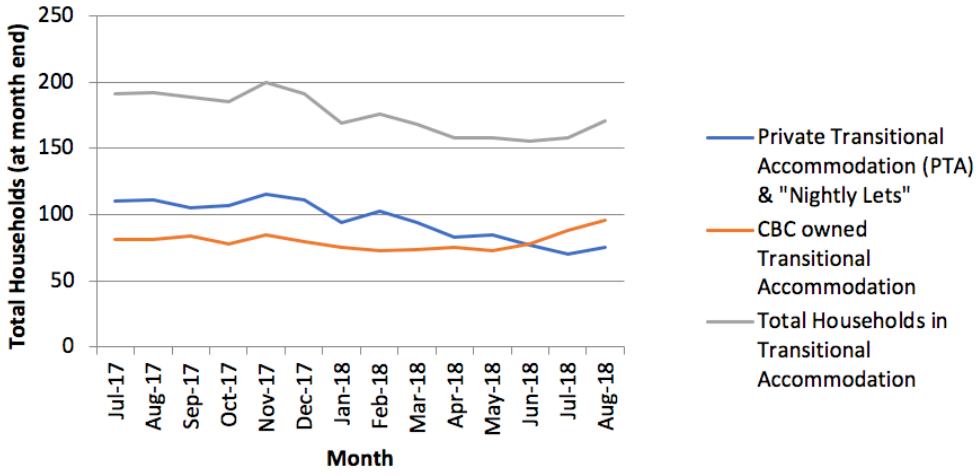


Figure: Households in Transitional Accommodation in Central Bedfordshire, July 2017-August 2018
(Source: Housing Service, Central Bedfordshire Council)

In December 2017, the 208 Central Bedfordshire households in transitional accommodation were concentrated in its main towns, though 28 were housed outside CBC in towns including Bedford, Letchworth, Luton, Milton Keynes and Hemel Hempstead. A survey of these households found the multiple primary reasons for their homelessness, the most common relating to the end of assured short-hold tenancy/alleged harassment/private renting sector issues and relationship breakdown/eviction. However, whilst the end of an assured shorthold tenancy remains the most common reason for homelessness, there is invariably a set of circumstances behind each case and it would be misleading to assume that private landlords simply wanted to increase the rent.

The reasons are as much to do with the relationship between landlord and tenant; unrealistic expectations and the problem of sustaining tenancies where affordability and debt cause tenancies to be always at risk. For example in 2017 circa 1,441 households claiming Housing Benefit in Central Bedfordshire are subsidising their rent by an average of nearly £36 per week due to the difference between their rent and the amount of Local Housing Allowance that is payable for the property (Source: Housing Service, Central Bedfordshire Council).

Location	Number of households
Dunstable	44
Leighton & Linslade	36
Houghton Regis	28
Biggleswade & Northill	12
Flitwick & Ampthill	11
Sandy & Beeston	9
Other smaller towns/villages in CBC	29
Outside of CBC	28
Miscellaneous	11

Figure: Main locations for Central Bedfordshire households in transitional accommodation in December 2017 (Source: Housing Service, Central Bedfordshire Council)

Primary reason given	Number
End of assured short-hold tenancy, alleged harassment, private renting sector issues	58
Relationship breakdown and eviction	57
Domestic violence; sexual abuse; violence and safety concern	44
Concealed household, sofa surfing and overcrowding	20
Rough sleeping and No Fixed Abode	9
Legal reasons; prison; witness protection; fire and no insurance	7
Anti-social behaviour	4
Unsuitable property	4
Mortgage repossession, death and no property rights	3
Unaffordable tenancy	2

Figure: Primary reasons for homelessness amongst Central Bedfordshire's Transitional Accommodation population in December 2017 (Source: Housing Service, Central Bedfordshire Council)

The root causes of homelessness

Several factors are driving the recent rise in homelessness in England, affecting both the vulnerability of individuals and families to homelessness and the wider societal conditions that give rise to homelessness. Important drivers include:

- Health, social and behavioural risk factors which are the focus of this report including complex and overlapping needs, substance misuse, mental ill health, offending behaviour and particular vulnerable groups such as veterans. This is the focus of this report and is discussed further below.
- Socioeconomic factors including relationship breakdown, rising relative poverty and problematic debt
- The supply of affordable housing – e.g. increasing cost in relative terms of the private rented sector compared with the social housing sector; and falling rates of owner-occupation contributing to a larger, but less affordable, private rented sector.
- Changes to the welfare system

Growth in relative poverty

Macroeconomic conditions are important contributory factors both to the housing crisis and the rise in homelessness nationally. Poverty is a key driver of homelessness and childhood poverty is a strong predictor of adulthood homelessness, which in turn increases vulnerability to poverty in adulthood. Since the financial crisis of 2008 relative poverty has risen among the working age population in England, against a backdrop of rising overall levels of relative poverty since 1961. Since a recent increase in relative poverty has occurred alongside a reduction in housing availability and affordability, this is likely to have contributed to increased vulnerability to homelessness in England.

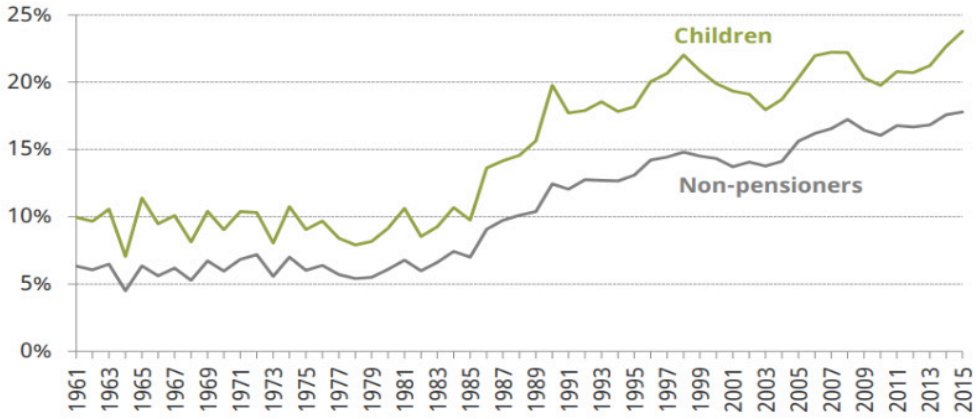


Figure: Relative poverty in the UK, 1961 – 2015
(Source: Institute of Fiscal Studies in Cribb et al., 2017)

Problematic household debt

In 2017, British households spent about £900 more than they received in income and growing levels of household debt are likely to have had a significant impact on the affordability of housing for families and individuals. A combination of wage stagnation, inflation and the impact of welfare reforms on the poorest households may increasingly force families to borrow to fund daily living, including the cost of housing. Household borrowing has increased since 2009 and overtook household savings in 2016/17 for the first time since 2007/08. In 2017, internal household profile data for Central Bedfordshire Council reveal that around 15% of all households are in the most deprived groups but there are considerable variations within the authority, with much higher proportions in these categories in Houghton Regis, Dunstable, Sandy and Biggleswade. Whilst these households will not all have problematic debt, they are more likely to have squeezed budgets and require low cost housing.

The supply of affordable housing

Alongside an overall shortage of housing in England, there is evidence that long term underinvestment in affordable housing, combined with recent reforms to welfare and local government have increased vulnerability to homelessness nationally and undermined protections for the homeless population (Downie et al., 2018). In recent years the national supply of affordable housing and the availability of additional social rented housing have exerted further pressure on housing for the homeless population. This picture is also reflected in Central Bedfordshire, with continued low numbers of new additional affordable homes being built when compared to all net additional homes and CIPFA neighbours (see figure below). In actual numbers, recent data reports some 246 new build affordable homes built in 2016-17 in Central Bedfordshire compared to 175 in 2015-16 (MHLG, 2018).

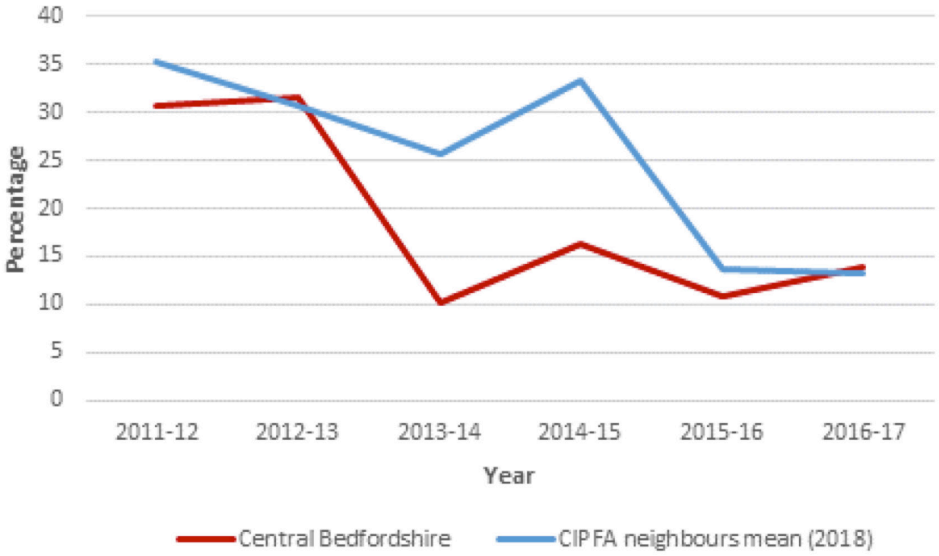


Figure: New affordable homes as a percentage of total new additional homes in Central Bedfordshire and CIPFA (2018) neighbours average (Source: Homes England and Ministry of Housing, Communities & Local Government)

Wider affordability issues are also reflected in local data, including:

- A decrease in affordable lettings from 1,080 in 2012/13 to 887 in 2016/17 (Source: Central Bedfordshire Council Housing Services)
- From 2013/14 to 2016/17 Central Bedfordshire has seen the second highest increase in private rents (21%) amongst its benchmarked local authorities (after St Albans at 23%) (Source: Valuation Office Agency, TBC).
- On 1st October 2018 (1st Oct 2017 in brackets) of the 1879 (2068) local tenants in the private rented sector on housing benefit, 1312 (1481) were paying on average around £37.20 (£35.63) on average per week in rent above the Local Housing Allowance rate cap (Source: Revenues & Benefits Service, Central Bedfordshire Council).
- Affordability has therefore also become a powerful driver for many Central Bedfordshire residents towards social housing, where local rents in the social housing sector are typically 55% of rents in the private rented sector (Source: Housing Service, Central Bedfordshire Council).
- In December 2017, 25 of the 208 households (12%) in transitional accommodation included a household member in employment, but none could afford shared ownership for reasons including debt and low income.

Recommendations to improve the supply of affordable housing supply are beyond the scope of this report, but Central Bedfordshire Council's Housing Services argue that issues including affordability and demand from vulnerable households (e.g. the homeless, families requiring 4+ bed properties) should be subject to more scrutiny during strategic processes including planning, the Strategic Housing Market Assessment and the Joint Strategic Needs Assessment.

Welfare reform and impact of universal credit

Reductions in housing-related welfare payments associated with the introduction of universal credit have resulted in an increasing proportion of accommodation options becoming unaffordable for individuals and families. A related issue has been the impact of the late payment of benefits on affordability of housing, combined with the rising cost of temporary accommodation including housing. Furthermore, a 2017 survey of 1,137 private landlords found that 43% had an outright ban on letting to housing benefit recipients (Shelter, 2018a), whilst some Right to Buy mortgages explicitly exclude the ability to rent properties to households claiming benefits.

The cost of homelessness

Research shows that early intervention and prevention can have a big impact on reducing the financial cost of homelessness to society and taxpayers, from a whole-system perspective.

Economic costs

In 2012 the cost of homelessness in England was reported to be up to £1 billion per year (Department for Communities and Local Government, 2012), whilst in 2015-16, local authorities in England spent £1,148 million on homelessness services (National Audit Office, 2017). The single largest component of local authority spending on homelessness is temporary accommodation which increased by 39% in real terms between 2010/11 and 2015/16 from £606 million to £845 million (National Audit Office, 2017). One study reported that the cost of a single person rough sleeping in the UK for 1 year was £20,128 (Pleace, 2015). This includes costs incurred by NHS services responding to the health impacts of homelessness, including A&E departments and mental health services.

Impact on public services

Homelessness costs an average of £4,298 per person to the NHS, £2,099 per person to mental health services and £11,991 per person for offenders (Pleace and Culhane, 2016). In Scotland it has been shown that homeless people use NHS services 24% more than the general population (Scottish Government, 2018). Research shows that homelessness increases reoffending by about 20% (Scottish Government, 2018).

The complex relationship between homelessness and health

This section explores the relationship between homelessness and health for a range of groups who are particularly vulnerable to homelessness and its negative impacts on health. This relationship is complex because of the multiple, interacting risk factors that characterize homelessness and make it so difficult to tackle and prevent at all levels.

Homelessness and health: Focus on children, young people and their families

Children's life chances are strongly influenced by the quality of their housing in early life (Harker, 2006) and research shows that in order to thrive, children, young people and their families require housing that is 'supportive, affordable, decent and secure' (Hogg et al., 2015). Housing issues that can have a negative impact on family health, wellbeing, and life chances include homelessness, overcrowding, insecurity, housing that is in poor physical condition, and living in deprived neighbourhoods (Harker, 2006).

The size of the issue

In 2017, the Local Government Association (LGA) reported an increase of 68% in the number of families with children in temporary accommodation since December 2010 (Leng, 2017), and according to statutory figures, total family homelessness increased from 36,773 in 2011 to 43,919 in 2017. Despite this, homeless households headed by a young person aged 16-24 years decreased from 16,000 to 12,937 over approximately the same period.

The impact on health

Children who have been in temporary accommodation for more than a year are over three times more likely to demonstrate mental health problems such as anxiety and depression than non-homeless children (Shelter in Leng, 2017).

Children, young people and families without a secure home environment are vulnerable to multiple disadvantages through exposure to a range of risk factors associated with poor quality housing or homelessness. Homeless children and young people (including those living in temporary accommodation) are at greater risk of the following poor outcomes (PHE, 2018):

- Premature birth, low birth weight, failure to thrive and developmental delay among babies of mothers living in temporary accommodation during pregnancy (Stein, 2000 and Sleed et al., 2011).
- Health problems associated with overcrowding and damp, e.g. respiratory infections and exacerbations of asthma.
- Poor access to healthcare, e.g. missing routine vaccinations (Leng, 2017).
- Lower educational attainment through absenteeism, school moves and overcrowded home environments. 51% of young homeless people have been excluded from school and 57% are not in education, employment or training.
- Behavioural problems at home and at school, bullying and social isolation.
- Mental health problems, which are 3-4 times more common among homeless children, and 33% experience self-harm.
- Adverse childhood experiences including all forms of abuse, neglect and exposure to domestic violence.

- Accidents, including household fires (e.g. through living in accommodation without smoke alarms) (Shelter, 2006).
- Severe physical ill health or disability.
- Poor sexual health including sexually transmitted infections and unintended pregnancy (Leng, 2017).
- Future offending behaviour (e.g. almost 50% of male young offenders have experienced homelessness).
- Diminished future employment prospects.

Local issues

Family homelessness is counted as "the number of applicant households with dependent children or pregnant woman accepted as unintentionally homeless and eligible for assistance" (PHE, 2018)

Family homelessness

In Central Bedfordshire the rate of family homelessness has been below the national rate since 2011/12 and continues to fluctuate but is currently around two-thirds the national rate. In 2016/17 there were 129 homeless families with dependent children, with 298 children in transitional accommodation in September 2018. Welfare reforms and rent increases continue to impact on this vulnerable local group, whilst the availability of suitable larger family properties (4+ beds) remains limited and a priority for Central Bedfordshire. Few new build larger affordable properties are delivered and therefore Central Bedfordshire Council's attention has turned to property extensions and remodelling to provide larger properties.

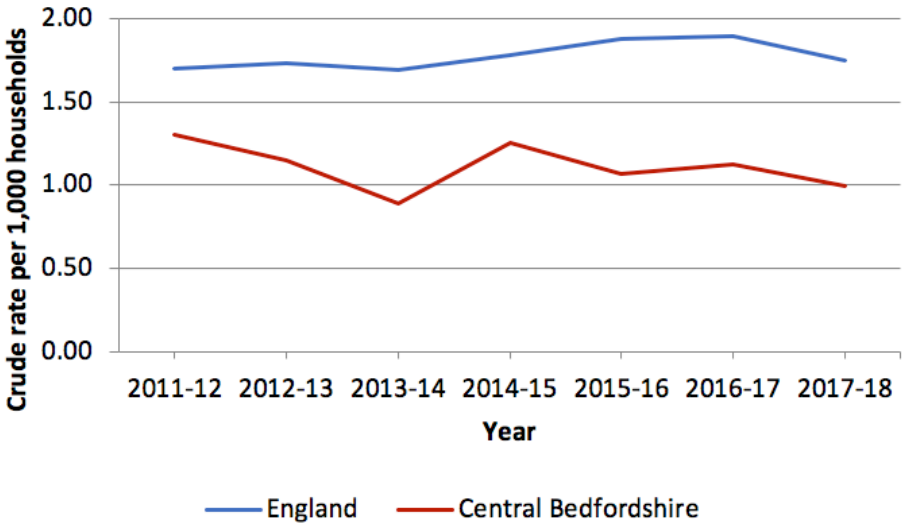


Figure: Rate of family homelessness in Central Bedfordshire and England, 2010/11 to 2017/18
(Source: Ministry of Housing, Communities & Local Government)

Homeless young people

In Central Bedfordshire in 2016/17 there were 50 households headed by a young person, just below the national rate but a persistent challenge for this most vulnerable group. Further, the 2014 Homelessness Review by Central Bedfordshire Council identified significant gaps in the availability of accommodation based and floating support for local young people, particularly for teenage parents and those living in the north of Central Bedfordshire.

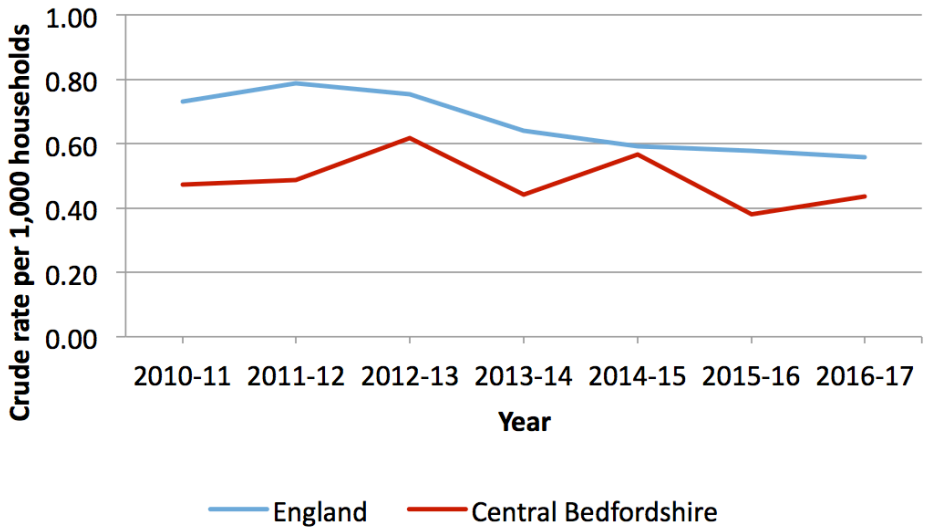


Figure: Rate of households headed by a young person aged 16-24 in Central Bedfordshire and England, 2010/11 to 2016/17 (Source: Ministry of Housing, Communities & Local Government)

Vulnerability to prevent homelessness

Vulnerability to homelessness can be increased by a wide range of social issues. Mrs T is a mother with 6 children and was experiencing domestic abuse from her partner. She was reluctant to leave him because he was the lead tenant in their privately rented house and she was therefore vulnerable to being categorised as 'intentionally homeless'. Mrs T engaged with drug and alcohol treatment services regarding her misuse of prescription drugs with the intention of attending residential detoxification and rehabilitation. Social services assessed her and determined that her partner was not an appropriate person to care for their children whilst Mrs T was attending residential services and they agreed to support her with child care. Social services confirmed that they would support Mrs T in her decision to separate from her partner, but advised that it was her responsibility to seek support from local housing services.

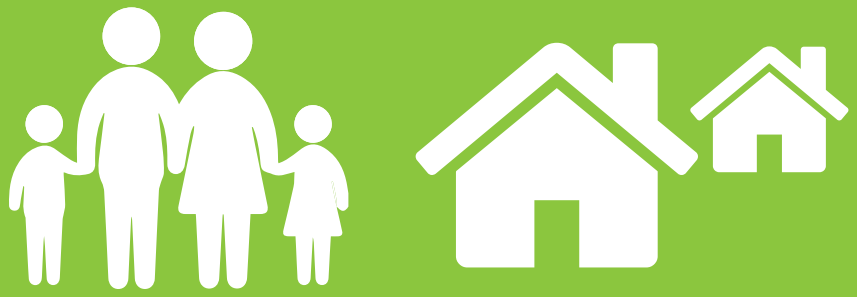
The drug and alcohol treatment provider agreed that Mrs T was eligible for detoxification and rehabilitation, but questions were raised about its long-term success if she returned to the family home. The provider was willing to support her rehabilitation, dependent upon secure housing options upon discharge from treatment. Mrs T stated that she would like her aftercare plan to centre on her and her two children still living at home, but without her partner. The provider agreed this would be the preferred plan for Mrs T to sustain her recovery and remain the primary carer of her children.

Mrs T's story highlights the importance of close partnership working between homelessness prevention services and other local authority commissioned services, including health services, to better understand housing need (on the basis of good quality assessment, strong decision-making) and prevent homelessness. Here work is needed to strengthen existing relationships and communication strategies to promote prevention, alongside early intervention to prevent homelessness and address its health impacts among vulnerable individuals like Mrs T.

Case study: How accommodation-based support can help rebuild families

Mr V self-referred to the Independent living team because he had no fixed abode and was staying with various friends and family members. He was in arrears with the council and had been convicted of a drinking and driving offence that resulted in a criminal conviction, driving ban and maximum points on his license. His relationship with his wife had also broken down due to his alcohol addiction. Mr V participated in support sessions with his accommodation support officer where his goals and aspirations were discussed, action plans agreed and implemented.

Mr V wanted to move into his own accommodation because he was the registered carer for one of his children and he requested support in re-apply for his driving license once the ban had expired and in repaying his debts. Mr. V also requested help to improve his relationship with his ex-wife so that they could work together better as a family unit when he was spending time with his children. Mr V achieved all these goals and moved into his flat (via the home finder service) and was supported for around 2 years before becoming independent.



Homelessness and health: Focus on the hidden homelessness

As illustrated by the pyramid of homelessness, rough sleepers and applicants to housing services represent the tip of the iceberg of the wider homeless population. Vulnerable homeless are often hidden from view in so-called 'concealed households' – such people tend to manage their lives informally and may experience homelessness without engaging with services. Armed forces veterans (see later section) are an example of one group particularly predisposed to becoming the 'hidden homeless', perhaps due to their perceived superior coping strategies.

Defining the hidden homeless

There is no agreed definition of hidden homelessness and the term is used inconsistently. Crisis (2011) defined the hidden homeless as 'non-statutory homeless people living outside mainstream housing provision', i.e.:

- "Those who meet the legal definition of homeless but to whom the local authority owes no duty to house (because they have not approached or do not meet the criteria in the homelessness legislation), and;
- Whose accommodation is not supplied by a housing/homelessness provider."

Who are the hidden homeless?

- There is no nationally agreed definition of 'hidden homelessness' but it may include the following groups:
- Individuals not receiving formal homelessness support from a local authority (e.g. single homeless).
- Those living as concealed households (as family units or as single adults) with friends or family.
- People living in shared accommodation in same dwelling, but not sharing living room or regular meals.
- People 'sofa surfing' with friends, relatives or strangers.
- People living in unsafe or insecure accommodation e.g. squats, 'beds in sheds' or overcrowded conditions.
- Individuals with no right to live in a fixed place (e.g. no local connection or no recourse to public funds), or cannot stay in a fixed place (e.g. victims of abuse).
- Rough sleepers who are not included in the annual rough sleeper count.

The size of the issue

Quantifying the 'hidden homeless' population is inherently difficult, but estimates are available from the Crisis Homelessness Monitor, as summarised in the Table below.

	England (Source: Bramley, 2017)		England (Source: Fitzpatrick et al., 2018)
Category	**2011**	**2016**	**2017**
Sleeping in tents, cars and on public transport	5,000	8,000	-
Living in insecure accommodation: squatting and non-residential accommodation (e.g. 'beds in sheds')	6,800	11,500	-
Sofa surfers	35,000	60,000	-
Overcrowded households	No data	Unknown	678,000
Households in shared accommodation	No data	Unknown	400,000
Concealed households	No data	Unknown	2.32 million

Table: Estimates of hidden homelessness (Source: Crisis Monitor)

A study conducted by Crisis between 2010 and 2011 comprised of a survey of 437 homeless people across 11 towns and cities in England, including 27 in-depth interviews with single homeless people who had been 'hidden' (Crisis, 2011). Key findings of the study were:

- The majority of single homeless people are in fact hidden: 62% of those surveyed were hidden homeless at the time of interview and nearly all (92%) had experienced hidden homelessness in the past.
- Survey respondents were more likely to have slept rough and stayed with friends than to have stayed in a hostel, and squatting was more common than temporary housing arranged by a local authority or support agency. For every month that the respondents had collectively spent in formal temporary accommodation, they had spent 3 months using informal accommodation or no accommodation at all, e.g. squatting, sleeping rough or staying with friends or relatives.
- Most survey respondents had never stayed in a hostel (57%) or in temporary housing arranged by a local authority or support agency (75%). This included respondents with a long history of homelessness; 43% of those homeless for more than 6 years had never stayed in a hostel or temporary housing.

The impact on health of hidden homelessness

Evidence on the health impacts of concealed homelessness is limited, but the health needs of the hidden homeless are likely to reflect the health needs of homeless people more broadly. The few published studies of the hidden homeless illustrate how individual and structural factors influence their complex health needs:

- In one Canadian survey (23 male, 11 female, aged 15-69 years), many participants reported concerns about physical (e.g. dental health, respiratory problems) and mental health and all reported current problems with addiction, particularly smoking, alcohol and drugs (Crawley et al., 2013).

- Another Canadian survey (13 men and 8 women) reported that participants found it difficult to practice healthy behaviours (e.g. poor diet, challenge of drugs and alcohol, unsafe sex) and this in turn affected their physical and mental health (e.g. dental problems, blood pressure, anxiety and depression) (Watson et al., 2016).
- A UK survey of 2,011 16-25 year olds found that 703 (35%) had experience of sofa surfing, of which some 409 (20%) sofa surfed in the last year and a further 79 of these had also slept rough (Clark, 2016). Though sofa surfing for many reasons (e.g. eviction, domestic violence, leaving prison), some reported the experience could be positive (e.g. more flexibility to access education, employment and to maintain/repair relationships) - though this may be due to respondents comparing it to the situation they left behind and moving away from a home situation of conflict or severe over-crowding. For many their homelessness was temporary and did not lead to wider vulnerabilities associated with other homeless, whilst others failed to find a quick route out and suffered longer term effects.

A Crisis study (Crisis, 2011) shed further light on the possible health impacts associated with being hidden homeless, all of which contribute to and reinforce a cycle of vulnerability, particularly among single homeless people. Single homeless people may resort to desperate measures to put a roof over their head. The study found evidence of people in engaging in sex work to pay for a night in a hotel, committing crimes in the hope of being taken into custody, and forming unwanted sexual relationships to secure a bed for the night.

Hidden homelessness in Central Bedfordshire

Limited local data were available on the extent of hidden homelessness in Central Bedfordshire, as most hidden homeless people will not be in contact with local services. For example the December 2017 survey of the Central Bedfordshire population in transitional accommodation found that up to 10% (20 of 208) could previously have been categorised as 'hidden homeless'. Another indicator are homeless people 'not in priority need', i.e. people who approach the local housing authority but are not eligible for priority assistance, including single adults who do not meet vulnerability criteria under prior homelessness legislation (e.g. no dependent children, not pregnant) are more likely to become 'hidden' from homelessness statistics and rough sleeper counts. In Central Bedfordshire the number of homeless people not in priority need was 14 in 2017-18 and has fluctuated little in recent years (range of 11-22 in national count) and remains below the national rate, but one bedroom social housing remains in short supply whilst welfare reforms and rent increases continue to restrict the options available for this vulnerable local group.

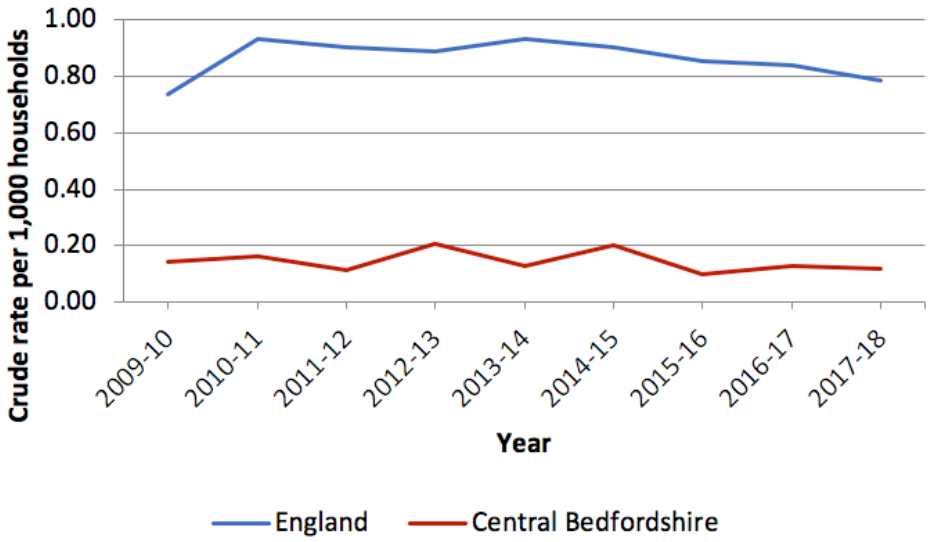


Figure: Rate of eligible homeless people not in priority need in Central Bedfordshire and England, 2009-10 to 2017-18
(Source: Ministry of Housing, Communities & Local Government)

Homelessness and health: Focus on complex needs

Homelessness commonly overlaps with a wide range of health and socioeconomic vulnerabilities, particularly:

- Mental ill health
- Substance misuse
- Offending behaviour (JRF, 2011)

Individuals with complex needs often lead chaotic lives and experience multiple interrelated or overlapping problems, collectively resulting in poor health and the consequences of increased vulnerability, including social and economic exclusion (Revolving Doors, 2015).

The reflections of two Central Bedfordshire GPs on the complex needs of the local homeless

Central Bedfordshire has an ageing population of single homeless men approaching middle and late middle age who often have long term conditions (e.g. COPD, coronary heart disease) associated with high morbidity if not adequately managed. However it can be difficult to encourage homeless patients to access primary care for routine chronic disease reviews and many are so used to these barriers that they tend to 'give up'.

Primary care should be managing their chronic conditions and other complex needs, but many end up attending A&E more often than the average patient. However, persuading the homeless to attend secondary care for non-emergency investigations can also be challenging because some sites are not easily access by public transport.

Compliance with medication and treatment plans can also be challenging. Patients living chaotic lives do not prioritise the collection of regular medication and instead will often use it only intermittently or to control their symptoms, rather than prevent chronic disease. Chronic disease reviews in primary care are often increasingly target focused and template driven and this can result in a seemingly impersonal, formulaic approach that does not accommodate or engage in the unusual circumstances of homeless patients and can sometimes alienate them. Further, many homeless patients are not eligible for potentially beneficial interventions (e.g. exercise on prescription, flu immunisation) unless they meet certain conditions (e.g. GP registration) or have chronic disease or mental health needs.

There are also some significant and dangerous gaps in the prevention of homelessness. One is demonstrated by another of our patients, a middle aged homeless man with a chronic memory disorder and other complex needs who is a long term homeless hostel resident. This accommodation is entirely inappropriate for this patient as the hostel is closed for the most of the day and therefore he is forced out onto the street. He has been to court a number of times for drinking alcohol in the street because he cannot remember where alcohol consumption is banned.

We and the hostel volunteers have raised our concerns with local housing and social services several times to highlight his vulnerability and risk, but little has changed and he remains very vulnerable. Those in homeless hostels also find the process of bidding for properties difficult and often request support with this. Those with learning difficulties particularly struggle, whilst the housing available tends to be located at the opposite end of Bedfordshire which people can be reluctant to move to for many reasons, including the destabilisation of local support and employment that such moves can create.

Severe and multiple disadvantage (SMD) refers to the combined complex health and social needs of individuals, including how they intersect and interact (LGA, 2017).

- SMD1 - experiencing disadvantage in one domain only. This can be "homelessness only", "offending only" or "substance abuse only".
- SMD2 - experiencing disadvantage in two out of three disadvantage domains. These can be "homelessness & offending", "substance misuse & offending" "homelessness & poor mental health" and "homelessness & substance misuse".
- SMD3 - experiencing all three disadvantage domains. This can be "homelessness & offending & substance misuse".

Homeless Link identified in a survey that 32% of hostel residents had complex needs. They reported that 66% of their respondents had experienced difficulties in accessing mental health services. In addition, 36% respondents reported difficulties accessing drug services and 33% difficulty accessing alcohol services (Homeless Link, 2017).

Different ways of talking about complexity

Complexity refers to the complex needs of homeless individuals who may not fit into a current service descriptor. It is sometimes unclear how to resolve issues or provide the best support to such individuals (Shelter, 2016).

Complex needs: Individuals may have multiple issues relating to each other such as: mental ill health, substance abuse, homelessness, offending behaviour and learning difficulties (Crisis, 2017). They are multiple terms used to refer to complex needs. These include: dual diagnosis, chronic or multiple exclusion; severe and multiple disadvantage (Shelter, 2016).

Severe and multiple disadvantage: Refers to overlapping problems faced by individuals that can include homelessness, substance misuse and offending behaviour (LGA, 2017).

Multiple exclusion homelessness: Multiple exclusion homelessness is a form of deep social exclusion such as institutional care, substance misuse or participation in street culture activities (Fitzpatrick et al., 2012; PHE, 2018).

Dual diagnosis: Dual diagnosis refers to the co-existence of mental health and substance misuse problems (MIND, 2016).

Factors associated with severe and multiple disadvantage

A number of factors are associated with a higher index of complexity of health needs among the homeless population (PHE, 2018; Bramley et al., 2015):

- **Demographic factors** - younger people aged 16-24 years and single person households are more likely to have complex needs.
- **Economic factors** - unemployment and poverty are strong predictors of complex needs.
- **Housing factors** - housing markets with concentrations of smaller properties (e.g. bedsits and small flats) are associated with complex health needs among residents.
- Institutional factors - concentrations of institutional populations, especially those living in mental health units and homeless hostels are associated with greater complexity of need.
- **Social factors in childhood** – adverse childhood experiences including abuse, neglect, witnessing alcoholism, domestic violence, homelessness as a child and negative school experiences all increase the likelihood of future complex health needs (Fitzpatrick et al., 2010; JRF, 2011).

Complex needs in England

In 2010/11, approximately 586,000 individuals accessed services across the three domains of severe multiple disadvantage (SMD) (Bramley et al., 2015). The figure below highlights that many of these individuals had overlapping (and thus complex) needs – 28% of service users were experiencing two categories of disadvantage (SMD2) and 9.9% of service users were experiencing all three disadvantages of homelessness, substance misuse and offending behavior (SMD3).

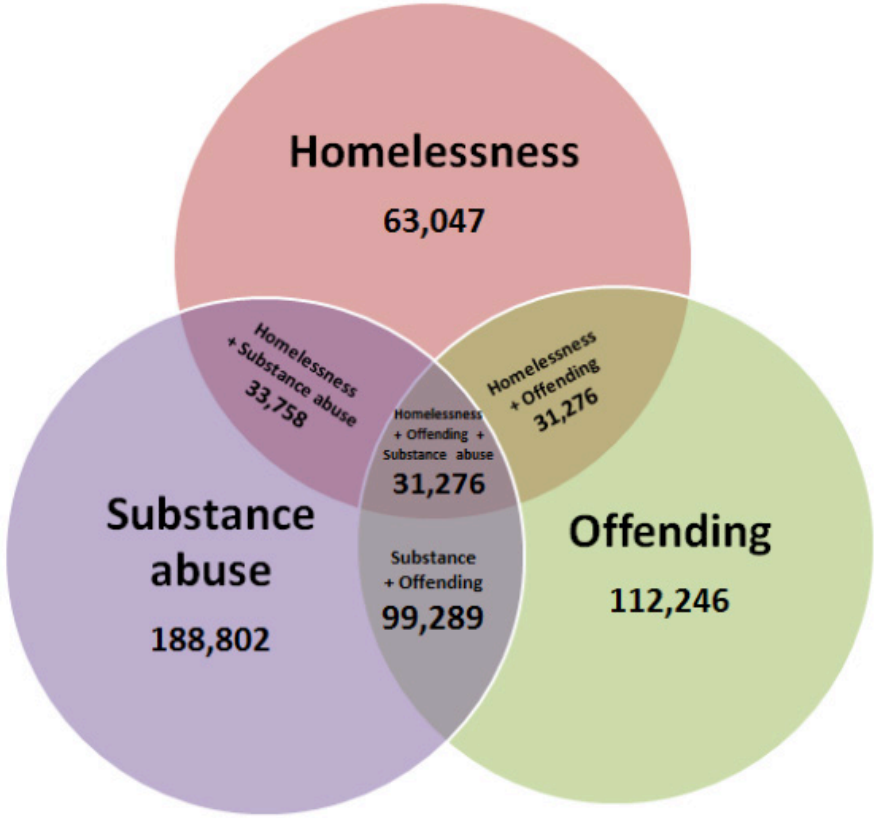


Figure: Snapshot of severe multiple disadvantage among housing/substance misuse/offender service users in England, 2010/11.

Complex needs in Central Bedfordshire

The figure below illustrates a snapshot of severe and multiple disadvantage in Central Bedfordshire in 2010/11. At that time, the most prevalent combination of disadvantage among local service users was one major category of SMD complicated by a mental health problem.

Severe and Multiple Disadvantage Domain	Count	Estimated % with mental health problems
Homelessness only	80	38%
Offender only	270	22%
Substance only	240	58%
Offender + substance misuse	180	39%
Homelessness+ Substance misuse	60	33%
Homelessness + Offender	50	40%
All three disadvantage domains	70	29%
Total using housing, substance misuse and/or offender services	950	38%

Figure: Snapshot of severe multiple disadvantage amongst housing/substance misuse/offender service users in Central Bedfordshire, 2010/11
(Source: Ministry of Housing, Communities & Local Government)

Consequences of inequalities in access to healthcare services among homeless people with complex needs

Homeless people experience greater difficulty accessing healthcare relative to the general population, worsening health and widening inequalities in health outcomes (Seria-Walker, 2018). Common consequences include:

- **Late presentation to secondary care with serious physical and mental health problems** - homeless people are more likely to present late with a serious physical or mental health condition. Subsequent care is likely to be of increased complexity and higher cost to the NHS.
- **Increased use of A&E** – due to difficulty accessing primary care and elective services, homeless people use Accident and Emergency departments up to 6 times more often than the general population and stay in hospitals three times longer (Deloitte, 2012 and King's Fund, 2014).
- **Maintaining the cycle of poverty** – due to the prevalence of mental illness among the homeless population, access to and engagement with mental health services are likely to be key factors that enable vulnerable homeless people to escape poverty and become productive members of society.

Homelessness and health: Focus on people who misuse substances

Problems with misuse of drugs or alcohol are often significant factors underlying homelessness and its negative health consequences. Substance misuse is often a key factor underlying insecure housing and homelessness, and both a cause and consequence of becoming homeless. Misuse of drugs and alcohol is highly prevalent among the homeless population. Two thirds of homeless people cite drug or alcohol use as a reason for first becoming homeless, and those who use drugs are seven times more likely to be homeless (Crisis, 2018). There is a complex interrelationship between drug and alcohol misuse and a range of health and social factors. For example, substance misuse may trigger events which lead to homelessness, and homelessness may exacerbate drug or alcohol dependence. The longer someone experiences homelessness or rough sleeping, the bigger the adverse impact on their health and wellbeing and the greater the likelihood of substance misuse becoming a factor in sustaining their homelessness (HM Government, 2017).

The size of the issue

Housing problems are highly prevalent among people who engage with substance misuse services, and evidence shows that those who use drugs are seven times more likely to be homeless (Crisis, 2018). For example, among opiate users who engage with treatment services, National Drug Treatment Monitoring System data shows that 12% are homeless at start of treatment. For non-opiate substance misusers, about 5% are homeless (PHE, 2017). Similarly, two thirds of homeless people cite drug or alcohol use as a reason for first becoming homeless (Crisis, 2018).

As described in the previous section homeless people often have multiple and complex health needs including 'tri-morbidity' - the co-occurrence of poor physical health, mental ill health and substance misuse (London Housing Foundation, 2017). Importantly, homeless people may be particularly vulnerable to new and dangerous street substances, including synthetic opiates and cannabinoids. For example, among users of new psychoactive substance users entering treatment in 2015-16, 50% reported housing problems at the point of treatment entry - twice the level reported by drug users overall (Public Health England, 2017).

The impact on health

Key health issues relating to substance misuse among homeless populations include:

- Rough sleeping is strongly associated with injecting drug use and there is a higher prevalence of blood borne viruses among homeless people who misuse substances, including Hepatitis C and HIV (Beijer, Wolf and Fazel, 2012).
- Excess mortality is higher among people who misuse substances, particularly for those who also experience 'persistent homelessness' (HM Government, 2017).
- Homeless people are between seven and nine times more likely to die from alcohol-related diseases than the general population, and twenty times more likely to die from a drug-related cause (Thomas, 2012).
- Excess mortality has been a consistent feature of the ill health of the homeless for 20 years, although changes in relative proportions of causes of deaths have occurred. For example, there are now relatively more deaths resulting from substance misuse disorders and overdose, with fewer related to HIV infection (Adebowale, 2018).
- It is harder for the homeless to access the health and social care services that the general population. This often results in late presentation to services, with associated poorer outcomes (Seria-Walker, 2018).
- The homeless population attend Accident and Emergency six times as often as the general population and stay in hospital three times as long (Deloitte, 2012).

The impact of homelessness on engagement with drug and alcohol services

- Homelessness reduces motivation for behaviour change and weakens engagement with substance misuse treatment services, whilst access to safe and secure housing can have a positive impact on behaviour change.
- Access to treatment services can be impaired by not having a fixed address, not being registered with a GP, being unable to claim welfare, or having restricted access to transport.
- It is more difficult for treatment providers to maintain contact with homeless service users, for example if they frequently change address.
- The risk of relapse is increased if no housing is available on completion of inpatient or residential treatment (PHE, 2017).

Local issues

In Central Bedfordshire the drug and alcohol service provider records the housing circumstances of all new clients during their initial assessment. The table below shows the proportion of clients engaged with drug and alcohol services who report housing problems at different stages of treatment, compared with the national benchmark. The stages of treatment are based on Treatment Outcome Profile and Alcohol Outcomes Record (AOR) which are tools to review the progress towards recovery aims. The Treatment Outcome Profile Adult Review (6 Month) presents how well clients are performing after six months. The Treatment Outcomes Profile Exit presents the achieved outcomes at the planned treatment exit.

	Central Bedfordshire		England	
	2016/17	2017/18	2016/17	2017/18
Start of Treatment	6.0%	7.0%	13.7%	13.6%
Treatment Outcome Profile Adult Review (6 Month)	8.6%	7.0%	10.2%	10.1%
Exit Treatment outcome profile (Last 28 days)	8.5%	2.1%	8.3%	7.9%
Planned Exit	0.4%	0.7%	2.9%	2.5%

Table: National Drug Treatment Monitoring System data for Central Bedfordshire service users who report housing problems

In Central Bedfordshire between 2017/18 some 7% of service users reported housing problems at the start of drug and alcohol treatment compared to 0.7% who may have achieved treatment outcomes at their planned exit. In comparison, 13.6% service users in England reported housing problems at the start of drug and alcohol treatment compared to 2.5% who may have achieved treatment outcomes at their planned exit.

The reflections of two Central Bedfordshire GPs on alcohol and homelessness

Alcohol presents a particular problem for our local homeless. Many maintain long periods of abstinence but the instability and recurrent stresses of homelessness often trigger relapses. This can result in a vicious cycle whereby patients become unable to stay in hostels or night shelters as a result of their drinking and end up rough sleeping. During these spells they tend to present very frequently to A&E and to primary care.

Occasionally they undergo short-term detoxification in hospital for two to four days before being discharged but this often perpetuate the cycle for longer and in some cases it can lead to patients feeling that their drinking and associated behaviour needs to escalate to a high risk state in order to be able to access help through hospital admission. This undermines, rather than incentivises the establishment of the foundations of a meaningful recovery.

There currently appears to be no process by which a homeless patient who presents to A&E in crisis is offered or signposted to support with housing, transport or benefits. We have observed that homeless patients sometimes do not feel welcome at local recovery groups, but drug and alcohol drop-in services are helpful.

Case study: Substance misuse as a cause and consequence of vulnerability and homelessness

M is a 35-year-old alcohol dependent man who lived with his father (sleeping on his sofa) who is also dependant on alcohol. M works full time through an agency doing shift work. He was drunk whilst riding a bike, had a crash and was admitted to hospital. In hospital he underwent detoxification but received a letter from his father stating that M was no longer welcome to stay at his property. M's care was transferred to the drug and alcohol provider who prioritised interventions to support his long-term recovery. Upon discharge from hospital, M approached local housing services to make a homelessness application and was offered temporary accommodation in Birmingham. Relocation would have meant losing his job, a key factor identified by drug and alcohol services in sustaining his recovery from alcohol misuse.

He was also offered temporary accommodation by a local charity, but his shift hours meant he would be unable to abide by curfew times. In the absence of alternatives, M resorted to rough sleeping in an underpass, dramatically increasing his vulnerability to a relapse of his alcohol misuse problem.

M now experiences suicidal thoughts and low moods secondary to depression, which he believes originated from his childhood and living with an abusive father. Due to the severity of his vulnerabilities, his GP agreed to write a supportive letter to the Housing Service. The drug and alcohol service offered psychosocial support and M agreed to attend a medical assessment for relapse prevention medication. During the detox programme M stated his intention not to drink alcohol again and maintain his sobriety through focusing on work, but sleeping rough and the associated lack of safety and stability makes this extremely difficult to achieve. M's case highlights the highly interrelated nature of homelessness and health issues in general, and the complex relationship between alcohol misuse and rough sleeping in particular. In the context of the Homelessness Reduction Act, local services should work to improve their understanding of the heightened vulnerability associated with substance misuse problems, the resultant increased risk of homelessness (particularly rough sleeping) and worsening of pre-existing health problems such as alcoholism.

Homelessness and health: Focus on mental health

Mental health conditions and their symptoms can be both a cause and a consequence of homelessness and are a major public health problem among the homeless population (LGA, 2017). The importance of safe, secure and affordable housing to good mental health and wellbeing is well-evidenced, and there is a complex interrelationship between homelessness and mental health outcomes. Evidence shows that mental ill health and homelessness share many common risk factors, including:

- Financial insecurity
- Housing insecurity
- Overcrowding (particularly for children and young people)
- Low quality housing (LGA, 2017)

Homelessness and mental ill health often interact. Homelessness may exacerbate a pre-existing mental health problem, and mental ill health is a risk factor for sustained homelessness, making it more difficult for vulnerable people to find and maintain secure housing (Mind, 2017).

Common risk factors between homelessness and mental ill health (LGA, 2017)

- Exploitation and abuse.
- Insecure and unsafe housing.
- Financial insecurity.
- Poor quality housing, including experience of living in emergency or temporary accommodation.
- Overcrowding and cramped living conditions.
- Insufficient coping skills – for example, people with mental illness may not have the skills to manage difficult situations and conversations arising from housing needs (Mind, 2017).
- Difficulty accessing health services – chaotic living arrangements may result in failure to schedule and keep healthcare appointments (Glew, 2016).

The size of the issue

People with pre-existing mental health conditions are at greater risk of becoming homeless compared to the general population (Mind, 2017). 72% of the homeless population are affected by a significant mental health problem, compared to 30% of the population as a whole (Homeless Link, 2018). The prevalence of common mental health problems is over twice as high among the homeless compared with the general population, and prevalence of psychosis is up to fifteen times higher (NHS England, 2016). In a survey of 900 homeless people, Homeless Link found that 49% had depression and more than 40% had experienced anxiety (NHS Confederation, 2012).

Evidence also exists supporting links between homelessness and specific psychiatric conditions:

- Around 4% of people accessing homelessness services have a diagnosis of schizophrenia - significantly higher than the 0.7% of the general population who are affected (Homeless Link, 2011).
- A survey sample of patients with schizophrenia showed that over a third had experienced homelessness in the past (FPH, 2002).
- In a survey of homeless services in England, staff estimated two thirds of their clients had symptoms consistent with a personality disorder, many of whom were thought to be undiagnosed. (FPH, 2002).

The issue of dual diagnosis

A considerable proportion of homeless people are classified as having 'dual diagnosis', meaning they experience one or more mental health conditions alongside substance misuse (drugs and/or alcohol). Estimates of the prevalence of dual diagnosis among the homeless population range from 10 to 50 per cent, though poor quality data may mean the true figure is higher (Rees, 2009; St Mungo's, 2009). People with dual diagnosis almost always have multiple needs – they often present to services with physical health and social problems such as debt and unemployment, as well as mental health and substance misuse problems.

The reflections of two Central Bedfordshire GPs on dual diagnosis and mental health support

Dual diagnosis presents particular challenges for the homeless. Patients often perceive their problems with alcohol or drugs as being secondary to their mental health problems. This sometimes creates tension as mental health services are unable to work with them effectively until their substance misuse in controlled. Patients sometimes perceive that their concerns regarding their mental health are being ignored and this can then also become a barrier preventing them from engaging with drug and alcohol services.

Greater collaboration between mental health and substance misuse organisations could be helpful in avoiding this. Further, the current Improving Access to Psychological Therapies (IAPT) service for Bedfordshire tries to enable access for patients through a self-referral and telephone assessment process. Unfortunately this creates particular barriers for homeless people without a charged phone and who are uncomfortable discussing their mental health by phone. For them it would be beneficial if there were a local drop in assessment service in addition to this telephone assessment, preferably based at local substance misuse service sites to enable closer collaboration.

National guidelines exist to support the delivery of local services for people with coexisting severe mental illness and substance misuse (NICE, 2016). Homeless people should be identified by local areas as a key vulnerable group who are more likely to experience dual diagnosis, and therefore more likely to lose contact or not engage with services.

Important inequalities exist in how homelessness and mental health interact and impact on different groups in society

- The proportion of homeless people with mental illness from Black, Asian and minority ethnic (BAME) groups is higher than in the general population.
- Refugees and asylum seekers have high rates of mental ill health generally, which may present an additional challenge regarding sustainment of secure accommodation (FPH, 2002).
- Women experience some risk factors for both mental illness and homelessness to a greater extent than men and may have higher rates of mental ill health if they become homeless (Crisis, 2009).
- Histories of physical and sexual violence before and after becoming homeless are common and more likely in women (although the issue also affects men) (Vostanis, 2001).
- Child sexual abuse is known to be an independent risk factor for the onset of mental health conditions in adulthood.
- Domestic violence is associated with mental health disorders and women are more likely to cite relationship breakdown and violence as a causal factor in their homelessness (Crisis, 2009).

Access to mental health services

Homeless people with mental health problems experience particular barriers to effective engagement with services:

- Although at least 70% of people accessing homeless services have one or more mental health problem, many homeless people find it hard to access and effectively engage with mental health services and support (NHS Confederation, 2012). A survey of homeless people by Homeless Link (2011) found 64% reported difficultly accessing mental health services.
- Homeless people are 40 times less likely to be registered with a GP than the general population (NHS Confederation, 2012).
- Rough sleepers may experience barriers to access resulting from stigma and difficulty keeping appointments due to a chaotic lifestyle (Glew, 2016). Homeless patients are more likely to attend appointments late, unkempt and unwashed, which may further restrict their access to services if not handled appropriately by service staff.
- Access to services is also characterised by important inequalities among vulnerable sub-populations. For example, homeless refugees may not access mental health services at all due to uncertainty about their right to access healthcare (Kings Fund, 2014).
- Mental health symptoms may act as barriers to effective engagement, negatively impacting recovery. For example, poor mental health may affect the communication skills of homeless people, affecting their capacity to effectively engage with health services. They may become demotivated, putting them at risk of de-registration, thus creating new barriers to access (Kim et al.,2007).
- Effective assessment of the vulnerability of homeless applicants by local housing authorities may be impaired by the presence of a mental health problem.

Case Study: Homelessness and Mental Health

H is a 61-year-old man with a dual diagnosis of psychosis and alcohol addiction. He hears several voices commanding him and putting him down and uses alcohol to stop the voices, sometimes consuming up to 5 bottles of wine a day, plus beer and cider. H has also neglected his personal hygiene and steals alcohol daily. Though banned from local shops, he still uses them and security guards don't approach him because of his appearance and aggressive behaviour.

A mental health assessment was carried out to assess if H needed to be admitted to hospital for a period of assessment and settlement to establish the best care pathway. He was admitted to an inpatient ward after agreeing to a voluntary physical check at his local A&E. H was later discharged from A&E after becoming verbally aggressive and taken to a night shelter but was refused entry due to his appearance. A few hours later he was found by the police in a night club and was later taken by ambulance to a hostel.

More integrated transitions and pathways could have prevented H's deterioration, whilst improving the mental health knowledge of those he encounters could have led to earlier and more appropriate intervention.

Homelessness and health: Focus on ex-offenders

Offending and homelessness are closely interrelated and an estimated 20-33% of rough sleepers and the "hidden homeless" population have previously spent time in prison (Crisis 2011, Greater London Authority, 2016).

The size of the issue

Many prisoners are homeless prior to entering prison and many more have accommodation needs after release. One study of a prison population reported that 15% of prisoners were homeless before entering custody, with 9% sleeping rough. 37% of prisoners surveyed expressed a need for help finding a place to live after release from prison (Williams et al., 2012). Despite the efforts of resettlement services, prisoners are often released without safe and secure accommodation and can quickly fall into maladaptive behaviours such as substance misuse and offending.

- 13% of females and 15% of males on short term sentences are released with 'no fixed abode' (HM Inspectorate of Probation and HM Inspectorate of Prisons, 2016).
- 10% of prisoners who serve more than 12 months in prison are released without suitable accommodation (HM Inspectorate of Probation and HM Inspectorate of Prisons, 2017).

Health needs of homeless ex-offenders

Prisoners have greater health needs than the general population and many of these can be exacerbated by a lack of safe and secure housing, ongoing treatment and support. Particular health issues affecting the prison population include a higher prevalence and severity of mental ill health, with a risk of suicide approaching that of discharged psychiatric patients.

One national survey reported that 60% of male prisoners and 50% of female prisoners had a personality disorder (e.g. anti-social personality disorder); 40% (male) and 63% (female) had a neurotic disorder (e.g. depression, anxiety) and 7% (male) and 14% (female) had a psychotic disorder (e.g. schizophrenia) (Singleton et al., 1998).

There is also a higher prevalence of substance misuse and tobacco consumption (Fazel et al., 2006). 60% of female prisoners and 48% of male prisoners experience drug abuse or dependence, and 80-85% of all prisoners are smokers.

There is a higher prevalence of infectious diseases among prisoners, including tuberculosis, HIV and hepatitis C and poorer vaccine coverage and uptake. Prisoners are more likely to have long term conditions and poor physical health, and experience higher risk of death in the post-release period. This is particularly marked in the weeks immediately post release (especially for females) and is often associated with drug misuse (Revolving Doors Agency, 2017).

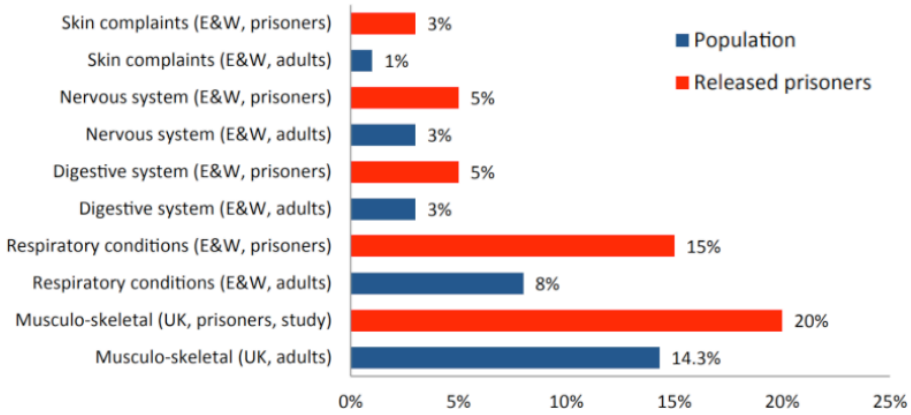


Figure: A comparison of the proportion of physical health issues of prisoners with the general adult population in England and Wales/United Kingdom (Source: Revolving Doors Agency, 2017)

Local information: Central Bedfordshire guidance for homeless when released from prison

Central Bedfordshire contains no prisons, but neighbouring authorities are home to significant prison populations who might apply to Central Bedfordshire Council for housing assistance upon release from prison. Alongside Bedfordshire's Integrated Offender Management Team and Probation Services, local service providers working with these services include the Langley House Trust which provides supported accommodation in Bedford towards preventing prisoners/ex-offenders becoming homeless and meeting their complex needs. Therefore Central Bedfordshire Council has created specific guidance on the application process that includes the following points:

- Whether prisoners/ex-offenders are priority need – factors might include length of time in prison, engagement with third party support networks (e.g. family & friends, probation service, drug & alcohol team) and evidence of vulnerabilities (e.g. mental health conditions, drug/alcohol misuse, history of being in care).
- Whether prisoners/ex-offenders are treated as intentionally homeless – this might consider factors including past actions/inactions, mental health and substance abuse issues and whether or not these contibuted to the loss of a home.
- Where can you be rehoused if considered homeless? – this will consider local connections to the area (e.g. immediate family nearby) and other important factors (e.g. domestic violence and anti-social behaviour issues).
- Help with housing and money before release.

(Available via: **http://www.centralbedfordshire.gov.uk/housing/homelessness/advice-support.aspx** - Homeless when released from prison - accessed on 26th September 2018)

Case Study - Transitional Housing and support for an ex-offender

Mr C was transferred on parole from prison to a bail hostel following a short sentence and was later advised to approach the council for supported accommodation. He has significant health problems including anxiety, depression, and alcohol and substance dependency that could contribute to a relapse to his former lifestyle and a recall to custody. A risk assessment and agreed collaboration arrangements between service providers - including Probation Services, Mental Health Services and Drug & Alcohol Services - were put in place to manage risks and provide ongoing support. Mr C was also supported with accessing welfare benefits, registering with local healthcare services, opening a Bank account and signposting to local services not listed in his Licence. He is also being supported to identify areas of interest for employment, education and training.

Over the last 15 months Mr C has abstained from drugs and alcohol and continues to mentor both family and friends to overcome similar dependencies. His financial capacity has been improved by training in this area and he continues to manage his own accommodation, rent and budgets impeccably. Having completed a difficult programme for restorative justice, Mr C has been commended for his commitment, dedication and accomplishments by the Probation service staff and local health service providers and he is being supported to join the council's housing register and is open to bidding for secure accommodation. His quality of life has improved dramatically with the support he received and opportunities open to him

Homelessness and health: Focus on armed forces veterans

What do we mean by veterans?

Veterans are defined as people who have served at least one day in Her Majesty's Armed Forces, Regular or Reserve, or Merchant Mariners who have served on legally defined military operations.

Armed forces veterans are recognised as a vulnerable group who may be at greater risk of experiencing homelessness and its negative health impacts. Evidence suggests that veteran status is strongly associated with homelessness, unemployment, alcohol misuse, mental health problems and offending behaviour. Although many health needs of veterans are similar to those of the general population, veterans face particular challenges related to social exclusion and access to services.

The size of the issue

Although the proportion of veterans experiencing homelessness is relatively small, affected individuals require significant investment of resources from public and voluntary sector services.

- In 2014 it was estimated that the proportion of veterans sleeping rough ranged from 3% to 6% (Forces in Mind Trust, 2014). This has fallen from above 20% in the mid to late 1990s, perhaps as a result of better resettlement provision by the Ministry of Defence and support from ex-Service personnel charities (RBL, 2010).
- In London, the proportion of rough sleepers with experience of serving in the armed forces has remained constant at around 8% in recent years.
- In 2015-16 there were 452 homeless veterans in England, of whom 142 were UK nationals (Murphy, 2016). Importantly, these figures exclude the 'hidden homeless' engaged in sofa surfing, living with friends or relatives and moving between hostels, and therefore are likely to be an underestimate of the true extent of homelessness among veterans.

The impact on health

Veterans are exposed to a range of risk factors that may predispose them to homelessness, particularly the social and psychological challenges of transitioning between military and non-military environments.

For some veterans, pre-existing vulnerabilities such as poor educational attainment, relationship breakdown, mental ill health, family unemployment, domestic abuse or substance misuse may be exacerbated by transitioning between military and non-military environments, increasing their risk of future homelessness (RBL, 2010).

Evidence gap: health needs of homeless veterans

Local and national evidence on health needs of homeless veterans is limited and low quality. It is characterised by out-of-date data, small sample sizes and limited geography (predominantly London-based) and demography (predominantly single white men). Importantly, very little research has focused on homeless veterans with dependants – this may be because statutory homelessness assistance is easier to obtain for households with children (RBL, 2010). Improving the evidence base on the health needs of veterans should therefore be a key priority at national level.

The health needs of homeless veterans are often similar to those of the wider homeless population, but some health issues particularly affect veterans. For example, veterans are:

- Commonly older than the general homeless population, with an average age of 52 years, and more likely to be male and white (Johnson et al., 2008).
- More likely to experience mental ill health. One study demonstrated that 23% of veterans had spent time in psychiatric inpatient units (Randall et al., 1994). Approximately 4% of current service personnel and veterans suffer from post-traumatic stress disorder, and reservists and combat troops are at greatest risk (Forces in Mind Trust, 2014).
- More likely to have served in the Army (rather than Navy or Air Force), and therefore more likely to come from disadvantaged backgrounds (Johnson et al., 2008).
- More likely to have slept rough before seeking help, and to have done so for longer – possibly because veterans feel better equipped to survive street homelessness (Randall et al., 1994).
- More likely to report alcohol misuse (Randall et al., 1994; Johnson et al., 2008) but less likely to report drug misuse (Gunner et al., 1997).
- More likely to report physical health problems compared to the wider homeless population (Dandeker, 2005).

Support for veterans in Central Bedfordshire

Central Bedfordshire Council has signed the Armed Forces Covenant pledging that members of the Armed Forces community, including veterans, should not suffer disadvantages as a result of their service. A wide range of local initiatives seek to raise awareness of veterans' needs and ensure access to specialist support. For example the Council work closely with RAF Henlow and RAF Chicksands and support multiple charities and organisations including SSAFA, the Army Families Federation, the RAF Families Federation, and the Royal British Legion. Further, Central Bedfordshire Council has created specific advice for homeless ex-armed forces members on the application process that includes the following points:

- Whether you are in priority need – this might consider factors including being pregnant or having dependent children and evidence of vulnerabilities (e.g. disability, mental health conditions, addiction).
- Whether vulnerabilities are linked with your service (e.g. time in forces and role, time in military hospital, discharge on medical grounds).
- Where can you be rehoused if considered homeless? – this will consider local connections to the area where you were based (e.g. immediate family nearby, working in local area).
- Help with housing prior to discharge (where possible) – Many organisations (e.g. Royal British Legion, SSAFA) provide support and advice for current and ex-services personnel. The Veterans' Gateway service (formerly Veterans' Housing Advice) was established by organisations and armed forces charities to support veterans in finding, securing and maintaining accommodation and signposting to other services.

(Available via: **http://www.centralbedfordshire.gov.uk/housing/homelessness/advice-support.aspx** - Homeless advice for ex-armed forces - accessed on 26th September 2018).

Case Study- Supporting a Veteran

Mr R is an elderly veteran who found his service difficult and frightening. He was discovered living in unhygienic conditions after a complaint of a leak from his flat caused by a blocked toilet. He was in very poor health, weak, unwashed and drinking heavily. A surveyor organised an emergency deep clean and ordered works to the blocked plumbing, whilst emergency referrals were made to social services and his local GP. He was admitted to hospital following a fall and was later referred to occupational therapy for support.

Mr R was prone to self-destructive behaviour and hard to understand. He continued to drink heavily and refused support with this and refused access to his carers in. Eventually his care was cancelled and though meals on wheels were arranged he did not pay for this service. His living conditions continued to deteriorate and though initially uncooperative, his ex-wife became involved and he gradually accepted more support in managing his finances. A charity provided help with his shopping but Mr R did not pay for the service so they withdrew.

Mr R was supported to purchase a new mattress, bedding, clothes, towels and microwave and helped to submit an application to the Housing register so that he could move to a ground flood sheltered scheme. He was also supported to apply for Attendance Allowance. His application was successful and though initially reluctant to move, a removal company was arranged and he moved successfully and settled with the help of his ex-wife and the housing officer. He was supported for a few weeks after his move and helped to change his address with everyone who he dealt with. Arrangements were also made for cleaning and shopping via a local charity organisation and he was eventually handed over to the sheltered housing officer.

What works?

What the evidence says about prevention of homelessness and improving the health of homeless people

Central Bedfordshire related services for preventing homelessness and improving health of the homeless

Details of the existing services for homeless people in Central Bedfordshire are described in the Appendix and summarized in the figure below.

Figure: Examples of existing services for the homeless in Central Bedfordshire

Evidence in form of outcomes in preventing homelessness and improving health is limited and hard to measure, but significant activities and achievements by these services include:

Central Bedfordshire Council services:

- Rough sleeper outreach team - arranged accommodation solutions for around half of rough sleepers.
- Independent Living sustainment team - prevented 23 evictions from CBC housing in 2017-18 and has prevented 6 evictions so far this year.
- Independent Living prevention team saw 755 customers last year to provide short term targeted intervention for those at risk of becoming homeless including some work with PSH.
- So far this year 190 customers are engaging with the prevention and sustainment service, with 56 classed as high needs (requiring 15 or more interventions or services for more than 12 months).
- Reviewing more than 40 customers per month at our drop-in service, circa 600 customers per year, and providing the 56 day prevention support required by the Homelessness Reduction Act 2017 (see below). There are currently 60 Homelessness Reduction Act customers, with 46 generic cases.
- A pilot lettings service has achieved 38 tenancies in the private rented sector to date, where CBC is managing properties on behalf of other landlords. This offer augments the successful 'Lets Rent' (see Appendix) model as one cornerstone of prevention.

NOAH outreach service:
From August 2016 to May 2017 engaged with 42 rough sleepers in Central Bedfordshire, 28 of whom had a local connection.

SMART outreach service:
From June 2017 to November 2017 engaged with 29 rough sleepers in Central Bedfordshire, 10 of whom had a local connection, and prevented 19 people from rough sleeping.

Supported & transitional accommodation:
42 successful transitions in two years (Oct. 2016-18) from Kilgour Court into permanent accommodation for customers with complex needs (e.g. addiction, mental health issues and offending behaviours). First customer to transition from Kilgour Court into University has happened this year.

The new duty to refer

Homelessness legislation in England is in the process of significant reform. The Homelessness Reduction Act 2017 introduces a duty on certain public authorities to refer service users who they think may be homeless or threatened with homelessness (i.e. likely to become homeless within 56 days) to a housing authority.

This duty to refer comes into effect from 1st October 2018 and will apply to public authorities including prisons, other parts of the criminal justice system, Jobcentre Plus, social service authorities and hospitals. Crisis also recommends extending the duty to refer to cover immigration detention centres and providers of asylum support accommodation (Downie et al., 2018).

If a public authority considers that a service user may be homeless or threatened with becoming homeless within 56 days, or if a service user positively discloses this information, the public authority will be required:

- to ask the service user if they would like to be referred to a local housing authority of their choice on the grounds that they are homeless or at risk.
- If the individual consents to a referral, the public authority will be required to make the referral, notifying the identified housing authority of the reason for the referral and how the individual may be contacted.

Although wider health services are not currently on the list of those public authorities with a duty to refer, a similar approach may enhance early intervention and prevention of homelessness. The benefits of increased early identification need to be balanced with the additional pressures placed by the new duty onto local authority housing teams.

Primary care registration and the wider role of primary care

Everyone living in the UK is entitled to free primary care, accident and emergency care and some other health services (e.g. contraception, treatment for specified infectious diseases), but homeless people have long faced barriers to accessing health services. In England access has become more complex since October 2017 when charging was introduced for individuals 'not ordinarily resident' (e.g. certain overseas visitors and migrants) to use most hospital-based health services and certain community-based services (e.g. mental health, midwifery, drug and alcohol services). Here service users who cannot prove their eligibility must now pay up front for non-urgent treatment, though exemptions exist (e.g. those requiring urgent/ immediate treatment, certain vulnerable groups – e.g. asylum seekers, children in care). Plans are in place to extend charging to primary care services and others (e.g. accident and emergency) in the future.

The reflections of two Central Bedfordshire General Practitioners on health and homelessness

We attempt to redress the imbalance in care for the local homeless by enabling and promoting GP access using an orange card system allowing homeless patients to access a GP of their choice on the day. We also provide outreach clinics offering ad hoc consultations, reviews of chronic disease and medications and other public health measures (e.g. Flu vaccinations) that seek to work around their complex needs. Further, keeping primary care encounters high through these interventions also enables us to keep A&E admissions low for our homeless population.

We would also like to see more support workers attached to GPs to whom we could refer patients with housing needs, alongside improved lines of communication between GPs, housing and social services. In accordance with the social prescribing model, we would also recommend the provision of more day time activities, that could be accessed by our local homeless, particularly those without day time accommodation.

Approximately 98% of the general population in England are registered with a GP (JHSU 2013) but for homeless people rates of GP registration are much lower. In 2014 a survey of 2,505 homeless people across England (Elwell-Sutton et al., 2016) found that only 89% of the hidden homeless, 83% of single homeless people in accommodation and 66% of rough sleepers were registered with a GP.

Revisions to guidance for GP practices in 2015 and 2017 on registering new patients are intended to improve equity of access to services for vulnerable individuals, including the homeless, but evidence suggests that GP registration remains problematic. For example the charity Doctors of the World (Patel & Corbett, 2018) collect yearly data on access to GP registration in England for their own patients,

some of whom are homeless. Of 1,717 attempts by caseworkers to register their patients with GPs in England in 2017, 80% were successful but 20% were refused, and the most common reasons for refusal were:

- Lack of paperwork.
- Lack of photo identification or proof of address.
- Gatekeeping behaviour of front line GP staff (e.g. GP has their own policy).
- Immigration status.

Improving registration

Homeless individuals are entitled to register in the area where they are without proof of address or identification and irrespective of immigration status, as long as the GP surgery has space for new patients. Recently, organisations such as the London Homeless Health Programme have been working to improve access to all healthcare for people who are homeless in London using "My Right to Healthcare" cards as well as e-learning modules for GPs and their receptionists.

Figure: Example 'Right to access healthcare' card as piloted by the Healthy London Partnership (Source: http://groundswell.org.uk/what-we-do/health/my-right-to-healthcare-cards/)

Reducing financial vulnerability

Improved access to primary care itself also presents opportunities to engage with the homeless around issues that contribute to financial vulnerability. In Central Bedfordshire, two General Practitioners report that their homeless patients struggle managing their own finances due to the risk of robbery or coercion or uncontrolled spending related to substance misuse. Volunteers in their practice have helped patients to manage their finances, but they often feel uncomfortable doing this. They would welcome further support workers to help homeless patients with their finances and other administrative tasks (e.g. application forms). Modelling by Public Health England supports the case for investing in debt advice services in primary care towards to promote public mental health, particularly for the homeless and other vulnerable groups (PHE, 2017). Following an evidence review, PHE reported that face-to-face advice was critical (complemented by web and telephone-based support), and that after 5 years the intervention has the potential to deliver a return of investment of at least £2.60 for every £1 invested.

Transitions and pathways

People in a period of transition are potentially at greater risk of homelessness and include those leaving institutions (e.g. care, prison, hospital, armed forces, asylum support) and those leaving their homes to escape domestic abuse. For example:

- Around 60% of women prisoners have no homes to go to on release (Prison Reform Trust, 2018)
- Around 36% homeless people discharged from hospital onto the street without their housing or underlying health problems being addressed (Homeless Link 2014 in Downie et al., 2018:116

The Social Care Institute for Excellence were recently commissioned by Crisis to complete a 'Rapid Evidence Assessment' of interventions to tackle homelessness and establish a baseline for 'what works' to prevent homelessness (Sheikh & Teeman, 2018). For people in transition who may be at immediate risk of homelessness, they found that core elements of successful prevention included:

- **A case management approach to prevention** – providing personalised solutions to help households avoid homelessness, drawn up by housing professionals with household members.
- **Speedy access to financial support** – a flexible system that covers the basics (e.g. rent, deposits, utility bills) and other items.
- **Provision of expert advice** – including on welfare entitlements, relevant support services, and access to a case manager or similar to advocate on behalf of the homeless person where necessary.

Although these are all elements of a good Housing Options service (Downie et al., 2018), Sheikh & Teeman (2018) describe practical steps for how they can be incorporated into successful arrangements for those leaving institutions. Examples include the location of expert housing staff within institutional settings and the use of established protocols (frequently multi-agency) for moving people into secure housing, such that institutional services see homelessness prevention as a core part of their work.

In some UK hospitals these principles have been incorporated into the charity Pathway's model of integrated healthcare for homeless people (www.pathway.org.uk), which includes access to an expert hospital team that can provide:

- Advice on housing, benefits and documentation.
- Guidance on care planning and discharge.
- Support/referrals to manage complex needs (e.g. mental health, addictions).
- Links to community services & support with GP registration.
- Provision of new clothes etc., assistance in reconnecting with families and friends.

Such models are also an integral part of NICE guidance on transition for adults between hospital and community settings (NICE, 2015). A similar model called the Critical Time Initiative has also been developed in the US and other European countries to support people at risk of homelessness during transition from institutions. As an evidence-based, time-limited and housing led model it is increasingly being used in the UK and its main components are summarised below.

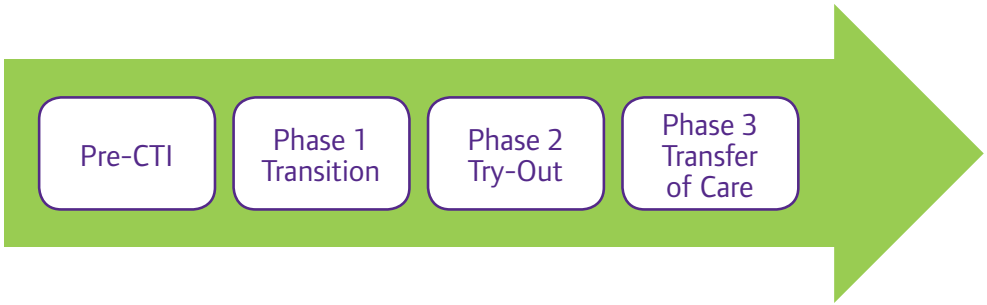


Figure: The Critical Time Intervention model (Source: CTI, 2018)

Improving the assessment of vulnerability is also vital to the effectiveness of local transition pathways. In addition to closer partnership working with mental health colleagues, one effective response is the provision of mental health first aid training for front-line staff, aiming to improve knowledge, skills, attitudes and literacy in mental health issues. One recent international meta-analysis of mental health first aid training supports the effectiveness of such an intervention, particularly in increasing knowledge, decreasing negative attitudes and increasing supportive behaviours towards those with mental health problems (Hadlaczky et al., 2014).

Case study: The importance of coordinated care

D was referred by an early intervention team whilst an inpatient at a local residential psychiatric unit after suffering his first episode of psychosis. He previously lived at home with his family and was working as a care support assistant but he had misused substances that contributed towards his psychosis and subsequent homelessness. D recovered well in the psychiatric unit and was ready for discharge into the community with support. He was immediately helped to familiarise himself with the local area and register with a GP and had a discharge meeting with his psychiatrist to better understand his condition and future support needs. D also now meets with a local psychologist for weekly therapy sessions and is finding this support incredibly helpful.

Homeless centres and outreach services

Homeless centres are an increasingly common way for local authorities and voluntary sector organisations to provide local face-to-face contact, information and support to help people access all services from a single site. They typically also provide access to wider support networks, for example running regular surgeries in areas like debt management and pensions. For example NOAH operate a Welfare Day Centre in Luton providing drop-in advice and support to meet the complex needs of rough sleepers (e.g. mental health, employment, food), including regular GP surgeries and a mobile dentist (see Appendix).

The nature of Central Bedfordshire means that access to outreach services remains essential. In June 2017 a Rough Sleeper Outreach Service began running across Bedfordshire and Milton Keynes and is provided by the Rough Sleeper Partnership (RSP) working to actively identify, engage and support those most vulnerable on the streets, sleeping rough and homeless. Street Outreach Teams supported by Central Bedfordshire Council and other organisations identify those at high risk of becoming rough sleepers and work proactively to prevent them from moving on to the streets of Central Bedfordshire via a range of outreach support services (see Appendix).

Case study: the role of drop-in centres

S arrived at a local day centre having just served a prison sentence for shoplifting and has a history of heroin use, but S completed a detox whilst in prison and has not used heroin for two months. However he was released without accommodation and too late to use the local drop in centre, and was therefore sleeping rough. His main concerns were finding somewhere safe to sleep, and avoiding old acquaintances on the street that might encourage him to use heroin.

S was signposted to a night shelter in the hope he could get a bed for the night, then referred to local hostels in the long term. He was also encouraged to make sure he arrived at the drop in centre first thing in the morning and encouraged to return the following day for support. There he was given fresh clothes and bedding should he end up on the street for a night, as well as a food parcel for the night and a hot meal at lunch time. S was also given the opportunity to shower and as much time as he needed to share his concerns and tell centre staff what he needed.

S would love to get back on his feet but at the moment is really struggling to stay clean and get a roof over his head. Therefore a support worker meets with him regularly to encourage S to engage with the drop in centre and all its resources. In the future S hopes to become a support worker himself but in the meantime his current support worker is exploring opportunities to get S involved in group work and volunteering to get vital experience.

Addressing complex needs: Housing First

Housing First is a housing model that provides immediate long-term housing for those sleeping on the street with ongoing flexible support for an individual's complex needs. The original Housing First model was developed by an American charity in the late 1980s to meet the housing and treatment needs of chronically homeless people with histories of severe psychiatric illness, often compounded by substance abuse (Tsemberis et al., 2004).

At that time traditional treatment based approaches required individuals to remain sober, to abstain from drugs and alcohol and to participate in mental health treatment (as required) to demonstrate their 'readiness' for housing. The original Housing First model prioritised access to housing for homeless people with psychiatric illness, although in recent years the model has been adapted and widened to target different homeless people with complex needs (Woodhall-Melnik & Dunn, 2016).

Models vary but typically follow a series of core principles. The approach centres on first fulfilling the right to housing (hence 'Housing First'), with participants given their own tenancy agreements, not subject to any 'housing ready' tests and able to choose and control their support in the long term. Further, Blood et al. (in Downie et al., 2018) stress the following:

- **Separating the right to housing from support:** the choices people make about the support they engage with does not affect their housing.
- **Flexible support is provided for as long it is needed:** this requires providers to commit to long-term offers of support and help should be given quickly when needed, without the need for re-referral or assessment.

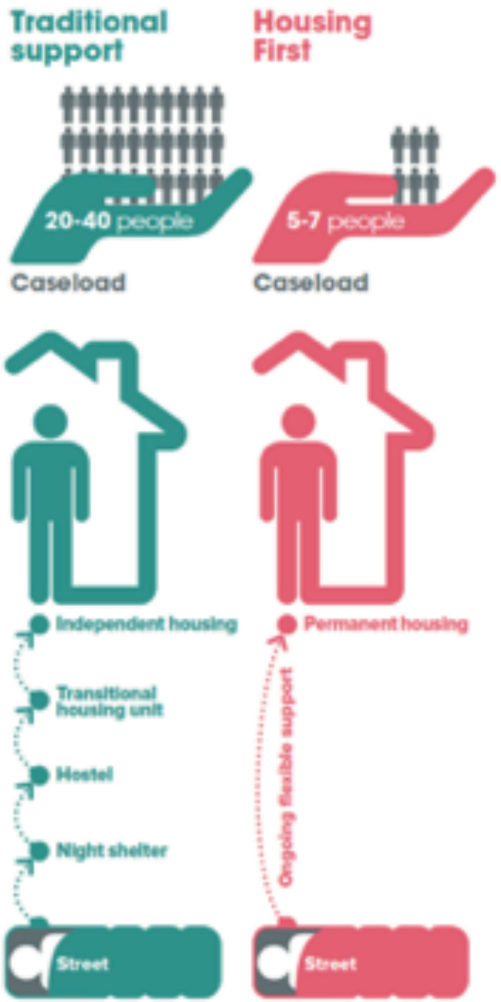


Figure: Rehousing the homeless: comparing traditional support approaches to Housing First (Source: Housing First England)

- **Active engagement:** this might include dedicated caseworkers who regularly contact their clients and are available at short notice.
- **Harm reduction** underpins Housing First by encouraging people to use treatment services (as appropriate) but not forcing them to do so as a condition of their tenancy.

The impact of Housing First

Three systematic reviews report a strong evidence base for interventions targeted at homeless populations that include improved housing retention outcomes for 60 to 90% of international Housing First (HF) study participants including 78% of participants from England in nine Housing First programmes (Downie et al., 2018; Mackie et al., 2017; Woodhall-Melnik & Dunn, 2016; Bretherton & Pleace, 2015).

However, evidence of improved health outcomes for HF study participants is more mixed. Bretherton & Pleace's (2015) evaluation of nine HF services in England found some evidence of improvements in mental and physical health and reductions in drug and alcohol use amongst service users. There was also some evidence of improved social integration and reductions in anti-social behaviour and service users also valued the greater choice, security and flexibility offered by HF.

In cost effectiveness terms, as an intensive service offering open ended support HF is not a low-cost option, but creates potential for longer term savings (e.g. via reduced service costs) for homeless people with complex needs:

- In greater Manchester for every £1 invested, HF created outcomes worth £2.51 and would be cost neutral within 5 years (Centre for Social Justice in Mackie et al., 2017).
- English HF services cost around £26-£40 an hour but (assuming service users would otherwise be in high intensity supported housing) these could save between £4,794-£3,048 per person annually in support costs, with overall savings of around £15,000 per person per annum.

But the evidence emphasises that Housing First is not a panacea and cannot simply replace existing homelessness services. There is a lack of long term evaluations (>2 years) of housing retention and health outcomes (Mackie et al., 2017) and its effectiveness with some homeless populations (e.g. domestic violence, prison leavers) is unknown (Blood et al in Downie et al., 2018). However evidence of success with other homeless groups (e.g. young people, ethnic minorities) (Mackie et al., 2017) and its use in a preventative role with those at greater risk of long-term homelessness (Bretherton & Pleace, 2015) suggest the model may be adaptable:

Recommendations

How can we work together to reduce rough sleeping, better prevent homelessness and improve the health of homeless people in Central Bedfordshire

The considerable work in Central Bedfordshire to reduce homelessness is summarised in the Appendix. Central Bedfordshire Council's ongoing strategic priorities reflect this work and the need to work more in partnership both to prevent people becoming homeless and to provide a joined up response when people do become homeless. Central Bedfordshire's new Joint Health and Wellbeing Strategy 2018-2023 priorities are:

- Driving change to improve mental health and wellbeing for people of all ages.
- Enabling people to optimise their own health and wellbeing.
- Ensuring that growth delivers improvements in health and wellbeing for current and future residents.

Each of these priorities has the ability to impact positively on homelessness. More specifically, priorities in Central Bedfordshire's Homelessness Strategy 2017-20 are:

- Improving the provision of a range of housing options and services to effectively prevent and reduce homelessness (including a viability study of Housing First).
- Increasing housing supply to meet the accommodation and support needs of homeless people.
- Reducing the use of temporary accommodation and bed & breakfast.
- Minimising the impact of welfare reform whilst assisting homeless people to access opportunities for employment, education, training and support them to raise and meet their aspirations.
- Developing an integrated partnership approach to tackling homelessness.

Therefore homelessness is integrated into Central Bedfordshire Council strategy, but further work is required to prevent and address the health-related vulnerabilities that can lead to homelessness and to address the health impacts of homelessness itself. Work is also required to better understand the local homelessness picture to address less visible forms homelessness and their impact on health and wellbeing.

1. Improve awareness of the Homelessness Reduction Act 2017 and its implications for partner organisations, especially regarding the duty to refer

- To improve awareness among public authorities in Central Bedfordshire of the new duty to refer and consider whether there should be wider implementation than the listed public authorities, e.g. in primary care.
- To achieve commitment to the aims of the Homelessness Reduction Act (with a focus upon improved referral routes and advice offer), building upon the Duty to Refer portal already established by CBC and aligned to the Care Act 2014.
- To develop a CBC Rough-sleeping strategy to be adopted by CBC Health and Wellbeing Board and CBC Executive by August 2019. This will help strengthen partnerships e.g. with Housing Associations and a further enhanced housing advice offer.

2. Improve the identification, assessment, recording and sharing of housing vulnerability, including little understood groups such as the hidden homeless

To improve system-wide understanding of homelessness, its impact and the current response, Central Bedfordshire Council should build on existing good practice by expanding its multi-professional approach to housing need, identification and assessment through:

- Building on existing work to capture information on the hidden homeless and wider homeless groups.
- Consideration of developing a single assessment process for vulnerable households (Care Act 2014 compliant), to identify at first assessment (using pre-agreed criteria) those at risk of deteriorating health and wellbeing. The impact on health and wellbeing will then be evaluated.
- Determining how public sector bodies and commissioned services should routinely record housing status, housing vulnerability and the duty to refer during initial assessments, and proactively address risk factors for homelessness.
- Developing and encouraging long-term housing approaches for vulnerable people (e.g. strengthen existing work with hospital discharge teams, prison/offender management services and the veteran housing advice service).

3. Improve understanding of the overlap between mental health, other vulnerabilities and housing

- Improve mental health literacy by providing mental health awareness and intervention training for all frontline staff involved in homelessness prevention.
- Increase homelessness awareness within mental health and substance misuse services and ensure that care providers support individuals to obtain safe and stable housing.
- This improved partnership approach could include formal review meetings to learn from cases and transform services where required, including those relating to children leaving care and children in transitional accommodation.

4. Improve signposting and access to local services that can address the root causes of homelessness

- Improve system-wide knowledge regarding local services to maximise effectiveness and prevent duplication
- To improve signposting from primary care to local services, Central Bedfordshire Council should work with GP practices to build and launch a 'resource pack' for primary care professionals.
- Increase signposting to advisory services (e.g. homelessness and debt advisory services) in health settings including primary care, mental health and drug and alcohol services, linking with existing work on GP signposting and social prescribing.

5. Improve consistent healthcare access for homeless individuals, from primary care through to acute care

Increase the proportion of the homeless population registered with a GP practice (including children and families in temporary accommodation). Approaches to improve registration could include:

- Development of a shared strategy to improve registration of homeless patients across all GP practices in Central Bedfordshire.
- Education and training for GP practices to clarify rights and responsibilities in relation to registration of homeless patients.
- Introducing the 'My Right to Healthcare' card in Central Bedfordshire

6. Incorporate health and wider outcomes into evaluations of homelessness initiatives

- Measure the impact on health, wellbeing and socio-economic outcomes within any evaluation of homelessness initiatives e.g. the Rough Sleeper Outreach Service.

Appendix

How Central Bedfordshire is working to prevent homelessness and reduce its health impacts: local services and strategies

Overview of existing services for homeless people

Figure: Examples of homelessness services available in Central Bedfordshire

Partnerships and strategic work

Central Bedfordshire Council – Housing Solutions, Independent Living & Intensive Property Management Teams, Lettings Service, local welfare provision and Severe Weather Emergency Protocol

There has been considerable work in Central Bedfordshire to sustain tenancies as well as to prevent and reduce homelessness over the last few years. The work of the Council's own services is focused on the following principles/areas:

- Partnership working across the services (as one whole system) to deliver the new duty to refer (see below).
- Outreach and severe weather emergency services for the homeless, particularly rough sleepers
- Improved affordable housing supply, including greater system resilience via transitional accommodation & the independent living model (see Appendix).
- High quality housing advice and interventions, particularly in assessment and case management.

Making the best use of the available resources is central to this given the scarcity of local accommodation. A customer-centric approach is used to reach and assist households in need, whilst an assets-based approach helps people to help themselves. For example, the Council's Independent living Team employs an Employment Support officer to work with individuals in a targeted way to improve their life-skills. Central Bedfordshire Council are also investing in a wide range of services to manage demand towards positive and sustainable outcomes, not just to put a roof over someone's head. This demand management approach is not homeless-centric but is concerned with early intervention towards meeting housing-need in a planned and proactive way where possible.

Central Bedfordshire's Housing Solutions service operates 24/7, 365 days a year providing advice and support to those at risk of becoming homeless, a duty reinforced by the Homelessness Reduction Act 2017. This includes an assessment service alongside wider advice and support, some tailored to vulnerable people at risk of homelessness (e.g. domestic abuse sufferers, ex-offenders, ex-armed forces – see Section 6 below). Early guidance targeting those at risk of becoming homeless has been translated into a You Tube video published in June 2016 and reviewed below. Homeless people are also directed to their nearest regional assessment hubs (e.g. Open Door Milton Keynes, SMART in Bedford and Signposts in Luton). The Housing Solutions Team has a prevention mindset and aims to understand their customers on the basis of their assets (as people, what they can do for themselves), as well as their needs' (where they might need help). This approach is based upon good quality assessment, right-first-time decision making and holistic case-oversight and supported by a sub-structure comprising the joint work of the Independent Living and Intensive Property Management teams (see below). However it is recognised that partnership working with private landlords via the Lettings Service and Housing Associations could be strengthened.

In 2017 there was an update to the Homelessness Strategy Action Plan and the Council has invested significantly in creating the Independent Living model and expanding the provision of Transitional Accommodation (see below), so as to respond appropriately in each main town across Central Bedfordshire. For example the Independent Living service works to support people with a history of homelessness or other complex needs (e.g. tenancy breakdown, little experience of living independently) to help them remain independent and live confidently within their own home. Examples of support provided include budgeting, signposting to other organisations and services and employment and welfare advice. The model comprises both floating support and accommodation-based schemes, whilst new provision is also being created towards greater long term system resilience.

A 'making-moves' approach has also been established towards making the best use of scarce social housing by encouraging mutual exchanges, incentivising right-sizing and facilitating planned moves to sustain tenancies.

A Lettings Service has been created and the Let's Rent model remains a key facet of homelessness prevention. The model is aimed at households in need of housing or threatened with homelessness to provide help and assistance for them to live in good quality, well managed local private rented accommodation. Rent deposits, rent subsidy and interest-free loans are offered to tenants and landlords can take advantage of the service's Rent Guarantee and Lease schemes.

Local welfare provision includes assistance for homeless households, amongst others, to help establish new tenancies via basic furniture packages for example towards preventing households immediately getting into debt for essential items. Central Bedfordshire Council also works in partnership with local food banks, particularly to support those not eligible for welfare.

Central Bedfordshire's Severe Weather Emergency Protocol is instigated when the temperature is forecast to drop to zero degrees (or below) for three consecutive nights. Notification of services being available is sent to a range of organisations which provide services for people sleeping rough, including NOAH (see below).

Are you at risk of becoming homeless? – by Central Bedfordshire Council

via: https://www.youtube.com/watch?v=C3_RosvF_ro

This video provides key advice and information for individuals in Central Bedfordshire at risk of becoming homeless. It explains that Housing officers are available to negotiate on your behalf and provide advice on securing suitable accommodation. In the case of homelessness, CBC might be able to help you find temporary accommodation and wider issues, such as checking eligibility for benefits, negotiating a new rent with a landlord or providing a deposit. The video seeks to reassure viewers that CBC are willing to assist those at risk of homelessness and will act quickly to find suitable accommodation. In September 2018 the video had been viewed nearly 1300 times and provides a useful platform for communicating the complexities of housing and homelessness in around 2 minutes.

Rough Sleeper Partnership and outreach service

Central Bedfordshire Council is currently a member of the Rough Sleeper Partnership that operates across its areas and those of Bedford Borough, Luton and Milton Keynes local authorities. The funding is £623,000 in total across the four local authority areas, for two financial years from 2017 with Government funding set to end in May 2019 in Central Bedfordshire. The Rough Sleeper Partnership (RSP) provides a combination of outreach support and assessment Hubs where homeless people can access help and support, aiming to prevent rough sleeping or reduce time spent on the street. This Partnership and Central Bedfordshire's Homelessness Strategy Action Plan 2017-20 highlight the importance of partnership approaches to prevent rough sleeping and provide a joined-up response when people do end up on the street. This is in part a recognition of how drug and alcohol issues, mental health concerns and the incidence of domestic abuse are prevalent in the households approaching the Council. Thus mental health outreach workers are also available to provide mental health crisis support, whilst a Homeless Inter-agency Officer works with providers towards more collaborative working and across the community to improve public awareness of services supporting the homeless.

In June 2017 a Rough Sleeper Outreach Service began running across Bedfordshire and Milton Keynes. The service is provided by the Rough Sleeper Partnership (RSP) across its four Local Authority areas with a role to actively identify, engage and effectively provide support to those most vulnerable on the streets, sleeping rough and homeless. The Street Outreach Team aims to identify those at high risk of becoming rough sleepers and work proactively to prevent them from moving on to the streets. The team also includes three dedicated Mental Health Crisis Workers employed by East London Foundation Trust and Central North West London Foundation Trust, alongside open referral into the service including mechanisms for self-referral. CBC have arranged accommodation solutions for around half of rough sleepers, but external funding of the outreach service ends in May 2019 and applications for further funding have been submitted.

Primary care services

Bedfordshire Clinical Commissioning Group commissions primary care outreach services for rough sleepers and other homeless patients across Central Bedfordshire from the Bassett Road Surgery in Leighton Buzzard. The surgery operates an Orange Card system to give homeless patients prioritized short term access to a GP of their choice to allow continuity. The service GP leads also operate a weekly Homeless Outreach

service at a drop-in centre and meet regularly with other stakeholders. Here patients can have immediate medical needs attended to, and where necessary, referrals will be made to other services. Over 2016-17 73 homeless patients were registered and being monitored by the practice. Clients are also encouraged to sign up with a GP, though they might need support with this as per our recommendations below.

NOAH - New Opportunities and Horizons Across Bedfordshire

NOAH have been working to support rough sleepers and those at risk of homelessness across Central Bedfordshire, Luton, Milton Keynes and Bedford Borough since 2013 and are local partners in delivering the outreach service. From August 2016 to May 2017 they engaged with 42 rough sleepers in Central Bedfordshire, 28 of whom had a local connection. NOAH also operate a Welfare Day Centre in Luton providing a wide range of advice and support to meet the complex needs of rough sleepers (e.g. mental health, employment, food), including regular GP surgeries and a mobile dentist. NOAH are also involved in making referrals to other partners to assist in preventing homelessness. They also operate an emergency winter night shelter in Luton, part of the Council's Severe Weather Emergency Provision, for up to 30 residents and run free skills training workshops across Luton and Bedfordshire for those who are not working or are on a low income.

SMART

SMART work to support rough sleepers and those at risk of homelessness across Central Bedfordshire, Luton, Milton Keynes and Bedford Borough and are local partners in delivering the outreach service. From June 2017 to November 2017 they engaged with 29 rough sleepers in Central Bedfordshire, 10 of whom had a local connection, and their wider work prevented 19 people from rough sleeping. Since September 2017 SMART have run the Prebend Street Day Centre in Bedford that provides advice and support and operates as a regional assessment centre.

Supported and transitional accommodation

A range of supported and transitional accommodation is run by Central Bedfordshire Council and others across the area to provide tailored support for the homeless, those at risk of homelessness and others with complex needs (e.g. troubled young people, disabled persons) towards more independent living. Existing accommodation in Central Bedfordshire includes:

- Franklin House in Dunstable.
- Bedford Court in Houghton Regis.
- Kilgour Court and Hockliffe Street in Leighton Buzzard.

For 2018-19 Central Bedfordshire Council is working to increase its provision of local supported and transitional accommodation, including:

- Kitts Inn in Dunstable.
- Puddlehill and The Brook in Houghton Regis.
- North Street in Leighton Buzzard.
- Birches in Shefford.

By October 2018 some 39 additional street properties for use as transitional accommodation across all towns in Central Bedfordshire, 10 of which are 4+ bed properties, through acquisition, conversion and extensions to properties. More properties are being acquired on a continuous basis.

Signposts

Signposts are one of the largest providers of temporary supported-accommodation to the homeless of Luton and Central Bedfordshire. Their thirteen properties provide 137 bed spaces for vulnerable homeless people, including accommodation in Dunstable and Houghton Regis (34 units in Central Bedfordshire). Signposts staff and volunteers (including current/former clients) work to provide tailored support, advice and training towards helping their clients access services and to live and develop in the community.

Amicus Trust

The Amicus Trust has 35 units in 12 properties. Six properties are in Sandy (two for care leavers), two in Leighton Buzzard (one for homeless veterans) and two in Dunstable (one for homeless veterans). Amicus also run the Night Owl Night Shelter bus in the more rural north area of Central Bedfordshire during severe weather that provides hot drink/food and shelter. Their night shelter bus service also provides pick-ups on certain days to take people to temporary overnight accommodation.

Leighton Linslade Homeless Service

The service provides an emergency night shelter and other support and advice services at the old Black Horse pub in North Street, Leighton Buzzard. It is independent of local authorities and relies on volunteers and donations and works closely with many of the town's churches to provide support to those in need. For example since July 2018 the Trinity Methodist Church in Leighton Buzzard has been running a weekly hot meals service.

Citizens Advice - Ampthill, Dunstable, Leighton Linslade

Local Citizens Advice services provide general information and advice on applying for homelessness related help from Central Bedfordshire Council, including how to make a homeless application, money advice and how to challenge the council's homeless decision.

The Salvation Army

The Salvation Army has a long history of providing outreach and other support to homeless people. In Central Bedfordshire the Salvation Army operates a network of church based drop in and food bank services for homeless and disadvantaged people operating across the local authority. A key worker from the Leighton Linslade Homeless Service attends to provide support and advice. The Salvation Army volunteers based in Dunstable also arrange transport for rough sleepers to NOAH's emergency night shelter in Luton when Central Bedfordshire Council's Severe Weather Emergency Protocol is triggered.

YMCA Bedfordshire

YMCA Bedfordshire provide a wide range of services for the homeless across the county. They have two hostels accommodating homeless young people, Cornerstone House (25 beds for people of 16 – 25yrs) and The Foyer in Bedford (34 units for people aged 16 – 30yrs). For adults accommodation is available at Weaver House (29 units), Linden House (16 units) in Bedford and Midland House in Luton (up to 78 residents, aged 16-64 yrs). The Supported Lodgings Scheme provides 8 beds in family homes where young people are supported to move on to their own accommodation. Cornerstone House residents have access to counselling services 6 hours a week, via Open Door. The YMCA takes a therapeutic approach to preparing residents for independence, encouraging healthy lifestyles through diet and exercise, and a life skills course for all residents, who can remain for up to two years. The average stay is between 9 and 12 months, and a Resettlement Officer prepares residents to move on to social housing. Six weeks of support is available to residents who have moved into their own homes, provided by One Housing's One Support scheme. YMCA Bedfordshire also runs two domestic abuse refuges in Central Bedfordshire (22 units) and a resettlement service to assist applicants made homeless by domestic violence, the latter mainly intended to help those in transitional accommodation provided by the Council.

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