

Worcestershire Health & Well-being Board

JSNA Homeless Health Profile 2018

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Summary

Homelessness covers a wide spectrum of housing situations and defining homelessness is not straightforward. Official data based on statutory homelessness are only part of the story. Counting homeless people is a challenge and hidden homelessness an issue.

Homelessness is an important concern in Worcestershire. Many indicators are close to the national level. The economic recession saw statutory homelessness in the county peak in 2011, since then it has fallen, but it still remains above pre-2011 levels.

Homeless people are at increased risk of a wide range of health problems related to physical health, mental health and substance misuse (usage of illegal and prescribed drugs, and of tobacco and alcohol).

Physical health problems include circulatory and respiratory conditions, joint aches and pains and poor oral health. There is evidence that many homeless people have two or more long-term conditions (LTCs), a situation known as 'multimorbidity'.

The Worcestershire Homeless Health Audit 2017 found the majority, 87%, of the sample were smokers. This is a similar proportion to national studies of similar homeless groups and is much higher

than the general population prevalence of 17%. Amongst those who were drinking, the average units consumed per day was 11 which is much higher than the officially recommended limit of 14 units per week.

Access to health services is an issue nationally and locally with significant proportions of homeless people facing barriers to access and/or insufficient treatment. This may have an effect on the diagnosis of chronic health conditions. For example, the Worcestershire Homeless Health Audit 2017 found diabetes was reported at a rate well below that recorded in the overall population, which suggests there may be under-diagnosis of this condition amongst this homeless population.

The Homelessness Reduction Act 2017 increased the scope of duties of local authorities towards the homeless. Proposed changes to legislation and benefits are likely to have an impact on homeless numbers.

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Introduction

Homelessness is the condition of people without a permanent dwelling, such as a house or flat. People who are homeless are most often unable to acquire and maintain regular, safe, secure and adequate housing.

Homelessness is an important social determinant of health and is associated with severe poverty, adverse mental and physical health and, for children, adverse childhood experiences (ACEs) and poor educational outcomes.

Homelessness is also a major contributor to health inequalities. It has been recognised that tackling homelessness and its health impacts requires a multi-agency approach.

Nationally, in 2018 Public Health England and other partners have signed up to a Memorandum of Understanding ('Improving Health and Care through the Home'¹) as a joint commitment between government, housing, social care and health sectors to work together to deliver better health and well-being outcomes and reduce health inequalities for homeless people.

The Local Government Association (LGA) produced some guidance in 2017 about the impact of homelessness on health. This included information and ideas to support local authorities in protecting and improving their population's health and well-being, and reducing health inequalities, by tackling homelessness and its causes².

Locally, a Worcestershire-wide Homeless Health Group has been in operation since 2016. This forum brings together local authorities, NHS partners and voluntary sector organisations and leads on the work committed to under the Memorandum of Understanding.

In recognition of the health issues faced by homeless people, the Worcestershire Health and Well-being Board have signed up to a charter to improve the situation (Figure 1). This report is aimed in particular at fulfilling the 'identify need' commitment within the Charter.

¹ Public Health England. 2018. *Improving Health and Care through the home*. PHE Publications gateway number 2017861

² Local Government Association, 2017, *The Impact of Homelessness on Health: a guide for local authorities*.

Figure 1: Worcestershire Charter for Homeless Health

Charter for Homeless Health

People who are homeless face some of the worst health inequalities in society. They are at much greater risk of mental and physical problems than the general population and their experience of homelessness often make it more difficult to access the healthcare they need.

The **Worcestershire Health and Wellbeing Board** is committed to changing this. We therefore commit to:

Identify need: we will include the health needs of people who are homeless in our Joint Strategic Needs Assessment. This will include people who are sleeping rough, people in sheltered accommodation [*please note, this refers to homeless hostels and night shelters for example*] and people who are hidden homeless. We will work with homeless services and homeless people to achieve this.

Provide leadership: we will provide leadership on addressing homeless health. Our Director of Public Health has a key leadership role to play in tackling health inequalities and will lead in promoting integrated responses and identifying opportunities for cross boundary working.

Commission for inclusion: We will work with the local authority and clinical commissioning groups to ensure that local health services meet the needs of people who are homeless and that they are welcoming and easily accessible.

Approach

This profile will:

- Look at definitions of homelessness
- Present statistics of the number of homeless people in Worcestershire (and discuss issues around the data)
- Discuss the relationship between poor health and homelessness (using three types of information: research evidence, national statistics and local data from the Worcestershire Homeless Health Audit)
- Provide information on use of health services and health interventions by homeless people (using research evidence and information from the Worcestershire Homeless Health Audit)
- Discuss the possible impact of policy developments in the future

There is a shortage of local information on the health of homeless people, so national data sources have been used and corroborated, where necessary, by using local survey data such as the Worcestershire Homeless Health Audit.

Definitions of Homelessness

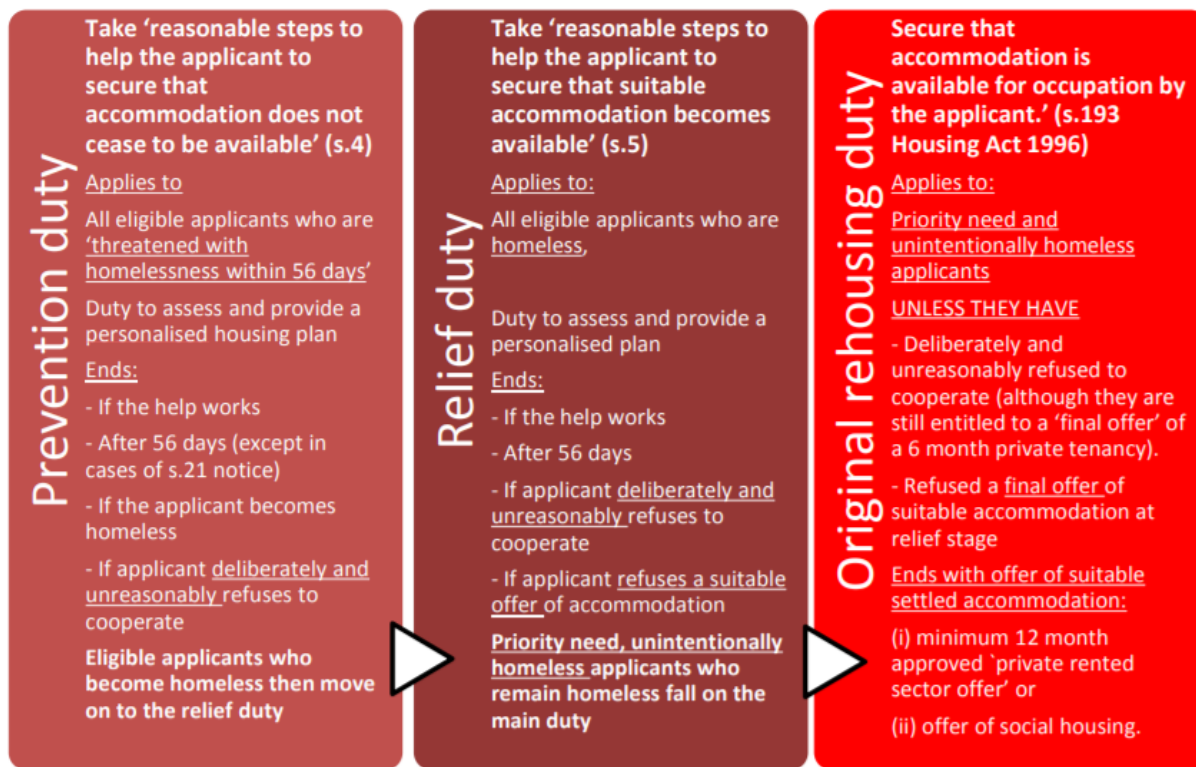
This section can only give a general summary of this complex and evolving area. For further information about homelessness legislation, please see the Homelessness Code of Guidance for Local Authorities³.

New Legal Framework

The Homelessness Reduction Act 2017 (HRA) came into force on 3rd April 2018. It places new legal duties on English councils so that everyone who is homeless or at risk of homelessness will have access to meaningful help, irrespective of whether they are judged to be in 'priority need' as long as they are eligible for assistance.

The HRA effectively adds two new duties to the original statutory housing duty (Figure 2).

Figure 2: Summary of changes introduced by the HRA



Source: Shelter (2017)⁴

These changes mean that more comprehensive data on homelessness and risk of homelessness should be available in the future. All applicants approaching as potentially homeless will now be recorded on H-

³ Ministry of Housing, Communities and Local Government (Feb 2018), Homelessness Code of Guidance for Local Authorities

⁴ Shelter (2017), Policy Briefing: Homelessness Reduction Act 2017

Clic (the new Ministry of Housing, Communities & Local Government monitoring system) so it is likely that the numbers of all those homeless or at risk of homelessness will be recorded. This differs from the previous system where only those that formally approached as homeless were recorded and detailed information was only captured for those that were owed the full rehousing duty (accepted for rehousing).

Previous Legal Framework

Prior to the Homelessness Reduction Act 2017, in England, local authorities only owed a main homelessness duty to those who fulfil all of the below criteria:

- Eligible for assistance
British citizen or have 'right to remain' and/or be 'habitually resident'
- In priority need
Because of: an emergency (flood, fire, etc.) / dependent children / pregnant woman / aged 16 – 17 / aged 18 – 20 and formerly 'in care' / vulnerable due a variety of reasons including old age, physical disability, or mental illness or disability, institutionalised
- Homeless
No accommodation available in UK or elsewhere – unreasonable for them continue living in existing accommodation (threat of violence, overcrowding, very poor conditions)
- Unintentionally homeless
Have not done anything, or failed to do anything, deliberately, which resulted in loss of accommodation
- Have a local connection
Normal residence, employment or family associations, or due to special circumstances

Most official statistics to date pertain to those who apply for help under the main homelessness duty. This means that the data will miss people who do not apply (for example in the knowledge that they won't fulfil the criteria).

Types of Homelessness

In this section, different types of homelessness are explored and some of the categories of homelessness that have been used by academic researchers are described.

Key points are:

- The homeless population covers a wide spectrum – well beyond the more obvious rough sleepers and hostel/shelter users. Homelessness can be viewed as a continuum, with sleeping rough at one extreme and living in insecure accommodation at the other. There are various ways of defining homeless people.
- The homeless are not a static population, people move in and out of homelessness or between different homeless states.
- Prior to the Homelessness Reduction Act 2017, statutory homelessness only measures those that approach under the main homeless duty. It only records detailed information on selected groups who are eligible for the full rehousing duty – for example it excludes single homeless people (unless they can demonstrate a priority need).

This report where possible will differentiate between homeless groups when presenting data and research findings. Studies may look at different subgroups of homeless people.

There have been many attempts to categorise and define homelessness. Here we give a flavour of these with particular reference to three examples:

Theoretical Categories of Homelessness (physical, social and legal domains)

Table 1 shows one attempt to define groups of homeless people. It usefully conveys the complexity of types of homelessness according to three key domains: the physical, legal and social domains.

Table 1: Seven Theoretical categories of homelessne

Conceptual category	Operational categories	Physical domain	Legal domain	Social domain
Homelessness	1 Rooflessness	No dwelling (roof)	No legal title to a space for exclusive possession	No private and safe personal space for social relations
	2 Houselessness	Has a place to live, fit for habitation	No legal title to a space for exclusive possession	No private and safe personal space for social relations
Housing exclusion	3 Insecure and inadequate housing	Has a place to live (not secure and unfit for habitation)	No security of tenure	Has space for social relations
	4 Inadequate housing and social isolation within a legally occupied dwelling	Inadequate dwelling (unfit for habitation)	Has legal title and/or security of tenure	No private and safe personal space for social relations
	5 Inadequate housing (secure tenure)	Inadequate dwelling (dwelling unfit for habitation)	Has legal title and/or security of tenure	Has space for social relations
	6 Insecure housing (adequate housing)	Has a place to live	No security of tenure	Has space for social relations
	7 Social isolation within a secure and adequate context	Has a place to live	Has legal title and/or security of tenure	No private and safe personal space for social relations

Source: Busch-Geertsema, Volker (2010). Defining and Measuring Homelessness. Homelessness Research in Europe.

Core and Wider Homelessness

While the above defines categories according to homelessness and housing exclusion, Crisis UK uses the terms 'core homelessness' and 'wider homelessness' which relate to the severity of the housing situation (Table 2).

Core homelessness refers to households who are considered homeless at any point in time due to experiencing the most acute forms of homelessness or living in short-term or unsuitable accommodation. Wider homelessness refers to those at risk of homelessness or who have already experienced it and are in accommodation which is on a temporary basis.

Table 2: Definitions of core and wider homelessness

Core homelessness
Rough Sleeping
Sleeping in tents, cars, public transport*
Squatting (unlicensed, insecure)*
Unsuitable non-residential accommodation e.g. 'beds in sheds'*
Hostel residents
Users of night/winter shelters*
DV victim in Refuge*
Unsuitable temporary accommodation (which includes bed and breakfast accommodation, hotels etc.
'Sofa Surfing' – staying with others (not close family), on short term/insecure basis/wanting to move, in crowded conditions (this does not include students)
Wider homelessness
Staying with friends/relatives because unable to find own accommodation (longer term)
Eviction/under notice to quit (and unable to afford rent/deposit)
Asked to leave by parents/relatives
Intermediate accommodation and receiving support
In other temporary accommodation (e.g. conventional social housing, private sector leasing)
Discharge from prison, hospital and other state institution without permanent housing

Source: Bramley, G. (2017). Homelessness Projections: Core Homelessness in Great Britain. Crisis UK.

Temporal Definitions of Homelessness

Homelessness can also be defined in a temporal fashion. Other researchers⁵ have defined three categories of homelessness in this way: chronic homelessness, intermittent homelessness, and crisis or transitional homelessness:

- **Chronic homelessness** is defined as an episode of homelessness lasting more than a year, or four episodes of homelessness in the previous 2 years in an individual who has a disabling condition.
- Individuals who cycle in and out of homelessness repeatedly, with episodes of homelessness alternating with housing and institutional care (jails, hospitals, treatment programmes) are thought to have **intermittent homelessness**.
- Individuals who are only homeless once or twice and for a relatively short period of time (less than a year) after an unexpected crisis (job loss, divorce, eviction) are thought to have had **crisis homelessness**.

⁵ Fazel, S., Geddes, J. and Kushel, M. (2014). The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations. *The Lancet*, 384(9953), pp.1529-1540.

Health and Well-being Related Causes and Effects of Homelessness

A recent editorial in the Lancet provides this concise explanation of the relationship between health and homelessness:

"Homelessness has many reasons that often function in a bidirectional way. Mental ill-health, substance use, imprisonment, and sex work are some of the risk factors that might lead to homelessness, and being homeless might lead to a reinforcement or new development of these risk factors...Providing stable housing is an important upstream intervention to reduce avoidable deaths and improve health and wellbeing - and one that socially excluded people themselves have identified as the number one priority⁶."

There are various causes of homelessness: structural (poverty/inequality/housing etc.) and individual factors (poor physical and mental health, alcohol/drugs etc.). Below is a summary:

Individual circumstances

Some factors and experiences can make people more vulnerable to homelessness: these include poor physical health, mental health problems, alcohol and drugs issues, bereavement, experience of care, and experience of the criminal justice system.

Wider forces

Structural factors can include poverty, inequality, housing supply and affordability, unemployment, welfare and income policies.

Complex interplay

Structural and individual factors are often interrelated; individual issues can arise from structural disadvantages such as poverty or lack of education. While personal factors, such as family and social relationships, can also be put under pressure by structural forces such as poverty.

The most common reasons for homelessness are the end of assured short hold tenancy and relationship breakdown, particularly if there is also domestic violence.

Young people can become homeless when parents/relatives are no longer willing to accommodate them. Another key reason involves the person living in a hostel or sleeping rough.

It is estimated that approximately 50% of homeless people have four or more Adverse Childhood Experiences (ACEs).

⁶ The Lancet (2018). A shared future for all: let's talk about homelessness. The Lancet, 391(10117), p.179.

Usefulness and Availability of Homelessness Data

Much of the data available on the numbers of homeless relates only to those who are known to services because they have applied to the local authority for assistance. The data therefore misses key groups, in particular single, homeless people who have previously been largely excluded unless they can demonstrate a priority need. The information on the numbers of homeless people/households is therefore likely to be an underestimation as it does not capture the 'hidden homeless' who may sofa surf and the like. The introduction of the Homelessness Reduction Act 2017 may improve the comprehensiveness of official statistics.

Table 3: Base estimates of the number experiencing core homelessness

Base Estimates (Med)	England	
	2011	2016
Core Homelessness		
Rough Sleepers	5,000	8,000
Car, tent, pub transport	5,000	8,000
Squatting (in unlicensed, non-residential buildings)	6,800	11,000
Hostels, refuges, and night/winter shelters	44,200	39,000
Unsuitable Temporary Accommodation	7,000	17,000
Sofa Surfers	35,000	60,000
Total (Medium)	103,000	143,000
Total (med) as % of household	0.45%	0.62%
Total (Low)	74,300	81,000
Total (High)	125,400	176,000

Core homelessness
Rough Sleeping
Sleeping in tents, cars, public transport*
Squatting (unlicensed, insecure)*
Unsuitable non-residential accommodation e.g. 'beds in sheds'*
Hostel residents
Users of night/winter shelters*
DV victim in Refuge*
Unsuitable temporary accommodation (which includes bed and breakfast accommodation, hotels etc.
'Sofa Surfing' – staying with others (not close family), on short term/insecure basis/wanting to move, in crowded conditions (this does not include students)

Source: Crisis UK⁷

Crisis UK estimate that 143,000 people in England experienced core homelessness in 2016, while official data showed that 115,000 people made homelessness applications in the same year (of whom 58,000 were accepted as being eligible and in priority need).

Local information on the health of homeless people is collected through an annual homeless audit. While a useful source of data, it focuses on single homeless people who are rough sleepers or hostel dwellers.

⁷ Bramley, G. (2017). Homelessness Projections: Core Homelessness in Great Britain. Crisis UK

Health Issues for Homeless People

There is a paucity of evidence on the health of homeless people nationally and locally, and what exists tends to be focused on rough sleepers and single homeless people. This section looks at national evidence on a range of health conditions which affect homeless people and data for Worcestershire that has been collected as part of the Homeless Health Audit. Please note that the data gathered from the Audit mostly applies to single people but some of the themes that emerge are also likely to apply to other homeless groups.

Physical Health

Homeless Link (2014)⁸ reports that *"available comparable data shows that almost all long-term physical health problems are more prevalent in the homeless population than in the general public"*. This finding is largely confirmed by data from the Worcestershire Homeless Audit for 2017.

Mental Health

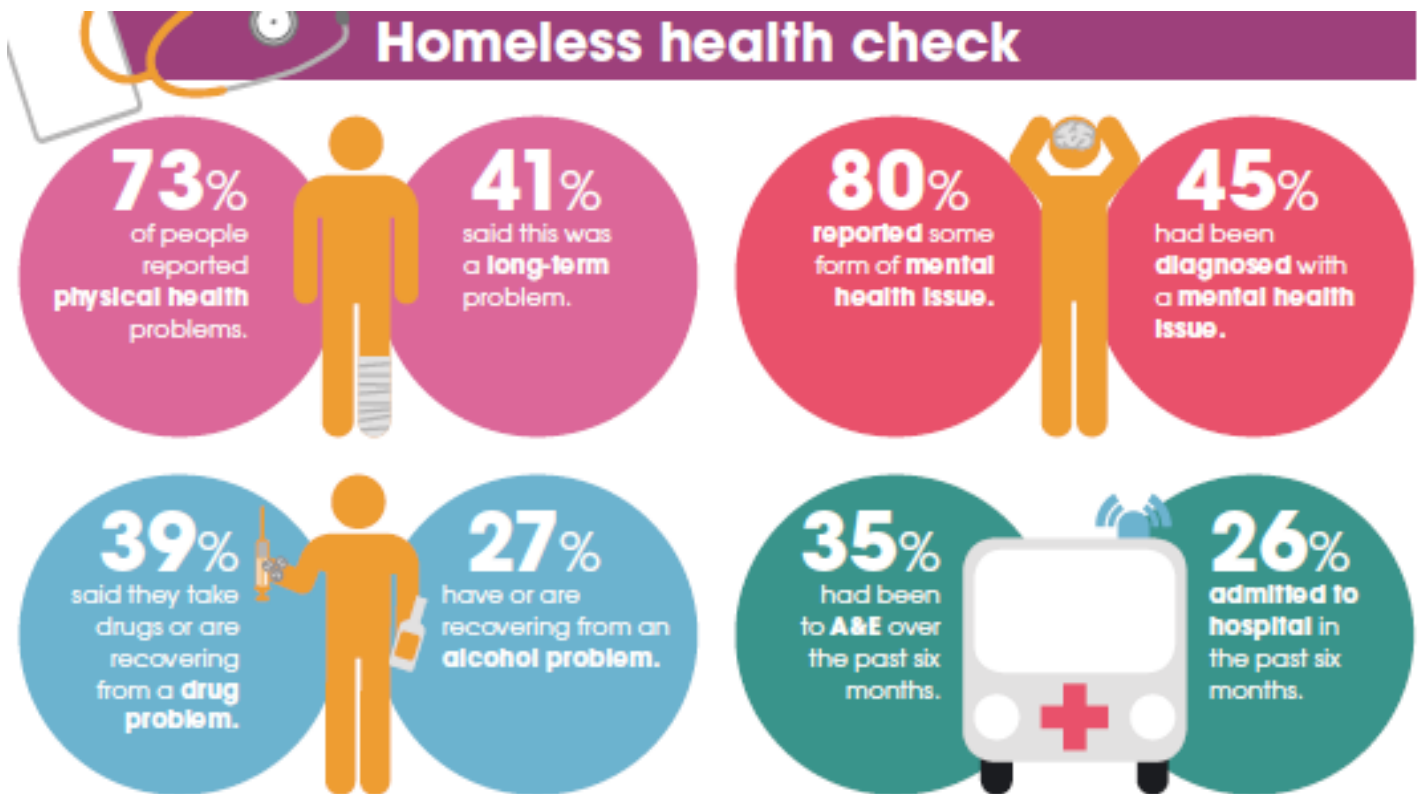
Homelessness and poor mental health often go hand in hand. Having a mental health problem can create the circumstances which can cause a person to become homeless in the first place. Yet poor housing or homelessness can also increase the chances of developing a mental health problem, or exacerbate an existing condition. In turn, this can make it even harder for that person to recover – to develop good mental health, to secure stable housing, to find and maintain a job, to stay physically healthy and to maintain relationships.

Single homeless people are much more likely to have mental health problems compared to the general population. In 2015, 32% of single homeless people reported a mental health problem, and depression rates are over 10 times higher in the homeless population. Unfortunately, other psychological issues such as complex trauma, substance misuse and social exclusion are also common⁹.

⁸ Homeless Link, The unhealthy state of homelessness – Health Audit Results 2014. London: Homeless Link

⁹ <https://www.mentalhealth.org.uk/blog/homelessness-and-mental-health>

Key findings from national homeless audit 2014



Worse than the general public	Health Issue	Homeless population	General population
Physical, mental and substance misuse issues remain prevalent among the homeless population and at levels that are much higher than those experienced by the general population.	Long term physical health problems	41%	28%
	Diagnosed mental health problem	45%	25%
	Taken drugs in the past month	36%	5%

Source: Homeless Link (2014)

The prevalence of serious mental illness (including major depression, schizophrenia and bipolar disorder) is reported as 25–30% in the street homeless population and those living in direct-access hostels. Homelessness is also associated with higher rates of personality disorder, self-harm and attempted suicide (Perry et al, 2015)¹⁰.

¹⁰ Perry, J. and Craig, T. (2015). Homelessness and mental health. Trends in Urology & Men's Health,6(2), pp.19-21.

Adverse Childhood Experiences (ACEs)

ACEs can significantly affect physical, mental and personal well-being throughout life. They can be categorised into three direct and six indirect experiences that have an impact on a child including: verbal abuse, physical abuse, sexual abuse, parental separation, domestic violence, mental illness, alcohol abuse, drug use and incarceration. A pioneering study undertaken in America, which has since been replicated in the U.K, found that an increase in ACEs resulted in an increase in negative health and well-being outcomes. This included risky behaviors such as smoking, alcohol and drug use or sexual risk taking, and also an increased risk of different types of diseases such as depression, liver disease and ischaemic heart disease. It is estimated that approximately 50% of homeless people have four or more Adverse Childhood Experiences (ACEs)^{11,12}.

Long-term Conditions

With the ageing of the homeless population, the incidence of chronic diseases and age-related conditions, such as cognitive impairment and functional decline, has increased. Additionally, homeless individuals aged 50 years and older have higher rates of age-related conditions (functional impairments, cognitive impairments, falls, and urinary incontinence) than a general population comparison that is 20 years older¹³.

Some researchers have therefore argued that homeless people should be considered eligible for services directed at older adults at age 50, instead of the general population cut off of 65.

Oral Health

Healthy Mouths is a research study into the oral health of people experiencing homelessness, which was conducted by Groundswell and was led by Peer Researchers. The study engaged 262 people who are currently homeless in London, utilising focus groups and one-to one interviews and also engaged over 50 professionals working in this area. The Healthy Mouths study reveals that homeless people suffer extremely poor oral health compared to the general population.

The oral health of participants was very poor and significantly worse than the general population.

- 90% have had issues with their mouth since becoming homeless. Particularly common were bleeding gums (56%), holes in teeth (46%) and dental abscesses (26%).
- Many participants had experienced considerable dental pain. 60% had experienced pain from their mouths since they had been homeless. 30% were currently experiencing dental pain.

¹¹ Bellis, M., Hughes, K., Leckenby, N., Perkins, C. and Lowey, H. (2014). National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviors in England. *BMC Medicine*, 12(1).

¹² Bellis, M., Hughes, K., Hardcastle, K., Ashton, K., Ford, K., Quigg, Z. and Davies, A. (2017). The impact of adverse childhood experiences on health service use across the life course using a retrospective cohort study. *Journal of Health Services Research & Policy*, 22(3), pp.168-177.

¹³ Fazel, S., Geddes, J. and Kushel, M. (2014). The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations. *The Lancet*, 384(9953), pp.1529-1540.

- 70% reported having lost teeth since they had been homeless and 7% had no teeth at all. 35% had teeth removed by a medical professional, 17% lost teeth following acts of violence and 15% of participants pulled out their own teeth.

The report identified some key factors underlying poor oral health in homeless people

- High levels of sugar consumption
- High rates of drug and alcohol misuse and smoking tobacco
- Rates of cleaning teeth were significantly lower than the advised minimum levels
- Rates of attendance and "sign up" at dentists were far lower than in the general population.

Alcohol and drugs were commonly used in an attempt to manage oral health issues. 27% of participants have used alcohol to help them deal with dental pain and 28% have used drugs. This may be contributing to continued drug and alcohol misuse¹⁴.

Substance Misuse, Smoking and Alcohol

Homeless people are at increased risk of a wide range of health problems related to substance misuse: this can be both a cause and consequence of homelessness. National and local research indicates high prevalence of usage of illegal and prescribed drugs, and of tobacco and alcohol.

According to the national Homeless Link audit¹⁵:

- 27% of homeless people taking part in the reported that they have or are recovering from an alcohol problem.
- Data on the regularity and amount homeless people drink implies that these needs may be more common. 39% of homeless men and 25% of women who took part in the audit drink twice or more a week, and around two-thirds of homeless men and women drink more than the recommended amount each time they drink.
- By comparison, one-third of the general public drink more than recommended amount on at least one day each week. Males appear to be more likely to drink more frequently than females.
- 77% were smokers and 41% of smokers wanted to quit (compared to 63% of the general population).

Nutrition

A review of research¹⁶ found in academic studies of homeless people's diet a recurrent theme of high levels of saturated fat, low fruit and vegetable intake and numerous micronutrient deficiencies, thus highlighting the presence of malnutrition. In summary: *"For the homeless individual even the basic survival requirements of food can be limited, resulting in a daily struggle both physically and mentally"*.¹⁶

¹⁴ Groundswell, Healthy Mouths Report

¹⁵ Homeless Link, The unhealthy state of homelessness – Health Audit Results 2014. London: Homeless Link

¹⁶ Seale, J., Fallaize, R. and Lovegrove, J. (2016). Nutrition and the homeless: the underestimated challenge. *Nutrition Research Reviews*, 29(02), pp.143-151.

Use of Health Services

National findings from Homeless Link in 2014¹⁷ showed that:

- 90% of surveyed homeless people said they are either permanently or temporarily registered with a GP. 21% of homeless people said they had used opticians in the last six months. 32% had visited a dentist.
- On average there were 1.18 hospital admissions per year for homeless people compared with 0.28 per year for the general public. This reflects previous research which found that homeless people usually stay in hospital for longer than the general public, mainly because of their more acute health issues.

¹⁷ Homeless Link. 2014. The unhealthy state of homelessness – Health Audit Results 2014. London: Homeless Link

Worcestershire Homeless Audit Data

A homeless health audit was carried out in each of the districts in Worcestershire in 2017/18 – this section represents a summary snapshot of the findings; a total of 76 responses are included.

There are significant gaps in our knowledge, for example amongst the hidden homeless and those living in temporary accommodation. The group in the audit is concentrated in those experiencing the most acute types of homelessness. Most participants in the audit are single.

Participants had an average (median) age of 44. Approximately three quarters of the sample (55 out of 76), were currently staying in Worcester.

Survey participants came from a range of homelessness types (Table 4), the biggest groups being in a hostel or supported accommodation and sleeping rough (which together accounted for about 70%). The sample may under represent hidden homeless people, for example, just 6.6% were sleeping on somebody's sofa or floor.

To effectively anonymise the information certain figures have been suppressed.

Table 4: Worcestershire homeless audit: where respondents are currently sleeping

Answer	Percentage (n=76)
In a hostel or supported accommodation	48.7%
Sleeping rough on streets/parks	21.1%
Sleeping on somebody's sofa/floor	6.6%
Housed -own tenancy in private rented sector	6.6%
In B&B or other temporary accommodation	<6.6%
In emergency accommodation, e.g. nightshelter, refuge	<6.6%
Housed - in own tenancy in social housing	<6.6%
Other	7.9%

Source: Worcestershire Homeless Audit 2017/18

Physical Health

The ten most prevalent responses to the question: **has a doctor or health professional ever told you that you have any of the following physical health problems?** were:

Table 5 Most Commonly Reported Physical Health Problems (n=76)

Joint Aches/Problems	49%
Skin/Wound Infection or Problems	39%
Dental/Teeth Problems	37%
High Blood Pressure	31%
Chronic Breathing Problems	25%
Circulation Problems/Blood Clots	25%
Stomach Problems	22%
Difficulty Seeing/Eye Problems	21%
Asthma	21%
Fainting/Blackouts	16%

Source: Worcestershire Homeless Audit 2017/18

Responses illustrate the high prevalence of adverse health issues amongst the population of homeless people surveyed.

Other reported health problems included epilepsy/seizures, liver problems, diabetes and Tuberculosis (TB). Diabetes was reported at a rate that was well below the reported prevalence in the overall population, possibly suggesting under-diagnosis of this condition amongst this homeless population.

Mental Health

The ten most prevalent responses to the question: **Has a doctor or health professional ever told you that you have any of the following mental health or behavioural conditions?** were:

Table 6 Most Commonly Reported Mental Health Problems, n=76

Depression	75%
Anxiety Disorder or Phobia	55%
Dual Diagnosis with a drug or alcohol problem	30%
Psychosis (including Schizophrenia or Bipolar Disorder)	19%
Personality Disorder	17%
ADHD (Attention Deficit Hyperactivity Disorder)	12%
Eating Disorder	10%
Learning Disability or Difficulty	8%
Post-Traumatic Stress Disorder (PTSD)	7%
Other Mental Health or Developmental Condition	<6.6%
Autism/Aspergers	<6.6%

Source: Worcestershire Homeless Audit 2017/18

There appears to be a relationship between substance misuse and mental health. A majority (53%) of the sample said that they used drugs or alcohol to help cope with their mental health (self-medicating).

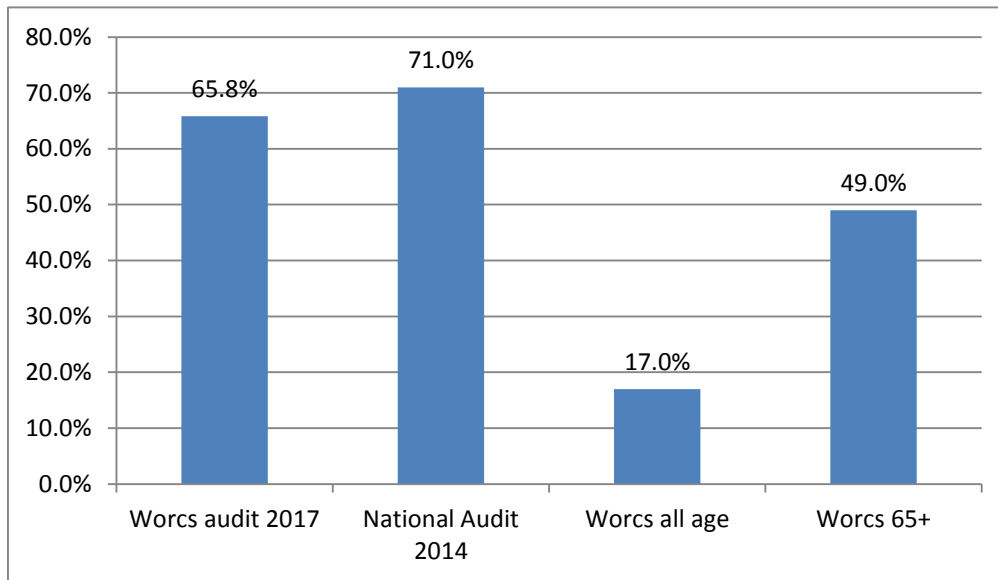
Maggs Day Centre have also completed a survey of mental health of individuals who rough sleep, 82% of those who were surveyed reported seeking help for a mental health condition, of which only 69% said they were receiving treatment at the time of the survey. 46% of those receiving treatment were taking medication – interestingly 54% of service users said that they felt they needed more practical support alongside taking medication for long-term treatment to be effective, as they felt the medication was only treating their symptoms and not their underlying issues. In total, 62% reported that they self – medicate with alcohol or drugs to deal with their mental health issues¹⁸.

Long-term Conditions

Nearly two thirds of respondents to the Worcestershire Homeless Health Audit said that they had a long-term health problem or disability, this is similar to the national audit finding in 2014 (Figure 3). This proportion is much higher than that in the general population (which is about 17%) and in the 65 and over population (49%).

¹⁸ Worcestershire Homelessness Review 2016

Figure 3: Percentage with long-standing illness, disability or infirmity



Source: Worcestershire Homeless Health Audit, Census of Population 2011

Oral Health

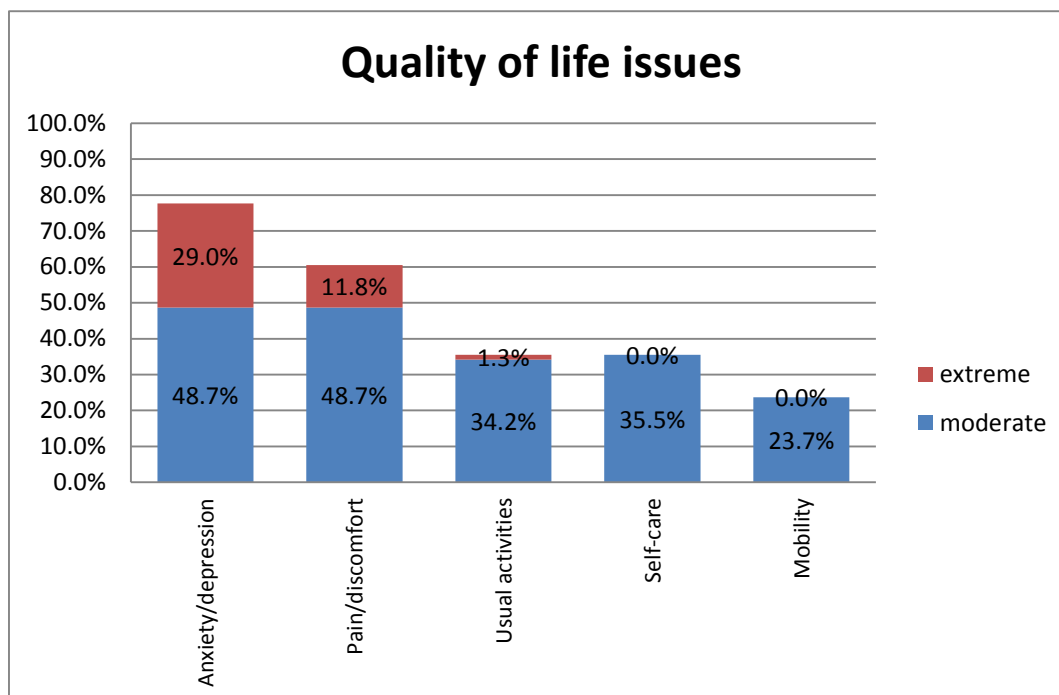
Local research confirms oral health as a major issue affecting homeless people. According to the Worcestershire homeless audit, just 29% of respondents were registered with a dentist locally (22 out of 76). Some said that they had been refused registration to a dentist in the last 12 months. 37% of respondents reported dental problems. Oral health prevalence was third highest in the list of physical conditions asked about in the audit (see page 16).

Quality of Life

The homeless audit asked five standard questions regarding quality of life. The results are shown in Figure 4. Most striking are the high numbers for anxiety/depression and pain/discomfort.

It is also worth noting the high proportions of people who have multiple instances of moderate or extreme quality of life issues (Table 7). Two thirds had two or more such issues, and nearly a third had four or more issues.

Figure 4: Quality of Life issues



	Anxiety/depression	Pain/discomfort	Usual activities	Self-care	Mobility
None shown (not in graph)	not anxious or depressed	no pain or discomfort	no problems with performing usual activities	no problems with self-care	no problems in walking about
Moderate	moderately anxious or depressed	moderate pain or discomfort	some problems with performing usual activities	some problems washing or dressing myself	some problems in walking about
Extreme	extremely anxious or depressed	extreme pain or discomfort	unable to perform usual activities	I am unable to wash or dress myself	confined to bed

Source: Worcestershire Homeless Health Audit 2017

Table 7: number of quality of life issues reported

Number Moderate or Extreme	Count	%
0	12	16%
1 or more	64	84%
2 or more	50	66%
3 or more	33	43%
4 or more	24	32%
5	7	9%

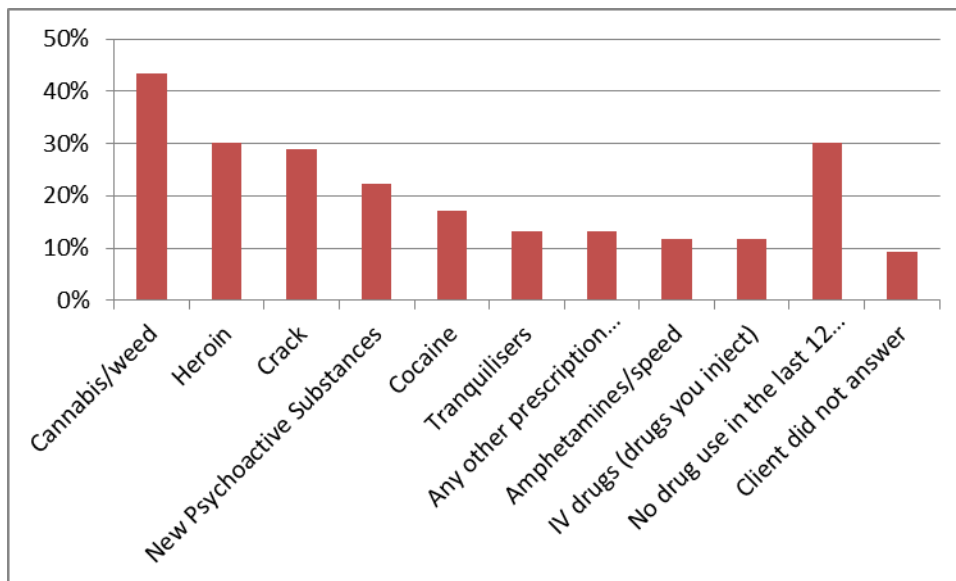
Source: Worcestershire Homeless Health Audit 2017

Substance Misuse, Smoking and Alcohol

Homeless people are at increased risk of a wide range of health problems related to substance misuse: this can be both a cause and consequence of homelessness. National and local research indicates high prevalence of usage of illegal and prescribed drugs, and of tobacco and alcohol.

In the Worcestershire Homeless Health Audit for 2017, 26% of the sample said that they had a drug problem and a further 18% said that they were in recovery.

Figure 5: In the last 12 months have you taken any of the following substances?



Source: Worcestershire Homeless Health Audit. Respondents can select more than one option.

The substance misuse identified in the audit was varied. The most prevalent drug taken was cannabis/weed (43%), with around 30% having taken Heroin or Crack.

16% of respondents said they were taking methadone, subutex or any other substitute drugs under prescription. A further 8% said they were taking these even though they had not been prescribed them.

The majority, 87% of the sample were smokers, this is a similar proportion to national studies of similar homeless groups. This is much higher than the general population prevalence of 17%.

The audit also found a much lower proportion wanting to give up smoking than seen in studies of smokers generally (24% compared to 61% in a national survey in 2017¹⁹). Most (60%) had not been offered help to stop smoking.

Table 8: How often have you had an alcoholic drink in the last 12 months?

Frequency	Count	Percentage
Almost every day	26	34.2%
Five or six days a week	<5	<6.6%
Three or four days a week	5	6.6%
Once or twice a week	5	6.6%
Once or twice a month	11	14.5%
Once every couple of months	5	6.6%
Once or twice a year	6	7.9%
Not at all in the last 12 months	13	17.1%
Client did not answer	<5	<6.6%

Source: Worcestershire Homeless Health Audit

34% of the Worcestershire Homeless Health Audit sample consumed alcohol every day. This is much higher than the rates for the general population which are 9% of women and 6% of men.

Amongst those who were drinking, the average units consumed per day were 11 – much higher than the officially recommended limit of 14 units per week.

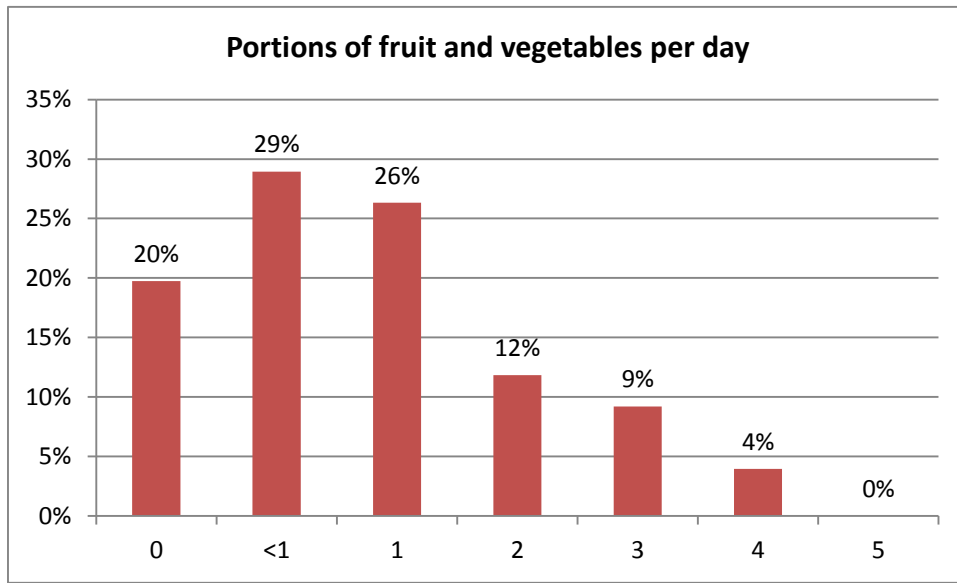
26% (20) of the sample stated that they currently had an alcohol problem, and some others (<6.6%) were currently in recovery. Two thirds (16) of this group were receiving support, half of whom said that it met their needs, while the other half said that they needed more help.

¹⁹ Office for National Statistics 2017, Opinions and Lifestyle Survey

Nutrition

Responses to the homeless audit confirms the poor diet that this group of people have (Figure 6). No respondents were eating the recommended five or more portions of fruit and vegetables per day (the average was 1 portion). This compares with estimates of 26% and an average of 3.6 portions per day for the general population - which itself is not particularly good compared to the recommend number (Health Survey for England, 2016).

Figure 6: Portions of fruit and vegetables consumed per day



Source: Worcestershire Homeless Health Audit

Use of Health Services

Meeting the physical health care needs of the homeless population poses significant challenges in comparison to the settled population, particularly with the clear evidence of the high rates of chronic disease and co-morbidity. In the audit, 22.8% of respondents with a physical health problem reported that they were not receiving support/treatment for it.

Table 9: If yes to any physical health need, are you receiving support/treatment to help you with your physical health problem?

Answer	Count	Percentage
Yes, and it meets my needs	30	52.6%
Yes, but I'd still like more help	14	24.6%
No, but it would help me	7	12.3%
No, I do not need any	6	10.5%

Source: Worcestershire homeless health audit, n=57 (there were 19 people to whom question did not apply)

In total, 40.3% of respondents with a mental health problem reported that they were not receiving support/treatment for it. This is a much higher proportion than in the case of physical health (22.8%).

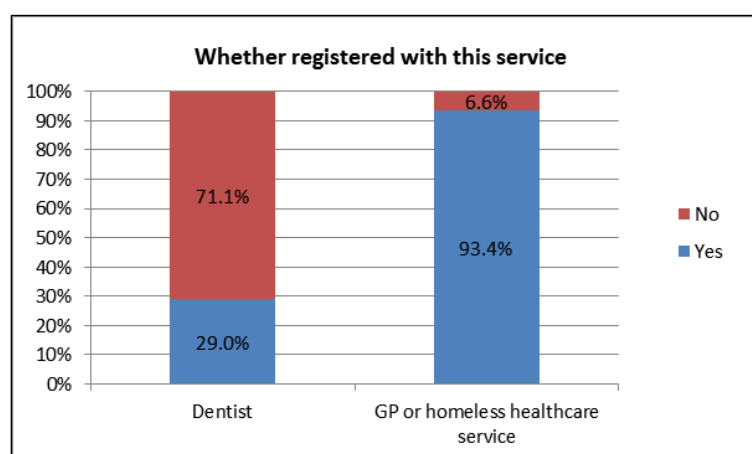
Table 10: If yes to any mental health need, are you receiving support/treatment to help you with your physical health problem?

Answer	Count	Percentage
Yes, and it meets my needs	21	33.9%
Yes, but I'd still like more help	16	25.8%
No, but it would help me	15	24.2%
No, I do not need any	10	16.1%

Source: Worcestershire homeless health audit, n=62 (there were 14 people to whom question did not apply)

The homeless health audit also included some questions about the use of health services. The responses indicated that some homeless people faced barriers to accessing services and that there were various reasons why this might be the case.

Figure 7: Whether registered with dentist or GP / homeless healthcare service



Source: Worcestershire homeless health audit, n=76

Respondents were much more likely to be registered with a GP than with a dentist (N.B. people don't actually register with a dentist but this is still an indicator related to whether they were attending one).

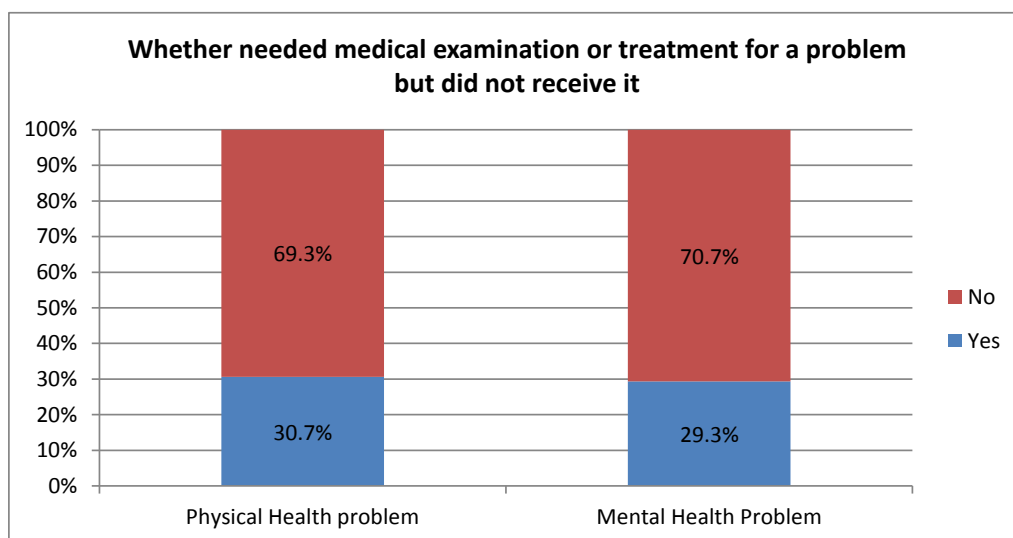
Some of the respondents (<6.6%) said that they had been refused registration with a GP, homeless health service or dentist. Reasons given for refusal of registration included:

"refused registration due to living in homeless hostel and G.P claims not having to register people living there. Also said they have enough patients with high medical needs"

and

"missed appointments due to anxiety and they refused to re-register me".

Figure 8: Whether needed medical examination or treatment for a problem but did not receive it



Source: Worcestershire homeless health audit

There were similar proportions reporting that they needed medical treatment for a physical and mental health problem but did not receive it (30.7% and 29.3% respectively).

Table 11: Main reason for not receiving the examination or treatment (Physical Health)

PHYSICAL HEALTH - WHAT WAS THE MAIN REASON FOR NOT RECEIVING THE EXAMINATION OR TREATMENT (THE MOST RECENT TIME)?	Total
Couldn't get an appointment	8
Waiting list	<5
Wanted to wait and see if problem got better on its own	<5
Other	<5
Was refused treatment/examination	<5
Too far to travel/no means of transportation	<5
Fear of doctor/hospitals/examination/ treatment	<5
Grand Total	22

Source: Worcestershire homeless health audit

Table 12: Main reason for not receiving the examination or treatment (Mental Health)

MENTAL HEALTH - WHAT WAS THE MAIN REASON FOR NOT RECEIVING THE ASSESSMENT (THE MOST RECENT TIME)?	Total
Couldn't get an appointment	9
Fear of doctor/hospitals/examination/ treatment	6
Waiting list	<5
Wanted to wait and see if problem got better on its own	<5
Due to my drug or alcohol use	<5
Other	<5
Grand Total	23

Source: Worcestershire homeless health audit

Tables 11 and 12 show that a high proportion of those who didn't receive treatment reported that they couldn't get an appointment. Amongst other reasons there were similar responses for physical and mental health apart from *fear of doctor/hospitals/examination/treatment*, which was more prevalent amongst those requiring treatment for a mental health problem.

Table 13: Are you receiving support/treatment to help with your health problem?

Answer	Physical health need	Mental health need
Yes, and it meets my needs	39.5%	27.6%
Yes, but I'd still like more help	18.4%	21.1%
No, but it would help me	9.2%	19.7%
No, I do not need any	7.9%	13.2%
No answer	0.0%	1.3%-
Not completed or Not displayed	25.0%	17.1%

Source: Worcestershire homeless health audit

Case Studies

Themes from three case studies of people attending a local hostel are presented below²⁰. The issues highlighted are by their nature self-reported.

A theme common to all three case studies was that the person reported a poor early start in life. Childhood experiences reported included:

- Parental abuse
- Being labelled delinquent and being sent to a boarding school
- Being taken into care
- Institutional physical and emotional abuse



Created by Luis Prado from Noun Project

All three cases also reported mental health problems. These included:

- Anxiety
- Panic attacks
- Depression
- Schizophrenia
- Borderline Personality Disorder
- Obsessive Compulsive Disorder (OCD)



Two of the three cases were addicted to Class A drugs.

Two of the three cases reported multiple problems with their physical health including:

- Chronic Obstructive Pulmonary Disease (COPD)
- Asthma
- Cellulitis
- Ulcers



Other issues that the case studies highlight include:

- Lack of family support
- Sleeping rough
- Loss of accommodation



Created by Ed Harrison from Noun Project

²⁰Unfortunately the cases cannot be presented separately as this would risk identifying individuals. The cases were two men and a woman of varying ages.

Graphics from the Noun Project

- The possibility of a drug dealer using their tenancy as a base (cuckooing)
- Involvement in crime
- Extended family involved in drugs and crime
- Prison sentences for involvement in gangs and crime

Population Level Data

In considering the scale of public health issues which arise for the homeless population, it is important to look at both numbers and recent trends in homelessness. This can present some challenges, as statutory homelessness does not measure all the groups affected.

To assess numbers and trends in homelessness in Worcestershire we have drawn upon two key sources of data. Public Health England (PHE) indicators and local data (P1E) and from homeless teams). PHE is the official data source but is based on the statutory homeless only, which excludes some key groups. Local data from P1E and homeless teams has been added to provide a more comprehensive and detailed picture.

Key Indicators (Public Health England)

Table 14– Key Public Health Homelessness Indicators

	England	West Midlands	Worcs	Worcs - count	Worcs vs. England
1.15i) Statutory homelessness – eligible homeless people not in priority need per 1000 households 2016/17 (mostly single homeless)	0.8	1.1*	1	240	Significantly higher
1.15ii) Statutory homelessness – households in temporary accommodation per 1000 households 2016/17	3.3	1.1	0.4	110	Significantly lower
Homelessness applications – total decisions made: rate per 1,000 households 2015/16	5	6.6	4.9	1198	Similar
Family homelessness – rate per 1000 households 2016/17	1.9	2.7	1.9	467	Similar
Homeless young people aged 16-24 per 1000 households, 2016/17	0.56	0.81	0.75	186	Significantly higher

Source: Public Health Outcomes Framework (<https://fingertips.phe.org.uk/search/homeless>)

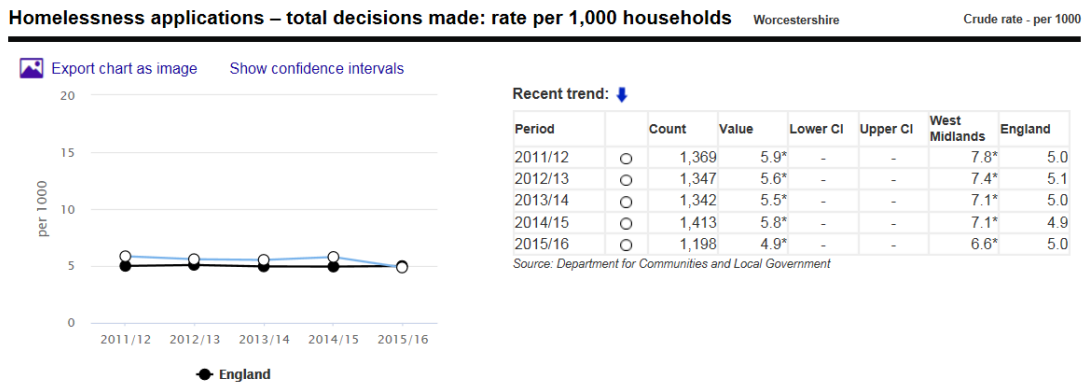
- In 2016/17 the Worcestershire county rate of eligible homeless people 'not in priority need' was 1.0 per 1000 households (240 people) significantly higher than the England average (0.8 per 1000 households)
- There is a significantly lower than national rate of statutory homeless households in temporary accommodation recorded in Worcestershire in 2016/17 (110 households, 0.4 per 1000)

households). This is a good outcome as people living in temporary accommodation have high rates of some infections and skin conditions; and children have high rates of accidents²¹.

- The rate of homelessness applications in Worcestershire in 2015/16 is 4.9 per 1000 (1,198 people), this is similar to the national rate of 5.0.
- The family homelessness rate is similar to that nationally 1.8 per 1000 (449 households) compared to 1.9 for England.
- The homeless young people aged 16-24 rate in 2016/17 is 0.75 per 1000 (186 people), which is significantly higher than the national level of 0.56.
- It should be noted that the above figures relate primarily to applications under the homelessness legislation in force before April 2017, and will underestimate true levels of need.

Figure 9 shows a decline in homeless applications in 2015/16. The period since 2011/12 has seen a narrowing of the gap with the national level.

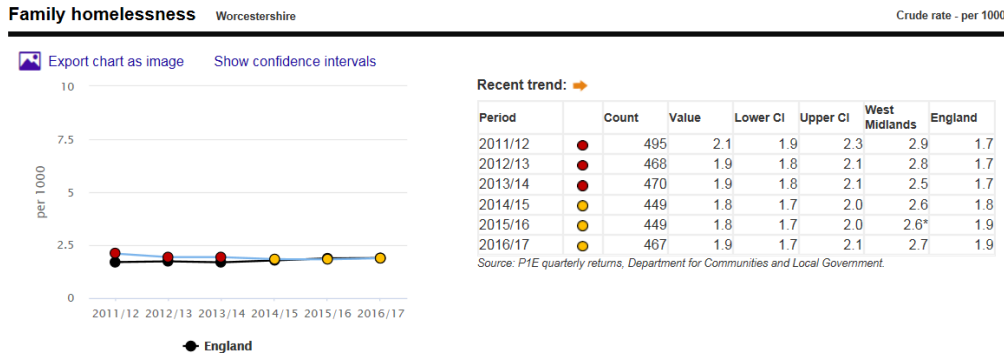
Figure 9: Homelessness applications per 1,000 households, 2011/12 – 2015/16



Source: Public Health Outcomes Framework

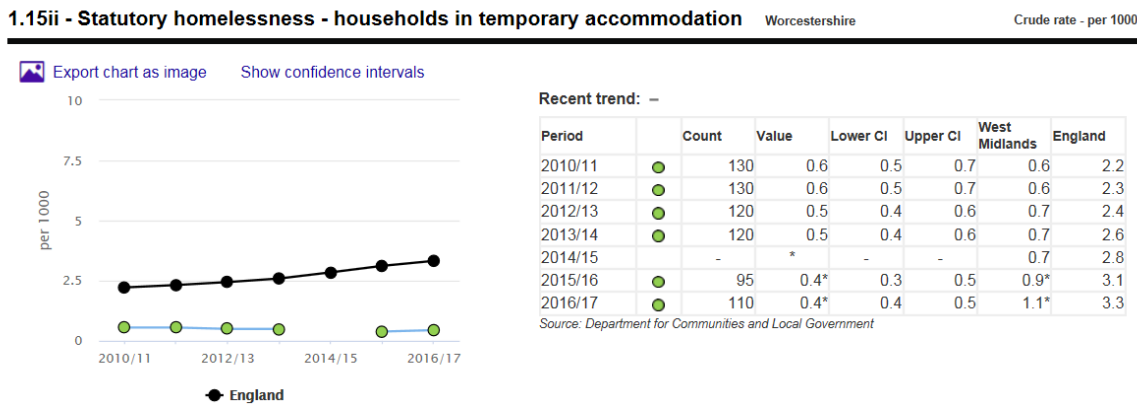
Trends in numbers of family homelessness (accepted as unintentionally homeless and eligible for assistance) can be seen in Figure 10. The rate in Worcestershire has remained at or above the England level since 2011/12, though for the last three years levels are no longer significantly high.

²¹ Shelter. 2006. *Chance of a lifetime – The impact of poor housing on children’s lives*. London: Shelter.

Figure 10: Family Homelessness 2011/12 – 2016/17


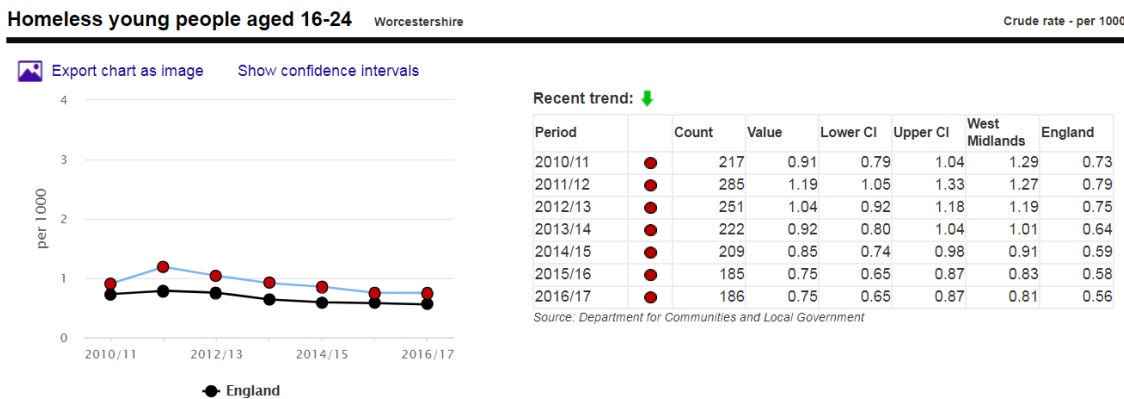
Source: Public health Outcomes Framework

There were 110 statutory homeless households in temporary accommodation in 2016/17 (Figure 11), a rate of 0.4 households per 1,000. This figure has stayed fairly constant while the national level has increased since 2010/11.

Figure 11: Statutory Homelessness – households in temporary accommodation, 2010/11-2016/17


Source: Public Health Outcomes Framework

The rate of homeless young people has fallen from a peak in 2011/12 but remains statistically significantly higher than nationally.

Figure 12: Homeless young people aged 16-24, 2010/11 to 2016/17


Levels of Homelessness in Worcestershire (P1E and homeless teams)

To be deemed 'statutorily homeless' and owed a full rehousing duty a household must have become unintentionally homeless and be considered to be in 'priority need'; hence they represent some of the most vulnerable members of our communities.

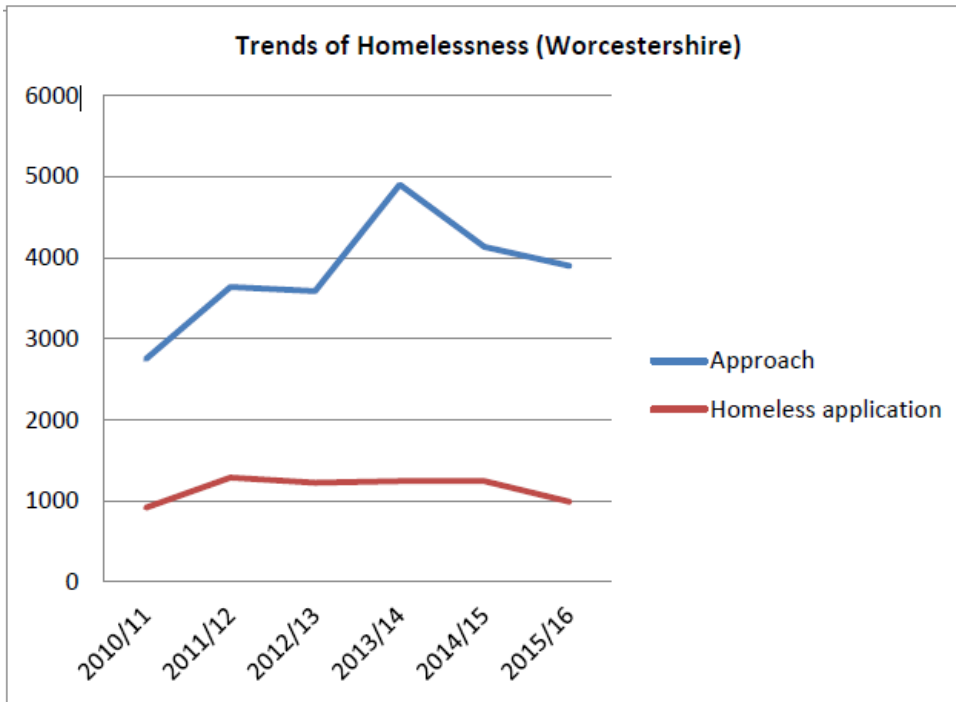
It can be seen from the PHE data that in Worcestershire there is a significantly higher rate of people who might be otherwise eligible but are not categorised as in priority need. These, 'hidden homeless', particularly young single people (both males and females), do not qualify as priority need and therefore statutory assistance. However, there are a range of support services in place for those who are not owed a statutory duty including the county-wide 'No Second Night Out Protocol' for those who are new rough sleepers.

When looking at homelessness it is important to look beyond the numbers of homeless applications as many cases of potential or threatened homelessness are dealt with through housing options services and prevention. To determine a more complete picture of the level of homelessness we have assessed the total number of prevention and relief approaches for homeless assistance through the districts which includes prevention work as well as statutory homeless applications/decisions.

In all districts, where data was available, there has been an increase in the level of single people approaching for housing assistance. In Bromsgrove, Malvern and Worcester the levels of single households approaching for homeless assistance is higher than the levels of family households. Within Bromsgrove, the level of approaches from single households has always been greater than the levels of approaches from family households. Within Wychavon, the level of approaches from single households has increased as a proportion from 35% to 42%. These single homeless will often be single men, including offenders and ex-services personnel and will often experience multiple health conditions.

Throughout Worcestershire, the overall increase in homelessness since 2010 is 8.1%. Approaches for prevention and relief have been increasing at a faster rate since 2010/11 than statutory homeless applications (Figure 13), to a figure of approximately 4,000, indicating a possible increase in the numbers of those who are not classed as statutory homeless but need assistance.

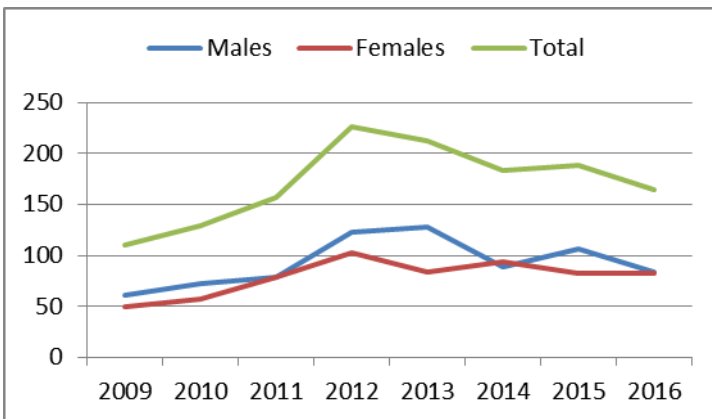
Figure 13: Homelessness applications and approaches, Worcestershire



Source: Worcestershire Homeless Review 2016

NB. Homeless application= statutory homeless application, Approach= prevention and relief approaches for homeless assistance through the districts which includes prevention work as well as statutory homeless applications.

Figure 14: Statutory Homelessness – single homeless accepted as statutory homeless, 2010-2016



Source: P1E Worcestershire

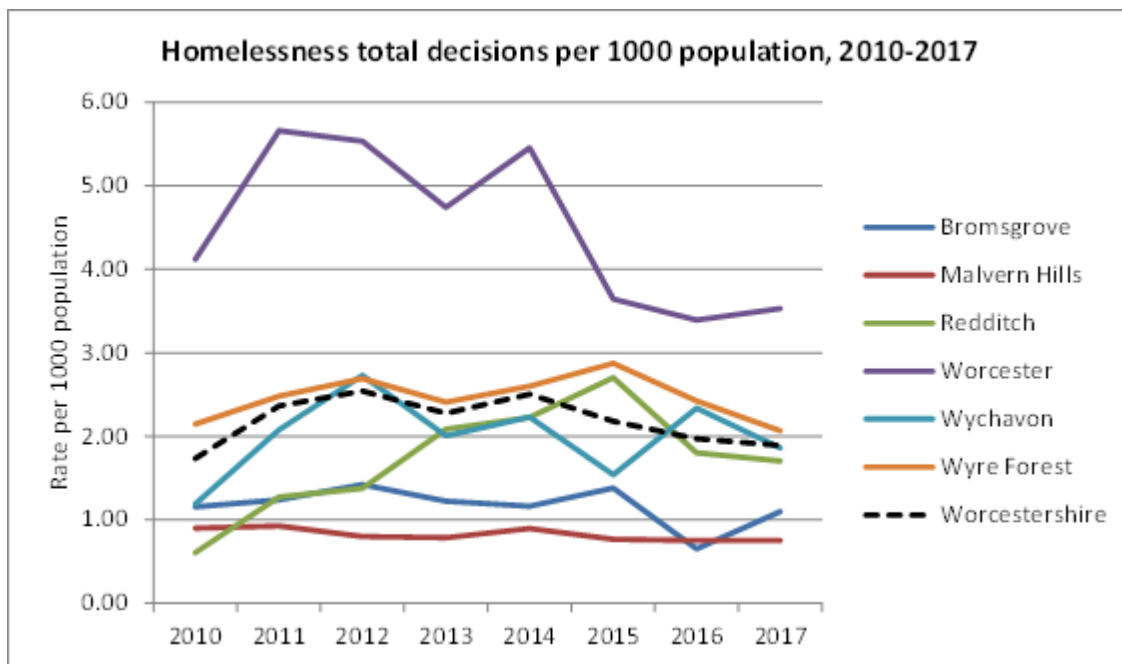
Worcestershire had an increase in the number of single statutory homeless from 2010 to 2016, possibly linked with the recession. There were 165 single homeless amongst the statutory homeless acceptances in Worcestershire in 2016 – much higher than the 2009 total of 110 people. The single

homeless total increased to a peak of over 220 in 2012 and has decreased slightly since, possibly due to homeless prevention activity and/or wider economic factors. The increase could also have been partly due to a higher proportion of single homeless applicant being accepted as statutory homeless, The situation has improved over the last couple of years with a decrease in the number of single homeless, but is not back to previous levels yet (Figure 14).

The number of homelessness acceptances and single homeless increased considerably in Worcestershire during the recent recession but has decreased since then.

There is a similar rate of statutory homelessness applications in Worcestershire in 2015/16 (4.9 per 1000 households) to the national average (5.0 per 1000 households).

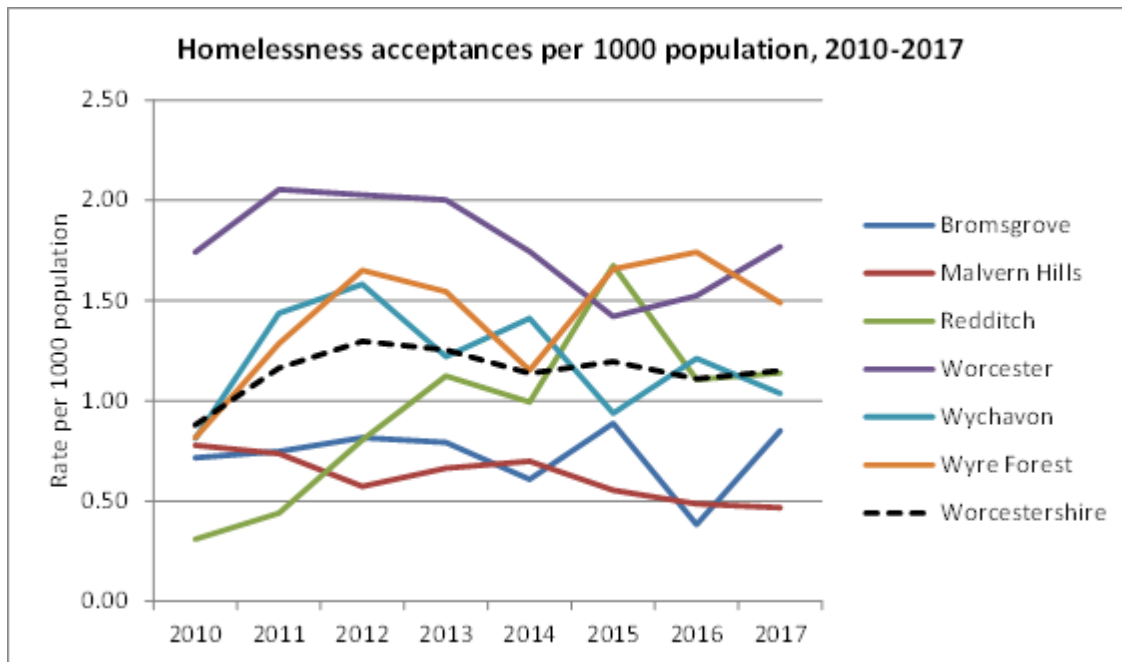
Figure 15: Trends in statutory homelessness (total decisions) rates in Worcestershire 2009-2016



Source: P1E Worcestershire

- Homelessness total decisions are a count of decisions made on homelessness applications by the local authority. Measuring the total number of decisions made on homelessness applications may be a better indication of need than the number of acceptances in local areas.
- While the Worcestershire rate has declined since 2012, there has been fluctuation in homelessness total decision rates by district (Figure 15).
- Worcester city has by far the highest rate of homelessness decisions (3.5 per 1000).

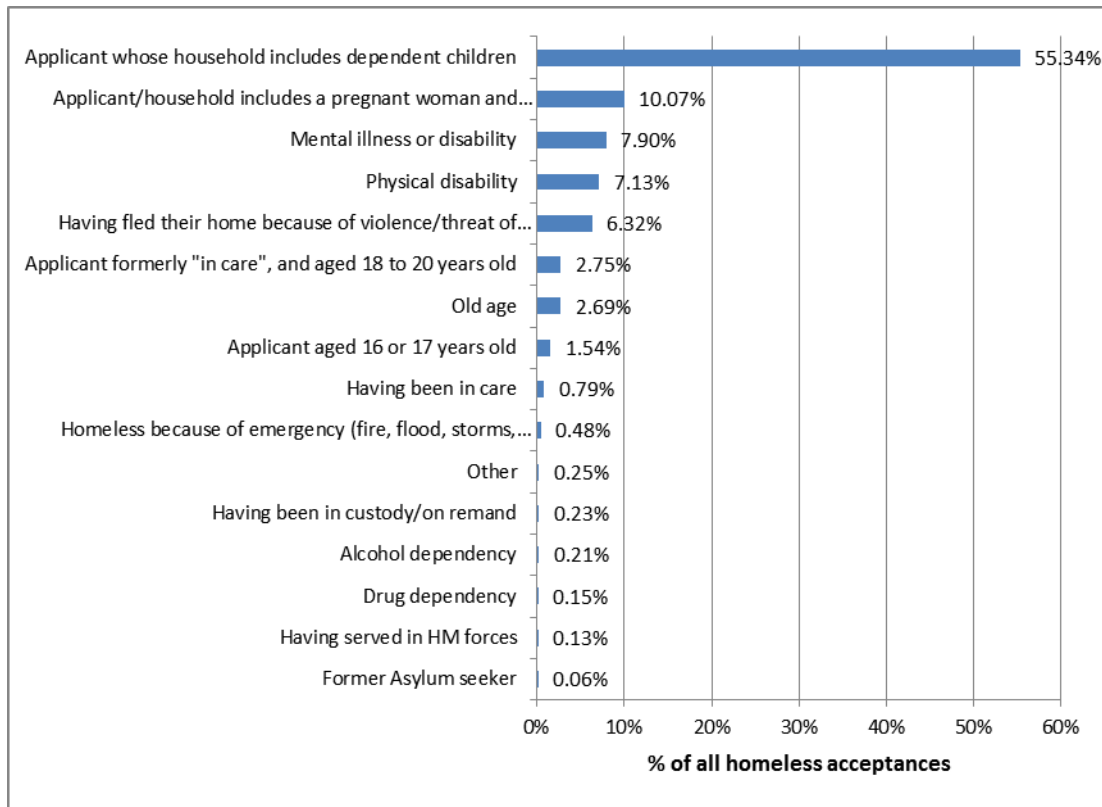
Figure 16: Trends in statutory homelessness (acceptances) rates in Worcestershire 2009-2016



Source: P1E data

- There has been fluctuation in homelessness acceptances rates by district across the five year period.
- Worcester City has the highest rate of homelessness acceptances (around 1.8 per 1000); Malvern Hills the lowest (around 0.5 per 1000). There is a greater difference between decisions and acceptances in Worcester than in other districts, perhaps reflecting the greater degree of single homelessness in Worcester.
- Redditch has seen the greatest increase in the homelessness acceptance rate from 0.3/1000 in 2009 up to 1.2 per 1000 by 2016.
- Comparing statistics to the 2011 data, which uses the P1E statistics, we can see that in 2010/11, 76% of homeless acceptances were from households with either dependent children or whom were pregnant. In 2015/16, 66% were with either dependent children or pregnant; this shows that there has been an increase in the proportion of single households, especially considering that P1E statistics for homelessness acceptances will have a bias towards over representation of homelessness demand for families with children or pregnancy as these are automatic priority needs.

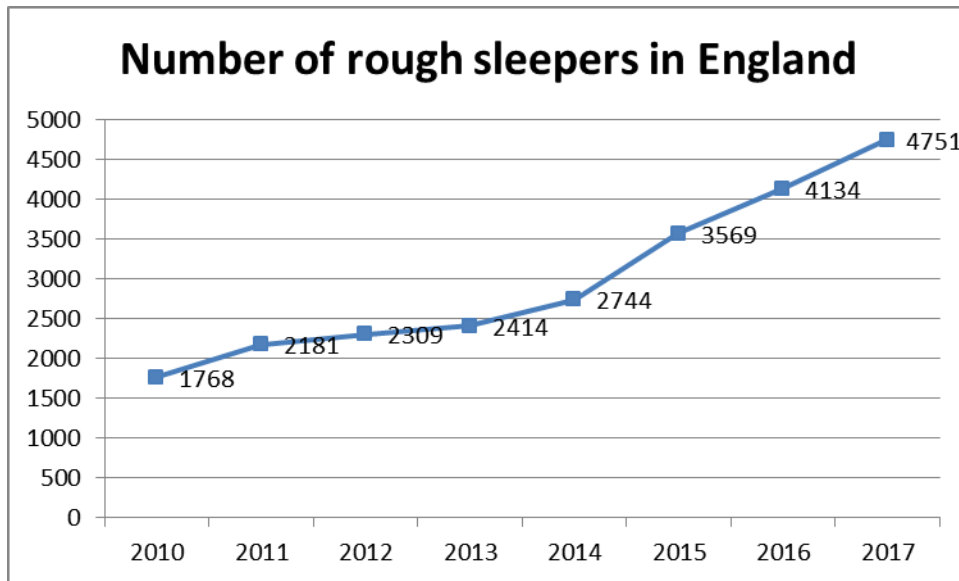
Figure 17: Priority need by category in Worcestershire 2010-2016 combined



Source: P1E data

- The most common reasons for becoming 'priority' homeless are illustrated (Figure 17). this data represents a robust seven year dataset.
- The presence of children under 16 in the household is by far the most prevalent reason, accounting for over half the homeless acceptances (55%).
- The next most prevalent reason is pregnancy (10%). Domestic violence is also a category of priority need, which accounted for 6% of homeless acceptancy.
- Vulnerability caused by various forms of illness represents the other significant categories of priority need, including physical disability (8%) and mental illness (7%).
- Young people and care leavers are other key priority need cases.

Figure 18: Rough sleeping – Government statistics 2010 – 2017

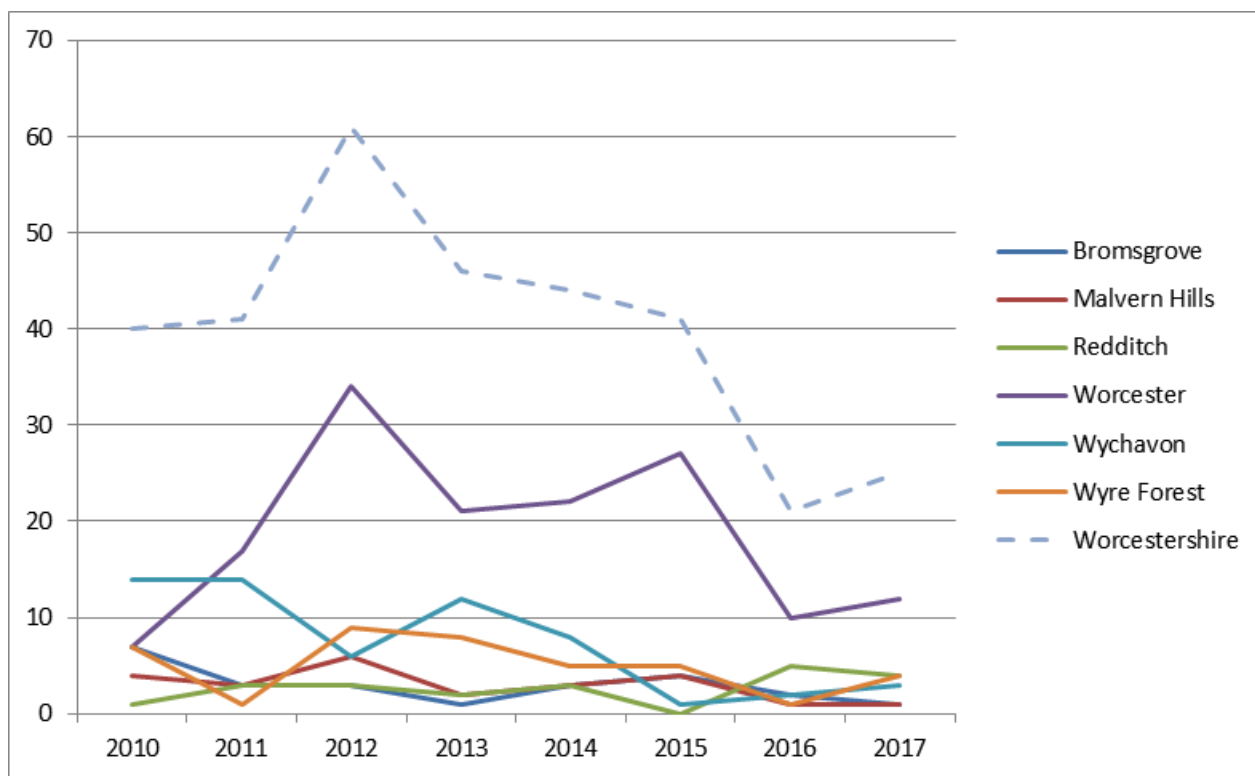


Source: ONS/DCLG, www.gov.uk/government/statistics/rough-sleeping-in-england-autumn-2017

Latest figures (Figure 18) show a 15% increase in the number of rough sleepers in England from 4,134 in 2016 to 4,751 in 2017. Worcestershire figures showed an increase from 21 to 25 rough sleepers over the same period (a 19% rise, similar to England). Nearly half the number (12) were in Worcester.

Over the longer term, DCLG figures estimate a consistent increase in the number of rough sleepers in England from 2010 to 2017. While Figure 19 shows that numbers in Worcestershire have fallen over the same period. Worcester tends to account for around half the numbers of rough sleepers in the county.

Figure 19 – Number of rough sleepers in Worcestershire Districts, Autumn 2010 - 2017



Source: DCLG Rough sleeping returns (annual)

NOTES:

Each Local Authority either conducts a street count or provides an estimate; the Autumn rough sleeping counts and estimates were carried out between 1 October and 30 November.

A count is a single night snapshot of the number of rough sleepers in a local authority area. Counts are independently verified by Homeless Link.

Policy Developments

The Homelessness Reduction Act 2017

The Homelessness Reduction Act became an Act of Parliament on the 27th April 2017. The Act places new legal duties on English councils so that everyone who is homeless or at risk of homelessness will have access to meaningful help, irrespective of their priority need status, as long as they are eligible for assistance. The Act amended part VII of the Housing Act 1996.

Part VII of the Housing Act 1996, as amended by the Homelessness Act 2002, sets out the duties owed by English local housing authorities (LAs) to someone who is homeless or threatened with homelessness. Section 175 of the 1996 Act defines that a person is threatened with homelessness if it is likely that they will become homeless within 28 days. The Homelessness Reduction Act 2017 extends the number of days from 28 to 56. In addition, people who have received a valid notice under section 21 of the Housing Act 1988 and the expiry date is within 56 days, will be treated as being threatened with homelessness.

Housing and Planning Act 2016 – effect on investment in social rented properties

This Act, which became law in May 2016, will have a number of effects on the provision of affordable housing which has for a long time provided a housing option to both prevent households becoming homeless and as an option for households if they become homeless. With the decreasing use of the private rented sector as a tool of prevention and an inability to use it to discharge homeless duties, any reductions in the availability of affordable housing will have a detrimental impact upon homelessness.

One such change is the inclusion of 'Starter Homes' as affordable housing. Traditionally, when a developer builds a certain number of properties they need to provide a proportion as affordable housing. Many developers can be reluctant to do so believing it will make the development less economically viable. Starter Homes count as affordable properties for the purpose of developments and section 106 agreements and some commentators^{22,23} have expressed concern that developers may offer a greater proportion of properties for sale as Starter Homes leading to a decrease in the supply of other forms of affordable housing.

Supply of affordable housing could further be reduced by the roll out of the Right-to-Buy to housing association properties. Even though Right-to-Buy is being rolled out on a voluntary basis, from a practical point of view as housing associations will need to ensure that households are assisted to own properties, there may be little option but to adopt the Right-to-Buy. Although housing association tenants currently have a Right-to-Acquire, this is generally less generous than the Right-to-Buy provision for tenants of local authority dwellings. As properties are purchased under Right-to-Buy there is an expectation that they will be replaced on a one for one basis with receipts from the sales recycled towards the cost of this. However, it may be difficult to achieve this and the Chartered Institute of Housing anticipates that the amount of properties in the social rented sector will reduce²².

²² What you need to know about the Housing and Planning Act 2016 (CIH)

²³ UNISON BRIEFING: THE HOUSING AND PLANNING ACT 2016

Working Benefits Frozen for Four Years from April 2016

This will affect all claimant households of working-age benefits and will make housing benefit claimants more unappealing to private sector landlords. It could lead to an increase in evictions from the private sector as although housing benefit is only increasing by 1% a year, rents are increasing in the West Midlands between 4% and 5% a year. The impact of benefit rates increasing by 1% rather than being linked to the Consumer Price Index (CPI) is slightly mitigated by current low levels of inflation in the UK, however, the policy could serve as a further disincentive to private landlords to consider tenants in receipt of housing benefits.

1% Rent Reductions

The Welfare Reform and Work Act 2016 imposes an obligation on social landlords to reduce rents by 1% per year from April 2016 for a four year period.

According to the Institute for Fiscal Studies, the 1% rent reduction for all social rents, including affordable lets, could have an effect on the supply of affordable housing as there would be less rental income to enable housing development. On the other hand, cuts in social rents will be of little direct benefit to most households living in social housing in England. Most social tenants are on low income and receive housing benefit, which will typically be reduced pound-for-pound with rent cuts – leaving their income after paying rent unchanged²⁴.

Universal Credit

Universal Credit is replacing the following benefits:

- Child Tax Credit
- Housing Benefit
- Income Support
- Income-based Jobseeker's Allowance (JSA)
- Income-related Employment and Support Allowance (ESA)
- Working Tax Credit

A report by the National Audit Office in 2018²⁵ stated that:

- While elements of Universal Credit are working well, some claimants have struggled to adjust to Universal Credit.
- Rent arrears increase at the start of a claim, because claimants must wait five weeks before their first payment. The majority of claimants do not have the money to manage over this period.

²⁴ Social rents policy: choices and trade-offs, Institute for Fiscal Studies

²⁵ National Audit Office (2018). Rolling out Universal Credit.

- One in five claimants do not receive their full payment on time, the average delay being 4 weeks beyond the initial 5 week period.
- The Department [Department of Work and Pensions] lacks the ability to monitor the treatment of vulnerable claimants nationally. It has not yet developed means to record different vulnerabilities in its data systems.
- As a result of the delay in receiving rent payments the private landlords and their representatives that we [NAO] spoke to told us that from a business perspective there is increasing reluctance to rent to Universal Credit claimants.
- Some claimants do not prioritise rent payments, or do not realise that their Universal Credit payment includes their rent as they are used to Housing Benefit being paid directly to the landlord.

While the above issues are not specific to homeless people, they are likely to have an impact on homeless people and those at risk of homelessness, the majority of whom will be claiming the benefit.

Best Practice Recommendations

The National Institute for Health and Care Excellence (NICE) has published a number of clinical guidelines concerning homelessness and its co-morbidity with substance misuse (harmful drinking *CG115*); mental ill health (particularly psychosis *CG120* and depression *CG128*); tuberculosis (*PH37*) and looked after children and young people (*PH28*). The NICE recommendations provide useful interventions and other practical advice; more specifically:

- (i) Joint working between housing organisations and specialist substance misuse services.
- (ii) Offer an intensive community programme of assisted withdrawal consisting of a drug regime and psychosocial support including motivational interviewing.
- (iii) Use of a care programme approach and care coordinator in complex multi-agency cases.
- (iv) Offer a comprehensive multidisciplinary assessment including history of homelessness and stability of current living arrangements; and mental and physical health.

Use of Transition Support Services (TSS) for looked after children and young people has been found to prevent homeless episodes.

Conclusions

This report presents information on what is known about the health of homeless people in Worcestershire. It aims to raise the profile of homelessness as a public health issue and has been written against the backdrop of two key Health and Wellbeing Board commitments; the Charter for Homeless Health and the Memorandum of Understanding ('Improving Health and Care through the home'²⁶). The detail of these commitments includes:

- Ensuring that needs of homeless people are included in Joint Strategic Needs Assessments to inform local planning and commissioning
- Ensuring awareness amongst policy makers of severity and nature of health problems for homeless people
- Improving access to health services through joint working between local agencies

It should be recognised that 'homelessness' encompasses a diversity of housing situations and that there are significant gaps in the data, for example, we don't know much about the 'hidden homeless' or about the health of homeless families. It is hoped that the implementation of the Homelessness Reduction Act 2017 will improve intelligence gathering for these groups in particular.

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²⁶ Public Health England. 2018. *Improving Health and Care through the home*. PHE Publications gateway number 2017861