

Homelessness – health needs and effective interventions

1) Introduction

Homelessness has serious health implications for both individuals and populations. This paper outlines the main health needs of people who are homeless and evidence around best practice for effective interventions to address these needs.

The term 'homelessness' is often used to define people 'sleeping rough', yet most national data relates to those who are statutorily homeless (those meeting specific legislative criteria for whom the local authority accepts a homeless duty). Rough sleepers are defined as people sleeping, about to bed down or actually bedded down in the open air or in buildings or other places not designed for habitation. 'Priority need groups' include households with dependent children or a pregnant woman and people who are vulnerable in some way e.g. because of mental illness or physical disability.¹ The average life expectancy of male rough sleepers is 47 years compared to 77 years for the general population, and for females it is just 43 years.²

In 2014, in the official one night snapshot count or estimate, there were 2,744 rough sleepers in England, compared to 1,768 in 2010, a 55% increase.³ In that same year, there were 53,250 UK households eligible for homelessness assistance from their local authority, these are mainly households in priority need because they have children or because they are particularly vulnerable due to their age or ill-health.

Homelessness is not just a housing problem but can be caused by a multitude of social, individual and economic factors.⁴ However, examining the number of people experiencing homelessness is difficult firstly because the definition is contested, and secondly because people who are homeless are typically mobile and therefore difficult to monitor.⁵

Analysis suggests the total cost of hospital usage by homeless people is over £85 million, 4 times the level of the general population, with inpatient costs (the bulk of the usage for this

client group) being 8 times higher than the comparison population (aged 16-64).⁶

In the main, this paper relates to single homeless people who are rough sleeping or in temporary hostel accommodation, revolving between the two, or sofa surfing.

2) Risk factors and triggers

The most common risk factors for homelessness include drug or alcohol problems, poor educational attainment / qualifications, ongoing mental health issues and relationship or family breakdown. Triggers can include bereavement, job loss, debt, social exclusion, crime, leaving an institution (e.g. the armed forces), a sudden deterioration in mental health, and relationship or family breakdown.^{7,8}

3) Health needs

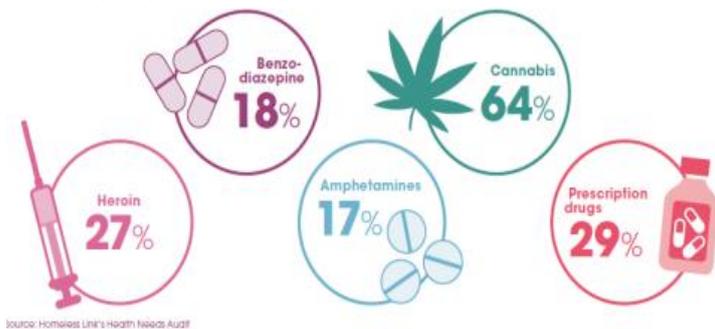
Ill health can be both a cause and a consequence of homelessness.⁹ Health problems, particularly mental health problems, substance misuse and alcohol dependency are more prevalent among the homeless population, especially among rough sleepers, with potentially significant costs for health and support services. Expert opinion suggests the majority (around two thirds) of serious chronic health problems pre-exist the person becoming homeless, but become exacerbated by their homelessness. Additionally, evidence suggests many homeless people have multiple concurrent health needs such as physical illness, mental health problems and substance misuse.¹⁰

3.1 Drug and alcohol dependency

Substance misuse is both a mental and physical health issue, with a high prevalence of illicit drug use and alcohol dependence evidenced amongst homeless people.¹¹ Many patients as a result present to health services with potentially serious neurological, gastroenterological, cardiovascular or psychosocial complications. Substance misuse in particular counts for just over a third of all deaths of homeless people. There is an estimated prevalence of 24.4% drug dependence and 37.9% alcohol dependence in this population.¹² A 2014 audit of 2,500 homeless service users in England found two in five people (40%) were taking drugs or

recovering from a drug problem, and 36% had taken drugs in the last month (7 times the general population). Cannabis appears to be the most commonly used drug by those experiencing homelessness (Figure 1). However, a quarter reported taking heroin and prescription drugs not prescribed for them.¹³

Figure 1: Illicit drug use amongst homeless people who reported a substance misuse issue



3.2 Sexual behaviour related

Despite little available data, research has suggested that increased risk behaviour amongst the homeless population increases the rate of sexual health problems such as sexually transmitted diseases (STIs) and blood borne viruses; there are also higher rates of sexual abuse in the homeless population.^{14,15} There is evidence of unmet need in terms of: the supply of information about, and testing for, STIs; condom supply and use; contraceptive advice; and cervical cytology.¹⁶

3.3 Physical health

People who are homeless are much more likely to have physical health problems than the general population. The Homeless Link Health Needs Audit 2014 revealed that: three quarters of people who are homeless have a physical health problem, most commonly joint/muscular problems, chest and breathing issues, dental problems, eye problems, liver disease, infections (includes sepsis, abscesses, MRSA and C-difficile), physical trauma and stomach complaints. Two fifths (41%) reported a long term health problem (compared to 28% of the general population).^{17,18}

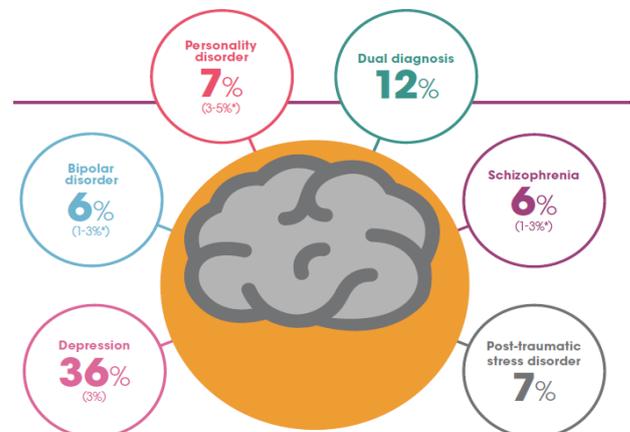
Other health problems particularly prevalent in homeless populations include: deep vein thrombosis (DVT), gastroenterological diseases, skin conditions, epilepsy/ fits, urogenital

diseases, learning/ physical disability, anaemia, cardiovascular diseases and cancer. In the 2014 national audit, physical problems were most common for those who were squatting (88.2%) and rough sleeping (83.8%).¹⁹

3.4 Mental health

Homeless people have nearly twice the prevalence of diagnosed mental health problems (45%) compared with the general population (25%).²⁰ The 2014 national audit of 2,500 homeless service users in England found that homeless people experience high levels of depression, stress, anxiety and other signs of poor mental health (Figure 2). Nearly 1 in 8 of those with a diagnosed mental health issue also reported alcohol and drug issues, 41% of whom used drugs or alcohol to cope with their mental health issues. Research by the Salvation Army found that 53% of homeless women, and 34% of homeless men had attempted suicide at least once.²¹

Figure 2: Diagnosed Mental health issues in the homeless population (general population in brackets)



3.5 Dual diagnosis

The prevalence of co-occurring mental illness and substance misuse (dual diagnosis) is high in homeless populations. Many homeless people demonstrate a combination of physical illness, mental health problems and substance misuse; as many as 40% of rough sleepers have these multiple concurrent health needs.²² In a survey of European homeless-specific programmes, substance misuse was a stated exclusion criterion in more than 25 (22%) of mental health services; it was associated with aggressive behaviour in 49 (44%).²³

3.6 Hospital admissions

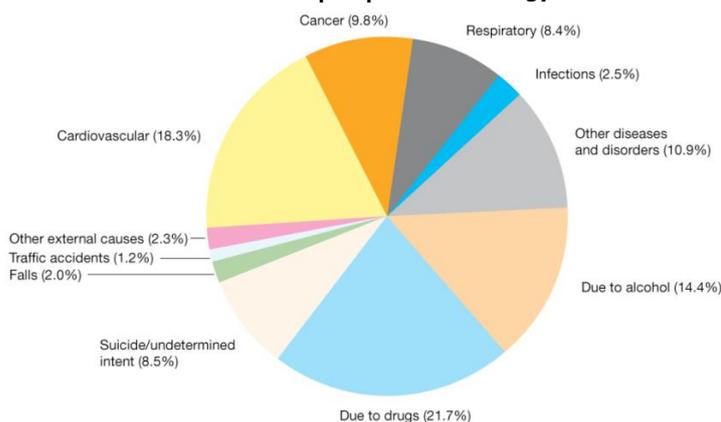
National evidence from people either sleeping rough or those living in a hostel (40,500) suggests that compared to the general population, homeless people are 3.2 times more likely to have an impatient admission, and at 1.5 times higher cost;²⁴ four times more likely to turn to the emergency department when they are unable to speak to a GP, five times more likely to attend the emergency department. They are admitted 3.2 times as often as those who are not homeless and stay in hospital three times as long. An audit by Homeless Link found that the most common reasons that people who are homeless use A&E are: a violent incident or assault; an accident; alcohol use, or breathing problems/chest pains.²⁵

If not supported and treated effectively, homeless people are one of the most costly populations for the NHS – with lack of access to appropriate preventive or responsive treatment leading to increased use of services, such as ambulances and accident and emergency departments.²⁶

3.7 Causes of death

National research has found that the average age of death while homeless (including those in homeless hostels or night shelters) was 47 for men and 43 for women.²⁷ Homeless mortality data, (2001-2009) shows that the homeless population are more likely than the general population to die of external factors, such as drugs and alcohol, mental health, suicide, traffic accident, infections and falls, as opposed to diseases such as cardiovascular disease and cancers (figure 3).²⁸

Figure 3: Distribution of causes of death for homeless people 2001-2009, UK



Deaths due to drugs and alcohol account for over a third of all homeless deaths, and these factors can both be a cause of the homelessness or a result of homelessness. Homeless people are also over 9 times more likely to commit suicide than the general population.²⁹

The Faculty for Homeless and Inclusion Health notes, *"when homeless people die they do not commonly die as a result of exposure or other direct effects of homelessness, they die of treatable medical problems, HIV, liver and other gastro-intestinal disease, respiratory disease, acute and chronic consequences of drug and alcohol dependence"*.³⁰

3.8 Barriers to healthcare

Evidence suggests homeless people are not getting healthcare which meets their needs, and that there are real gaps in health provision for homeless people³¹ with one study suggesting that this client group are forty times more likely than the general population to have no GP.³² Barriers include: mainstream GP surgeries requiring proof of address for registration; homeless people generally having chaotic lifestyles making it difficult to book and keep appointments; only seeking assistance until health is critical, as health needs are often surpassed by other, more immediate needs.³³ Additionally homeless people can experience discrimination from staff at health and other services and difficulty prioritising or addressing health needs due to lack of stable housing.³⁴

4) Preventing homelessness

The [Housing Act 1977](#), [Housing Act 1996](#), and the [Homelessness Act 2002](#), placed statutory duties on local housing authorities to ensure that advice and assistance to households who are homeless or threatened with homelessness is available free of charge.³⁵

'Homelessness prevention' means providing people with the ways and means to address their housing and other needs to avoid homelessness. 'Homelessness relief' is where an authority has been unable to prevent homelessness but helps someone to secure accommodation, even though the authority is under no statutory obligation to do so.³⁶

Although everyone is entitled to Advice and Assistance, in many areas the record in terms of offering it to people who are not owed a statutory duty is not good.

Homelessness prevention activity has been well documented in recent years³⁷, but a recent review of the evidence by Public Health England and Homeless Link³⁸ suggests considerable potential for those commissioning health and wellbeing services across the NHS and public health to not only incorporate these approaches within the services they already commission, but to target those more at risk of homelessness. This review looked at four different models for preventing homelessness across a 3-tier system:

4.1 WELFARE RIGHTS AND CONSUMER ADVICE (PRIMARY PREVENTION)

This includes: advice within primary care settings such as GP surgeries; targeted welfare advice for patients leaving secondary care; holistic advice services (including debt, mental health, youth advice) to young people in a non-health setting.

Housing and welfare problems can lead to and exacerbate mental health problems; and there are evidenced links between financial exclusion, debt and homelessness. Evidence shows that advice can help to prevent homelessness, provides financial gains (to both the client and public services), and can improve mental health and wellbeing by decreasing stress and anxiety.

4.2 HOLISTIC IN-TENANCY SUPPORT (SECONDARY PREVENTION)

This involves holistic support and services to help people living in their own home/tenancy to live independently and successfully maintain accommodation. This is usually targeted at those who are at risk of losing their homes and repeat homelessness, for example, those with mental health problems and in treatment programmes.

Existing evaluations identify benefits to this model including: reduced A&E use; gaining employment and improved mental health, with programmes such as Family Intervention programme (FIP) and Supporting People providing evidence of cost effectiveness. Evidence suggests there is potential for greater focus on health interventions within in-tenancy support, as well as coordinating input from other services. There is also potential to be located

within health and community settings, e.g. GP practices, clinics and community centres.

4.3 TARGETED SUPPORT AND ADVOCACY TO PEOPLE LEAVING INSTITUTIONS (SECONDARY PREVENTION)

Targeted support and advocacy will plan and respond to known 'transition' points from institutions where there is greater risk of homelessness and repeat admissions, for example hospital, psychiatric care, prisons and the care system. Targeted support could include pre-discharge housing and income support for psychiatric patients; or a residential programme for young people leaving care.

Research shows that effective health setting discharge planning improves health outcomes and prevents repeat homelessness, particularly for care leavers in relation to longer term health improvement, employment outcomes and tenancy sustainment.

4.4 CRITICAL TIME INTERVENTION (CTI) TARGETED AT GROUPS IN THE COMMUNITY (TERTIARY PREVENTION)

CTI is targeted at groups in the community who have already experienced homelessness and who are at high risk of become homeless again once back in their own accommodation. There are 'critical times' where support is needed to prevent homelessness, particularly for those who have other support needs including substance misuse issues, fleeing violence, offending history and mental health needs.

CTI can cost effectively reduce repeat homelessness. CTI should be used alongside primary prevention to reduce need for critical time interventions at a later date.

Homelessness prevention should be at the heart of efforts to reduce health inequalities by:

- **Developing stronger leadership and joint strategic working**, for example homelessness within the JSNA, clear and coordinated direction for services to ensure every contact counts, and embedding a prevention first approach.
- **Providing access to advice and early intervention**, for example primary homelessness prevention in primary and secondary settings, greater engagement of housing and health professionals with

schools and early years settings, training for professionals and clear identification of local services for health professionals.

- Improving data collection and evaluation**, for example, improved data recording and sharing for targeting and best practice, routine measuring of housing status when accessing health services, and public health helping services evaluate cost effectiveness and return on investment.³⁹ Further to this, the DCLG joint approach to preventing homelessness paper⁴⁰ sets out a number of challenges to local authorities and partners to deliver a gold standard service for homelessness, including: corporate commitment; partnership working; offering a Housing Options prevention service; adopting a *no second night* model; housing pathways in place; a suitable private rented sector offer; preventing mortgage repossessions; a proactive homeless strategy; not placing 16-17 year olds in B&Bs; and only using B&Bs for families for up to 6 weeks in an emergency.

International research conducted in Canada and the UK has suggested the most effective interventions for certain populations of homeless people, including primary health care programmes, mental health care, permanent supportive housing, medical respite, substance misuse and homeless young people. Key findings from the research can be found at:

[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(14\)61133-8/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)61133-8/abstract)

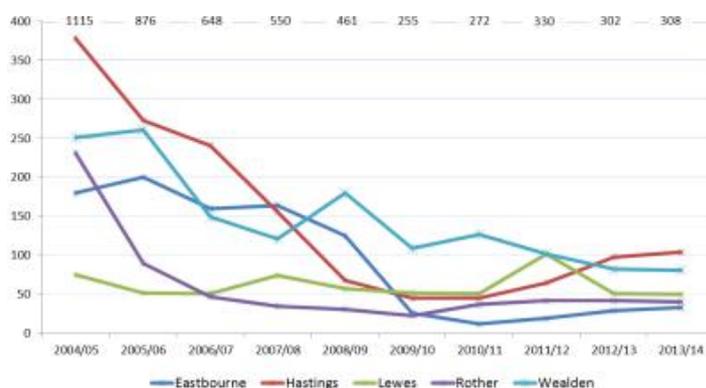
5) Homelessness in East Sussex

Households in priority need

Figure 4 shows the number of additional households who have been accepted by the local authority as homeless and in priority need for accommodation in East Sussex and its districts.

Over the last decade the number of households in priority need has fallen from 1,115 in 2004/05 to 308 in 2013/14. However, since 2009/10 the number has increased from 255 households to 308, indicating a rise in households needing priority accommodation. The most notable rise has been in Hastings which has seen a 230% increase from 45 households in 2009/10 to 104 in 2013/14 (Figure 4).

Figure 4: Additional homeless households accepted in priority need 2004/05-2013/14

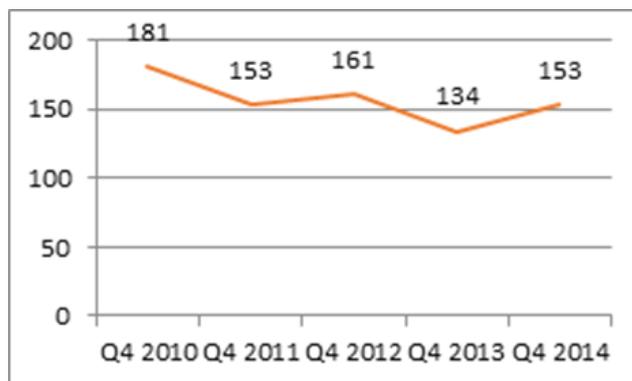


Households in temporary accommodation

The number of households in temporary accommodation in East Sussex fell steadily between 2005 and 2011, but in recent years, rates have fluctuated, with 2014 showing an increase on 2013 (figure 5).

Figure 5: Households in temporary accommodation 2004-2014

Source: Department for Communities and Local



Government (DCLG)

Rough Sleepers

For the purposes of rough sleeping counts and estimates, rough sleepers are defined as:

People sleeping, about to bed down (sitting on/in or standing next to their bedding) or actually bedded down in the open air (such as on the streets, in tents, doorways, parks, bus shelters or encampments). People in buildings or other places not designed for habitation (such as stairwells, barns, sheds, car parks, cars, derelict boats, stations, or "bashes" which are makeshift shelters, often comprised of cardboard boxes). The definition does not include people in hostels or shelters, people in campsites or other sites used for recreational purposes or organised protest, squatters or travellers. Data from the Department for Communities and Local Government estimate that in East Sussex in autumn 2014 there were 24 rough

sleepers: Eastbourne 11, Hastings 12, Lewes 0, Rother 0, Wealden 1.

Homeless prevention and relief

Nationally collected data from July 2014 indicates that despite having the smallest number of households, Hastings had the highest numbers of households assisted to remain in their homes (972) or to find alternative accommodation (788) in 2013/14. This is a rate of 44/1,000 households, nearly 4 times the rate of any other district or borough in East Sussex (Table 1).⁴¹

Table 1: Total reported cases of homelessness prevention by outcome -2013/14

	Number of Households	Assisted to remain in home	Assisted to find alternative accommodation	Total rate per 1,000 households	% assisted households change from 2012/13
Eastbourne	47,000	144	342	10.34	48%
Hastings	40,000	972	788	44.00	-7%
Lewes	44,000	315	222	12.20	93%
Rother	42,000	135	86	5.26	-56%
Wealden	63,000	511	184	11.03	10%

From 2012/13 to 2013/14 Lewes had the greatest increase in the number of households assisted to remain in their home or find alternative accommodation (93%) while Rother had the greatest decrease (-56%).⁴²

¹ Department of Communities and Local Government (2014) Homelessness data: notes and definitions

² Crisis UK (2011) Homelessness: a silent killer. A research briefing on mortality amongst homeless people

³ Department for Communities and Local Government. (2013) Statutory homelessness: October to December 2014 England.

⁴ Fitzpatrick et al (2000) Single homelessness: an overview of research in Britain. Joseph Rowntree Foundation.

⁵ Fitzpatrick et al (2000) Single homelessness: an overview of research in Britain. Joseph Rowntree Foundation.

⁶ McCormick, B, (2010) Healthcare for single homeless people Office of the Chief Analyst, Department of Health

⁷ Department for communities and local Government (2012) Evidence review of the costs of homelessness

⁸ Cambridge County Council and NHS Cambridgeshire (2010) joint strategic needs assessment – Homelessness and at risk of Homelessness

⁹ Department for communities and local Government (2012) Evidence review of the costs of homelessness

¹⁰ Department for communities and local Government (2012) Evidence review of the costs of homelessness

¹¹ Fazel S, Khosla V, Doll H, Geddes J. The prevalence of mental disorders among the homeless in western countries: systematic review and meta-regression analysis. *PLoS Medicine / Public Library of Science*, December 2008, vol./is. 5/12(e225), 1549-1277

¹² Dearbhal Murphy (FEANTSA). FAEANTSA policy statement (2006) How health professionals can work towards meeting the health needs of homeless people.

¹³ Homeless Link (2014) The unhealthy state of homelessness – health audit results 2014

¹⁴ John W, Law K. REVIEW: Addressing the health needs of the homeless. *British Journal of Community Nursing*, March 2011, vol./is. 16/3(134-9), 1462-4753;1462-4753 (2011 Mar)

¹⁵ Noell J, Rohde P, Ochs L, Yovanoff P, Alter MJ, Schmid S, Bullard J, Black C. Incidence and prevalence of chlamydia, herpes, and viral hepatitis in a homeless adolescent population. *Sex Transm Dis*. 2001 Jan;28(1):4-10

¹⁶ Collins E. A service to address the sexual health needs of the homeless population. *NursingTimes.Net*. Vol: 99, Issue 37, page 53. (2003)

¹⁷ Homeless Link (2014) The unhealthy state of homelessness – health audit results 2014

¹⁸ Department for communities and local Government (2012) Evidence review of the costs of homelessness

¹⁹ Homeless Link (2014) The unhealthy state of homelessness – health audit results 2014

²⁰ <http://www.mind.org.uk/information-support/types-of-mental-health-problems/statistics-and-facts-about-mental-health/how-common-are-mental-health-problems/>

²¹ Bonner, A and Luscombe, C (2009) The Seeds of Exclusion 2009 The Salvation Army, University of Cardiff and University of Kent

²² Department for communities and local Government (2012) Evidence review of the costs of homelessness

²³ Canavan R, Barry MM, Matanov A, et al. (2012) Service provision and barriers to care for homeless people with mental health problems across 14 European capital cities. *BMC Health Serv Res* 2012; 12: 222.

²⁴ Department of Health (2010) Healthcare for single homeless people.

²⁵ Homeless Link (2014) The unhealthy state of homelessness – health audit results 2014

²⁶ Public Policy Institute for Wales (2015) Tackling Homelessness A Rapid Evidence Review

²⁷ Crisis UK (2011) Homelessness: a silent killer. A research briefing on mortality amongst homeless people

²⁸ Crisis UK (2011) Homelessness: a silent killer. A research briefing on mortality amongst homeless people

²⁹ Crisis UK (2011) Homelessness: a silent killer. A research briefing on mortality amongst homeless people

³⁰ The Faculty for Homeless and Inclusion Health (2013) Standards for commissioners and service providers: Version 2.0

³¹ McCormick, B, (2010) Healthcare for single homeless people Office of the Chief Analyst, Department of Health

³² 'Critical condition', Crisis, 2002

³³ McCormick, B, (2010) Healthcare for single homeless people Office of the Chief Analyst, Department of Health

³⁴ Homeless Link and St Mungos Broadway (2014) needs to know – including single homelessness in joint strategic needs assessments.

³⁵ Department of Communities and Local Government (2014) Homelessness data: notes and definitions

³⁶ Department of Communities and Local Government (2014) Homelessness data: notes and definitions

³⁷ Crisis (2011) Homelessness: A silent killer, A research briefing on mortality amongst homeless people

³⁸ Public Health England and Homeless Link (2014) Preventing homelessness to improve health and wellbeing

³⁹ Public Health England and Homeless Link (2014) Preventing homelessness to improve health and wellbeing

⁴⁰ DCLG (2012) Making every contact count: A joint approach to preventing homelessness

⁴¹ <https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness>

⁴² <https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness>