



Homelessness and health:
improving the health and wellbeing
of those without safe and stable
housing in Bedford Borough

Director of Public Health Report, 2018

Foreword

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

Ill health can be both a cause and consequence of homelessness. Being homeless is associated with extremely poor health outcomes relative to those of the general population, with the average age of death of homeless people in 2012 being 47 years for men and 43 years for women when compared to 77 for the general population (74 for men, 80 for women). Homeless people are more likely to have poor physical and mental health, and people with physical and mental health problems are more vulnerable to becoming homeless. As with other risks to public health, prevention and early intervention can help to keep people housed appropriately, stopping the escalation of issues that can lead to losing stable accommodation and worsening health.

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

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

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

- Better identify the overlapping vulnerabilities that put people at risk of homelessness and its health impacts, to enable **better prevention and early intervention**.
- **Improve health** and mitigate risks to health among people who experience homelessness, including people living in temporary accommodation and rough sleepers.
- Strive to **reduce health inequalities** among vulnerable populations who experience homelessness.



Muriel Scott

Director of Public Health, Bedford Borough Council

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Understanding homelessness

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

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

Core homelessness: those experiencing the most acute forms of homelessness	Wider homelessness: a broader group of those experiencing insecure or poor housing
<ul style="list-style-type: none"> • Rough sleepers. • Sleeping in cars, tents, public transport. • Squatting (unlicensed, insecure accommodation). • Hostel residents. • Users of night/winter shelters. • Domestic abuse victims, e.g. living in refuges. • Living in unsuitable temporary accommodation (e.g. bed and breakfast). • Staying with others (not close family) in crowded conditions (e.g. sofa surfers). 	<ul style="list-style-type: none"> • Long term staying with friends/relatives. • Eviction/under notice to quit (and unable to afford rent/deposit). • Asked to leave by friends/relatives. • In intermediate temporary accommodation and receiving support. • In other temporary accommodation (e.g. social housing, private rented sector). • Discharged from prison, hospital (other state institutions) without permanent housing.

Homelessness in England

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

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

UK Government targets related to homelessness policy include:

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



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

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

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

- 1. Improved advice and information about homelessness and the prevention of homelessness.** A review of prior homelessness legislation found that information and advice provided to single homeless people needed to be much more effective (Crisis, 2015). Under the HRA, local authorities are required to work with other relevant statutory and non-statutory services to identify at-risk groups and to develop high quality information and advice.
- 2. Extension of the defined period of “threatened with homelessness”.** Under prior legislation, an applicant was only assessed as threatened with homelessness if they are likely to become homeless within 28 days. Under the HRA, the period “threatened with homelessness” was extended to 56 days.
- 3. New duties to prevent and relieve homelessness for all eligible people, regardless of priority need and intentionality.** Under the HRA, all eligible people who are found to be homeless or threatened with homelessness are entitled to more tailored support from the housing authority, regardless of priority need status, intentionality, and local connection. All people found to be homeless and in priority need will be provided with temporary accommodation, and assessment of priority need status will increasingly require multi-agency working.

4. **Introduction of assessments and personalised housing plans.** Under the HRA local authorities are required to conduct an assessment with all eligible applicants who are homeless or threatened with homelessness. The aim of the assessment is to develop a personalised housing plan that sets out actions local authorities and applicants will take to secure accommodation.
5. **The duty to refer.** From 1 October 2018, the HRA will encourage public bodies to work together to prevent and relieve homelessness through a ‘duty to refer’. Under the new legislation, public bodies in England will have a new duty to refer service users (with consent) who may be homeless or threatened with homelessness, to a local housing authority. This requires the development of “effective referral arrangements and accommodation pathways that involve all relevant agencies to provide appropriate jointly planned help and support to prevent homelessness”

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

Homelessness in Bedford Borough

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

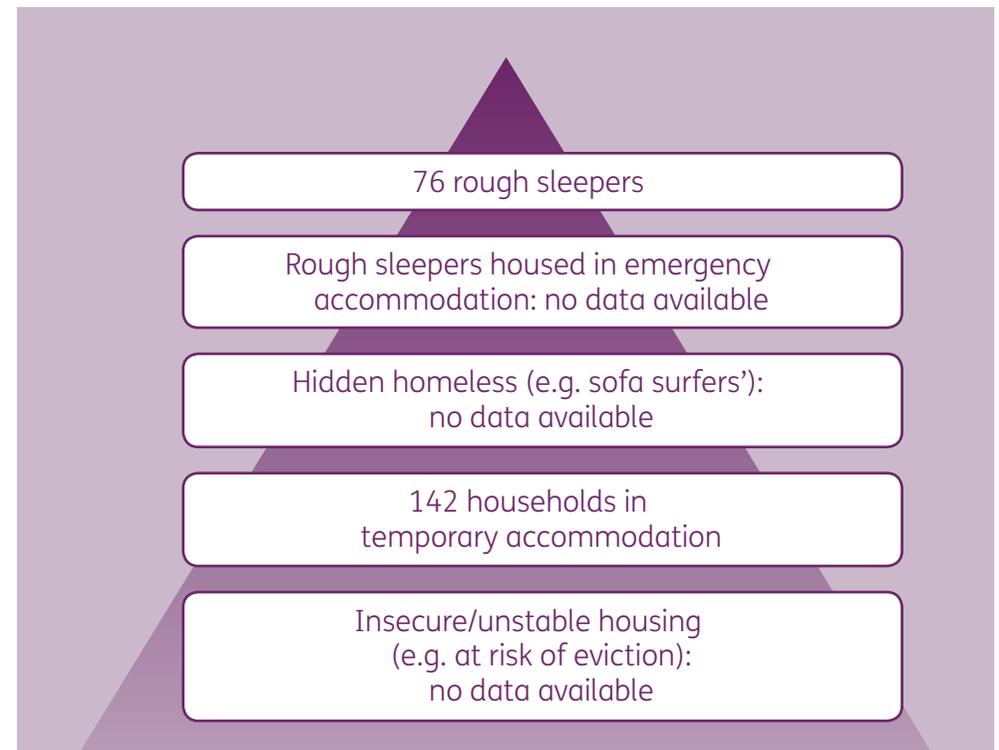


Figure: Pyramid of homelessness in Bedford Borough

In Bedford Borough, several measures of statutory homelessness have increased and remained above national rates since 2010/11. Since 2014, there have been steep increases in rough sleeping, family homelessness and overall statutory homelessness, though family homelessness and overall statutory homelessness have fallen since 2015/16.

- Rough sleeping has increased every year since 2010/11. There were an estimated 76 rough sleepers in Bedford Borough in autumn 2017, compared to 12 in 2010.
- Although the rate of households in temporary accommodation remains below the rate in England as a whole, numbers have risen significantly in recent years.
- Statutory figures show that in 2017/18, there were 132 households in living in temporary accommodation in Bedford Borough, compared to 29 in 2010/11.

Snapshot of current homelessness and recent trends

Rough sleeping

At the November 2017 national rough sleeper count, there were an estimated 76 people sleeping rough in Bedford Borough. The Bedford Borough Housing Team have conducted a detailed analysis of the background of this cohort of rough sleepers, and the findings are summarised here for the 65 male and 11 female rough sleepers.

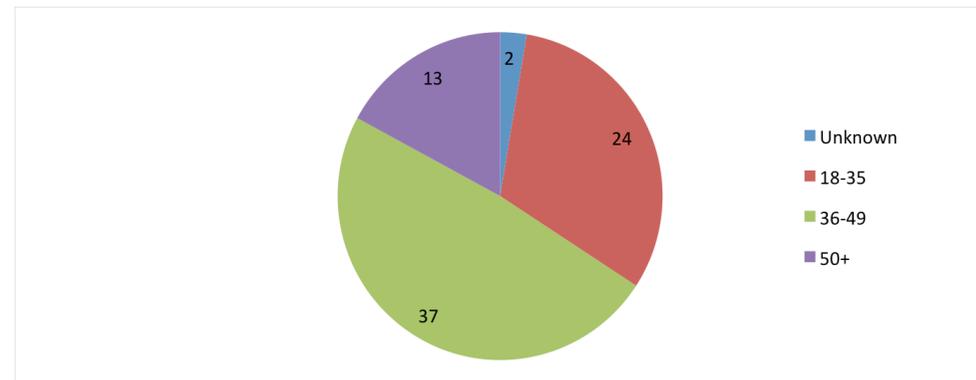


Figure: Age profile of Bedford Borough rough sleepers, 2017

Almost half of the rough sleepers (49%) were aged 36-49 years old. A minority were under 25 or over 60.

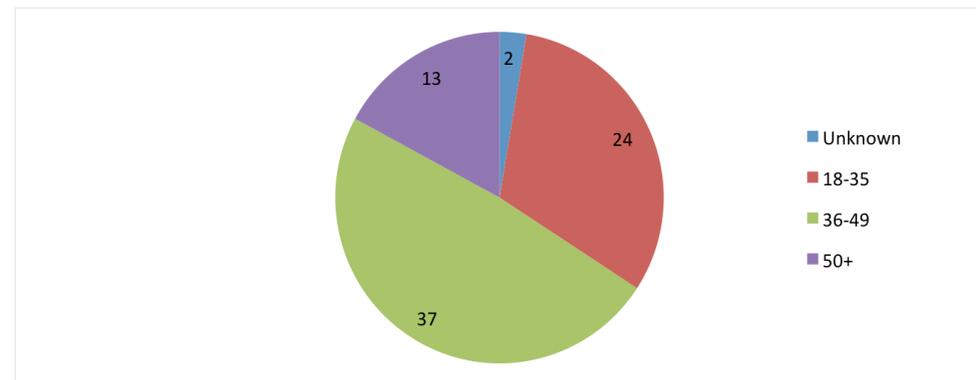


Figure: Rough sleeping locations of Bedford Borough rough sleepers, 2017

Most rough sleepers (57%) slept on the streets. 30% were sleeping in tents, 7% in cars or derelict buildings and 7% were sleeping rough in an unknown location.

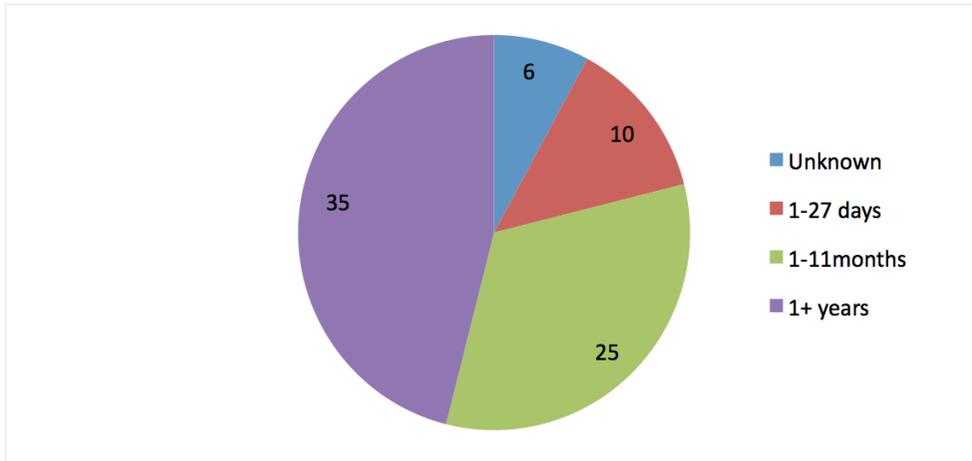


Figure: Duration of rough sleeping for Bedford Borough rough sleepers, 2017

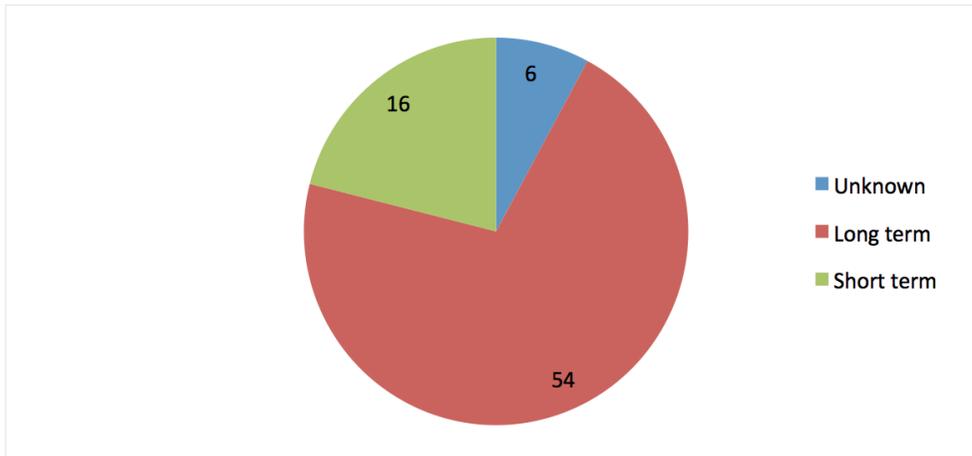


Figure: Short-term vs. long-term rough sleeping for Bedford Borough rough sleepers, 2017

At the time of the 2017 count, almost half of the rough sleepers in Bedford Borough (46%) had been sleeping rough for 1 to 5 years. The next most common duration of rough sleeping was 1 to 12 months (33% of estimated rough sleepers). 71% of rough sleepers were identified as 'long term' (rough sleeping for months or years); 21% were identified as 'short term' (rough sleeping for weeks); for 6 rough sleepers, the duration of their rough sleeping was not known.

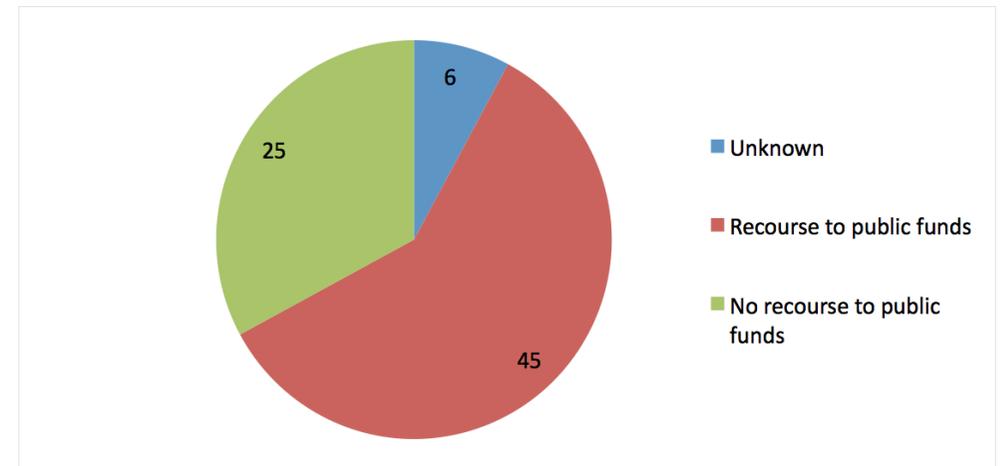


Figure: Recourse to public funds for Bedford Borough rough sleepers, 2017

59% (n=45) of rough sleepers were known to a local connection to Bedford Borough; 36% did not and the local connection status of 4 rough sleepers was unknown. Similarly, 59% had recourse to public funds, 33% had no recourse to public funds and the status was unknown for 6 rough sleepers.

Critically, 57 rough sleepers (75%) were identified as having 'multiple support needs', including mental health and substance misuse problems. Three did not, and the health status was unknown for 16 rough sleepers.

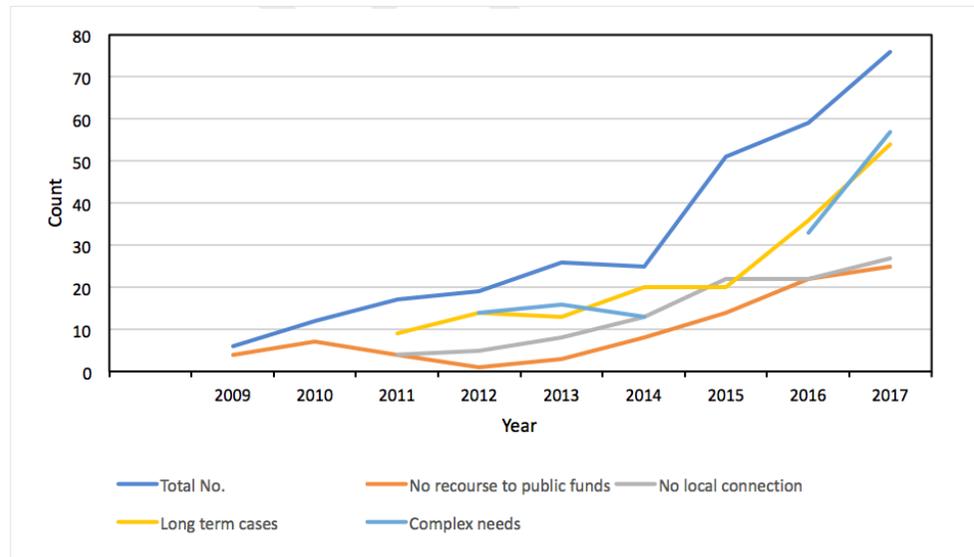


Figure: Rough sleeping trends in Bedford Borough, 2009 to 2017

Rough sleeping increased rapidly in Bedford Borough since 2009, peaking at 76 in the November 2017 annual rough sleeper estimate. The number of rough sleepers with no recourse to public funds has increased every year since 2012.

The number of rough sleepers with no local connection to Bedford Borough and the number who are long term rough sleepers have both increased since 2011 when data collection on those measures started. The number of rough sleepers with multiple support needs has increased from 14 in 2012 to 57 in 2017.

Temporary accommodation

The number of households living in temporary accommodation in Bedford Borough has increased in recent years, rising from 61 in April 2015 to 142 in June 2018 according to local data. Patterns in types of temporary accommodation in

use have shifted between 2015 and 2018.

- In April 2015, 97% of temporary accommodation use was private sector leasing (60 households), dropping to just 38% of temporary accommodation use in June 2018 (54 households) – most of this change was accounted for by increased use of nightly lets.
- Nightly lets increased from 0 in April 2015 to 87 in June 2018, and now accounts for 61% of all temporary accommodation use.
- Use of Bed and Breakfast (B&B) accommodation has fluctuated, peaking at 19 in July 2016.
- The number of households in B&B accommodation has declined since July 2016 and was 1 in June 2018.

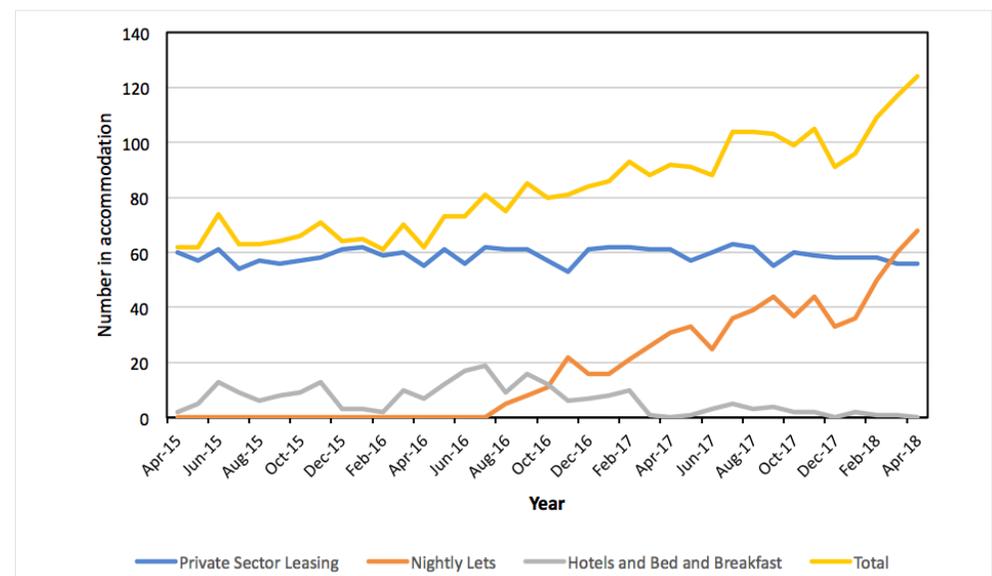


Figure: Use of temporary accommodation in Bedford Borough, April 2015 to April 2018

Statutory homelessness measures

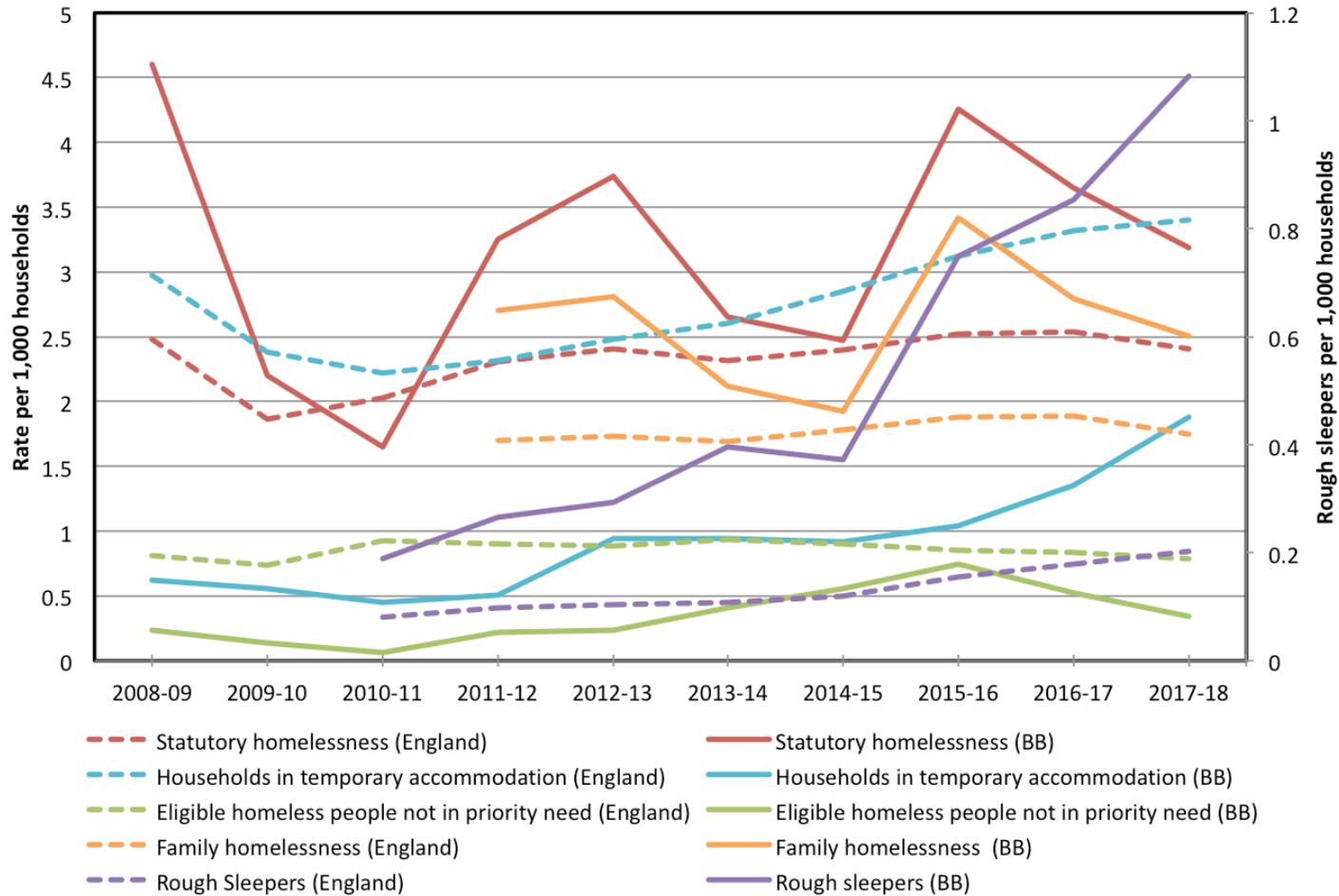


Figure: Statutory homelessness and rough sleeping trends- Bedford Borough and England
(Source: Ministry of Housing, Communities & Local Government)

The root causes of homelessness

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

- Health, social and behavioural risk factors which are the focus of this report including complex and overlapping needs, substance misuse, mental ill health, offending behaviour and particular vulnerable groups such as veterans. This is the focus of this report and is discussed further in section 7.
- Socioeconomic factors including relationship breakdown, rising relative poverty and problematic debt.
- The supply of affordable housing.
- Changes to the welfare system.

Growth in relative poverty

Macroeconomic conditions are important contributory factors both to the housing crisis and rise in homelessness nationally. Poverty is a key driver of homelessness and childhood poverty is a strong predictor of adulthood homelessness, which in turn increases vulnerability to poverty in adulthood.

Since the financial crisis of 2008 relative poverty has risen among the working age population in England, against a backdrop of rising overall levels of relative poverty since 1961. Since a recent increase in relative poverty has occurred alongside a reduction in housing availability and affordability, this is likely to have contributed to increased vulnerability to homelessness in England.



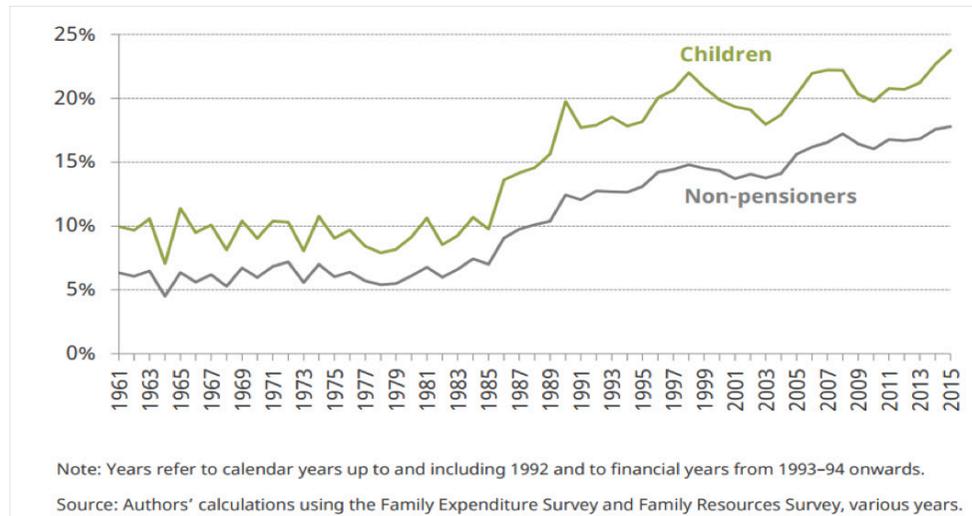


Figure: Relative poverty in the UK, 1961 – 2015
(Source: Institute of Fiscal Studies)

Problematic household debt

In 2017, British households spent about £900 more than they received in income and growing levels of household debt are likely to have had a significant impact on the affordability of housing for families and individuals. A combination of wage stagnation, inflation and the impact of welfare reforms on the poorest households may increasingly force families to borrow to fund daily living, including the cost of housing.

Household borrowing has increased since 2009 and overtook household savings in 2016/17 for the first time since 2007/08. There are also important regional inequalities in household problematic debt, affecting 7% of households in London compared to 3% of households in Scotland.

The supply of affordable housing

Alongside an overall shortage of housing in England, there is evidence that long term underinvestment in affordable housing, combined with recent reforms to welfare and local government have increased vulnerability to homelessness nationally and undermined protections for the homeless population (Downie et al. 2018). Since 2009/10 there has been a decline in the overall supply of affordable housing in the UK housing market, and particularly the availability of affordable social rented housing (see Figure below).

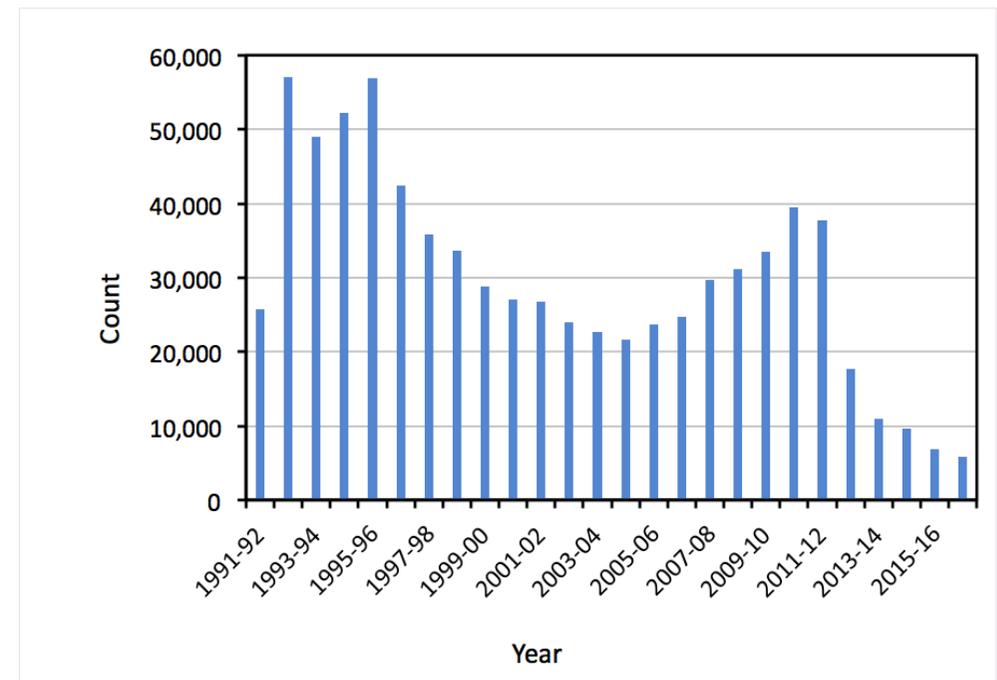


Figure: Additional social rented homes in England, 1991/92 – 2016/17

Welfare reform and impact of universal credit

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

The cost of homelessness

Research shows that early intervention and prevention can have a big impact on reducing the financial cost of homelessness to society and taxpayers.

Economic costs

In 2012 the cost of homelessness in England was reported to be up to £1 billion per year (Department for Communities and Local Government, 2012), whilst in 2015-16, local authorities in England spent £1,148 million on homelessness services (National Audit Office, 2017). The single largest component of local authority spending on homelessness is temporary accommodation which increased by 39% in real terms between 2010/11 and 2015/16 from £606 million to £845 million (National Audit Office, 2017).

One study reported that the cost of a single person rough sleeping in the UK for 1 year was £20,128 (Pleace, 2015). This includes costs incurred by NHS services responding to the health impacts of homelessness, including A&E departments and mental health services.

Impact on public services

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

How Bedford Borough is working to prevent homelessness and reduce its health impacts: local services and strategies

Overview of existing services for homeless people

There has been considerable work in Bedford Borough to reduce homelessness and especially rough sleeping over the last few years. The Rough Sleeping Partnership and Bedford Borough's Homelessness Strategy 2016-21 highlight the importance of partnership approaches both to prevent people from sleeping rough in the first place and to providing a joined up response when people do end up on the street.

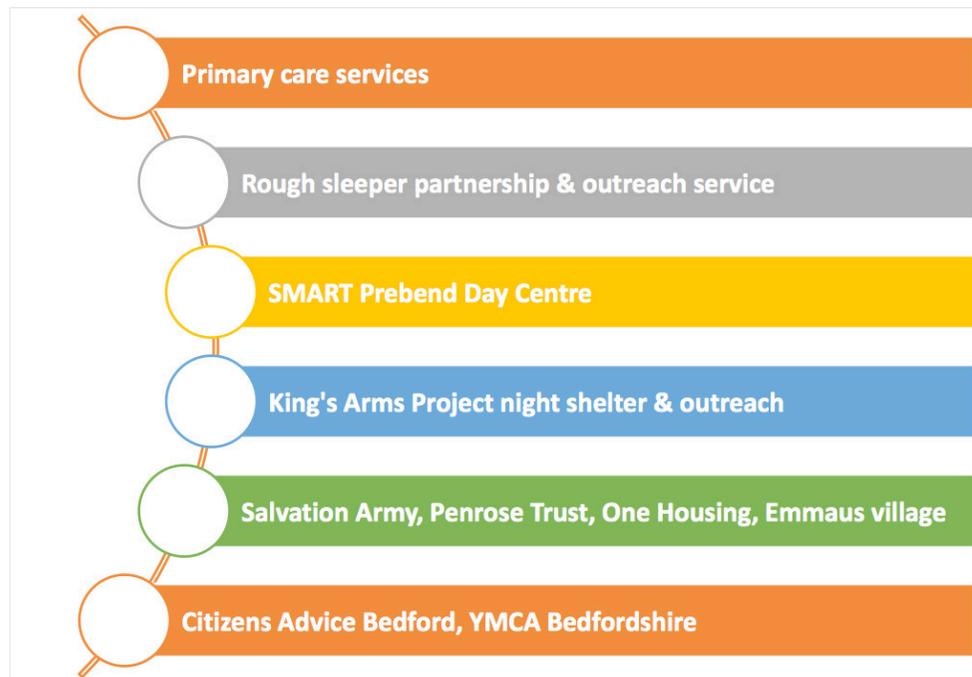


Figure: Examples of homelessness services available in Bedford Borough

Partnerships and strategic work

Primary care services

Bedfordshire Clinical Commissioning Group commissions primary care outreach services for rough sleepers via the Goldington Medical Practice. These include a local GP, nurse and dentist operating from the King's Arms Project's night shelter and regular clinics provided by nurses, chiropodists and vets at the SMART Prebend Day Centre. Clients can have immediate medical needs attended to, and where necessary, referrals will be made to other services. Clients are also encouraged to sign up with a GP, though they might need support with this as per our recommendations below.

Rough Sleeper Partnership and outreach service

Bedford Borough is the lead authority for the Rough Sleeper Partnership across the Bedford Borough, Central Bedfordshire, Luton and Milton Keynes local authority areas. In Bedford Borough the Rough Sleeper Partnership includes the SMART CJS and the Kings Arms Project, as well as Bedfordshire CCG and East London NHS Foundation Trust (ELFT) Community Mental Health Services. SMART, which operates the Prebend Street Day Centre, is facilitating the provision of services across the entire partnership. The funding is £623,000 in total across the four local authority areas, for two financial years from 2017. The Rough Sleeper Partnership (RSP) provides a combination of outreach support and assessment Hubs where homeless people can access help and support, aiming to prevent rough sleeping or reduce time spent on the street. Mental health outreach workers are also available to provide mental health crisis support. A Homeless Inter-agency Officer also works with providers towards more collaborative working and across the community to improve public awareness of services supporting the homeless.

In June 2017 a Rough Sleeper Outreach Service began running across Bedfordshire and Milton Keynes (Bedford Borough Council, 2017). The service is provided by the Rough Sleeper Partnership (RSP) across four Local Authority areas (Bedford Borough Council, Central Bedfordshire Council, Milton Keynes Council and Luton Borough Council) with a role to actively identify, engage and effectively provide support to those most vulnerable on the streets, sleeping rough and homeless (SMART, 2017). The Street Outreach Team aims to identify those at high risk of becoming rough sleepers and work proactively to prevent them from moving on to the streets. The team includes three dedicated Mental Health Crisis Workers employed by ELFT and Central North West London Foundation Trust, alongside open referral into the service including mechanisms for self-referral.

Further, Bedford Borough was recently successful in bidding for additional funding to tackle rough sleeping locally, through the national Rough Sleeper Initiative Fund. Additional funding of £307, 477 over 2018/19 will support:

- 1 Rough Sleeper Co-Ordinator Post.
- 6 Additional Support Workers.
- 32 Units of Accommodation.
- 10 Emergency winter beds.
- Additional Accommodation for People with “No Recourse to Public Funds”.

Between June 2017 and January 2018, the Rough Sleeper Partnership was in contact with 37 rough sleepers in Bedford Borough, 29 male and 8 female. 14 of these had been rough sleeping for between 6 and 12 months and the majority had local connections to Bedford Borough, with 19 supported to find temporary accommodation. 27% (n=10) were recorded as presenting with a mental health problem, 16% (n=6) an existing (diagnosed) mental health problem and 11% (n=4) a previously undiagnosed mental health problem.

SMART is contracted by Bedford Borough Council to run the Prebend Day Centre, which they took over in September 2017. The Day Centre can see up to 70 people a day, but numbers are usually around 100 a week. Staff have noticed the female homeless population is increasing, but the majority of clients are white European men. A number of these are Eastern European men with no recourse to public funds. The health issues of men and women are different, but common concerns include mental health and sexual health.

King’s Arms Project (KAP) is one of the largest providers of services to the homeless in Bedford Borough. KAP runs the Night shelter in Clarendon Street, which has 18 beds and can provide accommodation for up to 10 weeks. A weekly outreach meal is also available at the Guild House, where there are opportunities for individuals to access other services such as the Night shelter. For those individuals wishing to move from the Night shelter, KAP provides move-on hostel accommodation at various locations in Bedford Borough. A Pathways to Employment programme, including pre-tenancy training, also supports individuals moving into permanent accommodation. KAP also provides accommodation and support to refugees moving to Bedford Borough. KAP is working in partnership with Bedford Borough Council to support individuals with no recourse to public funds. A grant from the Controlling Migration Fund was awarded to Bedford Borough Council in November 2017 to provide accommodation and other assistance for up to 4 people at any one time, with funding available for the next 18 months to support up to 20 individuals.

The Salvation Army has a long history of providing outreach and other support to homeless people. In Bedford Borough the Salvation Army opens the Congress Hall as a severe weather shelter when the temperature is predicted to fall below zero degrees on three consecutive nights. Camp beds, bedding, hot drinks and food are made available and the shelter is open to anyone rough sleeping.

Penrose Trust is commissioned by Bedford Borough Council to provide support at Holman House to individuals with low to moderate mental health needs, and including those who are at risk of homelessness, sofa surfing or rough sleeping. Holman House has 19 beds, and individuals can remain for up to two years. Penrose encourage residents to register with BPHA, Bedford Borough's largest housing association, and during their stay at Holman House individuals are encouraged to take on living skills before moving into permanent accommodation. Residents at Holman House are predominantly male and since the Penrose Trust took over the contract in November 2016, one resident has found employment, one is hoping to go to university, and many have attended Recovery College courses run by ELFT.

One Housing provides support for individuals with complex support needs. Data from the Rough Sleeper Partnership shows that the majority of individuals contacted have drug and alcohol problems, but mental health needs as well. For those individuals being moved into accommodation with little support may result in them losing a tenancy and returning to rough sleeping. Clarence House opened in March 2018, and can accommodate 29 people, and offers 24 hour support for those individuals with complex needs. The project aims to help individuals to move into permanent accommodation.

Emmaus village, Carlton is part of a national network across the UK, supporting up to 750 homeless people nationally. Emmaus residents, known as "companions" are offered a home for as long as they need it in return for:

- working for 40 hours per week, or give as much time as they are able, in the community's social enterprise; the shop and the café.
- behaving in a respectful way towards one another.
- not using alcohol or illegal drugs on the premises.
- Signing off all benefits, with the exception of housing benefit.

Citizens Advice Bedford provides information and advice on applying for homelessness related help from Bedford Borough Council, including how to make a homeless application and how to challenge the council's homeless decision.

YMCA Bedfordshire has two hostels accommodating homeless young people. Cornerstone House has 25 beds for young people aged between 16 and 25, and The Foyer has 34 units for young people aged between 16 and 30. For adults, aged between 18 and 65, there are 29 units at Weaver House, and 16 at Linden Road. The Supported Lodgings Scheme provides 8 beds in family homes where young people are supported to move on to their own accommodation. Cornerstone House residents have access to counselling services 6 hours a week, via Open Door. The YMCA takes a therapeutic approach to preparing residents for independence, encouraging healthy lifestyles through diet and exercise, and a life skills course for all residents, who can remain for up to two years. The average stay is between 9 and 12 months, and a Resettlement Officer will prepare residents to move on to social housing. Six weeks of support is available to residents who have moved into their own homes, provided by One Housing's One Support scheme.

The complex relationship between homelessness and health

This section explores the relationship between homelessness and health for a range of groups who are particularly vulnerable to homelessness and its negative impacts on health.

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

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

The size of the issue

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

The impact on health

Children who have been in temporary accommodation for more than a year are over three times more likely to demonstrate mental health problems such as anxiety and depression than non-homeless children (Shelter, 2006).

Children, young people and families without a secure home environment are vulnerable to multiple disadvantages through exposure to a range of risk factors associated with poor quality housing or homelessness.

Homeless children and young people (including those living in temporary accommodation) are at greater risk of the following poor outcomes (PHE, 2018):

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

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

Local issues

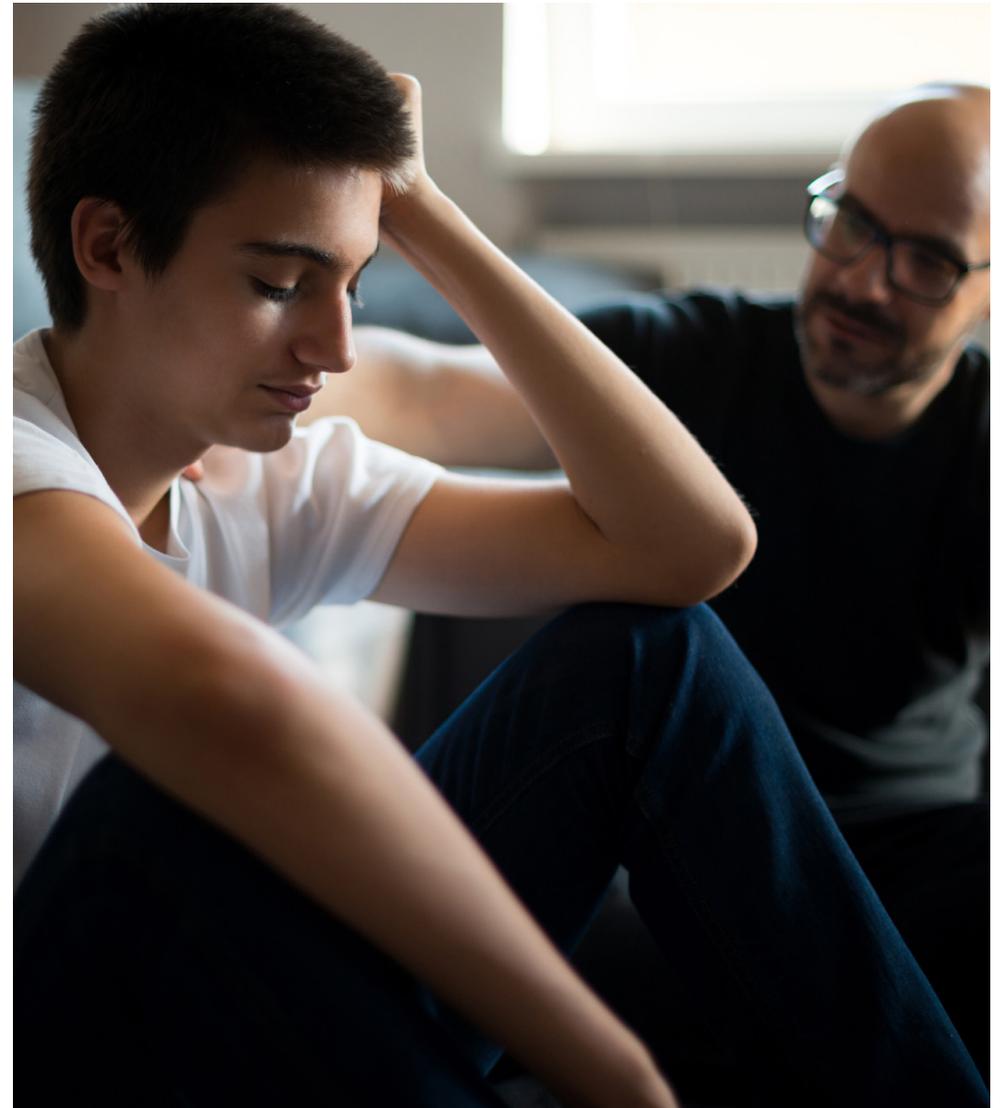
Family homelessness is counted as “the number of applicant households with dependent children or pregnant woman accepted as unintentionally homeless and eligible for assistance” (PHE, 2018)

Family homelessness

In Bedford Borough, the rate of family homelessness more than doubled between 2011/12 and 2015/16 and remains above the national rate. In 2016/17 there were 173 homeless families with dependent children.

Households headed by young people

In Bedford Borough in 2016/17, there were 50 households headed by a young person and the local rate of this measure remains above the national rate.



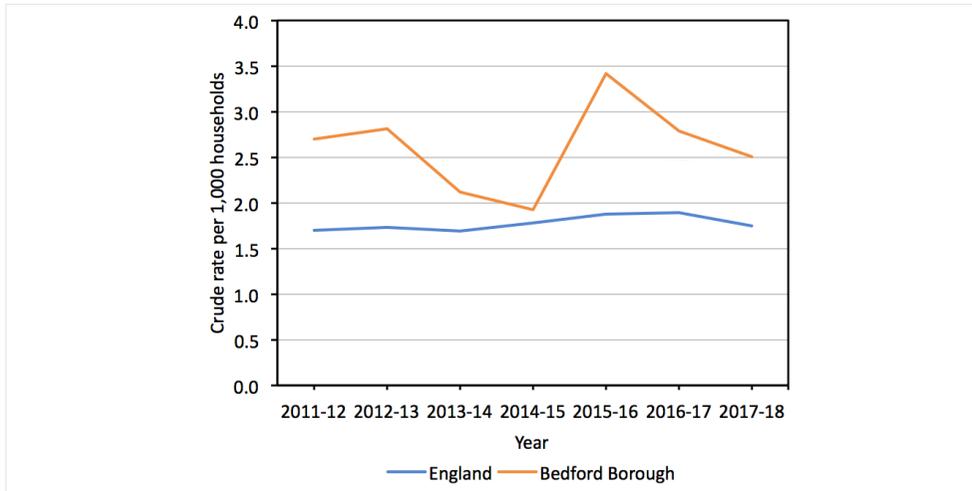


Figure: Rate of family homelessness in Bedford Borough and England, 2010/11 to 2017/18 (Source: Ministry of Housing, Communities & Local Government)

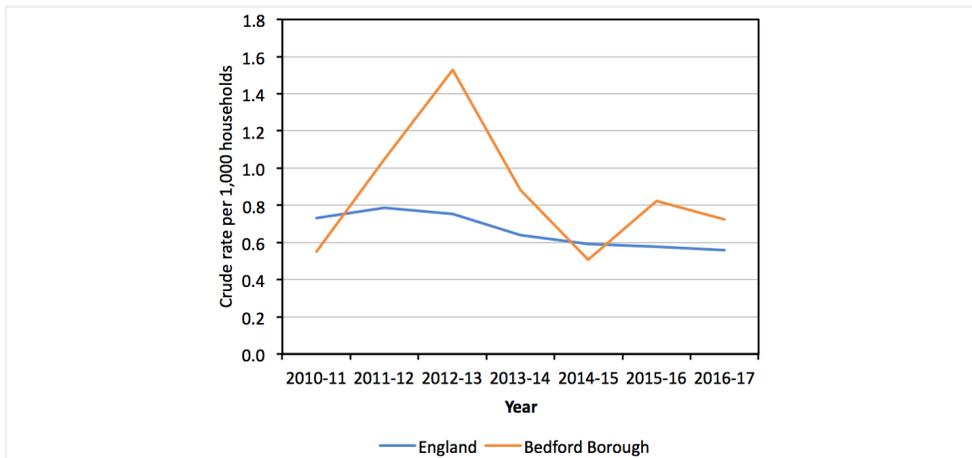


Figure: Rate of households headed by a young person aged 16-24 in Bedford Borough and England, 2010/11 to 2016/17 (Source: Ministry of Housing, Communities & Local Government)

Case Study

Understanding and addressing vulnerability to prevent homelessness

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

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

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



Homelessness and health: Focus on the hidden homelessness

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

Defining the hidden homeless

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

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

Who are the hidden homeless?

There is no nationally agreed definition of ‘hidden homelessness’ but it may include the following groups:

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

The size of the issue

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

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

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

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

Key findings of the study were:

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

The impact on health of hidden homelessness

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

- In one Canadian survey (23 male, 11 female, aged 15-69 years), many participants reported concerns about physical (e.g. dental health, respiratory problems) and mental health and all reported current problems with addiction, particularly smoking, alcohol and drugs (Crawley et al. 2013).
- Another Canadian survey (13 men and 8 women) reported that participants found it difficult to practice healthy behaviours (e.g. poor diet, challenge of drugs and alcohol, unsafe sex) and this in turn affected their physical and mental health (e.g. dental problems, blood pressure, anxiety and depression) (Watson et al. 2016).
- A UK survey of 2,011 16-25 year olds found that 703 (35%) had experience of sofa surfing, of which some 409 (20%) sofa surfed in the last year and a further 79 of these had also slept rough (Clark, 2016). Though sofa surfing for many reasons (e.g. eviction, domestic violence, leaving prison), some reported the experience could be positive (e.g. more flexibility to access education, employment and to maintain/repair relationships) - though this may be due to respondents comparing it to the situation they left behind and moving away from a home situation of conflict or severe over-crowding. For many their homelessness was temporary and did not lead to wider vulnerabilities associated with other homeless, whilst others failed to find a quick route out and suffered longer term effects.

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

Hidden homelessness in Bedford Borough

No local data is available to evidence the extent of hidden homelessness in Bedford Borough, as most hidden homeless people will not be in contact with local services. Homeless people ‘not in priority need’, i.e. people who approach the local housing authority but are not eligible for priority assistance, including single adults who do not meet vulnerability criteria under prior homelessness legislation (e.g. no dependent children, not pregnant) are more likely to become ‘hidden’ from homelessness statistics and rough sleeper counts.

In Bedford Borough, there was a sharp increase in the rate of homeless people not in priority need between 2010/11 and 2015/16.

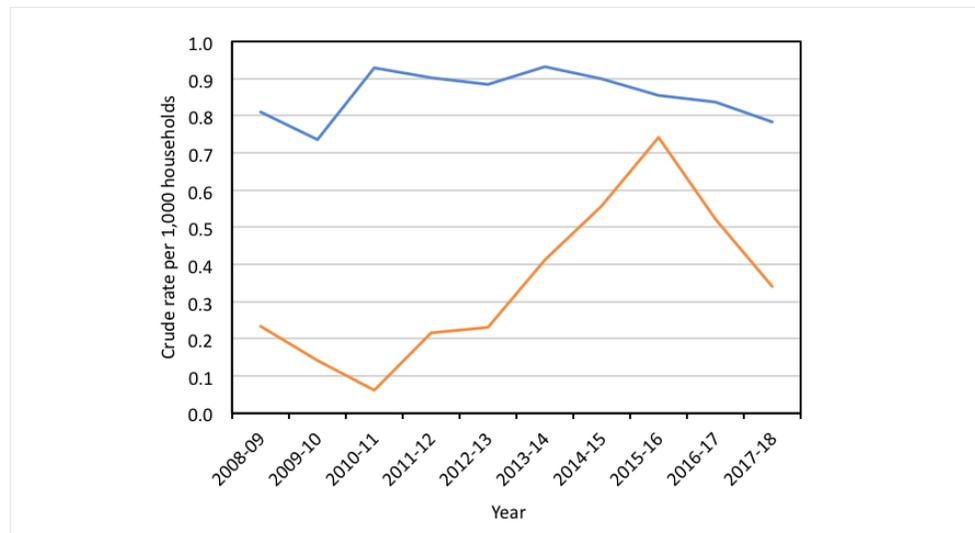


Figure: Rate of homeless people not in priority need in Bedford Borough. (Source: Ministry of Housing, Communities & Local Government)

Homelessness and health: Focus on complex needs

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

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

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

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

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

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

Different ways of talking about complexity

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

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

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

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

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

Factors associated with severe and multiple disadvantage

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

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

Complex needs in England

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

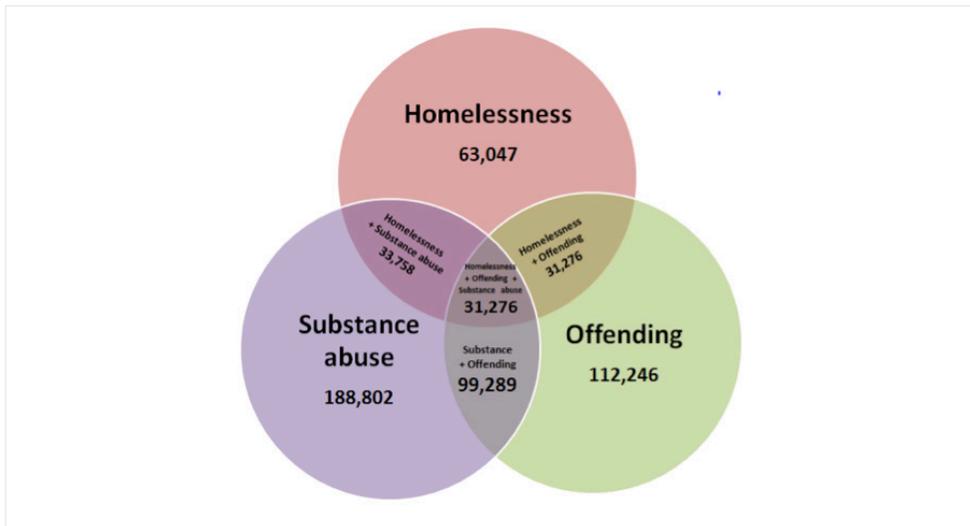


Figure: Snapshot of severe multiple disadvantage among all service users in England, 2010/11.

Complex needs in Bedford Borough

The figure below illustrates a snapshot of multiple disadvantage in Bedford Borough in 2017 and further highlights the complex needs of rough sleepers, particularly for the 10% experiencing all three disadvantages.

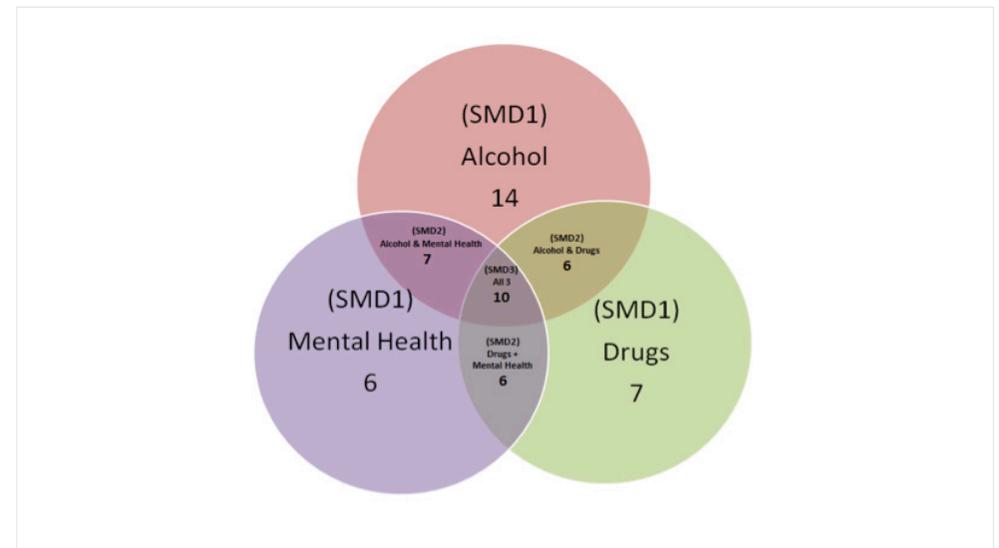


Figure: Snapshot of severe multiple disadvantage among rough sleepers in Bedford Borough in 2017 (count) (Source: Bramley et al., 2015)

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

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

Late presentation to secondary care with serious physical and mental health problems - homeless people are more likely to present late with a serious physical or mental health condition. Subsequent care is likely to be of increased complexity and higher cost to the NHS.

Increased use of A&E – due to difficulty accessing primary care and elective services, homeless people use Accident and Emergency departments up to 6 times more often than the general population and stay in hospitals three times longer (Deloitte, 2012 and King's Fund, 2014).

Maintaining the cycle of poverty – due to the prevalence of mental illness among the homeless population, access to and engagement with mental health services are likely to be key factors that enable vulnerable homeless people to escape poverty and become productive members of society.

Homelessness and health: Focus on people who misuse substances

Problems with misuse of drugs or alcohol are often significant factors underlying homelessness and its negative health consequences. Substance misuse is often a key factor underlying insecure housing and homelessness, and both a cause and consequence of becoming homeless.

Misuse of drugs and alcohol is highly prevalent among the homeless population. Two thirds of homeless people cite drug or alcohol use as a reason for first becoming homeless, and those who use drugs are seven times more likely to be homeless (Crisis, 2018). There is a complex interrelationship between drug and alcohol misuse and a range of health and social factors. For example, substance misuse may trigger events which lead to homelessness, and homelessness may exacerbate drug or alcohol dependence.

The longer someone experiences homelessness or rough sleeping, the bigger the adverse impact on their health and wellbeing and the greater the likelihood of substance misuse becoming a factor in sustaining their homelessness (HM Government, 2017).

The size of the issue

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

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

The impact on health

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

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

The impact of homelessness on engagement with drug and alcohol services

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

Local issues

In Bedford Borough the drug and alcohol provider records the housing circumstances of all new clients during their initial assessment. The Table below shows the proportion of clients engaged with drug and alcohol services who report housing problems at different stages of treatment, compared with the national benchmark. The stages of treatment are based on Treatment Outcome Profile and Alcohol Outcomes Record (AOR) which are tools to review the progress towards recovery aims. The Treatment Outcome Profile Adult Review (6 Month) presents how well clients are performing after six months. The Treatment Outcomes Profile Exit presents the achieved outcomes at the planned treatment exit. In March 2018, 10.6% of all clients reported ‘housing problems’, highlighting the concentration of housing problems (including homelessness) among people who misuse substances.

	Bedford Borough		England	
	2016/17	2017/18	2016/17	2017/18
Start	13.3%	10.6%	13.7%	13.6%
6 Month Review	5.2%	5.0%	10.2%	10.1%
Exit Treatment Outcome Profile (Last 28 days)	2.5%	5.8%	8.3%	7.9%
Planned Exit	0.5%	0.9%	2.9%	2.5%

Table: National Drug Treatment Monitoring System data for Bedford Borough service users who report housing problems

In Bedford Borough between 2017/18, 13.3% of service users reported housing problems at the start of drug and alcohol treatment compared to 0.9% who may have achieved treatment outcomes at their planned exit. In comparison, 13.6% service users in England reported housing problems at the start of drug and alcohol treatment compared to 2.5% who may have achieved treatment outcomes at their planned exit.

Case Study

Substance misuse as a cause and consequence of vulnerability and homelessness

M is a 35-year-old alcohol dependent man who lived with his father (sleeping on his sofa) who is also dependant on alcohol. M works full time through an agency doing shift work. He was drunk whilst riding a bike, had a crash and was admitted to hospital. In hospital he underwent detoxification but received a letter from his father stating that M was no longer welcome to stay at his property.

M's care was transferred to the drug and alcohol provider who prioritised interventions to support his long-term recovery. Upon discharge from hospital, M approached local housing services to make a homelessness application and was offered temporary accommodation in Birmingham. Relocation would have meant losing his job, a key factor identified by drug and alcohol services in sustaining his recovery from alcohol misuse. He was also offered temporary accommodation by a local charity, but his shift hours meant he would be unable to abide by curfew times. In the absence of alternatives, M resorted to rough sleeping in an underpass, dramatically increasing his vulnerability to a relapse of his alcohol misuse problem.

M now experiences suicidal thoughts and low moods secondary to depression, which he believes originated from his childhood and living with an abusive father. Due to the severity of his vulnerabilities, his GP agreed to write a supportive letter to the housing department. The drug and alcohol provider offered psychosocial support and M agreed to attend a medical assessment for relapse prevention medication. During the detox programme M stated his intention not to drink alcohol again and maintain his sobriety through focusing on work, but sleeping rough and the associated lack of safety and stability makes this extremely difficult to achieve.

M's case highlights the highly interrelated nature of homelessness and health issues in general, and the complex relationship between alcohol misuse and rough sleeping in particular. In the context of the Homelessness Reduction Act, local services should work to improve their understanding of the heightened vulnerability associated with substance misuse problems, the resultant increased risk of homelessness (particularly rough sleeping) and worsening of pre-existing health problems such as alcoholism.



Homelessness and health: Focus on mental health

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

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

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

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

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

The size of the issue

People with pre-existing mental health conditions are at greater risk of becoming homeless compared to the general population (Mind, 2017).

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

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

- Around 4% of people accessing homelessness services have a diagnosis of schizophrenia - significantly higher than the 0.7% of the general population who are affected (Homeless Link, 2011).
- A survey sample of patients with schizophrenia showed that over a third had experienced homelessness in the past (FPH, 2002).

In a survey of homeless services in England, staff estimated two thirds of their clients had symptoms consistent with a personality disorder, many of whom were thought to be undiagnosed. (FPH, 2002).

The issue of dual diagnosis

A considerable proportion of homeless people are classified as having 'dual diagnosis', meaning they experience one or more mental health conditions alongside substance misuse (drugs and/or alcohol). Estimates of the prevalence of dual diagnosis among the homeless population range from 10 to 50 per cent, though poor quality data may mean the true figure is higher (Rees, 2009; St Mungo's, 2009).

People with dual diagnosis almost always have multiple needs – they often present to services with physical health and social problems such as debt and unemployment, as well as mental health and substance misuse problems.

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

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

The proportion of homeless people with mental illness from Black, Asian and minority ethnic (BAME) groups is higher than in the general population.

Refugees and asylum seekers have high rates of mental ill health generally, which may present an additional challenge regarding sustainment of secure accommodation (FPH, 2002).

Women experience some risk factors for both mental illness and homelessness to a greater extent than men and may have higher rates of mental ill health if they become homeless (Crisis, 2009).

Histories of physical and sexual violence before and after becoming homeless are common and more likely in women (although the issue also affects men) (Vostanis, 2001).

Child sexual abuse is known to be an independent risk factor for the onset of mental health conditions in adulthood.

Domestic violence is associated with mental health disorders and women are more likely to cite relationship breakdown and violence as a causal factor in their homelessness (Crisis, 2009).

Access to mental health services

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

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

Case Study

Homelessness and Mental Health

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

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

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



Homelessness and health: Focus on ex-offenders

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

The size of the issue

Many prisoners are homeless prior to entering prison and many more have accommodation needs after release. One study of a prison population reported that 15% of prisoners were homeless before entering custody, with 9% sleeping rough. 37% of prisoners surveyed expressed a need for help finding a place to live after release from prison (Williams et al., 2012).

Despite the efforts of resettlement services, prisoners are often released without safe and secure accommodation and quickly fall into maladaptive behaviours such as substance misuse and offending.

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

Health needs of homeless ex-offenders

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

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

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

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

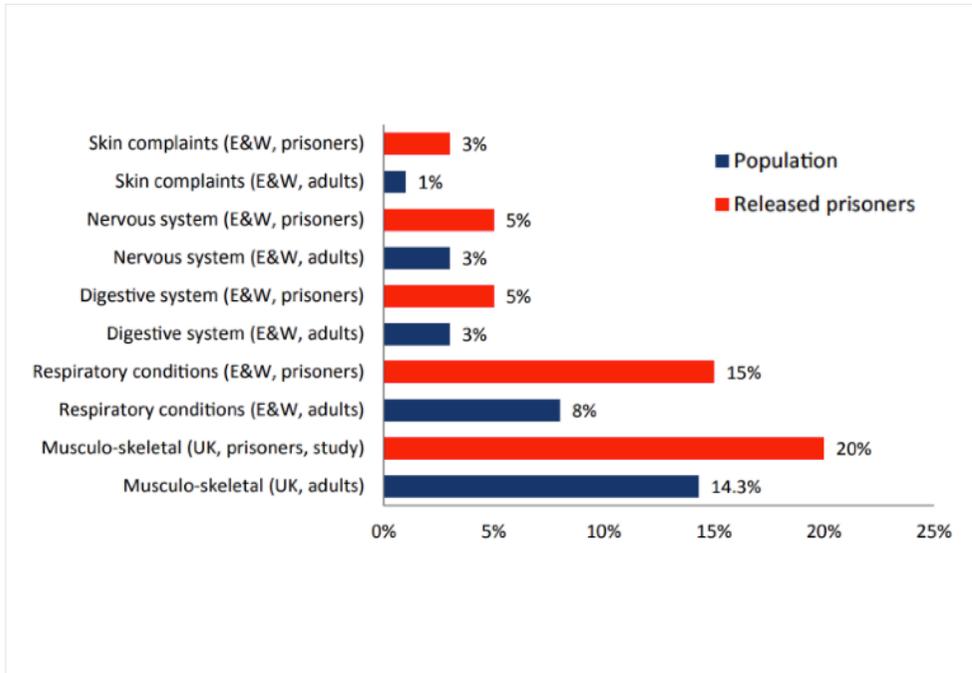


Figure: A comparison of the physical health issues of prisoners with the general adult population in England and Wales/United Kingdom (Source: Revolving Doors Agency, 2017)

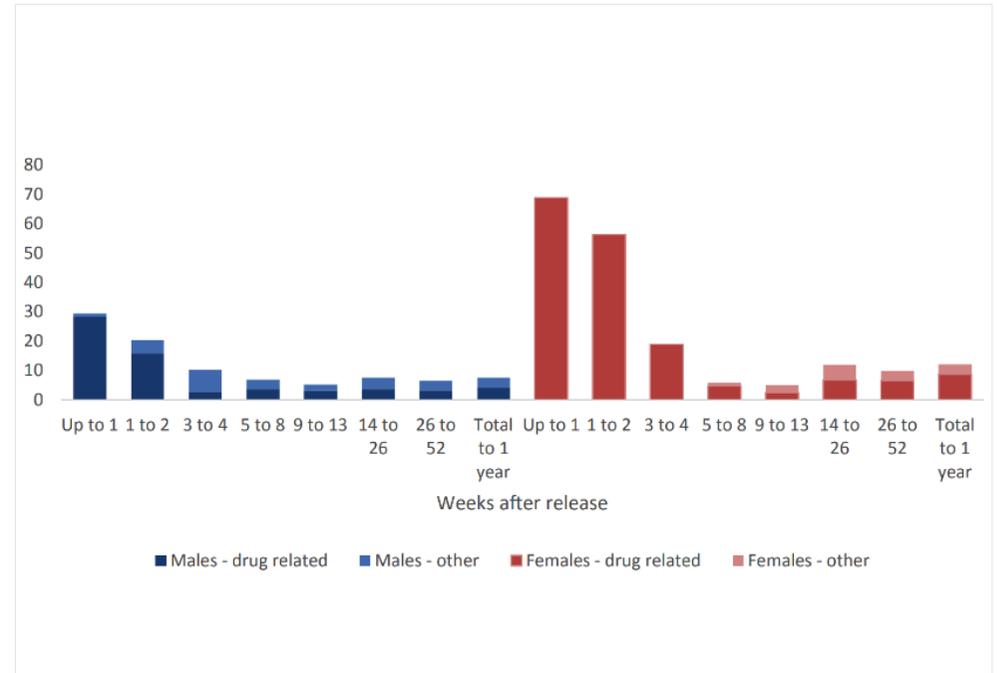


Figure: Excess mortality rates for released prisoners – drug related deaths and other causes (Source: Revolving Doors Agency, 2017)

Homelessness and health: Focus on armed forces veterans

What do we mean by veterans?

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

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

The size of the issue

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

In 2014 it was estimated that the proportion of veterans sleeping rough ranged from 3% to 6% (Forces in Mind Trust, 2014). This has fallen from above 20% in the mid to late 1990s, perhaps as a result of better resettlement provision by the Ministry of Defence and support from ex-Service personnel charities (RBL, 2010).

In London, the proportion of rough sleepers with experience of serving in the armed forces has remained constant at around 8% in recent years.

In 2015-16 there were 452 homeless veterans in England, of whom 142 were UK nationals (Murphy, 2016). Importantly, these figures exclude the 'hidden homeless' engaged in sofa surfing, living with friends or relatives and moving between hostels, and therefore are likely to be an underestimate of the true extent of homelessness among veterans.

The impact on health

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

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

Evidence gap: health needs of homeless veterans

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

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

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

Support for veterans in Bedford Borough

Bedford Borough Council has signed an Armed Forces Covenant, pledging that members of the Armed Forces community, including veterans, should not suffer disadvantages as a result of their service. The multi-agency Bedford Borough Covenant Steering Group has developed a wide range of local initiatives to raise awareness of veterans' needs and ensure access to specialist support.

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



The new duty to refer

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

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

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

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

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

Primary care registration and the wider role of primary care

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

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

Revisions to guidance for GP practices in 2015 and 2017 on registering new patients are intended to improve equity of access to services for vulnerable individuals, including the homeless, but evidence suggests that GP registration remains problematic. For example the charity Doctors of the World (Patel & Corbett 2018) collect yearly data on access to GP registration in England for their own patients, some of whom are homeless. Of 1,717 attempts by caseworkers to register their patients with GPs in England in 2017, 80% were successful but 20% were refused, and the most common reasons for refusal were:

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

Improving registration

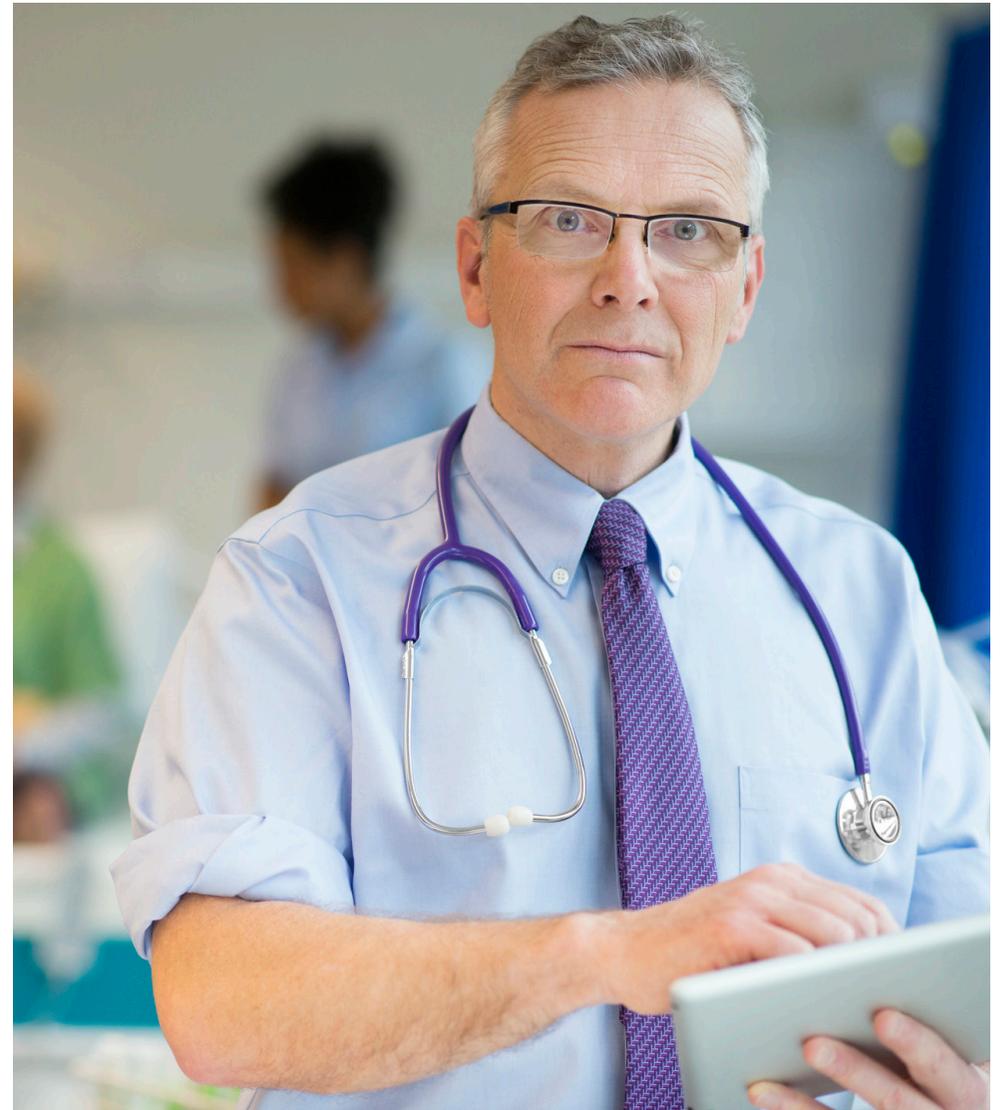
Homeless individuals are entitled to register in the area where they are without proof of address or identification and irrespective of immigration status, as long as the GP surgery has space for new patients. Recently, organisations such as the London Homeless Health Programme have been working to improve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



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

Reducing financial vulnerability

Improved access to primary care itself also presents opportunities to engage with the homeless around issues that contribute to financial vulnerability. For example, modelling by Public Health England supports the case for investing in debt advice services in primary care towards to promote public mental health, particularly for the homeless and other vulnerable groups (PHE, 2017). Following an evidence review, PHE reported that face-to-face advice was critical (complemented by web and telephone-based support), and that after 5 years the intervention has the potential to deliver a return of investment of at least £2.60 for every £1 invested.



Case Study

The importance of coordinated care

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



Transitions and pathways

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

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

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

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

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

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

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

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

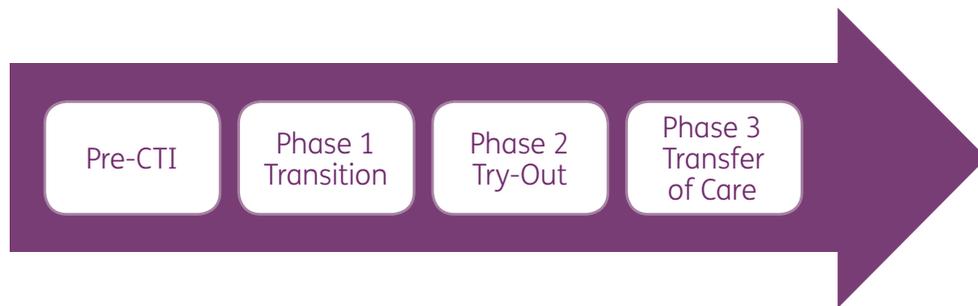


Figure: The Critical Time Intervention model
(Source: CTI, 2018)

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

Homeless centres and drop-in services

Drop-in centres are an increasingly common way for local authorities and voluntary sector organisations to provide local face-to-face contact, information and support to help people access all services from a single site. They typically also provide access to wider support networks, for example running regular surgeries in areas like debt management and pensions. SMART has been contracted by Bedford Borough Council to run the Prebend Day Centre since September 2017. The Centre is open 365 days a year and provides vital facilities and drop-in services for the homeless include:

- Breakfast, lunch, emergency food packs.
- Showers and toiletries.
- Clothes.
- Phone and postal services.
- Advocacy and signposting.
- Clinics provided by nurses, chiropodists and vets.

However, current challenges for their work include rising demand. Further, other services for the homeless remain essential because of other barriers to accessing services and the complex needs of wider homelessness groups.

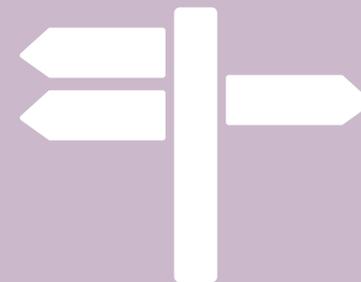
Case Study

The role of drop-in centres

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

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

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



Addressing complex needs: Housing First

Housing First is a housing model that provides immediate long-term housing for those sleeping on the street with ongoing flexible support for an individual's complex needs.

The original Housing First model was developed by an American charity in the late 1980s to meet the housing and treatment needs of chronically homeless people with histories of severe psychiatric illness, often compounded by substance abuse (Tsemberis et al. 2004). At that time traditional treatment based approaches required individuals to remain sober, to abstain from drugs and alcohol and to participate in mental health treatment (as required) to demonstrate their 'readiness' for housing. The original Housing First model prioritised access to housing for homeless people with psychiatric illness, although in recent years the model has been adapted and widened to target different homeless people with complex needs (Woodhall-Melnik & Dunn 2016).

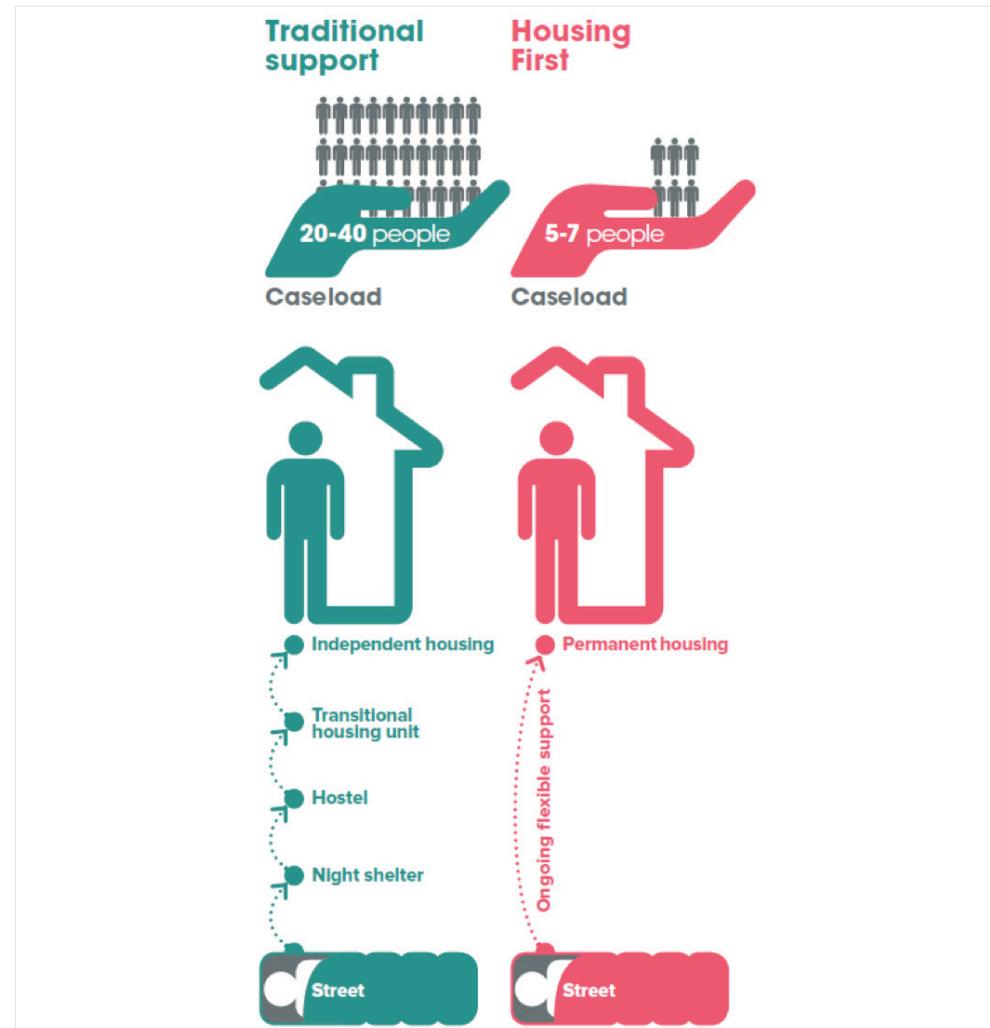


Figure: Rehousing the homeless: comparing traditional support approaches to Housing First (Source: Housing First England)

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

- **Separating the right to housing from support:** the choices people make about the support they engage with does not affect their housing
- **Flexible support is provided for as long it is needed:** this requires providers to commit to long-term offers of support and help should be given quickly when needed, without the need for re-referral or assessment.
- **Active engagement:** this might include dedicated caseworkers who regularly contact their clients and are available at short notice.
- **Harm reduction** underpins Housing First by encouraging people to use treatment services (as appropriate) but not forcing them to do so as a condition of their tenancy

The impact of Housing First

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

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

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

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

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



Recommendations: how can we work together to better prevent homelessness and improve the health of homeless people in Bedford Borough

There has been considerable work in Bedford Borough to reduce homelessness and especially rough sleeping over the last few years. The Homelessness Strategy 2016 -21 has highlighted the need to work in partnership both to prevent people becoming homeless in the first place and to provide a joined up response when people do become homeless. However, further work is needed to prevent and address the health impact of homelessness and to understand and address the wider forms of homelessness and their impact on health and wellbeing.



Recommendations



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

Improve awareness among public bodies in Bedford Borough of the new duty to refer and consider whether there should be wider implementation than the listed public bodies, e.g. in primary care.



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

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

- Determine how public sector bodies and commissioned services should routinely record housing status, housing vulnerability and the duty to refer during initial assessments, and proactively address risk factors for homelessness.
- Develop and encourage long-term housing approaches for vulnerable people (e.g. strengthen existing work with hospital discharge teams, prison/offender management services and the veteran housing advice service).



3. Improve understanding of the overlap between mental health, substance misuse and housing

- Improve mental health literacy by providing mental health awareness and intervention training for all frontline staff involved in homelessness prevention.
- Increase homelessness awareness within mental health and substance misuse services and ensure that care providers support individuals to obtain safe and stable housing.



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

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



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

Increasing the proportion of homeless populations registered with a GP surgery (including children and families in temporary accommodation). Approaches to improve registration should include:

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



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

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

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