Liverpool
Public Health
Observatory

Homelessness in Liverpool City Region

A Health Needs Assessment

Technical Supplement

June 2014

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Supplement to LPHO Report series number 96, May 2014

PROVIDING INTELLIGENCE FOR THE PUBLIC HEALTH

Contents

This report is a technical supplement to the Homelessness Health Needs Assessment for Liverpool City Region. It provides further details on national policy, additional background literature and additional data. It also includes the materials used for the focus groups and six case studies provided by health professionals working with homeless people.

1. Health needs assessment: definition

As described in the NHS Liverpool City Region Guide (McAteer and Du Plessis, 2012), health needs assessment (HNA) is a systematic method for reviewing the health needs and issues facing a given population, leading to agreed needs (priorities) for that population. HNA is a more in-depth analysis of need than that provided by Joint Strategic Needs Assessments. The starting point in HNA is a defined population. This population can be defined in a number of ways, which in this case is the experience of homelessness. This HNA will use an epidemiological approach, which includes an examination of available information on incidence and prevalence in order to assess need.

2. National Policy on homelessness

Statutory homelessness

The Housing Act 1977, Housing Act 1996, and the Homelessness Act 2002, placed statutory duties on each local housing authority to provide free advice and assistance to households within its area who are homeless or are threatened with homelessness (DfCLG, 2013a).

A main homelessness duty is owed where the authority is satisfied that the applicant is eligible for assistance, unintentionally homeless and falls within a priority need group (see Box 1) (DfCLG, 2013b). It is then the duty of the authority to ensure that suitable accommodation is available until a settled home becomes available for them. For other groups, the authority must provide advice and assistance to help them find accommodation for themselves.

Box 1
Homelessness priority need groups include:

- Households with dependent children or a pregnant woman
- People who are vulnerable in some way e.g. because of mental illness or physical disability

Extended in 2002 to include applicants:

- aged 16 or 17
- aged 18 to 20 who were previously in care
- vulnerable as a result of time spent in care, in custody, or in HM Forces
- vulnerable as a result of having to flee their home because of violence or the threat of violence (in addition to domestic violence which is one of the original priority need groups)

(DfCLG, 2013b)

Rough sleeping

The Government set up a ministerial working group with the aim of preventing and reducing homelessness, and improving the lives of those people who become homeless (DfCLG Working Group, 2013).
The first report of the group was *'Vision to end rough sleeping: No Second Night Out nationwide'* (DfCLG 2011). *'No second night out'* aims to prevent rough sleepers from spending a second night on the streets. Rough sleepers are identified and helped to assessment hubs. They are then provided with support and accommodation, with a focus on reconnection to a home area. Piloted in London, the government then committed to roll the scheme out across England, supported with £20m of funding (DfCLG, 2011). An early evaluation of the pilot showed promising results, but there were study limitations (Gavine, 2013).

The second report of the DCLG Working Group was *'Making every contact count – a joint approach to preventing homelessness'* (DfCLG, 2012). This report emphasised the key role of prevention, encouraging agencies to work together to support those at risk of homelessness.

Currently, most single homeless people remain outside the statutory safety net in England, with no legal rights to even emergency accommodation even when roofless, unless in a priority need group (see Box 2) (Fitzpatrick et al, 2012 & 2013). Fitzpatrick et al (2012 & 2013) point out that in this respect, the legal safety net for rough sleepers in England is weaker than that in a number of other European countries.

Prevention

Since 2002, the Government has made homelessness prevention a priority. Under the Homelessness Act 2002, local housing authorities must have a strategy for preventing homelessness in their district. The strategy must apply to everyone at risk of homelessness, including cases where someone is found to be homeless but not in priority need and cases where someone is found to be intentionally homeless (DfCLG, 2013a).

Shelter (online, 2013b) have described how new housing applicants are now typically required to participate in an initial 'housing options' interview. This involves a discussion of ways in which their immediate housing need could be met. Sometimes this means that no homelessness application is made. For instance:

- young people who have been living with family or friends and have been asked to leave may be offered mediation with a view to enabling them to return
- people who experience domestic violence are offered 'sanctuary schemes', involving the installation of security measures within the home
- young people leaving the family home may be offered supported lodgings schemes where members of the community provide a room as temporary respite accommodation
- a significant part of this new preventative approach involves referring households to the private rented sector, often facilitating the move through payment of rent deposits

- local authorities will also provide general housing advice on available services, housing options, housing benefit and rent arrears.

(Shelter, online 2013b)

New commissioning arrangements

Under the Health and Social Care Act 2012, reducing health inequalities is now a requirement. The new NHS Commissioning Board and local clinical commissioning groups (CCGs) are responsible for commissioning healthcare services, and local health and wellbeing boards are responsible for determining their commissioning priorities based on strategic needs assessments. CCGs have a duty to provide services for all patients in their locality, whether registered or not, including services for the homeless (Deloitte 2012).

The Health and Social Care Act 2012 promotes an integrated health and social care approach, with primary, community and acute providers working together. Such an integrated system should enable healthcare providers to keep better track of homeless patients and encourage them to seek care when it is needed, rather than waiting until a minor ailment has developed into a more serious problem (Deloitte, 2012).

Health and Well Being Boards (HWB) were formed under the new arrangements to coordinate commissioning across health, public health and social care in their local area. Homeless Link have suggested that it is crucial that homelessness and housing make strong links or are represented on the HWB (Homeless Link, 2012).

Homeless Link (2012) pointed out that the new funding and outcomes framework for public health in local authorities may present opportunities for the homeless sector. For example many services will contribute to these targets (e.g. reducing alcohol related harm; improving diet and wellbeing), presenting opportunities for commissioning or joint working. They also note the importance of including information and data about homelessness and homeless people's health in the HWB Joint Strategic Needs Assessment (JSNA).

3. Health, homelessness and vulnerable groups: Additional literature

Homelessness results from a combination of inter-related factors, often involving family breakdown, poverty, alcohol/drug abuse and poor mental and physical health. People with poor mental and physical health are more likely to be homeless and conversely, homeless people are more likely to have health problems – and find it more difficult to access preventive health care and continuing treatment regimes.
Vulnerable groups of people at particular risk of homelessness include those who are unemployed, care leavers, military veterans, ex-offenders and asylum seekers.

Unemployment
Lack of work is a major cause and consequence of homelessness. Not having a job can lead to people losing their home and not having a home can seriously harm a person's chances

of finding a job. Many homeless people have low or no qualifications and lack the skills for sustained employment (Crisis online; Warrington Homeless Commission, 2013).

Care leavers
Griffiths (2002) reported that between 25%-33% of people sleeping rough have been in local authority care.

Ex-offenders
There are strong links between offending, homelessness and mental health (Bradley, 2009). A homelessness health needs assessment in Devon (NHS Devon, 2011) described how the Bradley Review looked at the needs of people with mental health problems in the criminal justice system. It was noted that a high proportion of those in custody have mental health problems; 72% of male and 70% of female prisoners have two or more mental health problems. As many as 66% of them have a personality disorder compared to 5.3% in the general population. Of those with mental health problems 43% have no fixed abode upon the day of their release; 8% of men and 10% of women are homeless when they enter custody, so there is a suggestion that these prisoners are part of the homeless population (NHS Devon, 2011).

Barnado's summarised recent research which supported an earlier finding in 2004 that 15% of young offenders were reportedly in housing need (Glover and Clewitt, 2011). They note that this is likely to be an underestimate.

Accommodation on release was one of the top five issues of concern raised by young people to Barnado's. Having suitable accommodation arrangements in place significantly reduces the risk of reoffending. Of those offenders with an accommodation need, 69% reoffended within two years, compared to 40 per cent who were in suitable accommodation. Glover and Clewitt note that the structure and stability that can be instilled in one young person's life through supported accommodation on release from custody can produce **savings of more than £67,000** over a three-year period (per person).

One homelessness project in the north of England estimated that 30%-40% of those on the service caseload are young people who were released from custody approximately a year ago and who have exhausted their 'sofa surfing' options with family and friends (Glover and Clewitt, 2011).

Policy: An accommodation strategy in 2006 set a target to end the use of unsupported B&B accommodation, outlined a need for stronger alliances between criminal justice agencies and national housing providers and advocated for improved parenting support for families of offenders. Glover and Clewitt noted that by 2011, most of these aspirations had not been realised. There were however promising signs of a change of practice being shown in the Youth Justice Board Resettlement Consortia pilot, based at Hindley YOI, which trialled a more seamless, joined-up approach to the resettlement of young people in the North West of England. The pilot has a specific focus on accommodation, education and training (Glover and Clewitt, 2011).

Military veterans

It is estimated that between 5 to 12% of single homeless people are military veterans, having been in the armed forces at some time (Royal British Legion, 2011, National Audit Office, 2007). Service leavers with a shorter service history and those from the army are the most at risk of homelessness and will require extra tracking and support. Homeless veterans are on average older, have been homeless for longer, are less likely to use drugs and more likely to have alcohol-related problems when compared to the wider homeless population. Only a small number of veterans have been found to have post-traumatic stress disorder, with other types of mental illness being more common (Royal British Legion, 2011).

The literature review carried out by the Royal British Legion concluded that for a minority of homeless veterans, factors such as the trauma of combat, the mobility of the job and the drinking culture had reduced the ability to cope on leaving service. It was noted that some individuals may have been vulnerable before entering the forces (Royal British Legion, 2011).

People with learning difficulties and/or autism

Learning difficulties such as dyslexia, poor literacy and numeracy skills and low IQ are common amongst homeless people, making them extremely vulnerable to exploitation and robbery by other homeless people. IQ levels may often be just above 70, meaning they fail to qualify for support from adult social services (NHS Devon, 2011).

Little research has been carried out on the links between homelessness and autism or Asperger's syndrome. A Devon study found that out of 12 long-term rough sleepers interviewed, more than half (7) displayed behaviour suggesting a degree of autism, none of whom were receiving any support to manage their condition (NHS Devon, 2011).

It is possible that some of those along the autistic-mentally ill spectrum find it easier to be on the streets than dealing with day to day life, so that homelessness becomes a way of coping with psychological problems (NHS Devon, 2011).

Assertive and proactive outreach, with a person-centred approach, is considered to be an effective way of starting to engage with people who have a range of complex mental health problems (NHS Devon, 2011).

Initial findings from a study in Wirral suggest that homelessness can be a consequence of ADHD, with an estimated prevalence of ADHD in the young homeless population of 22%. They found that young homeless adults are **at least** 11 times more likely to be diagnosed with ADHD (Parry, 2014).

4. 'Priority cases': statutory homeless

Statutory homeless figures will not fully reflect the true numbers of homeless people. They count only those applying for housing assistance and accepted as being in 'priority need'. Where the local authority is satisfied that those who apply for housing assistance are

eligible, unintentionally homeless and fall within a specified priority need group, a 'main homelessness duty' is owed (DfCLG 2013a).

Table 3 in the main report illustrates the distinction between statutory and non-statutory homelessness. Those who are statutorily homeless tend to be lone female led families and asylum seekers.

Homeless application outcomes:
Decisions taken on the 1,626 homeless applications in Liverpool City Region during 2012/13 had similar outcomes to those taken nationally:

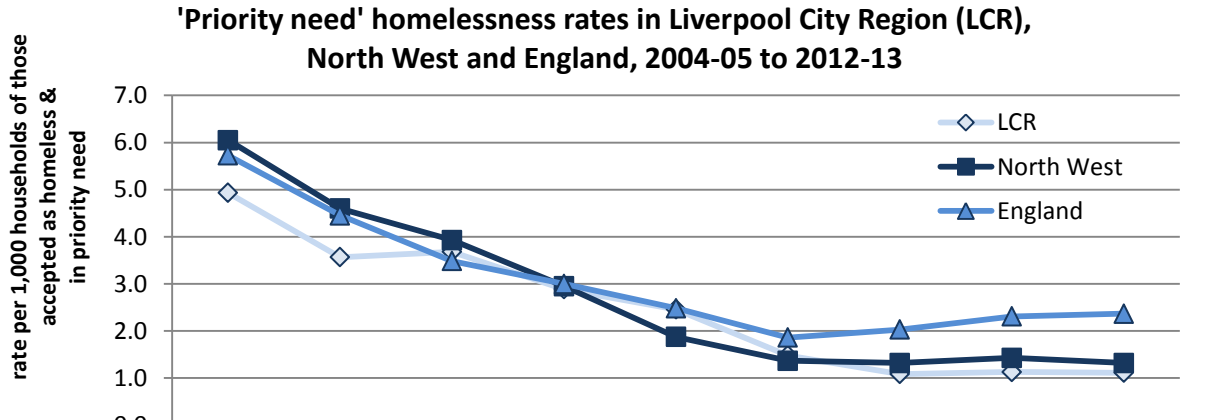
- 44% were accepted as owed a main homelessness duty (47% nationally);
- 31% were found not to be homeless (28% nationally);
- 18% were found to be homeless but not in priority need (18% nationally); and
- 8% were found to be intentionally homeless and in priority need (7% nationally).

Within Liverpool City Region, proportions accepted as owed a homelessness duty ranged from only 33% of applicants in Sefton, to 65% of applicants in St.Helens (see table 3 in the main report).

Trends

As shown in Figure 1, homelessness rates (those accepted as homeless and in priority need) declined between 2004-05 until 2009-10, nationally and in Liverpool City Region and the North West. This was mainly due to government prevention initiatives. The government set all local authorities a target to reduce temporary accommodation by half and employed specialist advisors to assist them in how to prevent homelessness. In addition, the government made funding available - a Homelessness Grant. The conditions attached to the grant were that it had to be spent on the prevention of homelessness.

Figure 1



	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13
LCR	4.9	3.6	3.7	2.9	2	1.5	1.09	1.13	1.11
North West	6.1	4.6	3.9	3.0	1.9	1.4	1.32	1.43	1.32
England	5.7	4.5	3.5	3.0	2.5	1.9	2.03	2.31	2.37

Source: https://www.gov.uk/government/statistical-data-sets

In Liverpool City Region, rates continued to decline until 2010-11, after which they flattened out at around 1.1 per 1,000 households. This is in contrast to the national picture, where rates have risen recently and are now more than twice as high as in Liverpool City Region.

As noted in the main report, where comparisons between local and national data are made, national data may be skewed due to the specific circumstances and high levels of homelessness in London. The London effect may not fully explain the large difference between national and local data. It is important to explore to what extent homelessness levels may be underestimated in Liverpool City Region.

Decisions made and proportion accepted: further details, by local authority.

Although there have been fluctuations in the numbers of people presenting as homeless over the last five years, there has been very little change in the proportion who are accepted as homeless, at around 44% in Liverpool City Region (LCR). Details for Liverpool City Region and England are presented in the main report. Table 1 shows data for each local authority.

Table 1
Decisions made on applications for assistance and % accepted, trends from 2008-09 to 2012-13. Local authorities in Liverpool City Region (LCR)

2008-09	Decisions made	Accepted as homeless and in priority need	% accepted	2009-10	Decisons made	Accepted as homeless and in priority need	% accepted
Halton	240	166	69%	**Halton**	214	158	74%
Knowsley	380	312	82%	**Knowsley**	318	217	68%
Liverpool	1,872	505	27%	**Liverpool**	838	233	28%
Sefton	263	97	37%	**Sefton**	299	213	71%
St. Helens	383	280	73%	**St. Helens**	160	66	41%
Wirral	348	197	57%	**Wirral**	121	51	42%
LCR	**3,486**	**1,557**	**45%**	**LCR**	**1,950**	**938**	**48%**

2010-11	Decisions made	Accepted as homeless and in priority need	% accepted	2011-12	Decisions made	Accepted as homeless and in priority need	% accepted
Halton	78	37	47%	**Halton**	152	64	42%
Knowsley	165	85	52%	**Knowsley**	180	51	28%
Liverpool	554	218	39%	**Liverpool**	667	268	40%
Sefton	288	224	78%	**Sefton**	150	46	31%
St. Helens	107	45	42%	**St. Helens**	263	182	69%
Wirral	195	77	39%	**Wirral**	212	100	47%
LCR	**1387**	**686**	**49%**	**LCR**	**1,624**	**711**	**44%**

2012-13	Decisions made	Accepted as homeless and in priority need	% accepted
Halton	166	86	52%
Knowsley	221	66	30%
Liverpool	524	187	36%
Sefton	178	59	33%
St. Helens	232	151	65%
Wirral	305	165	54%
LCR	**1,626**	**714**	**44%**

Source: DfCLG, Table 784, https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness#discontinued-tables

Reasons for homelessness: further details

The following data relates to people accepted as being statutorily homeless by the local authority. In Liverpool City Region between July 2012 to June 2013, the most common reason for homelessness was parents, relatives or friends not being able or willing to accommodate the applicant, which accounted for more than a quarter of cases (27.6%). The proportion due to parents no longer willing to accommodate in Liverpool City Region (17.9%) was similar to the national figure of 17.3% (Table 2).

In a further 19.5% of cases in Liverpool City Region (17.3% nationally), the reason for homelessness was the breakdown of a relationship with a partner, with three-quarters (73.3%) of these involving violence (96 violent; 35 non-violent). This was higher than nationally, where the proportion was 69.3% involving violence.

'Other violence and harassment' was also more commonly a reason for homelessness in Liverpool City Region (9.7% of acceptances, compared to 5.2% nationally).

Loss of rented accommodation accounts for another large proportion of homeless acceptances (18.3%), although this is less than the national figure of 29.3%.

Of all acceptances, the proportion due to mortgage arrears is twice as high in Liverpool City Region compared to nationally (4.8% compared to 2.2%). Proportions homeless due to rent arrears are similar to national figures (Table 2).

There are a greater proportion of homeless acceptances in Liverpool City Region due to people who have left asylum support, prison, hospital, local authority care or HM Forces (17.3%, compared to 12.4% nationally) (Table 3). Figure 2 shows that within Liverpool City Region, this is accounted for by higher than national average levels in Liverpool (27%) and also in Sefton and Wirral (note that Figure 2 and Table 3 use data over a 3 year time period, to allow for smaller numbers at local authority level).

Analysis of individual reasons by local authority reveals that in Liverpool, the high numbers are due to people being required to leave the National Asylum Support service. In Liverpool, 1 in 10 (11.0%) of all priority need homeless acceptances were people required to leave asylum support accommodation, in the period Jan 2010 to June 2013 (see Table 3 below).

The proportion of homeless acceptances due to leaving prison was nearly twice as high in Liverpool City Region compared to nationally (1.5% compared to 0.8%). It was especially high in Liverpool (3.2%) and Sefton (2.2%), which may be expected, due to the locations of prisons in Liverpool City Region.

Acceptances due to leaving care were half the national rate (0.7% compared to 1.4% nationally). They were however high in Sefton, at 2.2% of all priority homeless acceptances.

The proportion of homeless acceptances due to people leaving HM Forces, although small, at 0.8%, was twice the national rate of 0.4%. It was especially high on Wirral, at 3.4%.

See Table 3 for all numbers and percentages within this group.

Table 2
Reasons for homelessness, Liverpool City Region and England, July 2012 to June 2013
Percentages of total accepted as statutorily homeless and in priority need

	Parents no longer willing or able to accommodate	Other relatives/friends no longer willing or able to accommodate	Non-violent relationship breakdown with partner	Violent relationship breakdown with partner	Other violence and harassment	Mortgage arrears	Rent arrears	Loss of rented or tied accommodation	Left asylum support, prison, hospital, LA care, HM Forces or other	total
Liverpool City Region (LCR) %	17.9%	9.7%	5.2%	14.3%	9.7%	4.8%	2.8%	18.3%	17.3%	100%
LCR number	*120*	*65*	*35*	*96*	*65*	*32*	*19*	*123*	*116*	*671*
England	17.3%	13.2%	5.3%	12.0%	5.2%	2.2%	3.1%	29.3%	12.4%	100%

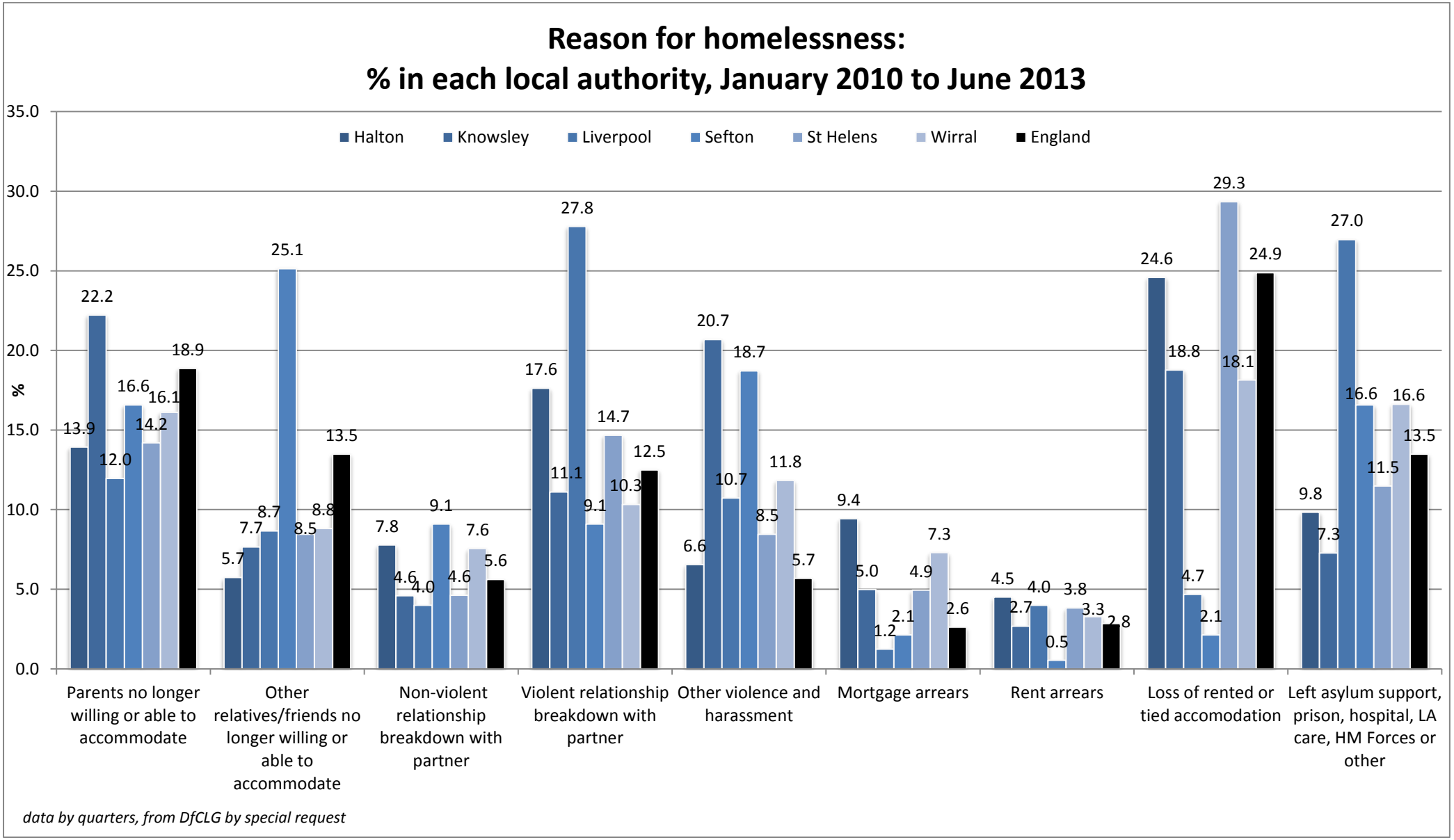
Source: provided by DfCLG by special request

Table 3
Reasons for homelessness:
Priority need homeless acceptances in Liverpool City Region due to people who have left asylum support, prison, hospital, local authority care or HM Forces. Jan 2010- June 13

	Required to leave National Asylum Support Service accommodation		Left prison/on remand		Left hospital		Left other institution or LA care		Left HM-Forces		Total number of homeless acceptances Jan 2010- June 13
	number	%	number	%	number	%	number	%	number	%	
Halton	0	0.0	0	0.0	1	0.4	1	0.4	4	1.6	244
Knowsley	0	0.0	1	0.4	1	0.4	2	0.8	1	0.4	240
Liverpool	85	11.0	25	3.2	17	2.2	6	0.8	1	0.1	772
Sefton	0	0.0	4	2.2	3	1.7	4	2.2	0	0.0	180
St Helens	0	0.0	3	0.5	3	0.5	2	0.3	1	0.2	622
Wirral	0	0.0	4	1.0	6	1.6	2	0.5	13	3.4	385
LCR	**85**	**3.5**	**37**	**1.5**	**31**	**1.3**	**17**	**0.7**	**20**	**0.8**	**2443**
England	**4821**	**2.8**	**1412**	**0.8**	**1842**	**1.1**	**2430**	**1.4**	**688**	**0.4**	**170948**

Source: data obtained by request from DfCLG,18/10/13,

Figure 2



data by quarters, from DfCLG by special request

Temporary accommodation

Nationally, between 2012 to 2013, the numbers in temporary accommodation rose by 10%, after having fallen between 2004 to 2011. Temporary accommodation includes emergency bed and breakfast accommodation (B&Bs). The number of homeless families living in B&Bs is at its highest in nearly ten years, with a rise of 14% between 2012 to 2013 (Shelter, online 2013c). This would suggest a greater reliance on B&Bs as homelessness rises.

There are rising numbers of households with children in B&Bs, with national levels more than doubling between 2010 to 2012 (Fitzpatrick et al, 2012 & 2013). Children are sometimes sent far from their usual schools (Mathiason et al, 2013). Housing families in short-term accommodation has cost the UK almost £2 billion in the past four years. In addition to being costly, B&Bs are often unsuitable, particularly for families, where a whole family may share a single room with no cooking facilities (Mathiason et al, 2013). There is a legal requirement limiting use of B&Bs to 6 weeks for families, but many often remain in this situation for months (Fitzpatrick et al, 2012 & 2013).

In 2012, Fitzpatrick et al reported that there had been no proportionate or absolute increase in rent or mortgage arrears as a cause of statutory homelessness. The proportion of mortgage arrears cases resulting in repossession by 2012 was not as large as expected during the current recession. This has been partly due to low interest rates. However, repossessions are forecast to rise over the next three years (Fitzpatrick et al 2012 & 2013).

There has been a rising incidence of terminated private tenancies, especially in London and the South (Fitzpatrick et al, 2012 & 2013).

Local data
There were 109 households in temporary accommodation arranged by local authorities under homelessness legislation in Liverpool City Region, as at 31st March 2013.

Nationally, 84% of homeless households were in temporary accommodation that was self-contained (either local authority, housing authority or private rented sector). The remaining 16% were in accommodation with shared facilities (bed and breakfast or hostel type accommodation). In Liverpool City Region, the proportion in accommodation with shared facilities was more than four times as high, at 70%, with only 30% in self-contained accommodation.

Table 4 gives a breakdown of the types of temporary accommodation found for those accepted as homeless in each local authority in Liverpool City Region, as a snapshot on 31st March, 2013:

- Actual numbers of households in temporary accommodation in each local authority were small. The highest rates per 1,000 households were found in Halton (0.30) and St.Helens (0.28).
- More than half of these were in hostel type accommodation (58%, compared to only 8% nationally). In Liverpool, all temporary accommodation would appear to be of the hostel type. Halton (60%) and Knowsley (50%) also had high proportions in hostels.

- As many as 12% were being housed in bed and breakfast accommodation (B&Bs) (8% nationally). In Wirral and Knowsley, around half were being accommodated in B&Bs, while in Halton, Liverpool and St. Helens, there were none.

- Fewer than 1 in 10 were accommodated with social landlords (8%, compared to 17% nationally). Across the whole of the North West, as many as 1 in 3 (33%) were placed with social landlords. In Sefton, the proportion was even higher, at 3 in 4 (although actual numbers of homeless households were small in Sefton).

- Around 1 in 5 were placed with private landlords (22%, compared with 67% nationally). In St. Helens, as many as 3 in 4 were placed with private landlords (76%).

There were 36 homeless households in Liverpool City Region for whom no accommodation could be found. These were in Wirral (16), St. Helens (12) and Halton (8) (as at 31st March 2013).

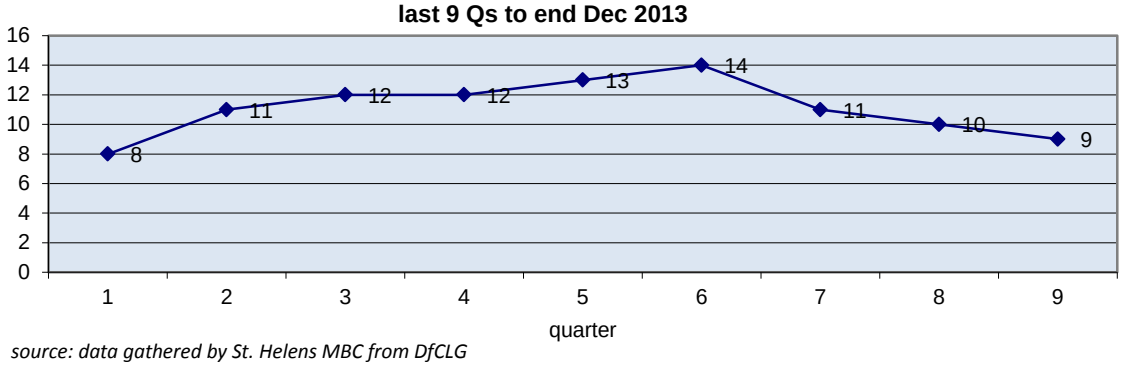
Table 4
Types of temporary accommodation found for those accepted as homeless, snapshot as at 31st March 2013.
Number of households (and % of all those in temporary accommodation)

	Bed and breakfast (including shared annexe)	Hostels (including women's refuges)	Social landlords	Private sector	Total in temporary accomm-odation
Halton	0 (0%)	9 (60%)	0 (0%)	6 (40%)	**15**
Knowsley	6 (43%)	7 (50%)	0 (0%)	1 (7%)	**14**
Liverpool	0 (0%)	41 (100%)	0 (0%)	0 (0%)	**41**
Sefton	2 (25%)	0 (0%)	6 (75%)	0 (0%)	**8**
St. Helens	0 (0%)	5 (24%)	0 (0%)	16 (76%)	**21**
Wirral	5 (50%)	1 (10%)	3 (30%)	1 (10%)	**10**
Liverpool City Region	**13 (12%)**	**63 (58%)**	**9 (8%)**	**24 (22%)**	**109**
North West	**(11%)**	**(32%)**	**(33%)**	**(24%)**	
England	**(8%)**	**(8%)**	**(17%)**	**(67%)**	

Data source: Dept. for Communities & Local Govt. Table 784
https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness#discontinued-tables

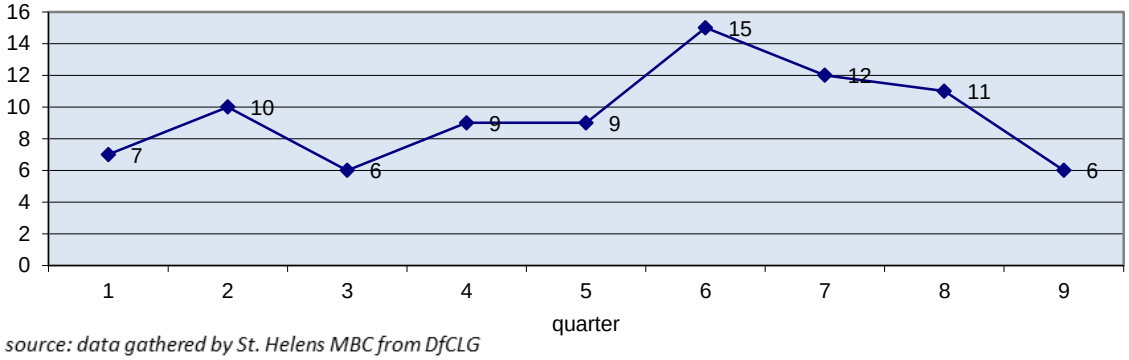
Figures 3 to 8 show the quarterly fluctuations in numbers of households in temporary accommodation in each local authority in Liverpool City Region over the last nine quarters up to the end of December 2013.

Figure 3
Knowsley households in temporary accommodation
last 9 Qs to end Dec 2013



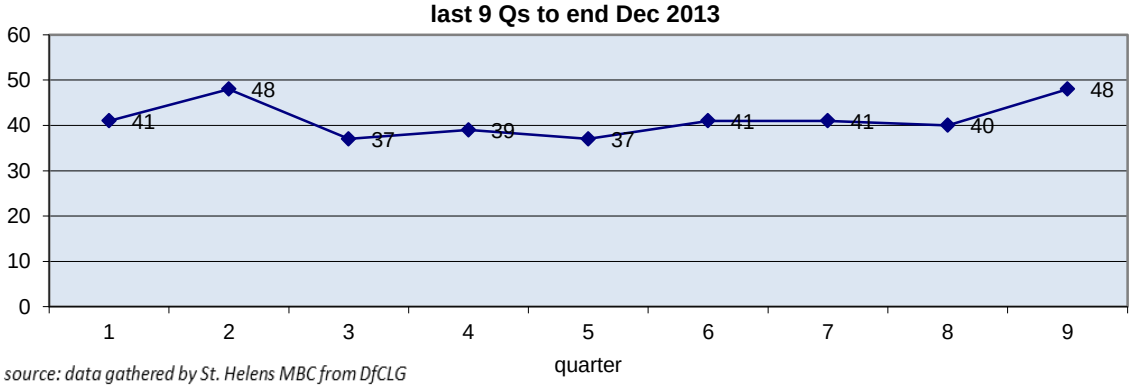
source: data gathered by St. Helens MBC from DfCLG

Figure 4
Halton households in temporary accommodation
last 9 Qs to end Dec 2013



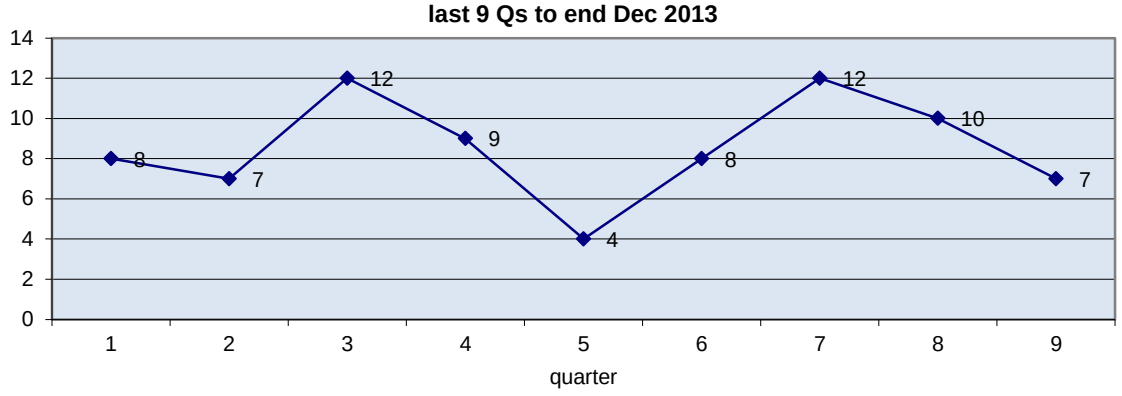
source: data gathered by St. Helens MBC from DfCLG

Figure 5
Liverpool households in temporary accommodation
last 9 Qs to end Dec 2013



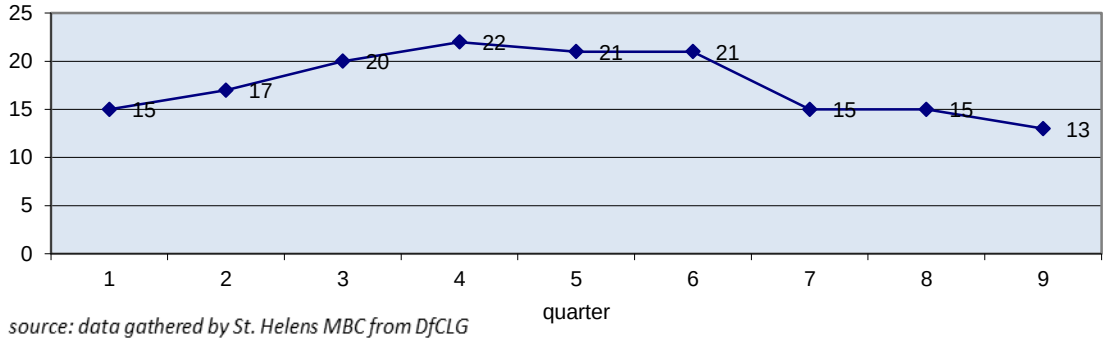
source: data gathered by St. Helens MBC from DfCLG

Figure 6
Sefton households in temporary accommodation
last 9 Qs to end Dec 2013



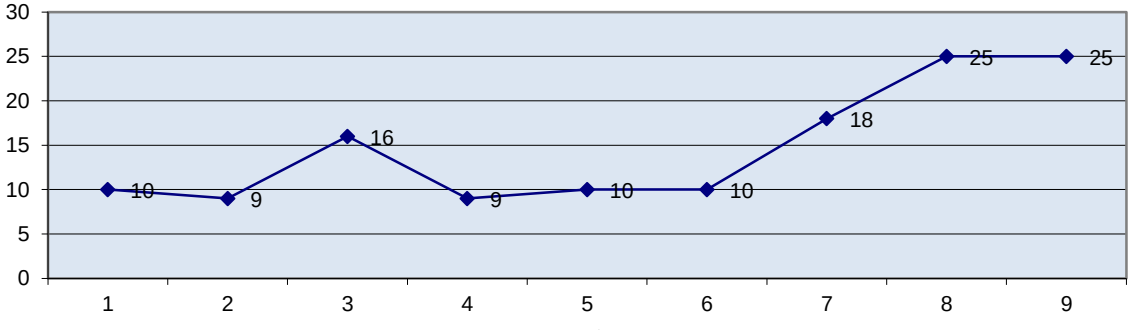
source: data gathered by St. Helens MBC from DfCLG

Figure 7
St. Helens households in temporary accommodation
last 9 Qs to end Dec 2013



source: data gathered by St. Helens MBC from DfCLG

Figure 8
Wirral households in temporary accommodation
last 9 Qs to end Dec 2013



source: data gathered by St. Helens MBC from DfCLG

B&B 6 weeks plus:

In England, of all families housed in B&B accommodation, 39% had been there for six weeks or more (as at 31/3/13). In Liverpool City Region, the situation is much more favourable. Between January 2007 and June 2013, no local authority in Liverpool City Region ever had more than one family at any one time in B&B accommodation for as long as six weeks or more (except on 30/6/12, when there were two families in Wirral) (DfCLG, 2013b, links to supplementary table p.16 and table 793).

It has been reported that in 2012-13, Liverpool managed to cut its spending on temporary accommodation, but that at £3.58m, it still remained significantly higher than Manchester (£2.48m), despite being a smaller city (Mathiason et al, 2013).

Homelessness Prevention and Relief

With the introduction of the 2002 Homelessness Act, the Government has made homelessness prevention a priority (see 'National Policy' above).

Homelessness prevention involves providing people with the ways and means to address their housing and other needs to avoid homelessness. This is done by either assisting them to obtain alternative accommodation or enabling them to remain in their existing home, for example through mediation, conciliation, use of a homeless prevention fund, debt advice, resolution of benefit problems, sanctuary schemes for domestic violence, crisis intervention and mortgage arrears interventions (DfCLG 2013a).

Homelessness relief occurs when an authority has been unable to prevent homelessness but helps someone to secure accommodation, even though the authority is under no statutory obligation to do so. Examples of accommodation that someone might be helped to obtain would include any form of hostel, private rented accommodation, accommodation with friends or relatives, supported lodgings, social housing or low cost home ownership schemes. (DfCLG 2013a).

Since 2008, local authorities have been required to provide data on the numbers of households for whom casework and positive action took place in order to prevent or relieve homelessness, either by the authority themselves or by a partner organisation (DfCLG 2013a).

Local data

It would appear that those local authorities with a higher rate of homelessness acceptances generally have a higher rate of homelessness prevention and relief although there are exceptions to this (the DfCLG found a weak positive correlation of 0.23) (DfCLG, 2013a).

As shown in Table 5, a total of 3,985 cases of homelessness prevention or relief are estimated to have taken place outside the statutory homelessness framework in Liverpool City Region in 2012/13. Of these cases, the vast majority were for preventions (3,901

[97.89%] were preventions and 84 [2.11%] were cases of relief). Nationally, the proportion of cases of homelessness relief was higher (10%, with 90% preventions).

With a rate of 6.21 per thousand households, levels of prevention and relief in Liverpool City Region were lower than the national average of 8.20 in 2012/13. Within Liverpool City Region, Knowsley (12.09) and Halton (8.62) had levels higher than the national average. Levels in Sefton were lowest, at only 2.65 per thousand households (Table 5 and Figure 9).

Trends

Numbers: Nationally, the total number of cases of homelessness prevention or relief has shown a steady increase since 2009/10. This is due to an increase in prevention cases, especially of those able to remain in their existing home, which increased by 10 per cent between 2011/12 to 2012/13 (DfCLG 2013a).

In Liverpool City Region, the picture is different, as shown in Figure 10. There has been an overall decrease in the number of cases of homelessness prevention or relief in the three years since 2010/11. This is accounted for by a drop in the numbers of those assisted to remain in their own homes. Numbers of cases of positive action in relieving homelessness have also fallen. On the other hand, there has been a steady increase in numbers assisted to secure alternative accommodation as a preventive measure.

Rates: As shown in Figure 9, rates of homelessness prevention and relief in England increased between 2009/10 to 2011/12, then fell back in 2012/13 (rates per thousand households). Within Liverpool City Region, rates have fluctuated in each local authority, but with the exception of Sefton, all were at a higher level in 2012/13 compared to 2009/10. In Sefton, rates were consistently low and fell to their lowest level in 2012/13.

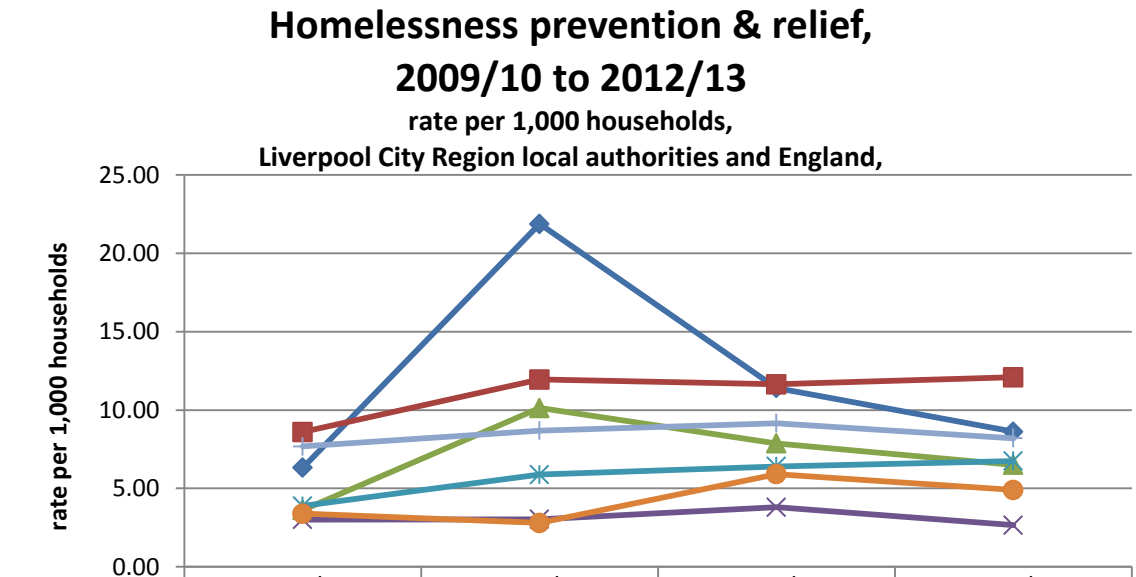
Table 5
Reported cases of homelessness prevention and relief, by outcome and local authority, 2012/13

		Number of cases where positive action was successful **in preventing homelessness**				Number of cases where positive action was successful **in relieving homelessness**		Total cases of **prevention and relief**	
	Number of households (2008 based projections for 2012) **(000s)**	Able to remain in existing home*	Assisted to obtain alternative accommodation*	Total preventing	***Rate per 1,000 households***	Total relieving	***Rate per 1,000 households***	Total cases of prevention and relief	***Rate per 1,000 households***
Halton	50	125	306	431	***8.62***	-	***-***	431	***8.62***
Knowsley	64	252	515	767	***11.98***	7	***0.11***	774	***12.09***
Liverpool	198	309	933	1242	***6.27***	46	***0.23***	1288	***6.51***
Sefton	118	41	253	294	***2.49***	19	***0.16***	313	***2.65***
St. Helens	76	118	391	509	***6.7***	4	***0.05***	513	***6.75***
Wirral	136	276	382	658	***4.84***	8	***0.06***	666	***4.90***
Liverpool City Region	642	1121	2780	3901	***6.08***	84	***0.13***	3985	***6.21***
England	22630	94200	87300	181500	***7.29***	21000	***0.92***	202400	***8.20***

Data source: Dept. for Communities & Local Govt. Table 792
https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness#discontinued-tables

Nationally, 47% remain in own home and 53% found alternative accommodation. In Liverpool City Region, proportions staying in own home are lower (except Wirral)

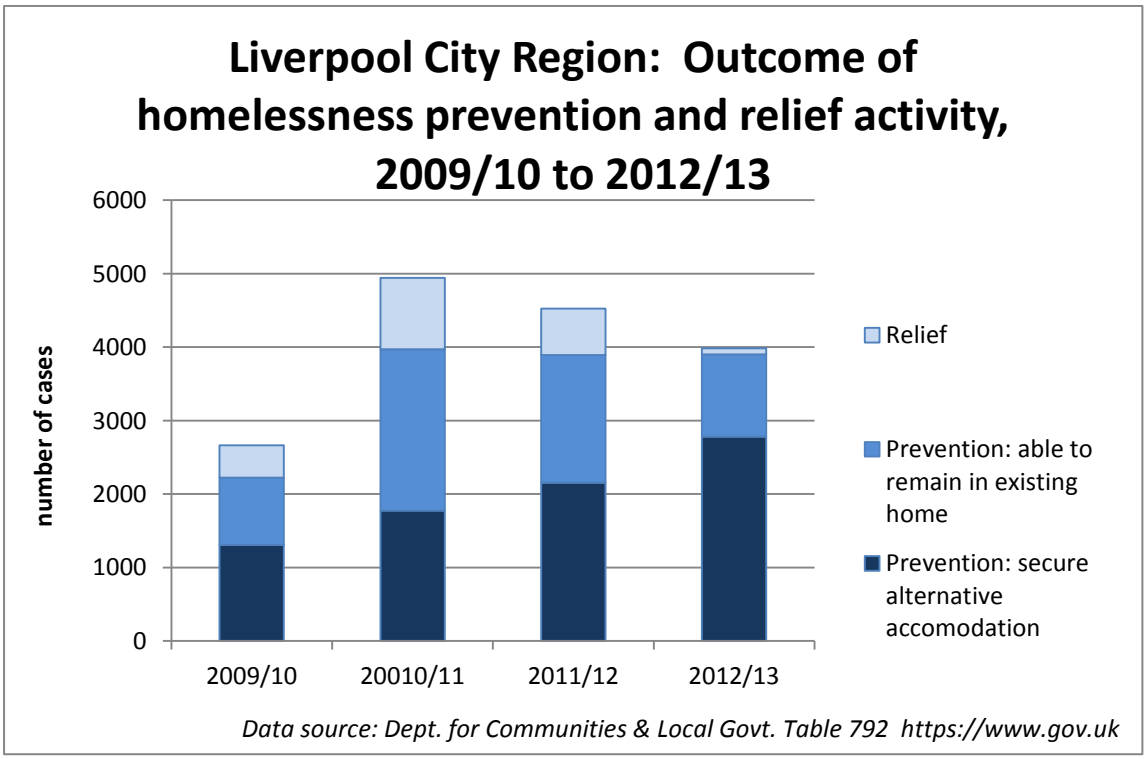
Figure 9



	2009/10	2010/11	2011/12	2012/13
Halton	6.32	21.88	11.41	8.62
Knowsley	8.60	11.95	11.65	12.09
Liverpool	3.63	10.13	7.87	6.51
Sefton	3.02	3.03	3.80	2.65
St. Helens	3.88	5.88	6.40	6.75
Wirral	3.39	2.80	5.91	4.90
England	7.68	8.69	9.16	8.20

Data source: Dept. for Communities & Local Govt. Table 792 https://www.gov.uk

Figure 10 (see Table 5 for numbers in each local authority)



Data source: Dept. for Communities & Local Govt. Table 792 https://www.gov.uk

Prevention: Recommendations

- Further investigation is required to determine whether low levels of reported prevention and relief could be due to under-reporting, rather than a lack of activity. The DfLG (2013a) pointed out that it is possible that some local authorities do not have systems in place to comprehensively record activity by partner organisations (i.e. any organisation that assists the authority in tackling and preventing homelessness, and is either funded by the authority or has clients referred to them by the authority).

- Shelter (online, 2013b) would like to see the Government's homelessness prevention strategy refocused to do more at an earlier stage to help people who are in danger of becoming homeless to keep their home, and to ensure that people who are homeless are offered secure housing they can afford.
  Shelter calls on the Government and local councils to:
  - improve access to tenancy sustainment services to ensure that vulnerable people have the support they need to remain successfully in their homes
  - reform the housing benefit system to make it simpler and easy to access for those in housing need.

- The provision of affordable housing needs to be increased throughout the social housing sector, the private rented sector and in the privately owned sector (Shelter online, 2013b).

5. 'Non-priority need' homeless

Liverpool: Homeless Link Health Needs Audit

The national homeless charity Homeless Link developed an audit tool to respond to the gap in evidence about homeless people's health. They produced the results of their national audit in 2010 (Homeless Link, 2010).

Liverpool is the only Liverpool City Region local authority to have undertaken the Homeless Link audit. This was carried out in July and August 2013 (Homeless Link, 2013). Surveys were conducted with clients from a range of homelessness agencies in Liverpool, with 455 completed questionnaires. The largest group of respondents were from hostels (45%) and 2nd stage supported accommodation (30%), with the remainder sleeping rough (11%), on sofas (3%) or in the Sit Up Shelter (4%) ('other' and 'not known' 8%). The health data gathered from the audit is presented in the relevant sections of the main report. Demographic information was as follows:

- around 1 in 3 clients were male
- the most common 10 year age band was 36-45 (28% of clients)
- 4% were White Irish
- 3% were Black British

- just under half (43%) considered themselves to have a disability (mainly related to mental health or mobility)
- 31% had been in prison (13% in the last 12 months)
- 3% were asylum seekers
- 3% had left care services in the past 5 years
- 3% were ex-armed forces personnel (less than the national estimated figure of between 5-12%. Royal British Legion, 2011 – see section 1.2 above)
- more than half (55%) were not in training, employment, volunteering or accessing guidance (a further 17% did not answer).

Rough sleeping data definitions

The government collects information from local authorities on street counts and estimates. This information is used by local authorities to assist them in commissioning services to prevent and tackle rough sleeping, and identify gaps in services (DfCLG, 2013c).

A new methodology for carrying out counts and providing estimates was introduced in October 2010. Conducting street counts became a choice for individual local authorities based on their assessment of whether the local rough sleeping problem justifies counting – for instance, where local intelligence suggests there are rough sleepers in the area on a regular basis or that numbers may be increasing. Where a local authority decides not to count they are asked to submit an estimate of the number of people rough sleeping on a typical night (DfCLG, 2013c).

For the purposes of rough sleeping counts and estimates, the government defines rough sleepers as:

- people sleeping, about to bed down (sitting on/in or standing next to their bedding) or actually bedded down in the open air (such as on the streets, in tents, doorways, parks, bus shelters or encampments)
- people in buildings or other places not designed for habitation (such as stairwells, barns, sheds, car parks, cars, derelict boats, stations, or 'bashes').

(DfCLG, 2013c)

The definition does not include people in hostels or shelters, people in campsites or other sites used for recreational purposes or organised protest, squatters or travellers. Bedded down is taken to mean either lying down or sleeping. About to bed down includes those who are sitting in/on or near a sleeping bag or other bedding.
https://www.gov.uk/homelessness-data-notes-and-definitions

Hidden homeless

Although homeless, there are a group of people who are not supported through the Supporting People programme and do not sleep rough. They may be living in bed and breakfasts, squats, in unsatisfactory or overcrowded accommodation, or staying with friends or families sleeping on floors or settees, with no official right to do so. By its very nature it is extremely difficult to accurately estimate the true levels of 'Hidden Homelessness' (NHS

Devon, 2011). In the form of overcrowded, concealed and shared households, there has been a long-term broadly rising trend in such levels of 'hidden homelessness', according to the latest Homelessness Monitor report (Fitzpatrick et al 2012 & 2013). Fitzpatrick et al noted that this started before the current recession, reflecting mainly housing access and demographic pressures.

Concealed households

'Concealed households are family units or single adults living within other households, who may be regarded as potential separate households that may wish to form given appropriate opportunity' (Fitzpatrick et al, 2012 & 2013). The latest Homelessness Monitor reported that numbers of concealed households had been static or in decline from 1990 to the early 2000s, but that there have been signs of recent increases (Fitzpatrick et al, 2012 & 2013).

According to the Homelessness Monitor, there were around 1.54 million concealed single households in England in 2012 (Fitzpatrick et al, 2012 & 2013)[1]. In addition, there were 214,000 concealed couples and lone parents. Fitzpatrick et al (2012 & 2013) note that there has also been a slowdown in new household formation, which provides indirect evidence for the increase in concealed households.

Shared households

'Sharing households' are those households who live together in the same dwelling but who do not share either a living room or regular meals together. This is different to 'concealed' households (see previous paragraph), where there may be a common living room (including larger kitchens) and/or people share some meals. In practice, the distinction between 'concealed' and 'sharing' households is a very fluid one (Fitzpatrick et al, 2012 & 2013).

The number of sharing households had been declining long-term until 2007 to 2010, when there was an increase (Fitzpatrick et al, 2012 & 2013).

Overcrowded households

'Overcrowding' is when bedroom allocation does not meet the standard of one bedroom to each couple or lone parent, one to each pair of children under 10, one to each pair of children of the same sex over 10, with additional bedrooms for individual children over 10 of different sex and for additional adult household members (Fitzpatrick et al, 2012 & 2013).

Overcrowding increased markedly from 2.4% in 2003 to 3.0% of all households in 2010, which was a reversal of previously declining trends (Fitzpatrick et al, 2012 & 2013).

[1] taken from the Labour Force Survey & English Housing Survey for the Homeless Monitor report. The Homeless Monitor Team may be able to extract data for Merseyside in future.

6. Health needs

People who are sleeping rough, in the single homeless temporary accommodation system or sofa surfers have the most extreme health needs. These can be summarised as involving the following:

- mental ill-health
- general ill-health
- dental ill-health
- communicable diseases
- violence/accidents
- substance misuse

It is possible that up to two-thirds of serious chronic health problems pre-exist before the person becomes homeless, but will worsen by being homeless (DH, 2010, quoting from a book written in 1994 by the Royal College of Physicians: 'Homelessness and ill health').

Dual diagnoses are common amongst this population, involving severe mental health problems (generally psychotic disorders) and severe substance misuse problems, which ideally should be treated concurrently (St. Mungo's 2009). Amongst those sleeping rough in London in 2012/13, there were reported to be 41% with an alcohol problem, 28% with a drug problem and 44% with a mental health problem (Chain, 2013). Often substance misuse is secondary to mental health and often used as a form of self-medication to cope with mental health problems and life on the streets (NHS Devon, 2011; St. Mungo's, 2009).

It has been noted that rather than a dual diagnosis, in practice many homeless people have multiple needs, which might include one or more medical problem and a range of social issues such as housing, income, employment and social isolation (NHS Devon, 2011).

Homeless people die on average 30 years before the general population. For all homeless people the mean age of death is 47 and for homeless women it is even lower at only 43[2] (Crisis, 2011). Members of the homeless population are 35 times more likely to kill themselves and 4 times more likely to die from unnatural causes (such as accidents, assaults, murder, drugs or alcohol poisoning) than the general population (Griffiths, 2002).

As well as the health and other consequences for individuals, there are also significant financial implications. The cost of acute health services **for the hostel population** alone is estimated at **£85 million per annum** for 40,500 people, which equates to over £2,100 per person per year and is probably an underestimate (DH, 2010).

[2] ** this is the average age at death of a sample of homeless people who die whilst they are homeless and does not take into account those people who become settled in a home (Department of Health 2010).*

Homeless Link Health Needs Audit

The national homeless charity Homeless Link developed an audit tool for use by local authorities to provide data on the health needs of those with more extreme forms of homelessness, mainly hostel residents, rough sleepers and sofa surfers. In 2010, a national audit was piloted across 9 PCTs, interviewing 727 homeless clients (Homeless Link, 2010).

Liverpool is the only Liverpool City Region local authority to have undertaken the Homeless Link audit (Homeless Link, 2013). Surveys were conducted with clients from a range of homelessness agencies in Liverpool, with 455 completed questionnaires. The largest group of respondents were from hostels (45%) and 2nd stage supported accommodation (30%), with the remainder sleeping rough (11%), on sofas (3%) or in the Sit Up Shelter (4%) ('other' and 'not known' 8%).

The national Homeless Link audit found that 8 in 10 (82%) single homeless people have one or more physical health condition (Homeless Link, 2010). The top four reported physical health needs related to joints/muscular pain; chest pain/breathing; dental; and eyesight (Table 6).

Over half of clients in the national audit reported that their health problem was chronic. 1 in 5 said they found it difficult to cope with their problem and wanted support.

Levels of physical health problems were higher than those reported nationally (see Table 6 above). Other common health issues included eyesight, stomach and feet problems.

15% of clients said they would like more support to manage their physical health and 10% said they receive no help or support but would like to be supported.

48% of clients [218] said they regularly take medication. Of these, 7% [16] said they have had issues with getting their prescriptions dispensed.

Table 6
Health needs and service use amongst people who are homeless

	Liverpool homeless audit n=455	National homeless audit n=727	General population
Joints/muscular pain	41%	38%	10%
Chest pain/breathing problem	34%	32%	5%
Dental problems	32%	29%	N/A
Eye complaints	29%	25%	1%
Mental health condition		72%	30%
Drug use	40%	52%	9%
Injecting drug use	1.3%	4.0%	
Alcohol - harmful drinkers	24%	20%	
Smoking	77%	77%	21%
Eat none of the recommended '5 a day'	28%	33%	
Been admitted to hospital in last 6 months	28%	31%	7%
Length of hospital stay (average)	6.0 days	7.2 days	2.1 days
Been to A&E at least once in last 6 months	34%	41%	
Used an ambulance at least once in last 6 months	26%	28%	
Used GP at least once in last 6 months	78%	82%	
Not registered with a GP	2.4%	15%	
Received vaccinations	28% (Hep A) 34% (Hep B) 30% (Flu)		
Received screening	31% Hep C *(of which 37% positive)* 20% TB *(of which 18% positive)* 31% HIV *(of which 14% positive)*		

Sources: Homeless Link 2013, Liverpool Audit; Homeless Link 2010, national audit
(Liverpool is the only Liverpool City Region local authority to have undertaken the Homeless Link audit).

Drug use

Research by Homeless Link found that more than half of hostels (58%) reported that a majority of their clients had a problem with drugs (Homeless Link, 2012b).

Local data
Of the 455 homeless clients in the Liverpool audit, 40% [183] stated that they used drugs. In the national homelessness audit, the figure was 52% (Homeless Link, 2010). This was compared to the much smaller figure for the general adult population, where 8.9% had taken one or more illicit drug in the last year (Homeless Link, 2013, quoting from Drug Misuse Declared Findings, 2011/12 Crime Survey, England and Wales). The Homeless Link data included people who use prescription drugs (e.g. methadone).

Of those in the Liverpool audit who used drugs, cannabis was most commonly used (58% [108 clients]), followed by crack/cocaine and prescription drugs.

Only 6 clients (1.3%) in the Liverpool audit said they currently injected drugs and only 2 said they shared injecting equipment. This is fewer than the national homelessness audit figure of 4% who said they injected drugs. There would appear to be awareness of services available, with 5 knowing where to go for needle exchange and 4 knowing where to go for advice around safe injecting.

Of the 185 who said they used drugs, almost two thirds (61% [112]) received support around drug use. Around 1 in 5 clients who use drugs would either like help or would like more help (20% [36]). This is more favourable than nationally, where only 1 in 4 receives some kind of support for tackling their drug use, with almost one third of these feeling the support was not adequate.

Alcohol use

Local data
Two thirds of the 455 homeless clients in the Liverpool Audit were drinkers (64%), with 1 in 4 (24%) reporting that they usually drink more than 3 times a week, the frequency recognised as being harmful (Homeless Link, 2013). This was more than the 1 in 5 in the national audit (Homeless Link, 2010).

1 in 4 (25%) has very harmful levels of alcohol consumption of 10 or more units each time they drink. Over two-thirds (37% [166]) say they have or are recovering from an alcohol problem. Just under half of these (44% [73]) said they would like some or more help around their alcohol use.

In comparison to the general population, there are more homeless people who say they never drink (33%, compared to 13% in the general population).

Screening/training: NHS Devon (2011) suggest that workers in the homelessness field working with clients who drink, could receive training to identify the signs of brain damage such as Wernicke's Encephalopathy and then assist their clients in going to see their GP. GPs can prescribe high doses of Thiamine as a preventative measure (50mg, 3 – 4 times daily).

Smoking

Smoking is more prevalent amongst single homeless people, with more than three quarters (77%) being smokers, compared to 21% in the general population (Homeless Link, 2010).

Local data
Similarly, the Liverpool Audit found that 77% of homeless clients were smokers (77% [352]), with 1 in 3 of these [150] saying they wanted to stop smoking. Just under half of all smokers said they had been offered smoking cessation advice or support [172]. Of those offered, only 1 in 4 [43] had taken up this support.

Supporting people health data for families and single homeless in short term accommodation support services

Clients using Supporting People accommodation services are asked whether they need support to better manage their physical health, mental health, or substance misuse issues. They are asked to assess whether their needs were met whilst they were with the service– e.g. a visit to a GP would be a need met. Data was extracted for all clients regarded as homeless for each local authority in Liverpool City Region. The main report gave full details of needs met. Further information on the background to the 'needs not met' data is presented here:

Reasons needs not met

Accommodation providers are asked to record why health needs had not been met. The full list of possible reasons is as follows:

- Factors to do with the client:
    - Client unable to engage with support
    - Client unwilling to engage with support
    - Client ceased to receive support before outcome was achieved

- Service unable to meet support need:
    - Difficulties with support planning

- Factors in the external environment:
    - Problems in accessing local primary health care services
    - Long waiting lists for primary health care services
    - Client awaiting assessment
    - Treatment ongoing
    - Other

Single homeless
Numbers of single homeless people with health needs unmet are too small to analyse in each local authority (too many categories have counts of less than 5).

Table 7 shows Liverpool City Region totals of the reasons given for why the physical, mental and substance misuse needs of single homeless people had not been met. In more than 1 in 8 cases, it was reported that these needs were not met due to either the client being unwilling to engage with support, or the client ceasing to receive support before the outcome was achieved.

Table 7
Single homeless people moving on from supported accommodation, 2012/13. Main reason health outcome not achieved. Totals for Liverpool City Region

	Client unwilling to engage with support	Client ceased to receive support before outcome was achieved	*ALL OTHER reasons	Total not achieving health outcome	*(Total number requiring support)*
Physical health need	78 (61.4%)	29 (22.8%)	20 (15.8%)	127 (100.0%)	*(944)*
Mental health need	98 (55.1%)	49 (27.5%)	31 (17.4%)	178 (100.0%)	*(817)*
Substance misuse need	315 (62.4%)	127 (25.1%)	63 (12.5%)	505 (100.0%)	*(1089)*

Source: Supporting People Outcomes Framework data, obtained from St. Andrews University by St. Helens Borough Council, Housing Dept.
**for 'all other reasons', see list of reasons in bullet points on p.29*

Homeless families
Numbers of homeless families with health needs unmet are too small to analyse in each local authority, with counts of less than 5 in many categories.

Across the whole of Liverpool City Region, there were only 12 families recorded as having unmet physical needs, 16 with unmet mental health needs and 10 with unmet needs relating to substance misuse. In three quarters of these cases, the unmet need was reported as being due to either the client being unwilling to engage with support, or support ceasing before the outcome was achieved. For the remainder, treatment was ongoing. (For those with mental health and substance misuse needs, in around half of all cases, needs were not met due to support ceasing before the outcome was achieved).

Numbers within each category for homeless families in Liverpool City Region are not presented, as counts were often below 5, even for aggregated Liverpool City Region totals.

7. Health service use/access to healthcare

Access to health care is a problem for homeless people. As problems are left to become more serious, people who are homeless are more likely to attend A&E or become hospital inpatients than the general population (DH 2010; Homeless Link online).

Homeless children living in temporary accommodation are also less likely to receive appropriate care (RCP, 1994; Shelter 2006). Shelter note that fewer homeless children are registered with a GP and, partly as a consequence of this, they are more likely to be admitted to hospital, regardless of the severity of their condition.

The national and Liverpool homelessness audits have suggested that homeless people are not currently accessing the interventions they need to address their health needs and prevent future problems (Homeless Link, 2010 and 2013). For example, of those with a mental health need, 35% said they would like more support with their mental health, especially talking therapies (Homeless Link, 2010).

For help with mental health, drug and alcohol issues, the main barrier for homeless people is that treatment services often like to see a degree of commitment or motivation by the client. For example some treatment agencies require clients to have been dry for six weeks before being accepted. Referral pathways can prove prohibitive for rough sleepers or hostel dwellers with chaotic lifestyles who struggle to keep appointments or are unwilling to attend traditional health centres or hospitals (NHS Devon, 2011).

Providing homeless people with access to GP services has been described as an essential step towards their reintegration into mainstream society (Crisis, 2002). Mahoney et al. (2008) reported how in primary care it is difficult to access services, or to register with a doctor without an address and therefore the delivery of normal care may be lacking for homeless people. Hostels can be listed as private addresses but professionals may be wary of the background of homeless people and therefore they may be discriminated against. HIV or hepatitis C status along with issues of substance abuse can all cause health professionals to treat homeless people as different from the general population (Tarzian, Neal and O'Neil, 2005). On the other hand, homeless people may be distrusting of professionals and fearful that abstinence of drugs or alcohol may be a condition of treatment (Moller, 2005).

Local data
GPs: The Liverpool Homeless Link Audit found that, of the 455 clients interviewed, almost all were registered with a GP. The majority were registered permanently, with only 2.4% (11) not registered at all (Homeless Link, 2013). This compares favourably to the national picture, where 15% of clients were not registered at all, with some having been refused access due to 'unsuitable behaviour' or lack of ID (Homeless Link, 2010).

In Liverpool, nearly 8 out of 10 of homeless clients used a GP at least once during a 6 month period (78%). This was slightly fewer than nationally, where the proportion was 82%.

Hospital attendance

Of the 455 clients interviewed for the Liverpool Homeless Audit, 1 in 3 (34%) had been to A&E at least once in the last six months (less than the 41% nationally). Also in the last six months, 26% had used an ambulance (28% nationally). The main reasons were related to violent injury or assault, breathing problems, alcohol and mental health (Homeless Link, 2013).

In the Liverpool audit, 11.5% of the clients interviewed (52) had been to A&E on 3 or more occasions during the last 6 months.

In the past six months, 28% (127) had been admitted to hospital (less than the 31% nationally), with the main reasons being alcohol related or breathing/chest pain. This level of hospital admission is four times the rate of 7% for the general population (Homeless Link, 2010).

The Liverpool homelessness audit found that length of hospital stay is far greater amongst homeless people, with an average of 6.2 days, compared to 2.1 days in the general population aged 16-64 (DH, 2010) (7.2 days in the national audit, Homeless Link, 2010).

Vaccinations and screening

Of the 455 homeless people interviewed for the Liverpool Homeless Link Audit (2013), roughly around one third of clients had received vaccinations (Homeless Link, 2013). Some clients were not sure, but 126 of the 455 clients had received the Hepatitis A vaccine, 154 Hepatitis B and 137 flu.

Between one-third and half of all clients reported that they had been screened for communicable diseases. Of the 142 saying they had been screened for Hepatitis C, 37% (52) were positive. Of the 93 people tested for TB, 18% were positive. For HIV, 14% of the 140 tested were positive.

The majority of clients (377) said they knew where to go for advice around sexual health and contraception. This leaves 14% (67) who did not know where to go for such advice. 1 in 3 (148) reported that they had been for sexual health screening in the past 12 months.

Clients views on access to health support

The Liverpool Homeless Link audit found that clients were often receiving good levels of information, with 80% of those in Liverpool saying they had been given useful information about the health services they can use from their hostel/day centre/housing project. However, there were gaps in support identified in the audit, described under the relevant headings above and summarised here as follows:

- Of the 289 homeless people in the Liverpool audit with support needs for their physical health, 24% said they would like more support and a further 16% said they receive no help but would like to be supported.
- Of homeless people with a mental health need, 35% said they would like more support with their mental health, especially talking therapies (national audit: Homeless Link, 2010).
- Of the 185 who said they used drugs, almost two thirds (61% [112]) received support around drug use. Around 1 in 5 clients who use drugs would either like help or would like more help (20% [36]). This is more favourable than nationally, where only 1 in 4 receive some kind of support for tackling their drug use, with almost one third of these feeling the support was not adequate.

- Of the 166 homeless clients in Liverpool who said they were recovering from an alcohol problem, just under half (73) said they would like some or more help around their alcohol use.
- Of the 352 smokers in the Liverpool audit, 1 in 3 (150) said they wanted to stop smoking. Just under half of all smokers said they had been offered smoking cessation advice or support [172]. Of those offered, only 1 in 4 [43] had taken up this support.
- Of the 218 clients in Liverpool who regularly take medication, 7% (16) reported issues with getting their prescriptions dispensed.
- Of all 455 clients in Liverpool, 14% (67) did not know where to go for advice around sexual health and contraception.

(Liverpool Audit, Homeless Link 2013)

Homeless Link Liverpool Audit (2013): Key issues and recommendations:

- *More alcohol support and advice*: of those who regularly drink, 44% say that they need more or any help with reducing their alcohol use. The use of alcohol also leads to clients using acute services and so if people were able to access help to reduce it would be a cost-saving for health services.

- *Improved access to dental care:* 1 in 5 have recent health needs due to dental and teeth problems (1 in 3 over a longer time period) – yet only 40% reported being registered with a dentist.

- *Investigate causes of breathing problems*: this is one the main reasons why people used ambulances, A & E and were admitted to hospital. The number of clients tested for TB was relatively low – further investigation is required into possible causes of breathing problems, whether TB or smoking.

- *Consider how to extend mental health support:* more than two-thirds reported low-level unmet mental health needs which accommodation providers could be supported to help with.
  (see Homelessness, Mental Health and Wellbeing Guide: http://homeless.org.uk/mental-health-guide and Looking After Number 1 http://homeless.org.uk/looking-after-number-1 - these resources aim to encourage individuals to learn about how they can improve and look after their own wellbeing and mental health by developing knowledge and accessing services) (Homeless Link, 2013).

Homeless Link (2011) pointed out that where it can be shown that services are already effectively meeting needs, this needs to be highlighted, in order to promote the need for continued investment (e.g. Section 4.1, where an audit found that almost all homeless people surveyed in Liverpool were registered with a GP).

8. Focus group questions and questionnaire

A series of focus groups were conducted to explore the views of professionals and service users on issues relating to homelessness and health needs. All invited participants were sent a questionnaire sheet in which they could add further comments.

Focus Group Questions

Health needs and services

1. Is current health provision meeting the needs of the homeless population? If not, how could it be improved?

Effects of cuts/welfare reform:

2. Have services been affected by any recent cuts to funding – or any expected soon - and if so, what impact will these have?

3. Is there any evidence of increased demands on services due to the effects of cutbacks/ welfare reform?

Anything else?

If there are any key issues we have not picked up in our discussions, please list them:

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Questionnaire

Health needs and services

1. What health care is available to homeless clients? (GP, dentist, other health care?).

2. Do you feel that clients seek help for all their health needs – are there some issues people are less likely to seek help for? How could this be improved?

3. Do homeless clients have access to advice on things like diet, exercise, smoking, alcohol, sexual health?

4. Is there any routine screening for health problems amongst homeless people? (Physical, mental, drugs, alcohol?)

Anything else?
If there are any key issues we have not picked up, please list them:

Focus Group Case study request
If you have any real life stories (case studies) you can share with us can you please discuss here.

9. Case studies from Focus Group Participants

Below is a summary of a group of case studies that were provided by health professionals attending the focus groups. These case studies highlight the complexity of the needs of the people that health and social care professionals and voluntary staff work with on a daily basis. The case studies are from the perspective of the health or social care professional that worked with the homeless person.

Case Study One

The resident is a consistent recipient of emergency services due to longstanding drug and alcohol misuse; this resident had not been in accommodation for longer than a few months when entering our service.

His healthcare needs are extremely complex and he has a variety of physical and mental issues which inhibit his progression into independence.

Health needs

- Male aged late 30s
- History of drug and alcohol abuse requiring preventive services such as detoxification and rehabilitation centres
- Complex healthcare needs including Hep C, epilepsy, seizures, suspected syphilis, incontinence, personal hygiene neglect, hip infection & associated mobility issues which require frequent A&E admissions
- Socially isolated with little or no established support networks externally
- Symptoms of suspected learning disability/difficulties
- Extreme dysfunction relating to independent living skills, resulting in benefit sanctions, missing healthcare

Case Study Two

His alcoholism has engulfed him and has resulted in numerous attempts at rehabilitation through a variety of models and pathways, which have proved unsuccessful. It has also

impacted his housing situation with many services refusing to accept him due to his anti-social behaviour. His overall situation has led to severe bouts of depression which have resulted in attempts to take his own life.

Health needs

- Male aged mid 40s
- History of extreme alcohol abuse which has resulted in numerous periods in services such as detoxification and rehabilitation centres
- Mental healthcare needs including depression and anxiety which have led to suicide attempts
- Complex healthcare needs including pancreatitis, peripheral neuritis, hypertension and mobility issues due to the severity of his broken ankle
- History of anti-social behaviour
- History of A&E admissions due to binge drinking
- Socially isolated due to alcoholism

Case study Three

A young person with a troubled upbringing was homeless by age 17. Social services were already involved in her life as her mother had died from alcoholism and she was a heavy cannabis user. There was no significant support given however. She failed to attend CAMHS appointments and was discharged. She was supported by staff and eventually attended a GP appointment. The GP referred her to mental health services but there was an 18 month wait. She feels let down by mental health services.

Profile

- Young person aged 20
- Heavy cannabis user since age 12, came into service aged 17 after finding mum dead who was an alcoholic
- Diagnosed with PTSD by GP
- Offered group sessions of Cognitive Behavioural Therapy but struggled in group so was offered one to one sessions but there was an 18 month waiting time. Had support of untrained staff during this period, but her needs were complex and the staff struggled.
- Re-housed from one area to another 18 months later, and has started to become independent but feels let down by mental health services.

Case study Four

A young woman with a history of severe epilepsy presented at a homeless service. Social services were excellent in quickly providing a package of care which addressed personal care and self care.

Because of her severe epilepsy she had a reduced ability to recall and remember things and over the Christmas period her health deteriorated. The social worker had been in touch with

the GP who said a referral to a specialist had been done but the young woman had missed the appointment. This could have been down to her having no fixed address when the letter had been sent out.

Her transient lifestyle affected her access to services and ability to access medical support. It is concerning that the medication was not reducing her epileptic fits but nothing proactive was done.

Health needs

- Single female in early 20s
- Severe epilepsy, having fits daily, medicated for epilepsy. GP made an appointment for a specialist although there was marked deterioration after this GP appointment and the social worker managed to bring the specialist appointment forward.
- Whilst waiting for the new appointment the young woman had several severe fits and was hospitalised. One the day of her appointment she died.

Case Study Five

A young man with an acquired brain injury, he suffered from depression and would self-harm, he was unable to make complex decisions and was deemed a vulnerable adult. He had little understanding of consequential behaviour. Over the months of being homeless he was referred to social services regarding his social issues. He was referred to his GP and district nurses attended the hostel to administer his anti-coagulant therapy. He was supported to attend his hospital appointments; I would liaise with the GP regarding his anticoagulant therapy and antidepressant medication. My original assessment highlighted his physical and mental presentation, which included the family history, his current presentation, which was hydrocephalus. As a result the GP referred him to a neurology surgeon and neuro psychologist and eventually he received a diagnosis of arrested hydrocephalus. I would liaise with the hostel regarding behaviour management. I would attend MDT meetings regarding his future placement. My support worker would support him with any appointments to ensure he attended. He had been referred to mental health services. He received his appointments, but would refuse to attend. At times there would be dietary issues which would require the support worker from the hostel taking him shopping, GP prescribing food supplements. I would often liaise with the GP regarding problems with this man and seek advice from her.

Health needs

- Young man
- Homeless and admitted to hospital with a head injury from an assault. He had a congenital acquired brain condition resulting in a learning difficulty with cognitive impairment.
- He also had a cardiac condition, resulting in continuous formation of pulmonary emboli which required continuous anticoagulant therapy.
- He was an alcoholic and had a dysfunctional family background
- He suffered from depression and would self harm

Case study Six

A service user who lost her accommodation when her children were removed from her care by social services approximately 10 years ago. Since then she has been sofa surfing and living on the streets with her violent partner. She has been on methadone for 22 years and had alcohol problems for 17 years. Her mother and father have both recently died and after many years of domestic violence she has left her partner. After many years of intensive input from services, she has a turning point in her life. During the past 3 years, she has successfully moved into independent living and secured her own independent accommodation which she furnished to a high standard. She completed a college course and volunteers for the services that previously supported her. She gained a part time job and in the last months has become a director of a charity. She is due to have her second operation on her brain aneurysm shortly.

Health needs

- Woman in her 50s
- Diagnosed with COPD, bunions, chronic pancreatitis and Hep C, brain aneurism, injuries from domestic violence including broken shoulder and internal bleeding from being thrown down concrete stairs.
- Children were taken away from her care by social services approximately 10 years ago.
- Has been on methadone prescription for 22 years and has drank alcohol 'problematically' for 17 years.
- She has many criminal convictions including shoplifting, thefts and violence towards others.

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