

Homelessness and health: improving the health and wellbeing of those without safe and stable housing in Milton Keynes



Foreword

The Director of Public Health report is an independent report focused on improving the health of the people of Milton Keynes. 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 and 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, healthcare 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 Milton Keynes. 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 Milton Keynes 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.



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

Core homeless	Wider homeless
<ul style="list-style-type: none"> • Rough sleeping • Sleeping in cars, tents, public transport • Squatting (unlicensed, insecure) • Unsuitable non-residential accommodation (e.g. beds in sheds) • Hostel residents • Users of night/winter shelters • Domestic abuse survivors in refuges • Unsuitable temporary accommodation (e.g. bed and breakfast, hotels) • Staying with others (not close family), on short term/ insecure 	<ul style="list-style-type: none"> • Staying with friends/relatives in the long term as unable to find own accommodation • Eviction/under notice to quit (and unable to afford rent/deposit) • Asked to leave by friends/relatives • Intermediate accommodation and receiving support • In other temporary accommodation (eg social housing, private rented sector) • Discharged from prison, hospital (other state institutions) without permanent housing

Homelessness in England

- The pyramid 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.



Sources: Ministry of Housing, Communities & Local Government statistics, Bramley 2017, MKC Homelessness Prevention and Housing Access, Housing and Community

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

The 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:

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. Examples of priority need (subject to caveats) include households with a pregnant woman, people who usually live with dependent children, homeless people aged 16 or 17 years and households considered vulnerable (e.g. mental health problems, fleeing domestic violence, time spent in prison/armed forces).

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 authorities 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”.

Public authorities subject to the duty to refer include prisons, youth offender institutions, probation services, Jobcentre Plus, social service authorities, emergency departments, urgent treatment centres, hospitals providing inpatient care and the Secretary of State for Defence (covering the armed forces).

The HRA significantly reformed England’s homelessness legislation by 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 shortage of both affordable housing and temporary accommodation nationally.

The root causes of homelessness

Changes to welfare reform

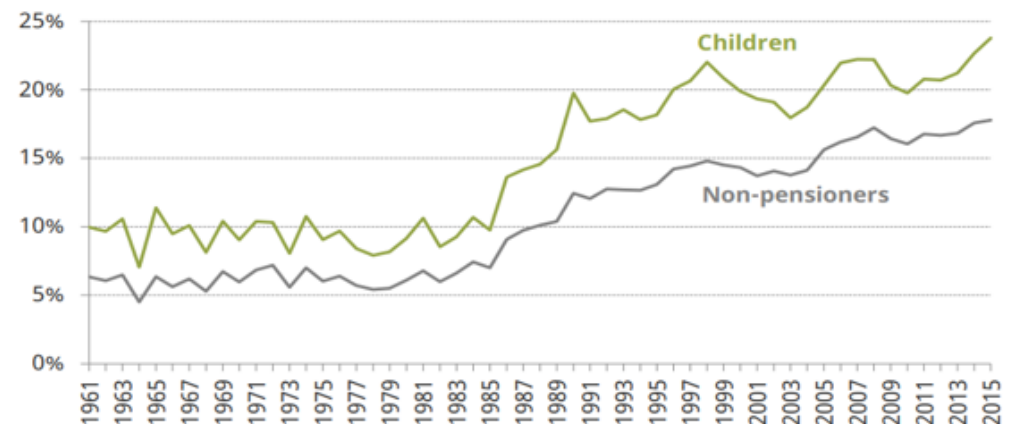
Several factors are driving the recent rise in homelessness in England, affecting both the vulnerability of individuals and families to homelessness and the wider societal conditions that give rise to homelessness. Important drivers include:

- **Socioeconomic factors** including relationship breakdown, rising relative poverty and problematic debt.
- **The supply of affordable housing**
- **Changes to the welfare system**
- **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.

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.



Note: Years refer to calendar years up to and including 1992 and to financial years from 1993–94 onwards.

Source: Authors' calculations using the Family Expenditure Survey and Family Resources Survey, various years.

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

Problematic household debt

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

Household borrowing has increased since 2009 and overtook household savings in 2016/17 for the first time since 2007/08. 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, especially the availability of affordable social rented housing, shared ownership properties and affordable home ownership.

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. Additional problems with the roll out of universal credit, as documented by the charity Crisis, include administrative errors, delays in payment and deductions made without notice, all of which can have severe consequences for those already homeless or at risk of homelessness (Downie et al., 2018).

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).
- 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.
- Temporary accommodation can also be an expensive option, Rugg (2016) describing in her study of London local authorities how costs can be 'hidden' (e.g. accounting across multiple budgets) whilst other pressures (e.g. welfare reform) continue to constrain budgets.

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, 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).



Homelessness in Milton Keynes

The 'pyramid of homelessness' illustrates the size of the issue in Milton Keynes, using estimates of numbers of households who experienced different forms of homelessness in July 2018. Hidden homeless and households at risk of homelessness are relative gaps for which there is no reliable local data available.

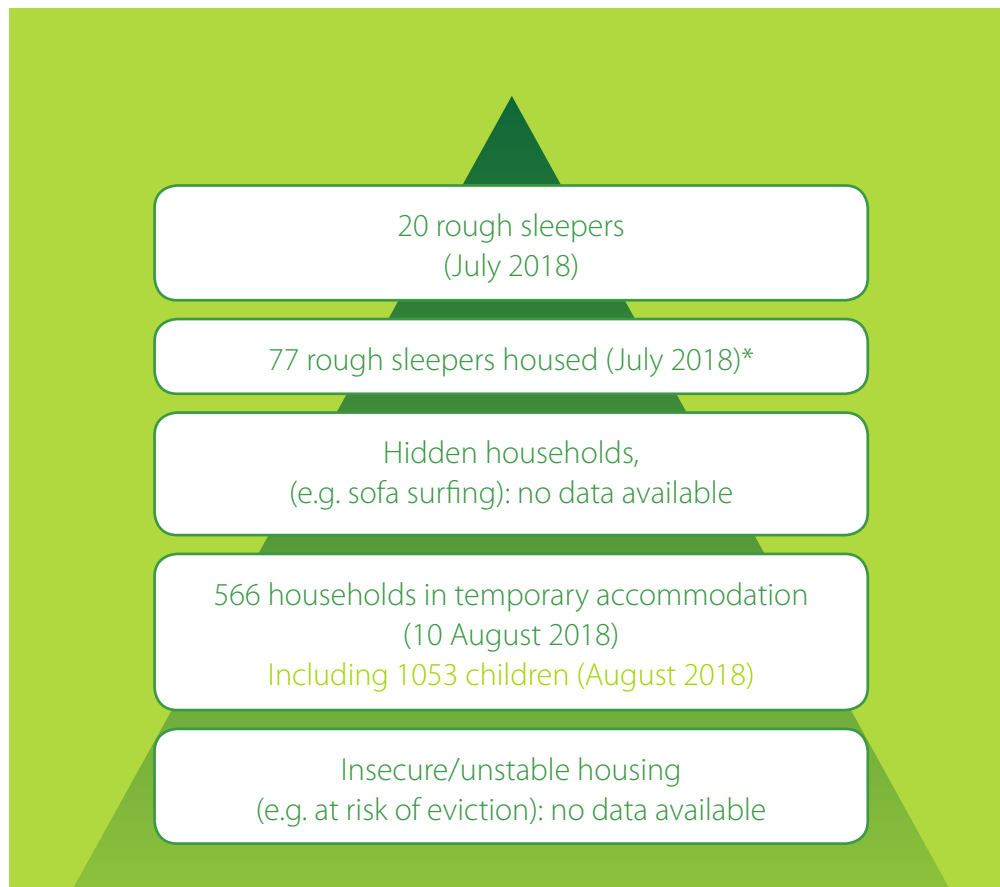


Figure: Pyramid of homelessness in Milton Keynes, July 2018

*Includes Housing First, permanent tenancies (self-contained units) and emergency accommodation (shelters, hostels, room in private rented flat, self-contained flat under private lease).

In Milton Keynes, homelessness increased at a much greater rate than in England as a whole since 2010. Since 2014, there has been a steep increase in numbers of people in temporary accommodation and rough sleepers.

- There were an estimated 48 rough sleepers in autumn 2017 (statutory rough sleeper statistics).
- Recent local trend data shows this number increased to 49 (confirmed) in December 2017 and 87 (unconfirmed) in February 2018.
- Statutory data shows households in temporary accommodation peaked at 754 households in 2016/17 (805 households according to local data).

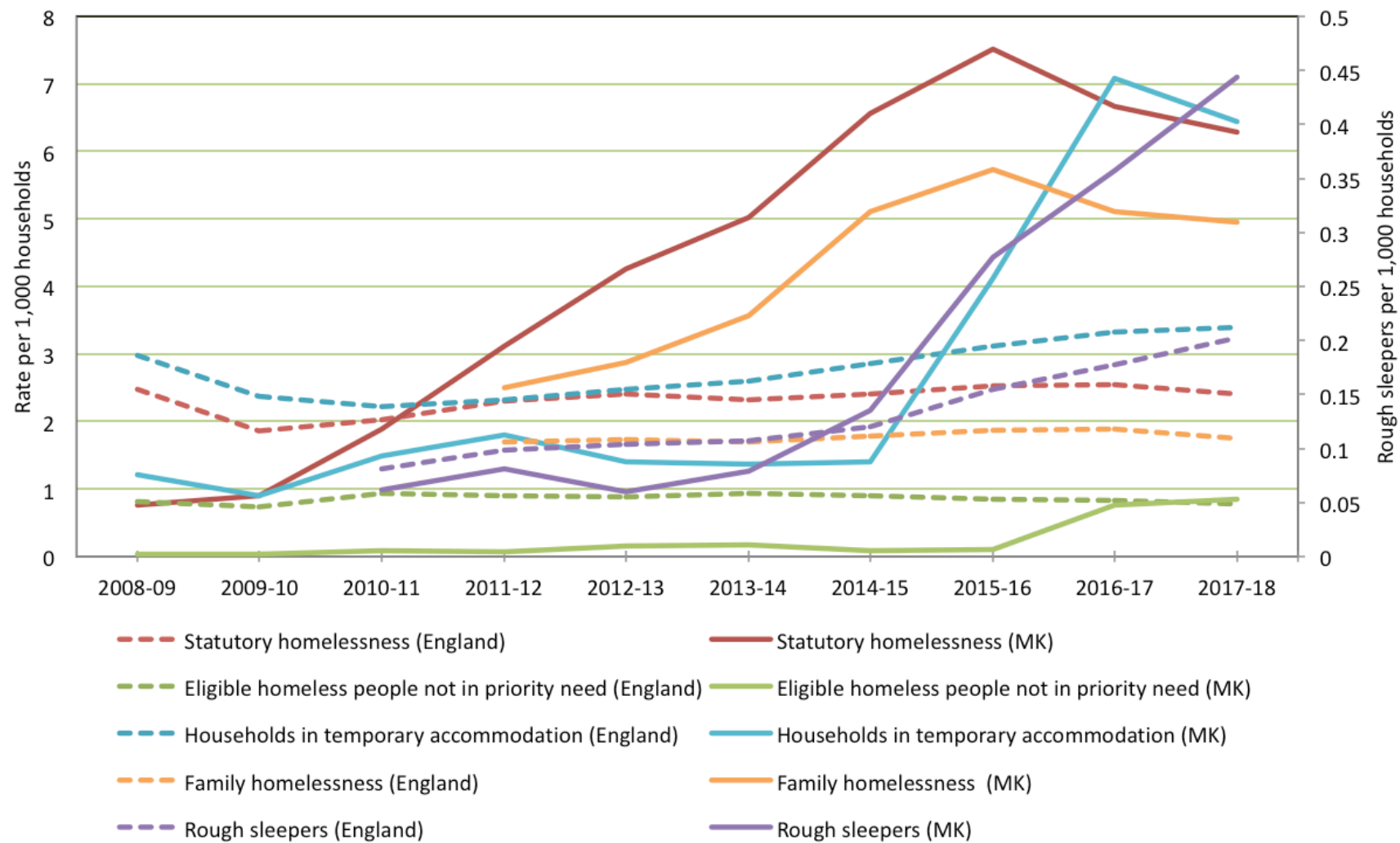


Figure: Snapshot of current national homelessness and recent trends (Source: Ministry of Housing, Communities & Local Government)

Rough sleepers

Data provided by Milton Keynes Council Homelessness Prevention and Housing Access team show that many more rough sleepers are housed this year compared to last year. Unconfirmed rough sleepers peaked at 87 in February 2018. The figure below shows recent changes in the rough sleeper population. In July 2018 there were:

- 20 confirmed rough sleepers.
- 27 unconfirmed rough sleepers.
- 77 housed rough sleepers.

Among confirmed rough sleepers in July 2018:

- 62% were engaged in active casework with homelessness prevention.
- 34% were not engaged.
- Most were permanently housed, in-area.
- 13% were housed out of area.
- For 75% it was unknown whether they were engaged with any commissioned service, e.g. drug and alcohol, mental health.

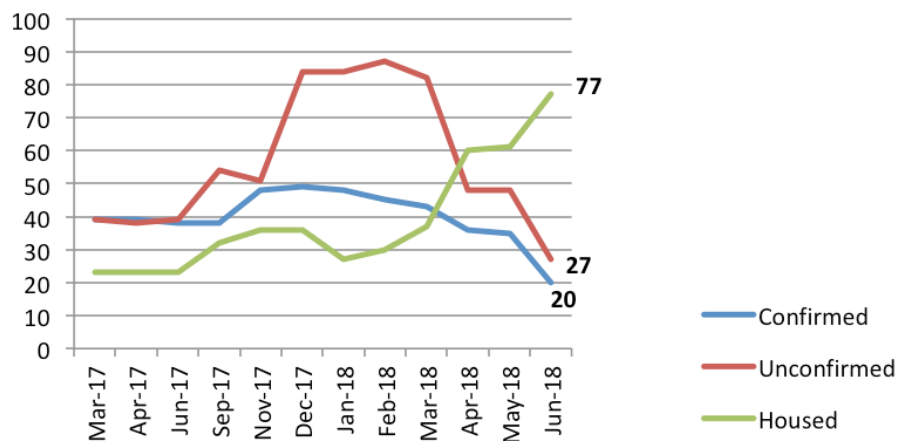


Figure: Rough sleepers in Milton Keynes, March 2017 - July 2018

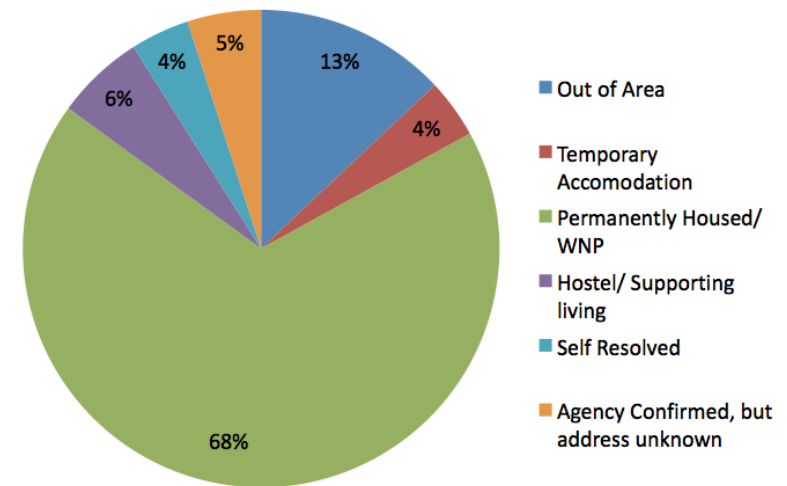


Figure: Locations of 'housed' rough sleepers, July 2018

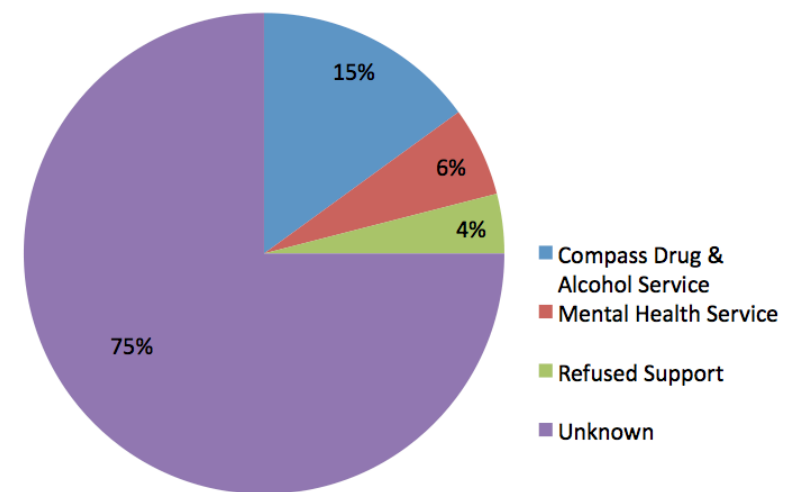


Figure: Rough sleepers current accessing health services

Temporary accommodation

In Milton Keynes, households in temporary accommodation rapidly increased between 2014/15 and 2016/17, rising to a peak of 754 households (or 805 households based on local data) from 146 households in 2014/15.

- Use of temporary accommodation has decreased since June 2017, but levels are still more than 4 times higher than in 2014/15.
- Reasons for homelessness vary but include termination of tenancy, relationship breakdown and parents/others no longer willing to house the individual.

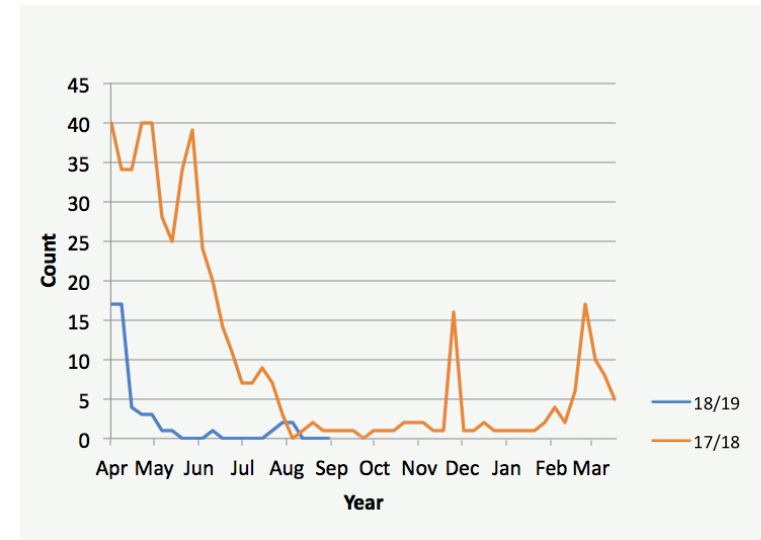


Figure. Households in Bed and Breakfast in Milton Keynes, 2017/18 & 2018/19



Figure: Households in temporary accommodation in Milton Keynes, 2017/18 & 2018/19

Underlying reasons for homelessness in Milton Keynes

The data on underlying reasons for homelessness in Milton Keynes in 2017/18 (provided by MKC homelessness prevention service) illustrate that termination of an assured shorthold tenancy (AST) accounted for 21% of homelessness applications in 2017/18. An AST entitles landlords to a possession order (eviction notice) immediately after the initial agreed period of a tenancy, usually 6 months. Preliminary local data for 2018/19 also suggests this reason for homelessness is increasing, but this is partly due to improvements in data collection in this important area.

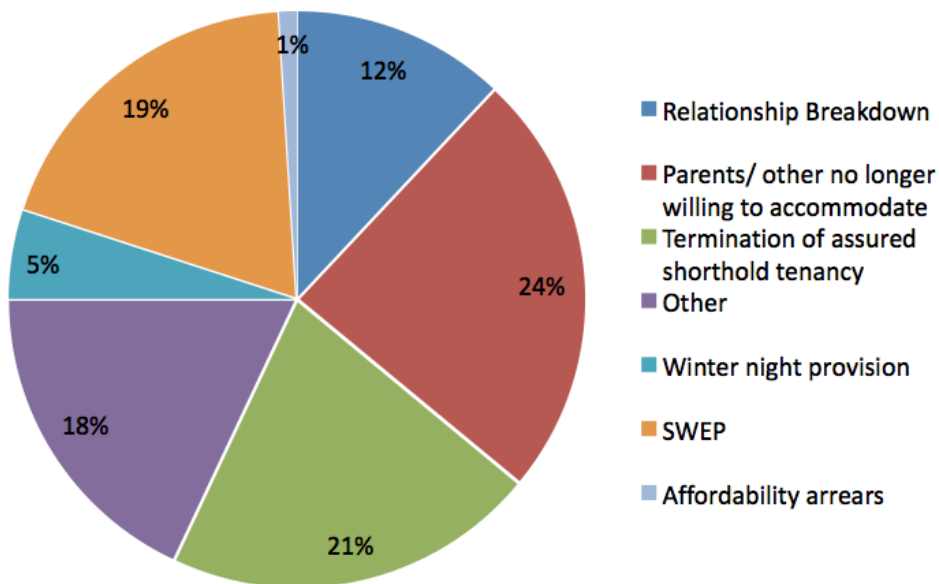


Figure: Reasons cited for homelessness in Milton Keynes, 2017/18.

In England, renting in the private sector is associated with a number of common problems (Source: Shelter online):

- Deposits are commonly unprotected or unreturned, despite the requirement for an approved tenancy deposit protection scheme.
- Leaks and other quality and safety issues, including pest/rodent infestation.
- Delays in the payment of housing benefit and often make private rent unaffordable for poor families, resulting in rent arrears and eviction.
- Due to rising costs in the private rental sector, housing benefit payment increasingly fail to cover the cost of monthly rent and basic housing costs such as utility bills.
- Relationship breakdown often results in a single person being left to cover rent, quickly leading to arrears and eviction.
- Eviction is common – assured shorthold tenants can be evicted with just 2 months' notice and a court order.

In the context of insufficient supply of alternative affordable housing options (including social housing) nationally, individuals, families and councils are often required to rely on the private rented sector for short term accommodation, including for the provision of temporary accommodation.

Current work to reduce homelessness in Milton Keynes

There has been considerable work in Milton Keynes to reduce homelessness and especially rough sleeping over the last few years. The Rough Sleeping Reduction Strategy 2018-2021 has highlighted the need to work in partnership both to prevent people from sleeping rough in the first place and to provide a joined up response when people do end up on the street, with investment in a Housing First model in Milton Keynes.



Recent successes in homelessness prevention in Milton Keynes

Despite increased pressures on housing services resulting from the introduction of the Homelessness Reduction Act, Milton Keynes Council homelessness prevention services have secured several important objectives in the past 2 years, including:

- A reduction in the use of temporary accommodation from 805 households at its highest in 2016/17 to 604 in June 2018.
- A reduction in the overspend on temporary accommodation from a forecasted £2.70m to £787k.
- An increase in successful homelessness preventions from 401 in 2016/17 to 629 in 2017/18.

Year-end snapshot illustrating improvements in homelessness prevention in Milton Keynes in 2017/18.

Snapshot on 31/03/17	Snapshot on 31/03/18
<ul style="list-style-type: none"> • 732 households in temporary accommodation. • 64 households in hotels. • 78% of all those in temporary accommodation were outside Milton Keynes. • 2 episodes of SWEP (Severe Weather Emergency Provision). • 26 households had an offer of accommodation. 	<ul style="list-style-type: none"> • 635 households in temporary accommodation. • 5 households in hotels. • 96% of all those in temporary accommodation were in Milton Keynes. • 7 episodes of SWEP (Severe Weather Emergency Provision).

The complex relationship between homelessness and health

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

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

Why focus on children, young people and their families?

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

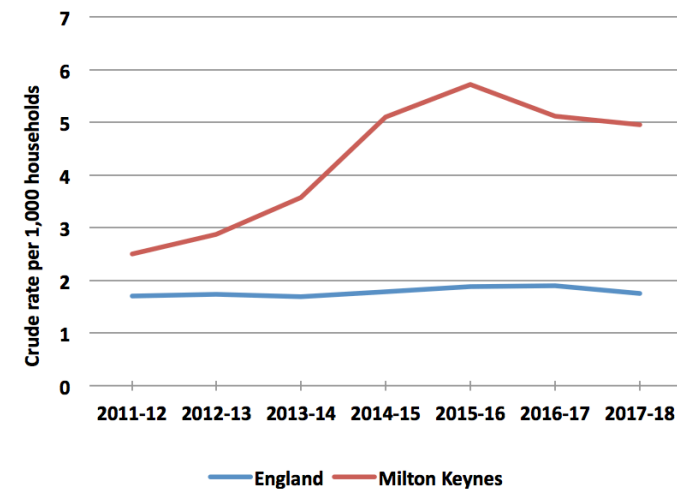


Figure: Family homelessness in England, 2011/12 - 2017/18
(Source: Ministry of Housing, Communities & Local Government)

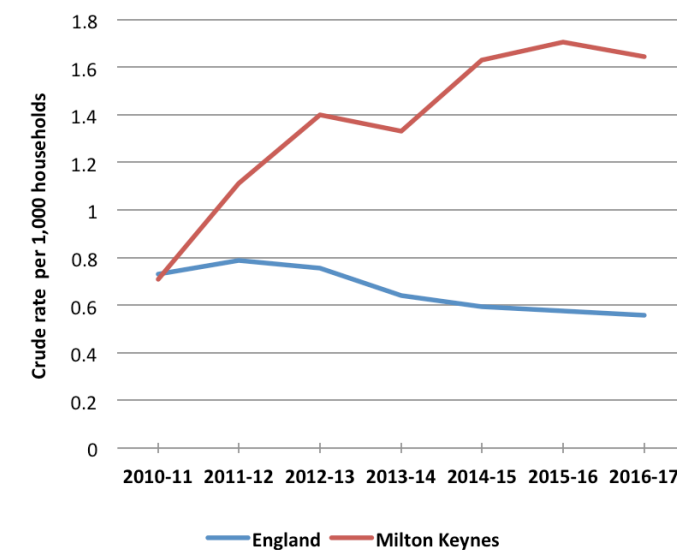


Figure: Homeless households headed by a young person aged 16-24 years, 2010-2017 (Source: Ministry of Housing, Communities & Local Government)

The impact on health

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 (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 Slead 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).
- 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” (Public Health England, 2018).

Family homelessness

In Milton Keynes, family homelessness more than doubled between 2011/12 and 2015/16, since when there has been a reduction. In 2016/17 there were 544 homeless families with dependent children. The rate of homeless families peaked in 2015/16 and remained above the England average at around 5 per 1,000 households in 2017/18.

Households headed by young people

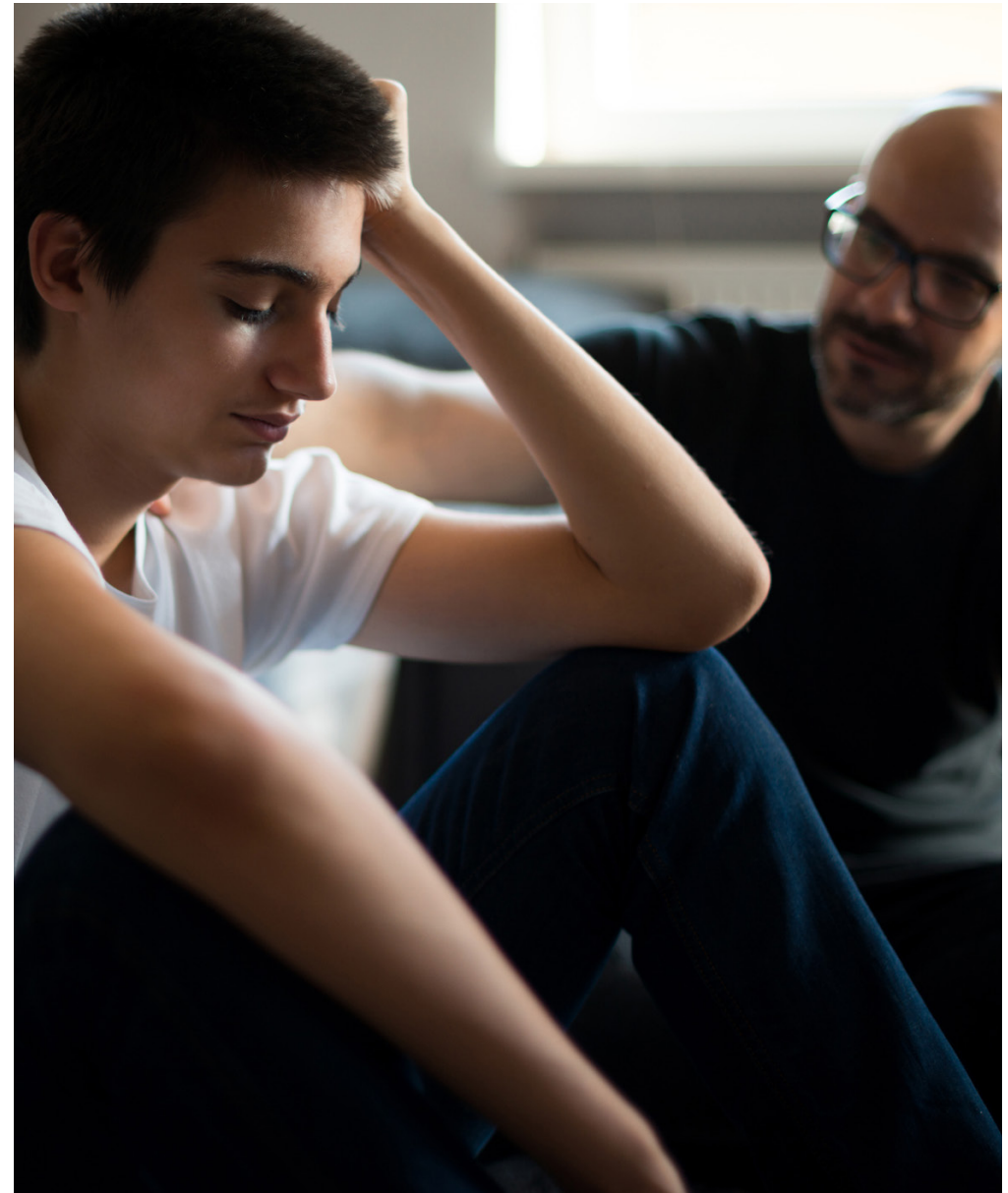
In Milton Keynes there were 175 households headed by a young person in 2016/17. This count has increased by 154% from a count of 69 households in 2010/11.

The Milton Keynes rate for homeless households headed by a young person is 1.63 per 1,000 households. This is higher than the national rate of 0.56 per 1,000 households. The Milton Keynes rate overtook the England rate in 2010/11 and the gap has widened over this period.

Local services

Current services available to support homeless families and children and young people in Milton Keynes include:

- Emergency support and information on solutions to prevent homelessness, provided by the Milton Keynes Council Housing Options and Homeless Service for homeless families. Access to housing is prioritised if someone in your household is under 18 (or under 19 if in full-time education).
- Housing advice for 16-17-year olds is provided by the Milton Keynes Young People's Team which consists of a Social Worker and a Housing Options Officer.

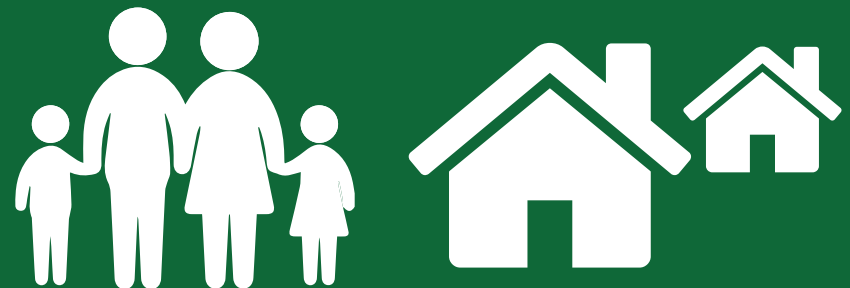


Case study

Vulnerability to homelessness can be increased by a wide range of social issues. Mrs X 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 X 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 X was attending residential services and they agreed to support her with child care. Social services confirmed that they would support Mrs X 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 X 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 X stated that she would like her after care 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 X to sustain her recovery and remain the primary carer of her children.

Mrs X's story highlights the importance of close partnership working between homelessness prevention services and other local authority commissioned services, including health services.



Homelessness and health: Focus on hidden homelessness

Why focus on the hidden homeless?

As illustrated by the 'pyramid of homelessness', rough sleepers and applicants to housing services often represent the tip of the iceberg of the wider homeless population.

Defining hidden homelessness

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

- "Those who meet the legal definition of homeless but to whom the local authority owes no duty to house (because they have not asked for help or do not meet the criteria in 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:

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

Category	England (Source: Bramley, 2017)		England (Source: Fitzpatrick et al., 2018)
	2011	2016	2017
Sleeping in tents, cars and on public transport	5000	8000	-
Living in insecure accommodation: squatting and non-residential accommodation (e.g. 'beds in sheds')	6800	11500	-
Sofa surfers	35000	60000	-
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

The size of the issue

Quantifying the 'hidden homeless' population is inherently difficult, but estimates are available from the Crisis Homelessness Monitor (see table).

An important study on hidden homelessness was conducted by Crisis between 2010 and 2011; 437 homeless people across 11 towns and cities in England were interviewed, including 27 in-depth interviews with single homeless people who had been 'hidden'. Key findings of the study were (Crisis, 2011):

- The majority of single homeless people are in fact hidden: 62% of those surveyed were 'hidden' homeless at the time of interview.
 - Nearly all (92%) survey respondents 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.
- A UK survey of 16-25 year olds (n=2011) 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.

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 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 males, 11 females, 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, misuse 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 Crisis study 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 (Crisis, 2011). Single homeless people can resort to desperate measures to put a roof over their head. For example, the study uncovered evidence of people 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 partnerships to secure a bed for the night.

Hidden homelessness in Milton Keynes

No local data is available to evidence the extent of hidden homelessness in Milton Keynes, as most will not be in contact with local services. There has been a recent increase in the few that are known to the local authority ('homeless people not in priority need').

Homelessness and health: Focus on complex needs

Why focus on complex needs?

Homelessness commonly overlaps with a wide range of health and socioeconomic vulnerabilities, particularly (JRF, 2011):

- Mental ill health
- Substance misuse
- Offending behaviour

Individuals with complex needs often lead chaotic lives and experience multiple interrelated and overlapping problems that collectively result in increased vulnerability to homelessness and poor health and wellbeing (Revolving Doors, 2015).

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

- **SMD1** – refers to disadvantage in one domain only. This can be “homelessness only”, “offending behaviour only” or “substance misuse only”.
- **SMD2** – refers to disadvantage in two disadvantage domains. These can be “homelessness & offending”, “substance misuse & offending” 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; 66% of respondents had experienced difficulties in accessing mental health services, 36% reported difficulties accessing drug services and 33% reported difficulties accessing alcohol services (Homeless Link, 2017).

Factors associated with Severe and Multiple Disadvantage

A number of factors are associated with greater complexity of health needs among the homeless population (Bramley et al, 2015 and PHE, 2018):

- **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 Milton Keynes

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

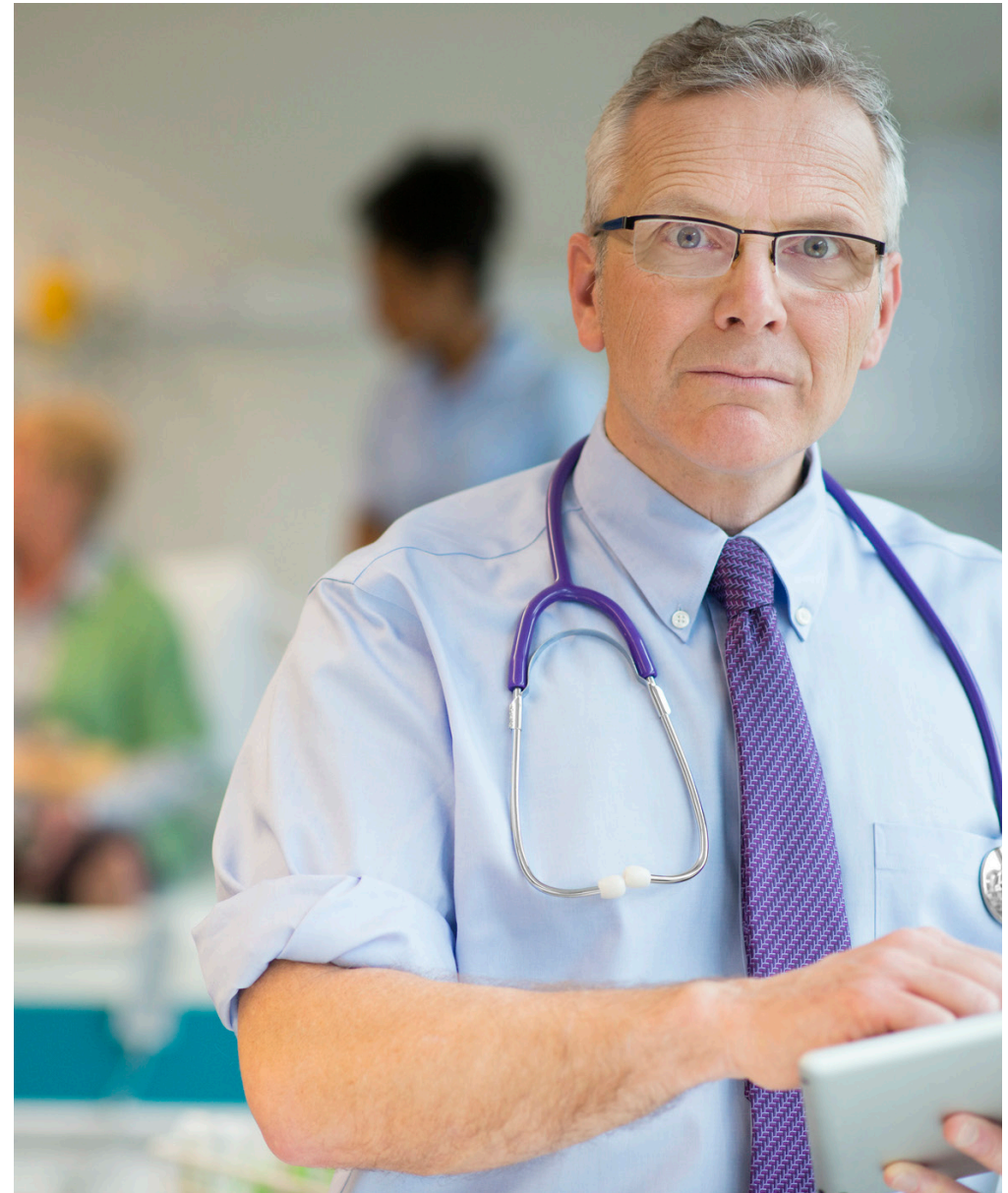
Severe and Multiple Disadvantage Domain	Count	Estimated percentage with mental health problems
Homelessness only	110	36%
Offender only	510	33%
Substance misuse only	520	58%
Offender + Substance misuse	450	53%
Homelessness + Substance misuse	90	67%
Homelessness + Offender	120	42%
All three disadvantage domains	290	38%
Total using housing, substance misuse and/or offender services	2090	46%

Figure: Snapshot of severe multiple disadvantage among all services users in Milton Keynes, 2010/11 (Source: Ministry of Housing, Communities & Local Government) and estimated percentage with overlapping mental health problems

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 substance misuse

Why focus on substance misuse?

Problems with misuse of drugs or alcohol are often significant factors underlying homelessness and its negative health impacts. Substance misuse is often a key factor underlying insecure housing and homelessness and is 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

Among opiate users who engage with treatment services, National Drug Treatment Monitoring System (NDTMS) 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 becoming homeless in the first place (Crisis, 2018).

Impact of homelessness on engagement with drug and alcohol services (PHE, 2017)

- Homelessness reduces motivation for behaviour change and weakens engagement with substance misuse treatment services.
- 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.

The impact on health

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

- Rough sleeping is strongly associated with injecting drug use.
- Drug and alcohol misuse are particularly common causes of death amongst the homeless population, accounting for over a third of all deaths (Thomas, 2012).
- Excess mortality is higher among people who misuse substances, particularly for those who also experience 'persistent homelessness' (HM Government, 2017).
- Higher prevalence of blood borne viruses among homeless people who misuse substances, including Hepatitis C and HIV (Beijer, Wolf and Fazel, 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).
- 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).

Housing issues among substance misuse service users

	Milton Keynes		England	
	2016/17	2017/18	2016/17	2017/18
Start of Treatment	9.9%	12.8%	13.7%	13.6%
Treatment Outcome Profile Adult Review (6 Month)	10.8%	7.4%	10.2%	10.1%
Exit Treatment Outcome profile (Last 28 days)	5.2%	2.3%	8.3%	7.9%
Planned Exit	1.5%	1.6%	2.9%	2.5%

Figure: National Drug Treatment Monitoring System (NDTMS) data for Milton Keynes: service users who report housing problem.

In Milton Keynes, the drug and alcohol provider records housing circumstances of all new clients during initial assessment.

- The table above presents data on the proportion of clients engaged with drug and alcohol services who report housing problems and are different stages of treatment, compared with national comparisons.
- 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.

Case study

Alcohol misuse is a key risk factor for experiencing homelessness and a common health problem among the homeless population. M is a 35-year-old alcohol dependent man who lived with his father (sleeping on his sofa) who is also alcohol dependant. M works full time through an agency doing shift work. He was drunk while 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 father's 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 at a local charity in Milton Keynes, but his shift hours meant he would be unable to abide by curfew times. In the absence of alternatives, M resorted to rough sleeping under an underpass in Milton Keynes, 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 its 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. With 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

Why focus on mental health?

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 (LGA, 2017):

- Financial insecurity
- Housing insecurity
- Overcrowding (particularly for children and young people)
- Poor quality housing, e.g. damp conditions

Homelessness and mental ill health often interact. For example, 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 and stable housing (MIND, 2017).

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

- **Exploitation and abuse.**
- **Insecure and unsafe housing.**
- **Financial insecurity.**
- **Insufficient coping mechanisms – 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).**
- **Poor quality housing, including experience of living in emergency or temporary accommodation.**
- **Overcrowding and cramped living conditions.**

The size of the issue

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

- 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).
- Over the life course, 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).
- In a survey of 900 homeless people, Homeless Link found that 49% had experienced depression and over 40% had experienced anxiety (NHS Confederation, 2012).

The issue of dual diagnosis

- A considerable proportion of homeless people are classified as having 'dual diagnosis', meaning they experience mental ill health alongside a substance misuse problem (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 complex needs – they often present to services with social problems such as debt and unemployment, as well as mental ill health and substance misuse.
- 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 disengage from 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 ethnic minority (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 females (although the issue also affects men) (Vostanis, 2001).
- 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).
- Child sexual abuse is known to be an independent risk factor for the onset of mental health conditions in adulthood.

Access to mental health services

Homeless people with mental health problems experience particular barriers to effective engagement with services and significant inequalities exist in terms of access to mental health services for vulnerable groups.

- 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.
- Although many homeless service providers now provide access to mental health services, 64% of 500 such providers reported that their clients had problems accessing specialist services (NHS Confederation, 2012).
- Access to services is also characterised by important inequalities among vulnerable sub-populations. For example, homeless refugees struggle to access mental health services 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).
- 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.
- Among local authority housing services, effective assessment of the vulnerability of homeless applicants may be impaired by the presence of a mental health problem.

Case Study

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 he 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 determine 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

Why focus on ex-offenders?

Offending and homelessness are closely interrelated; 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 (Williams et al., 2012):

- 15% of prisoners were homeless before entering custody, with 9% sleeping rough.
- Before entering prison, 28% of prisoners had lived in their accommodation for less than 6 months; 44% for less than a year.
- 37% of prisoners surveyed expressed a need for help finding a place to live after release from prison.

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, consistent treatment and support. Particular health issues affecting the prison population include (Revolving Doors Agency, 2017):

- Higher prevalence and severity of mental ill health, with a risk of suicide approaching that of discharged psychiatric patients. One national survey (Singleton et al., 1998) of prisoners reported that:
 - 60% (male) and 50% (female) had a personality disorder (e.g. anti-social personality disorder).
 - 40% (male) and 63% (female) had a neurotic disorder (e.g. depression, anxiety).
 - 7% (male) and 14% (female) had a psychotic disorder (e.g. schizophrenia).
- Higher prevalence of substance misuse behaviours and tobacco consumption (Fazel et al., 2006):
 - 60% of female prisoners and 48% of male prisoners may experience drug abuse or dependence.
 - 80-85% of all prisoners are smokers.
- Higher prevalence of infectious diseases, including tuberculosis, HIV and hepatitis C and poorer vaccine coverage and uptake.
- Higher prevalence of long-term conditions and poor physical health
- High mortality 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.

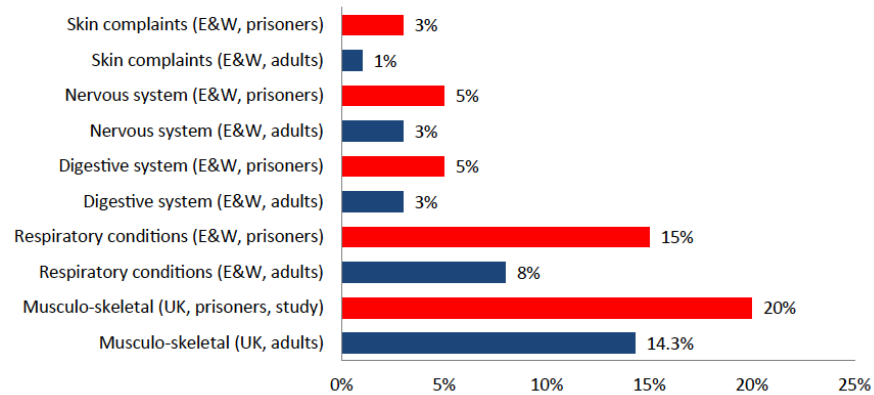


Figure: A comparison of the proportion of the physical health issues of prisoners with the general adult population in England and Wales/United Kingdom (Revolving Doors, 2017).

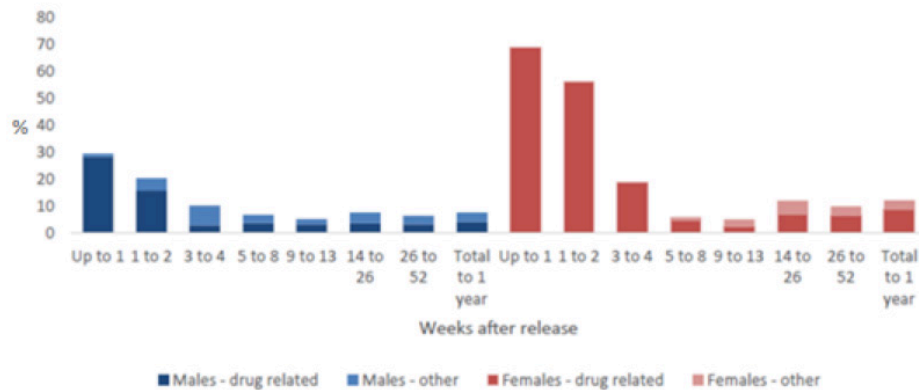


Figure: Excess mortality rates for released prisoners – drug related deaths and other causes (Revolving Doors, 2017)

Local information: HMP Woodhill

- HMP Woodhill is a ‘core local’ prison with mostly a mixture of men on remand and short-sentences and the mental health, substance misuse and other issues typical of local prisons. It also has a high security function for a small number of category A prisoners.
- At the most recent prison inspection in February 2018 (HMIP, 2018), a prisoner survey identified that:
 - 20% had “housing worries” on arrival
 - 21% has an alcohol problem
 - 31% had a drug problem
 - 14% developed a substance misuse problem while in prison.
- For the 46 individuals preparing for release in the next 3 months, although some felt they were receiving help, there was considerable proportion that felt they needed further help and support around finding accommodation, support for drug and alcohol problems and mental health support.

	Yes, I’m getting help with this	No, but I need help with this	No, and I don’t need help
Finding accommodation	4	26	15
Getting employment	5	21	19
Setting up education or training	3	21	21
Arranging benefits	8	17	19
Sorting out finances	6	17	19
Support for drug or alcohol problems	10	11	23
Health/mental health support	9	17	19
Social care support	3	11	26
Getting back in touch with family or friends	3	14	27

Table: Survey (by number) of 46 HMP Woodhill prisoners in response to question - are you getting help to sort out the following things when you are released? (Source: HMIP, 2018)

- The Inspection identified good links with community mental health teams, and community drug and alcohol services. Prisoners had access to specialist housing advisers and there was a wide range of help for housing problems. However, finding accommodation was identified as challenging due to a lack of available housing in the community and the monitoring of accommodation status on release was not sufficient to assess the effectiveness of provision.

Homelessness and health: Focus on veterans

Why focus on veterans?

Veterans are recognised as a vulnerable group who may be at greater risk of experiencing homelessness and its negative health impacts, relative to the general population.

Who 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.

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 2015-16 there were an estimated 452 homeless veterans in England, of whom 142 were UK nationals (Murphy, 2016).

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.

Evidence gap: identifying the health needs of homeless veterans

- **Local and national evidence on health needs of homeless veterans is limited and of poor quality.**
- **It is characterised by out-of-date data, small sample sizes and limited geography (predominantly London-based) and demography (predominantly single white men).**
- **Very little research has focused on homeless veterans with dependants (RBL, 2010).**

The health needs of homeless veterans are often similar to those of the wider homeless population, but some health issues and socio-demographic characteristics are particularly common among veterans. For example, veterans are 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).
- Suffer from post-traumatic stress disorder (PTSD). Approximately 4% of current service personnel and veterans suffer from PTSD (Forces in Mind Trust, 2014).
- Report alcohol misuse (Randall et al, 1994; Johnson et al., 2008) - but less likely to report drug misuse (Gunner et al., 1997).
- Report physical health problems compared to the wider homeless population (Dandeker, 2005).
- Have slept rough before seeking help, and to have done so for longer (Randall et al., 1994).
- Be older than the wider homeless population, and more likely to be male and white (Johnson et al., 2008).
- Have served in the Army (rather than Navy or Air Force), and therefore more likely to come from disadvantaged backgrounds (Johnson et al., 2008).

Support for veterans in Milton Keynes

- Milton Keynes 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 council has agreed to encourage all stakeholders to offer support to the local Armed Forces community, making it easier for them to access help and support from the Ministry of Defence, statutory providers and the voluntary sector.



“What works?”: Evidence base for the 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 they will become homeless within 56 days) to a housing authority.

This duty to refer comes into effect from 1 October 2018 and public authorities includes prisons, other parts of the criminal justice system (e.g. secure colleges, youth offending teams, probation service), Jobcentre Plus, social service authorities and hospitals (e.g. emergency and in-patient services). Crisis also recommend extending the duty to refer to cover immigration detention centres and providers of asylum support accommodation (Downie et al., 2018).

Although wider health services are not currently on the list of those public authorities with a duty to refer, a similar approach may be useful.

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 customer 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 consented 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.

Primary care registration and wider roles (e.g. debt advice)

Everyone living in the UK is entitled to free primary care, accident and emergency and some other services (e.g. contraception, specified infectious diseases), but the homeless 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 also 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 were registered with a GP (JHSU 2013), but for homeless people access to health services is a well-established problem. In 2014 one survey of homeless people (n=2505) across England (Elwell-Sutton et al., 2016) found that GP registration varied by type:

- 89% of hidden homeless
- 83% of single homeless in accommodation
- 66% of rough sleepers

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. Across 2017 of 1717 attempts by caseworkers to register their patients with GPs in England, 80% were successful but 20% were refused, similar results to 2016, and the most common reasons for refusal included:

- 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 (Patel & Corbett 2018).

Improving registration

Homeless individuals are **entitled to register in the area where they are without proof of address, 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 GP 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 in primary care

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 to promote public mental health, particularly for the homeless and other vulnerable groups (PHE 2017). Following an evidence review, PHE reported that face-to-face advice was critical (complemented by web and telephone-based support), and that after 5 years the intervention has the potential to deliver a return of investment of at least £2.60 for every £1 invested.

Transitions and pathways

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

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

The Social Care Institute for Excellence (Sheikh & Teeman 2018) 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. 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 (Sheikh & Teeman 2018).

Practically this can include the location of expert housing staff within institutional settings and the use of established protocols, so that services see homelessness prevention as a core part of their work.

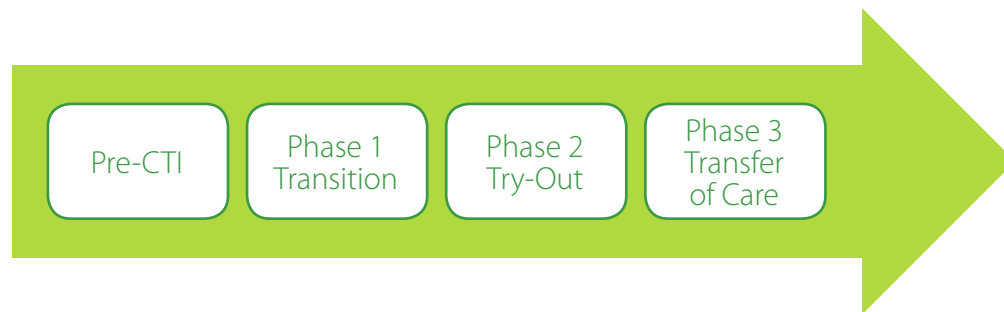
In UK hospitals these principles are part of NICE guidance on transition for adults between hospital and community settings (NICE 2015) and have been incorporated into the charity Pathway's model of integrated healthcare for homeless people that includes access to an expert hospital team that can provide:

- 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 loved ones.

(Pathway.org.uk)

The Critical Time Initiative (CTI) 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)



Pre-CTI – Case manager builds trusting relationship with client whilst still in institution.

Phase 1 Transition – Case manager provides intensive support (e.g. home visits, meetings, advice, negotiations) to start building connections between client, people and support agencies.

Phase 2: Try-Out - Case manager provides less intensive support to monitor and strengthen support network and client's skills and independence.

Phase 3: Transfer of Care – Planned ending of CTI services end once support network is established, including final meeting with client to mark final transfer of care (CTI, 2018).

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

Case Study

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



Homeless centres and 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. A 'One Stop Shop' for the homeless and other vulnerable groups has been developed by a partnership (Winter Night Shelter, Milton Keynes Development Partnership & Milton Keynes Council) at the Old Bus Station in central Milton Keynes. Managed by the Ridgway Community Trust (RCT), the project aims to create a local community centre for all but whose wider aims for the homeless/at risk of homeless include:

- Providing resources and services (e.g. food, clothing, mental health related) to prevent and support the homeless;
- Early preventative measures and infrastructure to support and maintain the recently rehomed;
- Clear pathways back to secure housing;
- A money advice facility to enable user to manage their money more effectively and offer debt advice; and
- A longer-term aspiration to provide assistance with rented housing.

However, current challenges to these kinds of initiatives include uncertainties about longer term funding as well as lease requirements impacting services that can be permitted.



Case study

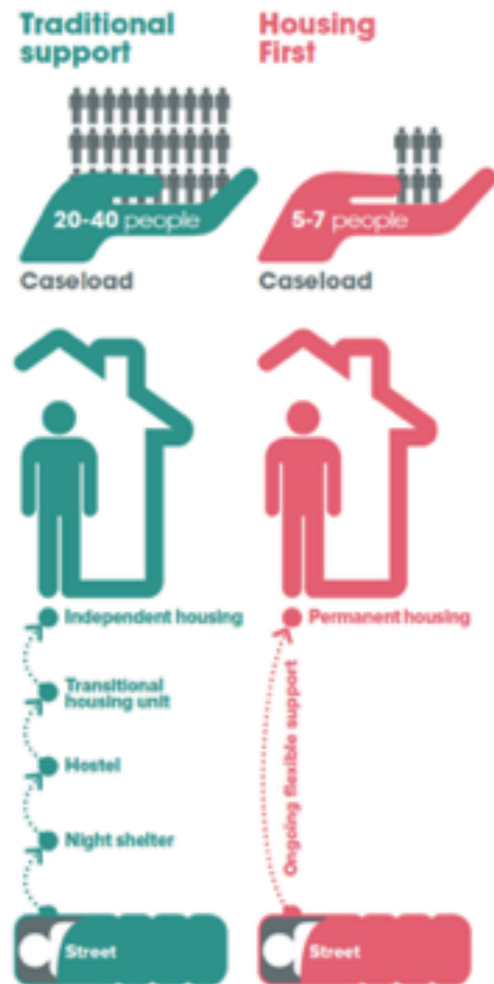
The local experiences of S illustrate why drop in centres remain so critical for the homeless. He arrived at a local day centre having just served a prison sentence for shoplifting. He has a history of heroin use but completed a detox whilst in prison and has not used for two months. However he was released without accommodation and too late to make the local drop in centre and was therefore sleeping rough. His main concerns were how to stay away from old acquaintances on the street that might tempt him back into using heroin and to find somewhere safe to sleep.

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



What is Housing First?

Housing First (HF) 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. Traditional, treatment-based approaches often require 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. Despite some successes with these approaches, critics identified those unable to meet the 'housing ready' test who continued to experience poor health and housing outcomes and questioned whether peoples' rights were being undermined.

The Housing First 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.

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

Housing First:

- **Separates 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.
- **Includes active engagement:** this might include dedicated caseworkers who regularly contact their clients and are available at short notice.
- **Focuses on harm reduction** by encouraging people to use treatment services (as appropriate) but not forcing them to do so as a condition of their tenancy.



Figure 21. A summary of Housing First key principals (Source: Housingfirsteurope.eu)

Pathways' original HF model prioritised access to housing for homeless people with psychiatric illness (Tsemberis et al., 2004), though in recent years the model has been adapted and widened to target different homeless people with complex needs (Woodhall-Melnik & Dunn, 2016).

Impact of Housing First

Three systematic reviews of the international and national HF literature report a well established and strong evidence base for interventions targeted at homeless populations that includes improved housing retention outcomes:

- for 60 - 90% of international HF study participants (Downie et al., 2018; Mackie et al., 2017; Woodhall-Melnik & Dunn, 2016)
- for 78% of England participants in 9 HF (Bretherton & Pleace, 2015)

Further, one review stresses these outcomes are particularly impressive given the complex needs of the homeless and are far stronger than for other housing-related interventions for the homeless (Mackie et al., 2017). However, evidence of improved public health outcomes for HF study participants were more mixed:

- Mackie et al.'s (2017) international review reflected that HF study participants maybe unlikely to see major health improvements due to the general severity of their health conditions at the start of interventions. But they also found some evidence that HF maybe equally and sometimes more effective in reducing levels of substance misuse than treatment based approaches. Further, many HF evaluations reported overall reductions in alcohol and/or drug consumption and involvement in criminal activity.
- 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.
- Woodhall-Melnik & Dunn's (2016) international review found mixed evidence of improvements in psychiatric outcomes, drug and alcohol use and quality of life indicators amongst study participants. Comparisons with treatment based approaches revealed little or no difference in these outcomes.

Housing First models also differ in terms of where/how service users are housed and how they are supported (e.g. degrees of case management, financial control, peer support). There appears to be no significant differences in terms of housing retention or health outcomes between services run using scattered site or communal HF configurations (Mackie et al., 2017).

They also found mixed evidence that substance misuse and criminal activity were higher in more communal HF models but the majority of homeless people themselves preferred scattered site HF, though self-reported loneliness was also more common there. 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 no panacea and should not simply replace existing homelessness services for many reasons. These include the lack of long term evaluations (>2 years) of housing retention and public health outcomes (Mackie et al., 2017) and its unknown effectiveness with some homeless populations (e.g. domestic violence, prison leavers) (Downie et al., 2018). However there is 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).

The funding of HF services is frequently precarious and vulnerable to short term commissioning cycles (Blood et al. in Downie et al., 2018). For example, in their review of nine Housing First services in England, Bretherton & Pleace (2015) reported that five were threatened with closure during or shortly after their evaluation and all utilised short-term contracts (e.g. 6 months) that failed the core principle of 'support for as long as required.'

Recommendations: How we can work together to better prevent homelessness and improve the health of homeless people in Milton Keynes

The Milton Keynes Health and Wellbeing Board Strategy 2018-2028 has prioritised areas of focus for 2018/19 to include homelessness, mental health and prevention of escalation. All Year One priorities are impacted by homelessness:

Starting Well

- SW2 Help children and young people to better mental health
- SW3 Prevent smaller problems from escalating and needing specialist social care and health services

Living Well

- LW2 Improve the lives of everyone living with mental illness through raised awareness and more effective support services
- LW4 Tackle the number of rough sleepers and the rise of households in temporary accommodation and reduce low quality housing
- LW5 Improve the detection and management of long term conditions

Ageing Well

- AW3 Develop high quality out of hospital services to reduce the need for hospital admission and get people home safely and quickly
- AW6 Promote positive mental health and reduce social isolation through strengthening social support and social network."

There is a considerable amount of ongoing activity in Milton Keynes to prevent and address homelessness, especially the issue of rough sleeping (see Appendix A). However, further work is required to prevent and address the health-related vulnerabilities that can lead to homelessness, and to address the health impacts of homelessness itself. Work is also required to better understand the local homelessness picture to address less visible forms homelessness and their impact on health and wellbeing.



Recommendations



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

- Improve awareness of the new duty to refer among public bodies in Milton Keynes and consider whether there should be wider implementation than the listed public bodies e.g. primary care and mental health.



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 current response, Milton Keynes Council should build on existing good practice by expanding its multi-professional approach to housing need identification and assessment by:

- Using wider homeless group definitions to provide further understanding of people at risk of homelessness.
- Determining how public sector bodies and commissioned services should routinely record housing status, housing vulnerability and the duty to refer during initial assessments ensuring they proactively address risk factors for homelessness.
- Determine and encourage long-term housing approaches for vulnerable people (e.g. by mental health service, prison/offender management services, drug and alcohol services).



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 the care provided also supports individuals to achieve safe and stable housing.



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

- Improve system wide knowledge around wider services available to maximise effectiveness and limit duplication
 - Improve healthcare signposting to local services, MK Council and the MK Homelessness Partnership should work with general practices to build and launch a 'resource pack' for primary care professionals.
 - Consider approaches for placing advisory services (e.g. debt advisory services) in primary care practices, linking with existing work on social prescribing
- Improve access and maximise the effectiveness of drop-in services, ensure unscheduled drop-in appointments are permitted and promoted at all homeless shelters.



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) should be a key priority. Approaches to improve registration should include:

- Development of a shared strategy to improve registration of homeless patients across all GP practices in Milton Keynes.
- Education and training for GP practices to clarify rights and responsibilities in relation to registration of homeless patients.
- Consider the 'My Right to Healthcare' card in Milton Keynes, building on work in London and elsewhere.
- Ensure effective implementation Homelessness Reduction Act and the duty to refer by public bodies including hospital emergency and inpatient services.



Incorporate health and wider outcomes into evaluations of homelessness initiatives

- Include impact on health and other system-wide outcomes within any evaluation of homelessness initiatives e.g. Housing First in Milton Keynes.

Appendix A: How Milton Keynes is working to prevent homelessness and reduce its impact on health



Examples of existing homelessness services and support in Milton Keynes

Primary care outreach service by Broughton Gate Practice

Broughton Gate, as part of their APMS contract, offer an additional outreach service for homeless patients (based at the YMCA). This is run on a monthly basis for 3 hours and uses a GP, PN and deputy PM. There is written feedback evidence from service users to support its continuation.

Rough sleeper outreach service

Funded by a grant from the Department of Communities and Local Government, a Rough Sleeper Outreach Service has been operational across Bedfordshire and Milton Keynes since June 2017. The service is hosted by the Rough Sleeper Partnership (RSP) across four Local Authority areas (Bedford Borough Council, Central Bedfordshire Council, Milton Keynes Council and Luton Borough Council). The project has two main aims:

1. To reduce the current levels of rough sleeping across the area
2. To prevent those at risk of becoming homeless from actually becoming homeless

The Street Outreach Team aims to identify those at high risk of becoming rough sleepers and work proactively to prevent them from moving on to the streets. The team includes three dedicated Mental Health Crisis Workers employed by East London Foundation Trust and Central North West London Foundation Trust. There is open referral into the service including self-referral.

Between June 2017 and January 2018, the outreach service made contact with 41 individuals in Milton Keynes, 26 male and 15 female. The majority had local connections to Milton Keynes, and 31 were supported to find temporary accommodation.

Current outreach service assessment hubs are:

- **Wednesday: 11-2pm** at Queensway Methodist Church Hall: Queensway, Bletchley, Milton Keynes MK2 2HB

Open Door MK

Open Door MK works with and for homeless people and those who are vulnerably housed and sleeping rough to support them into accommodation and to reintegrate them into society. They do this through providing where people can eat a hot meal and access advice and support services such as housing, health, mental health and drug and alcohol support. Locations include Queensway Methodist Church Hall, Queensway, Bletchley, MK2 2HB (Wednesdays 10am – 1.30pm – excluding public holidays).

Partners supporting Open Door drop-ins include:

- Broughton Gate Health Centre - providing health services including screening (first Monday of every month).
- Compass – drug and alcohol services (twice per month).
- STaSS – HIV testing (every other month).

Winter Night Shelter MK

The Winter Night Shelter is open from 1 November and provides access to supervised overnight accommodation using 30 beds at two different venues.

Services provided by the Winter Night Shelter include:

- Temporary emergency accommodation.
- Pastoral care.
- Links to other support services.
- Support to find other temporary and permanent accommodation.
- Support to move into employment.

The Winter Night Shelter employs a Welfare support officer, whose role includes:

- Signposting clients to drug and alcohol services.
- Providing help to find accommodation and employment.
- Providing help to replace lost documents and negotiate benefits on behalf of homeless people.

Temporary accommodation options secured by the Winter Night Shelter include:

- YMCA hostel
- YMCA flats
- Private rented accommodation
- Other long term housing solutions, e.g. Emmaus village.

One Stop Shop

As part of the MK Homelessness Partnership strategy, the Winter Night Shelter has worked in partnership with MK Development Partnership and MK Council to regenerate the Old Bus Station with the aim of utilising the building to provide a 'one stop shop' for vulnerable homeless people in MK.

The One Stop Shop aims to provide key support services for the homeless in a single location, including:

- Connecting local charities and support services under one roof.
- Community Centre
- Pathways to long term housing
- Life skills for young people
- Work preparation training, e.g. CV writing and interview preparation
- Money advice

Under the current lease terms, 'drop-in' is not permitted, thus clients can attend by appointment only. Partner organisations that provide services and support operation of the One Stop Shop include:

- MK Money Lifeline
- MK Food Bank
- Open Door MK
- MK Storehouse
- Citizens Advice Bureau
- British Red Cross
- PTSD/stress counselling service for vulnerable migrants
- Sanctuary Hosting
- Bus Shelter MK

YMCA MK

YMCA MK provide accommodation and support to approximately 350 homeless and formerly homeless young adults each year through emergency temporary accommodation, including a hostel and 123 flats. Further, YMCA MK was recently approved as a registered provider of social housing and its future plans include new accommodation for 196 young local people in difficult circumstances. YMCA aim to engage young adults who are homeless and unemployed and to work with them until they have a healthy sense of wellbeing, are in suitable accommodation and employment and have developed the skills to sustain them.

Bus Shelter MK

The Bus Shelter MK is a local charity that has purchased a bus to provide overnight emergency temporary accommodation for 16 people per night. The bus will be based at Campbell Park in Milton Keynes.

- Services provided include:
- Overnight accommodation (admits pet dogs).
- Mailing address.

Kitchen, bathroom and laundry facilities.

Look Ahead MK

In MK, Look Ahead support young people and care leavers who may need particular support. Services offered include:

- Looked-after children's services.
- Supported housing services – hostels, step-down and floating support.
- Parent and child services.

Salvation Army MK

The Salvation Army provide a wide range of services across the UK and the Republic of Ireland that work with people who have to sleep rough. Their role in all cases is to meet an immediate need either through providing support and basic supplies where possible, or by referring into emergency accommodation where available.

Housing First in Milton Keynes

Connection Support has been offered a 12 month trial to provide support to rough sleepers in a Housing First approach. Connection Support will:

- Provide one-to-one support to people, often entrenched in rough sleeping. They will help people to take up the opportunity of their own accommodation and make the changes in their lifestyle that improves the quality of their lives.
- Provide support to develop independent living skills that prevent people returning to rough sleeping.
- Work with Adult Social Care and other agencies, we will meet the needs of people with complex conditions and behaviours such as mental health, physical illness, learning disability, and substance misuse or relationship issues.

Assessments for Housing First will be made via the Homelessness Prevention Team and can be signposted by other agencies/services - this is likely to most commonly be outreach workers, Open Door and other homeless charities.

Referrals have begun to be made to Connection Support to the new scheme (approximately 5 a week). The team will be at capacity at 45 referrals (30 high level and 15 medium level needs). 54 people remain in our winter night provision accommodation that would otherwise be rough sleeping and that are being supporting into settled accommodation (a number of these will be via Housing First). 20 of the 54 are in Council stock and can automatically be converted over to Housing First. Support will also be provided to those in temporary accommodation pending a permanent tenancy being offered.

There will be an evaluation once Housing First is set up, after 3 and 6 months that will:

- Consult with professionals, stakeholders and partners in respect of service provision
- Consult with service users
- Health and wellbeing of the individuals

Additional Rough Sleeper Activities

In addition to this new provision, the Council has just been successful in securing an additional funding for 2018/19 to further tackle rough sleeping and make a significant impact this winter. This will fund:

- Rough sleeper coordinator
- 3x outreach-in reach support workers
- Extended emergency accommodation
- Reconnection officer
- Personal allowance per rough sleeper

The focus of this funding is to target those that are harder to engage with, entrenched rough sleeping or with no local connection and/or recourse to public funds, or where Housing First might not be the right solution to ending their homelessness. A further proposal for additional funding for 2019/20 has also recently been submitted.

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