HOMELESS HEALTH NEEDS AUDIT

PRINTABLE VERSION OF THE SURVEY

Welcome to the Health Needs Audit. This is the paper version of the audit questions. If you are using the paper version, please input the responses afterwards onto the online tool.

This survey asks clients questions about their health needs and access of health services in your local area. Interviewer: Please refer to **Information for Interviewers (R5)** to help you carry out the survey. Make sure the client has read **Information for Clients (R6)** and understands how this information will be used.

INTRODUCTION

Before you get started, we want to make sure you have read about this survey.

☐ I (the client) understand how this information will be used and am happy to go ahead

1 ACCESS OF HEALTH SERVICES

1 **ARE YOU REGISTERED WITH THESE SERVICES IN YOUR LOCAL AREA?**

	yes, permanent	yes, temporary	no
A homeless health care or NFA health service	○	○	○
GP	○	○	○
Dentist	○	○	○

2 **WHICH OF THESE SERVICES HAVE YOU USED IN THE PAST 6 MONTHS?**

	Not used	1-2 times	3-5 times	over 5 times
GP/doctor	○	○	○	○
Dentist	○	○	○	○
Optician	○	○	○	○
Nurse	○	○	○	○
Walk-in clinic	○	○	○	○
Outpatient appointment	○	○	○	○
Homeless health / NFA service	○	○	○	○
Visited A&E	○	○	○	○ number of times............
Used an ambulance	○	○	○	○ number of times............
Admitted into hospital	○	○	○	○ number of times............

2a) **If you have used ANY of A&E, hospital OR ambulance in the past 6 months please answer these questions:**

What was the reason why you last used:
Please select the reason which best fits the primary cause of using the service, or use the other box if the reason is not listed.

	A&E	Ambulance	Admitted into hospital
Violent incident or assault	○	○	○
Accident	○	○	○
Breathing problems/chest pains	○	○	○
Seizure/fitting	○	○	○
Stomach pain	○	○	○
Relating to mental health	○	○	○
Self harm	○	○	○
Relating to drug use	○	○	○
Relating to alcohol use	○	○	○
○Other for A&E, ……………………………………………			
○Other, for ambulance………………………………………			
○Other, for hospital …………………………………………..			

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2b) **If you were ADMITTED INTO HOSPITAL, please answer these questions about your most recent admission:**

How many nights did you stay in for? ……………………….. (Please estimate if you need to)

Did staff in the hospital make sure you had somewhere suitable to go when you were discharged?

○ Yes ○ No

3 **HAVE YOU BEEN REFUSED REGISTRATION TO A GP OR DENTIST IN THE PAST 12 MONTHS?**

○ Yes ○ No

IF YES, why was this?...

4 **HAS YOUR HOUSING OR HOMELESSNESS PROJECT GIVEN YOU INFORMATION ABOUT LOCAL HEALTH SERVICES YOU CAN USE?**

○ Yes ○ No ○ Don't know

IF YES, did you find it useful?

○ Yes ○ No ○ Don't know

5 **OVERALL, WHO HELPS YOU MOST WHEN IT COMES TO YOUR HEALTH?** Please choose **all** that apply:

☐ GP
☐ staff member at housing/homelessness project
☐ Homeless health care team
☐ A&E staff
☐ friend/peer
☐ family
☐ alcohol worker
☐ Other:…………………………………………………
☐ drug worker
☐ mental health worker
☐ nobody

2 YOUR PHYSICAL HEALTH

6 **DO YOU SMOKE?**

○ Yes ○ No If 'no' go to Q7.

Do you want to stop smoking?

○ Yes ○ No

Have you been offered advice or help to stop smoking?

○ Yes, and took this up ○ Yes, but did not take this up ○ No

7	**ON AVERAGE, DO YOU EAT AT LEAST 2 MEALS A DAY?** If this is difficult, please think about the meals you ate yesterday. ◯ Yes ◯ No
8	**HOW MANY PIECES OF FRUIT AND VEG DO YOU USUALLY EAT PER DAY?** If this is difficult to answer, please think about what you ate yesterday. ◯ none ◯ 1-2 ◯ 3-4 ◯ 5+
9	**DO YOU EXERCISE AT LEAST TWICE A WEEK?** (play sport, swim, or cycle for at least 30 minutes each time?) ◯ Yes ◯ No **IF NO, would you like to?** ◯ Yes ◯ No ◯ Don't know
10	**DO YOU EXPERIENCE ANY OF THE FOLLOWING HEALTH PROBLEMS?** Please choose **all** that apply:

	Yes, less 12 mnths	Yes, 12 mnths +	No
chest pain/breathing problems	◯	◯	◯
joint aches/problems with bones and muscles	◯	◯	◯
difficulty seeing/eye problems	◯	◯	◯
skin/wound infection or problems	◯	◯	◯
problems with feet	◯	◯	◯
fainting/blackouts	◯	◯	◯
urinary problems/infections	◯	◯	◯
circulation problems/ blood clots	◯	◯	◯
liver problems	◯	◯	◯
stomach problems	◯	◯	◯
dental/teeth problems	◯	◯	◯
diabetes	◯	◯	◯
epilepsy	◯	◯	◯
Other: ………………………………………………	◯	◯	◯

10b	**IF YES TO ANY PHYSICAL HEALTH NEED:** **Are you receiving support/treatment to help you with your physical health problem?** ◯ Yes, and it meets my needs ◯ Yes, but I'd still like more help ◯ No, but it would help me ◯ No, I do not need any

3 YOUR MENTAL HEALTH

11	**DO YOU EXPERIENCE ANY OF THE FOLLOWING MENTAL HEALTH DIFFICULTIES?**

	Yes, less 12 mnths	Yes, 12 mnths +	No
Often feel stressed	◯	◯	◯
Often feel anxious	◯	◯	◯
Panic attacks	◯	◯	◯
Feel depressed	◯	◯	◯
Difficulty sleeping	◯	◯	◯
Suicidal thoughts	◯	◯	◯
Self harm	◯	◯	◯
Hear voices	◯	◯	◯
I find it hard to control my anger	◯	◯	◯
I can be aggressive or violent towards others	◯	◯	◯

12	**DO YOU HAVE A MENTAL HEALTH NEED OR CONDITION WHICH HAS BEEN DIAGNOSED BY A DOCTOR OR OTHER HEALTH PROFESSIONAL?** ◯ YES ◯ DON'T KNOW ◯ NO (please go to Q13)

IF YES, what was this, and how long have you experienced it for? Please select all that apply

	Yes, less 12 mnths	Yes, 12 mnths +	No
Depression	◯	◯	◯
Schizophrenia	◯	◯	◯
Bipolar disorder	◯	◯	◯
Personality disorder	◯	◯	◯
Post traumatic stress disorder	◯	◯	◯
Dual diagnosis with a drug or alcohol problem	◯	◯	◯
Other mental health condition (please state)…………………………………	◯	◯	◯

13 **DO YOU GET SUPPORT WITH YOUR MENTAL HEALTH, eg from a worker, medic or support service?**

◯ Yes, and it meets my needs GO TO 13a
◯ Yes, but I'd still like more help GO TO 13b
◯ No, but it would help me GO TO 13b
◯ No, I do not need any GO TO 14

13a **What type of support helps you?** Tick all that apply

☐ Talking therapies (eg counselling, psychological therapies)
☐ A specialist mental health worker – eg Community Mental Health team
☐ Service to address my dual diagnosis
☐ Activities to do like arts, volunteering or sport
☐ Practical support to help me with my day to day life
☐ Other ……………………………………………………

13b **What sort of support would help you?** Tick all that apply

☐ Talking therapies (eg counselling, psychological therapies)
☐ A specialist mental health worker – eg Community Mental Health team
☐ Services to address my dual diagnosis
☐ Activities to do like arts, volunteering or sport
☐ Practical support to help me with my day to day life
☐ Other ……………………………………………………

14 **DO YOU USE DRUGS OR ALCOHOL TO HELP YOU COPE WITH YOUR MENTAL HEALTH – this can be called 'self-medicating'?**

◯ Yes ◯ No

4 DRUGS AND ALCOHOL

15 **DO YOU TAKE ANY DRUGS OR ARE YOU RECOVERING FROM A DRUG PROBLEM?** *(by drugs this does not include medication prescribed to you for a specific medical condition)*

◯ YES, use drugs ◯ No ***GO TO Q18***

If YES, IN THE LAST MONTH, HAVE YOU USED ANY OF THE FOLLOWING? Please choose **all** that apply:

☐ heroin
☐ crack/cocaine
☐ cannabis /weed
☐ amphetamines/ speed
☐ benzodiazepines/ benzos
☐ prescription drugs
☐ Other drugs, please say…………………………………………………………
☐ None

	Do you take methadone? ○ YES ○ NO **IF YES: is this prescribed to you**? ○ YES ○ NO
16	**DO YOU CURRENTLY INJECT DRUGS?** ○ YES ○ No (Go to Q17) **IF YES: Do you share injecting equipment with others?** ○ yes, usually ○ yes, sometimes ○ no **Do you know about:**
17	**DO YOU GET SUPPORT TO HELP YOU ADDRESS YOUR DRUG USE?** ○ Yes, and it meets my needs GO TO 17a ○ Yes, but I'd still like more help GO TO 17b ○ No, but it would help me GO TO 17b ○ No, I do not need any GO TO 18
17a	**How does this support help you?** Tick all that apply ○ Helps me to better control my drug use ○ Helps me to reduce my drug use ○ Helps me to use drugs more safely ○ Helps me to stop using drugs ○ other…………………………………………………
17b	**What sort of help would you like?** Tick all that apply ○ Help to better control my drug use ○ Help to reduce my drug use ○ Help to use drugs more safely ○ Help to stop using drugs ○ other…………………………………………………
18	**HOW OFTEN DO YOU HAVE AN ALCOHOLIC DRINK?** ○ never *go to Q 19* ○ monthly or less ○ 2-4 times per month ○ 2-3 times per week ○ 4 -6 times per week ○ every day **How many units do you drink on a typical day when you are drinking?** Please refer to flashcard to work this out ○ 1-2 ○ 3-4 ○ 5-6 ○ 7-9 ○ 10+

Q16 – Do you know about:

	yes	no
A needle exchange scheme you can use	○	○
Advice or training on safer injecting	○	○

19	**DO YOU HAVE OR ARE YOU RECOVERING FROM AN ALCOHOL PROBLEM?**

○ YES ○ NO (go to Q 20)

Do you get support to help with this?

○ Yes, and it meets my needs GO TO 19a
○ Yes, but I'd still like more help GO TO 19b
○ No, but it would help me GO TO 19b
○ No, I do not need it GO TO 20

19a How does this support help you? Tick all that apply

☐ helps me to better control my alcohol intake
☐ helps me to reduce my alcohol intake
☐ helps me to manage the impact drinking has on my health
☐ helps me to stop drinking
☐ other……………………………………………………………

19b What sort of support would help you? Tick all that apply

☐ help to better control my alcohol intake
☐ help to reduce my alcohol intake
☐ help to manage the impact drinking has on my health
☐ help to stop drinking
☐ other……………………………………………………………

5 VACCINATIONS AND SCREENING

20 HAVE YOU BEEN VACCINATED FOR THE FOLLOWING?

Please choose the appropriate response for each item:

	Yes	No	Don't know
Hep A	○	○	○
Hep B	○	○	○
Flu (past 12 mnths)	○	○	○

21 HAVE YOU BEEN TESTED FOR THE FOLLOWING HEALTH PROBLEMS?

	Not tested	Tested +ve	Tested -ve	Prefer not to say
Hep C	○	○	○	○
TB	○	○	○	○
HIV	○	○	○	○

If you tested positive for ANY of these, did you go on to receive any treatment?

	Yes	No, not offered any	No, offered but didn't take it up	N/A	Prefer not to say
Hep C	○	○	○	○	○
TB	○	○	○	○	○
HIV	○	○	○	○	○

IF TESTED FOR TB:

What type of TB screening was this? ○ skin test ○ x ray ○ Don't know

22 HAVE YOU HAD A SEXUAL HEALTH CHECK IN THE PAST 12 MONTHS?

○ Yes ○ No ○ Don't know

23 **DO YOU KNOW WHERE TO ACCESS ADVICE ABOUT SEXUAL HEALTH?**

○ Yes ○ No (go to Q25)

IF YES, Where would you go?
○ GP or nurse ○ Homeless/housing staff ○ GUU/sexual health clinic
○ Other…………………..........

24 **FEMALE CLIENTS ONLY: Have you had access to specialist women's health services?**

	Yes	No	Uncertain
cervical smear in past 3 years	○	○	○
breast examination in past 3 years	○	○	○

6 A FEW QUESTIONS ABOUT YOU

25 **HOW WOULD DESCRIBE WHERE YOU ARE CURRENTLY SLEEPING?** (if this frequently changes, please say where you slept last night)

○ sleeping rough on streets/parks
○ hostel
○ 2nd stage or supported accommodation
○ squatting
○ sleeping on somebody's sofa/floor
○ nightshelter
○ Other …………………………………………………………………..

26 **AT THE MOMENT, ARE YOU:**

	Yes	No
In training or education	○	○
volunteering	○	○
In employment	○	○
Accessing guidance around work or training	○	○

Do you think your health stops you being able to undertake any training, volunteering or employment that you want to?

○ Yes ○ No ○ Don't know

27 **PLEASE TICK IF YOU ARE WORKING WITH ANY OFFENDING SERVICES:**

○ currently with probation
○ current community order
○ Youth Offending service/YOT
○ Other …………………………………………………………………….

28 **DO YOU HAVE ANY OF THESE BACKGROUNDS? (this helps us to understand how your past experience may have affected your health or services you've been able to access)**

○ Left prison within last 12 months
○ Left prison more than 12 months ago
○ Left Care Services (for young people) within past 5 years
○ None of these backgrounds

29 **DO YOU CONSIDER YOURSELF TO HAVE A DISABILITY?**

○ Yes ○ No (Go to Q 30)

	How would you describe this disability? Choose any that apply ☐ mobility ☐ sensory impairment (eg hearing or sight problems) ☐ learning disability ☐ developmental disability ☐ mental health ☐ long term condition ☐ Other:………………………
30	**WHAT IS YOUR MIGRATION STATUS?** *Please refer to Definitions guidance if necessary* ◯ UK resident ◯ Indefinite leave to remain ◯ A2 national ◯ asylum seeker ◯ other EU national ◯ Unknown ◯ Other ………………………………………………………………………
31	**WHAT AGE RANGE DO YOU FALL INTO?** ◯16-17 ◯36-45 ◯66-75 ◯18-25 ◯46-55 ◯over 75 ◯26-35 ◯56-65
32	**GENDER: are you** ◯ **male** ◯ **female** ◯ **did not disclose** **Do you identity yourself as transgender?** ◯Yes ◯ No ◯ Don't know ◯ Prefer not to say
33	**WHAT IS YOUR SEXUAL ORIENTATION?** ◯ Heterosexual ◯ Gay man ◯ Gay woman/lesbian ◯ Bi-sexual ◯ Prefer not to say
34	**HOW WOULD YOU DESCRIBE YOUR ETHNICITY?**

White				Asian/Asian British				Black/Black British			Mixed				Other ethnic background		
White British	White Irish	White European	White other	Indian	Bangladeshi	Pakistani	Other Asian	African	Caribbean	Other black	White and Black Caribbean	White and Black African	White and Asian	Other mixed	Chinese	Romany/traveler	Other ethnic background
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	Please state: ………………

35	**IS THERE ANYTHING ELSE YOU WOULD LIKE TO TELL US ABOUT YOUR HEALTH & THE SUPPORT YOU RECEIVE?** **What works well?** **What could be improved?** **Any other comments:**
36	**INTERVIEWER: please write down the service where this survey was completed – eg day centre name** ……………………………………………………………………………………….

THANK YOU FOR COMPLETING THIS SURVEY