Appendix 1

HEREFORDSHIRE'S HOMELESS LINK HEALTH NEEDS AUDIT REPORT

February 2019

1. Executive summary

Overall the data show that participants' physical and mental health, on all dimensions, is extremely poor compared to that of the population as a whole.

On average, homeless men die 30 years earlier and homeless women 37 years earlier than the general population in England.[1] People sleeping rough or in insecure or unstable accommodation have significantly higher levels of mental and physical ill health, substance abuse problems and higher rates of mortality than the general population.

The Homeless Link's Homeless Health Needs Audit[2] is an audit tool that has been developed nationally and aims to i) increase the evidence available about the health needs of people who are homeless and the wider determinants of their health, ii) bring statutory and voluntary services together to develop responses to local priorities and address gaps in services, iii) give people experiencing homelessness a stronger voice in local commissioning processes, and iv) help commissioners understand the effectiveness of their services.

The Homeless Health Needs Audit was undertaken in Herefordshire between December 2016 and February 2018. In Herefordshire the audit was used to capture the health needs data of people who were/are sleeping rough, sofa surfing, otherwise chaotically housed or living in specialist supported accommodation. Audits were undertaken through face-to-face interview by Home Group, Supported Housing for Young People Project (SHYPP) and Herefordshire Council's Outreach Service (HCOS).

One hundred and two audits were completed. The majority of respondents were male (82%), white British (92%) and the average age was 34.5 years. Participants were sleeping in a hostel or supported accommodation (n=43; 42%), in emergency accommodation (n=23, 23%), rough on the streets or in a park (n=15, 15%) or on

[1] Homelessness Kills, University of Sheffield and CRISIS: An analysis of the mortality of homeless people in early twenty-first century England, 2012

[2] Homeless Health Needs Audit toolkit. 2015. https://www.gov.uk/government/publications/homeless-health-needs-audit-toolkit

someone's sofa/floor (n=14, 14%). Six percent of respondents did not have recourse to public funds.

Backgrounds in institutions, including prison, local authority care and mental health admissions were common. The majority of respondents identified the cause of their most recent homelessness to be related to the loss of their individual personal support networks.

Health needs:

- **Physical health**: The most common physical health problems identified were joint/bone/muscle problems (26%), dental problems (19%), eyesight/eye problems (16%) and asthma (16%).
- **Mental health**: Participants experience high levels of stress, anxiety and other signs of poor mental health. Overall 76% of respondents reported a mental health problem/behaviour condition. Dual diagnosis (severe mental health issue and substance misuse) was reported by 18% (18 people, 78% of whom were told in the last 12 months); 14% reported psychosis (of whom 71% were told in the last 12 months). Just under half of those with a mental health problem felt that they were not receiving treatment that they would benefit from, this included respondents with severe mental health conditions and common mental health conditions.
- **Drugs and alcohol:** 43% of respondents did not use drugs, 15% used cannabis only and 42% used Class A, prescription or other non-cannabis drugs. 25 people identified themselves as having a drug problem or being in recovery, of which 32% felt they would benefit from more treatment. Approximately half of respondents drank frequently (from almost every day to once or twice a week). Those that drank, drank on average 10.7 units on a typical day.
- **Access to services:** 78% of respondents were registered with a GP and 29% with a dentist. Use of acute care services was common, and frequent. Mental health problems and self-harm/attempted suicide contributed to approximately 40% of A&E, ambulance and hospital admissions. Violence and accidents were the main reasons for approximately 30% of use of these acute services.
- **Staying healthy:** Basic nutrition in this population was identified as a problem with only 19% of respondents reporting an average of 3+ meals per day.

Uptake of preventative health interventions was low in this population, for example <10% of respondents had the flu vaccine last year.

Conclusion: The health inequalities faced by people who are homeless are considerable and the loss of decades of life, compared to average life expectancy, is stark. Whilst prevention of homelessness and insecure accommodation, and the risk factors that lead to it are paramount in reducing such inequalities, so is meeting the needs of population who are homeless. This audit has identified considerable need for physical and particularly mental health support. It has shown high use of acute, emergency and secondary care, often driven by mental health problems.

Recommendations:

- The Health and Wellbeing Board sign up to the 'Charter for Homeless Health' and implement its commitments, including identifying need, providing leadership and commissioning for inclusion;
- The Health and Wellbeing Board members review within their organisations access to services, including mental health services, primary and secondary health care and preventative services for homeless people with the aim to improve health and reduce first-line use of A&E and ambulance services;
- The Health and Wellbeing Board seeks assurance from lead agencies (including Herefordshire Council, Herefordshire Clinical Commissioning Group, Wye Valley NHS Trust and 2gether NHS Trust) on the actions they are taking to address this inequality and considers these in a future session together with local consideration/adoption of the national memorandum of understanding on health and housing "Improving health and care through the home: A National Memorandum of Understanding";
- The Homeless Health Needs Audit be undertaken again in 3 years' time (2022; completing the audit cycle) and reported to the HWBB.

2. Acknowledgements

We would like to acknowledge the efforts of the individuals who carried out the face-to-face health audits with homeless individuals in Herefordshire:

- Wendy Dyer – Home Group and Home Group Support Workers
- Khadine Whitefoot – Home Group and Home Group Support Workers
- Alicia Lawrence – SHYPP and SHYPP Support Workers
- Annie Doherty – Herefordshire Council Outreach Service

3. Contents

4. Introduction

4.1. Aims and Objectives

Homeless Link's Homeless Health Needs Audit[3] was first developed in partnership with the Department of Health. It was updated in 2015, with funding from Public Health England.

The audit aims to:

- Increase the evidence available about the health needs of people who are homeless and the wider determinants of their health.
- Bring statutory and voluntary services together to develop responses to local priorities and address gaps in services.
- Give people experiencing homelessness a stronger voice in local commissioning processes.
- Help commissioners understand the effectiveness of their services.

4.2. Background

4.2.1. Causes of homelessness:

Homelessness is usually the result of the cumulative interaction of structural, social and economic factors with individual personal and social support characteristics.

- Structural issues relate to the effects of the wider economy and the availability of a housing market, which is both affordable and accessible to single homeless people.
- Individual risk factors include poverty, traumatic relationship events such as family violence, abuse or breakdown; a background in local authority care;

[3] Homeless Health Needs Audit toolkit. 2015. https://www.gov.uk/government/publications/homeless-health-needs-audit-toolkit

experience of prison or the armed forces; mental ill-health and problematic drug and/or alcohol misuse.

In some cases, individual characteristics and circumstances may be a symptom of homelessness as well as an underlying cause. Drug and alcohol addiction, and crime and offending behaviour, are examples of where causal and symptomatic effects can sometimes be difficult to separate.

4.2.2. Health of the homeless population

Nationally, rough sleepers and people in insecure or unstable accommodation have significantly higher levels of mental and physical ill health, substance abuse problems and higher rates of mortality than the general population. The **average age of death is 47 years for men** compared to 77 years for the general population and **43 years for women** compared to 80 years for the general population.[4]

The 'Homelessness Kills' report[4], published in 2012, investigated the mortality of homeless people in England for the period 2001-2009. The report identified:

- At the ages of 16-24y, homeless people are at least **twice as likely** to die as their housed contemporaries; for 25-34 year olds the ratio increases to **four to five times**, and at ages 35-44y, to **five to six times**.
- Drug and alcohol misuse are particularly common causes of death amongst the homeless population, accounting for just over a third of all deaths.
- Homeless people have **seven to nine times** the chance of dying from alcohol-related diseases and **20 times** the chance of dying from drugs.
- Homeless people have **three times** the chance of dying from chronic lower respiratory diseases than their housed contemporaries, with an average age of death from chronic lower respiratory diseases of 56 years compared to 76 years in housed contemporaries.

[4] Homelessness Kills, University of Sheffield and CRISIS: An analysis of the mortality of homeless people in early twenty-first century England, 2012. https://www.crisis.org.uk/media/236799/crisis_homelessness_kills_es2012.pdf

- Homeless people are **twice as likely** to die as the general population from heart attacks and chronic heart disease, at an average age of 59 years, 16 years lower than the average age of 75 years of the general population.
- Homeless people have **seven times** the chance of dying from falls than the general population, with an average age of death of 45 compared to 77.
- Rough sleepers are over **nine times** more likely to die by suicide than the general population.[5]
- Research published by the Salvation Army found that 53% of homeless women, and 34% of homeless men **had attempted suicide** at least once.[6]

In addition, single homeless people can encounter barriers to accessing healthcare services and their experience of homelessness can mean that they neglect to do so. As a consequence, they are much more likely to use emergency ambulance and A&E services than the population as a whole.

Here we present the results of Herefordshire's Homeless Link Health Audit, undertaken to gain a better understanding the health of the homeless population in Herefordshire.

5. Methods of Herefordshire Audits

One hundred and two health needs audits were completed between December 2016 and February 2018. Audits were undertaken through face-to-face interview by Home Group, SHYPP (Supported Housing for Young People Project) and Herefordshire Council's Outreach Service. Home Group and SHYPP provide supported accommodation for single homeless people. HCOS works with single people who are sleeping rough or who are chaotically homeless or 'sofa surfing.' These might be considered to be experiencing the most extreme form of homelessness at the time of the audit.

The Audit consists of 42 questions including background information, physical and mental health, drug and alcohol use, access to services and staying healthy. The audit tool is given in Appendix 1.

[5] Quoted in Rough Sleeping (England), House of Commons Library Briefing Paper, February 2018
[6] The Seeds of Exclusion 2009, The Salvation Army, University of Cardiff and University of Kent

In Herefordshire the audit was used to capture data on the health needs of people who were/are sleeping rough, sofa surfing, otherwise chaotically housed or living in specialist supported accommodation. Participants were primarily single people who, although homeless, do not meet the 'priority need' criteria for housing as set down in statute and subsequent homelessness case law.

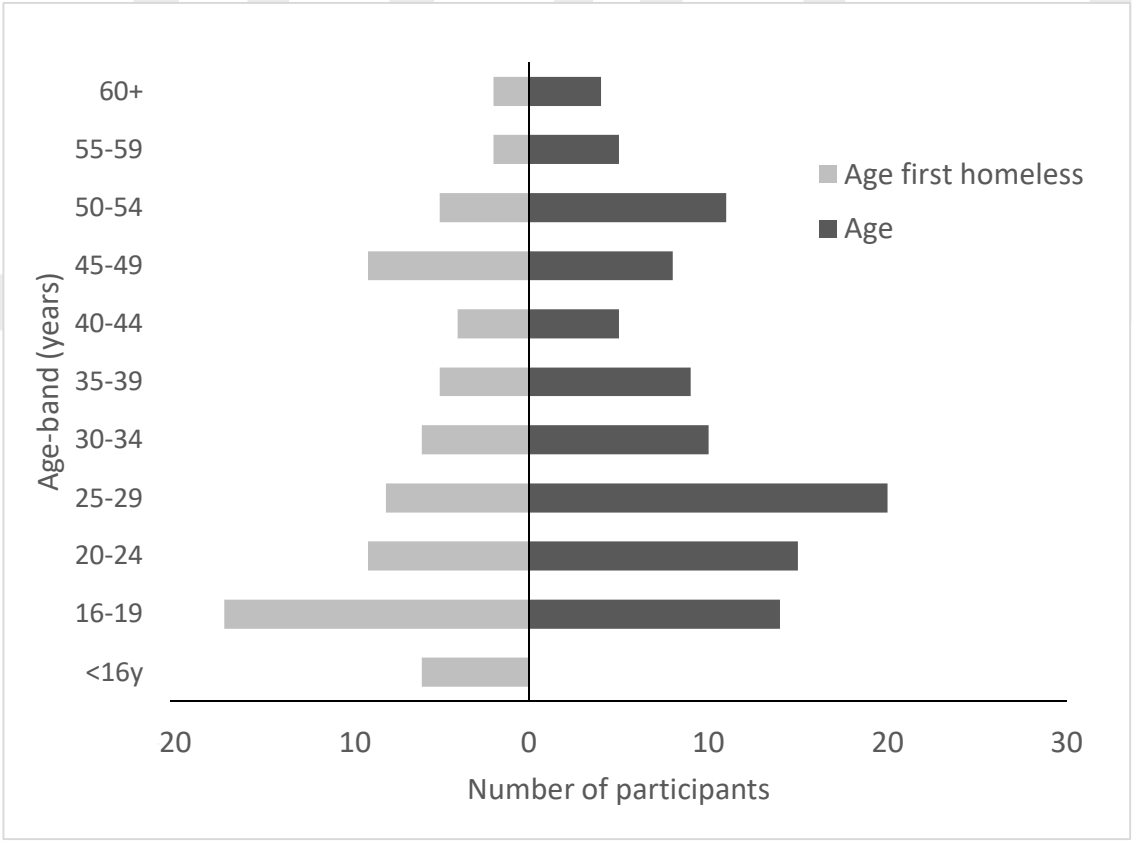
6. Results of Herefordshire Audits

6.1. Socio-demographics

6.1.1. Age, gender, sexuality and ethnicity

The average age of participants was **34.5 years (youngest 17 years, oldest 74 years)**. The average age at which respondents reported they had first become homeless[7] was 31 years (youngest 12 years, oldest 72 years). The age-distribution and age of first homelessness is shown in Figure 1 for all audit participants.

Figure 1. Age-distribution of Herefordshire Homeless Health Needs Audit participants, and age at which first homeless.



[7] Age at which respondent reported first staying at a hostel, foyer, refuge, night shelter or B&B hotel or any other type of homelessness service; stayed with friends or relatives because had no home of own ('sofa surfed'); slept rough; or applied to the council as homeless

Participants in the audit were overwhelmingly:

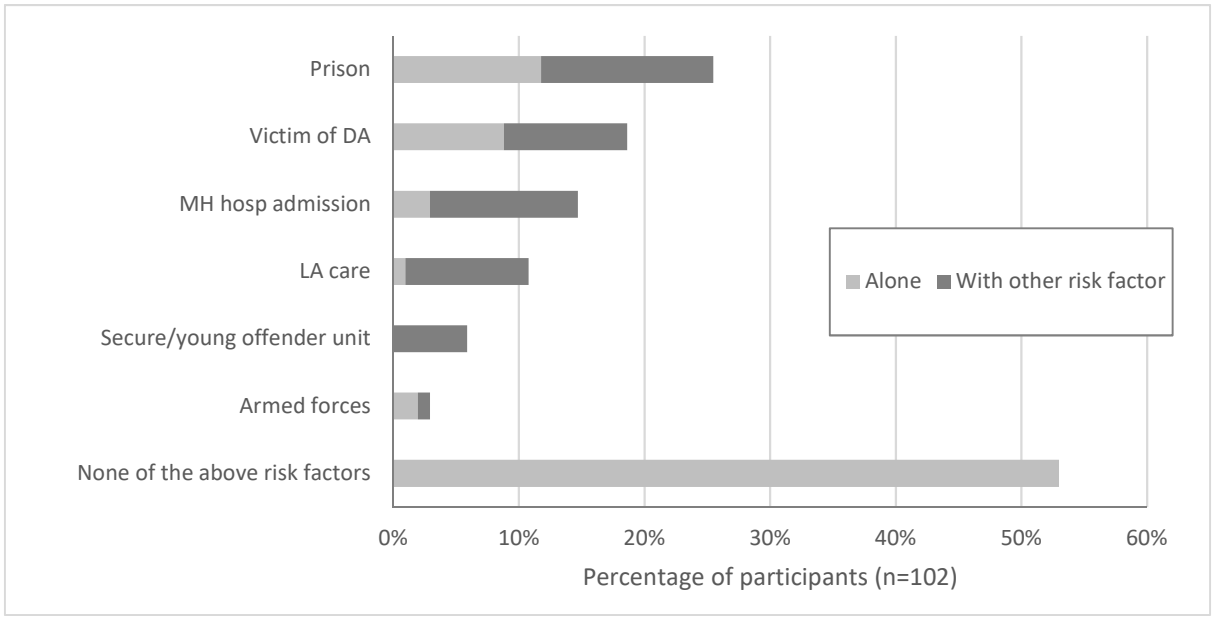
- Male (82 male and 18 female. 2 people did not answer).
- Heterosexual (7 out of 101 respondents described themselves as gay, lesbian or bisexual)
- UK nationals (96 participants) and,
- White British (94 participants).

Six participants (6% of those who answered the question) stated that they **did not have access to public funds** (welfare benefits); 93 participants had recourse to public funds; one did not know and two respondents did not answer.

6.1.2. Personal history

Almost half of participants (47%, 48 people) reported past experience of time spent in prison, secure unit/young offender institute, local authority care, armed forces, mental health hospital admission, or victim of domestic abuse. Figure 2 shows the breakdown of these background risk factors: 25% of respondents had spent time in prison (n=26), 19% been the victim of domestic abuse (n=19), 15% had been admitted to hospital because of a mental health issue and 11 (11%) had spent time in local authority care. Twenty participants had at least two of these background risks.

Figure 2. Percentage of participants who reported background risk factors for homelessness.



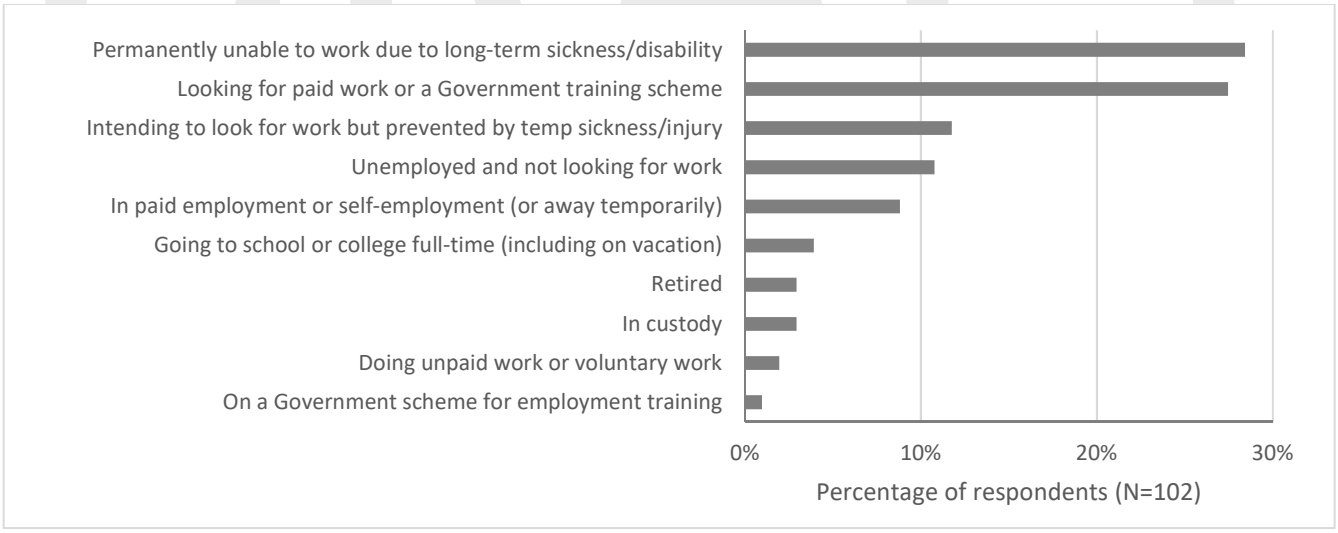
To some extent, the prevalence of local authority care and prison backgrounds in the homeless population in Herefordshire appear lower than national data, but caution should be exercised in interpreting these differences due to small numbers.

- **11%** of Herefordshire participants had a background in local authority care. In comparison, research commissioned by CRISIS,[8] which surveyed 437 single homeless people found that 25% of these had been in care at some point in their lives.
- **25%** of Herefordshire participants had spent time in prison compared to the **41%** of the homeless population in the broader 'Nations Apart' study.[9]

6.1.3. Employment

Forty percent of participants (41 people) were not working or looking for work due to their health, due either to long-term sickness/disability or temporary sickness/injury (Figure 3). Fifteen percent of participants were either studying or working, on a paid or volunteer basis.

Figure 3. Current employment status



[8] The Hidden Truth about Homelessness, Centre of Regional Economic and Social Research at Sheffield Hallam University, July 2015. https://www.crisis.org.uk/media/236815/the_hidden_truth_about_homelessness.pdf

[9] MacKie PK and Thomas I 2014. Nations apart? Experiences of single homelessness across Great Britain. London: Crisis http://orca.cf.ac.uk/70789/1/NationsApart.pdf

6.2. Homelessness experience

Participants were most commonly currently sleeping in a hostel or supported accommodation (n=43; 42%), in emergency accommodation (n=23, 23%), rough on the streets or in a park (n=15, 15%) or on someone's sofa/floor (n=14, 14%). The main reasons (primary or secondary) given for becoming homeless (most recent time) are shown in Figure 4. Many respondents gave reasons related to their individual personal support networks: parents/carers or other relatives/friends being unable or unwilling to accommodate or breakdown of a relationship (non-violent). Mental or physical health problems were reported as a reason by 13% of respondents, drug and alcohol problems by 12% and domestic abuse or violence for nearly 10%.

Figure 4. Reason given for most recent episode of homelessness (primary and secondary reasons) (% of respondents, N=102).

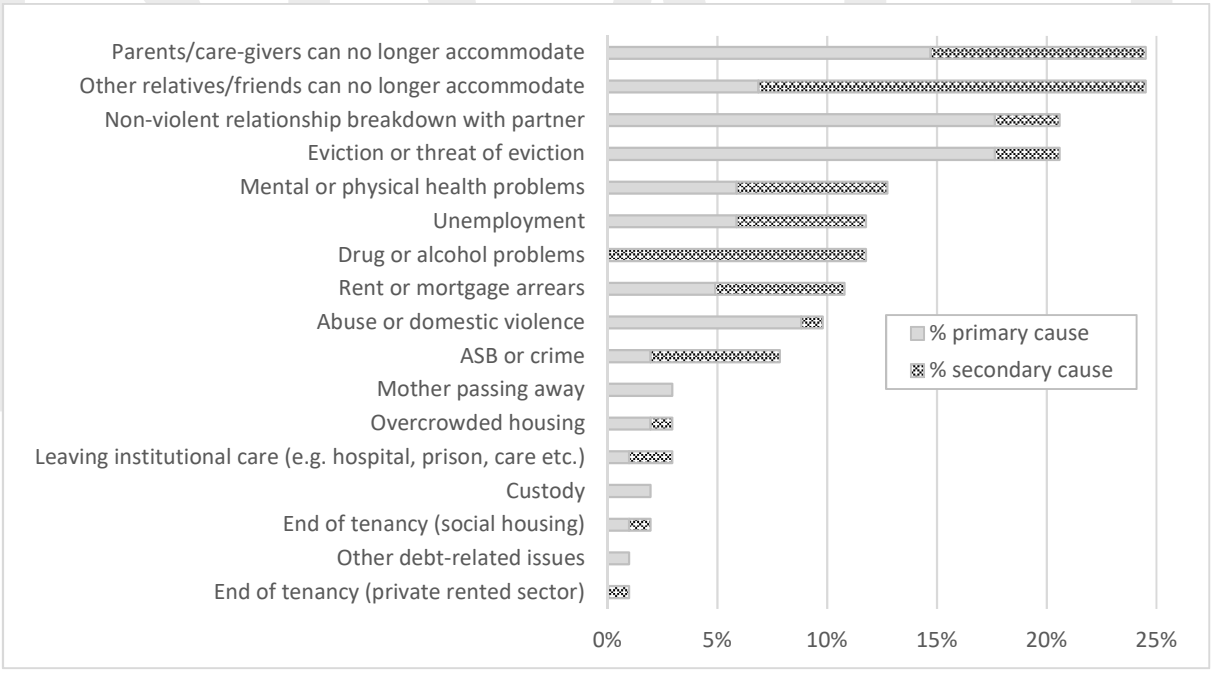
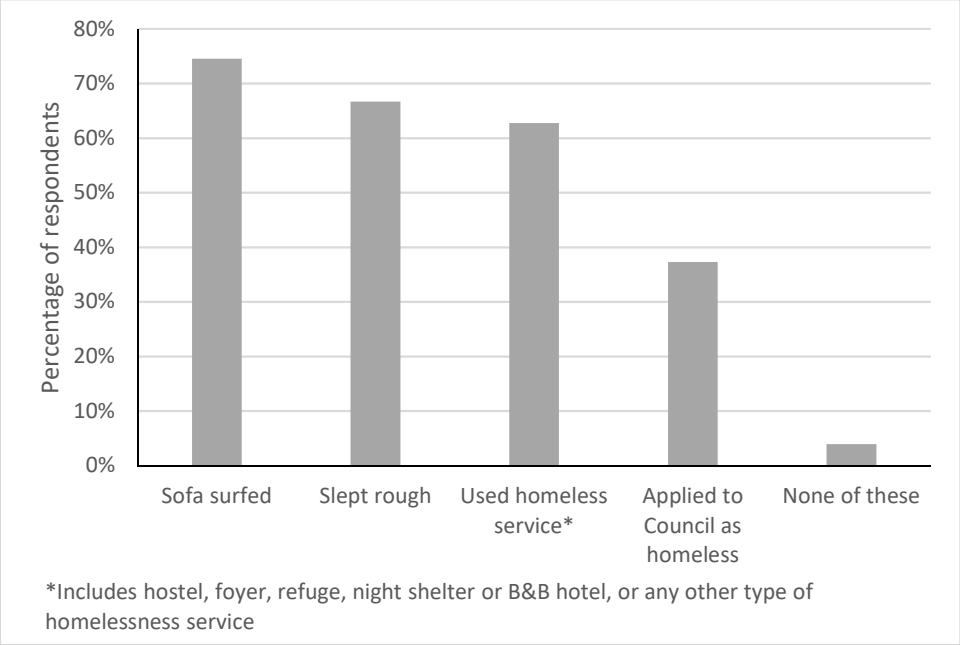


Figure 5 shows participants' previous homelessness history. The majority had previously experienced the most extreme forms of homelessness: rough sleeping (68 people, 67%). Three quarters had sofa surfed (76 people, 75%) and 37% (38 people) had made a homeless application to the council at some point. Three-quarters of respondents had experienced more than one type of homelessness previously.

Figure 5. Previous experience of homelessness (n=102)



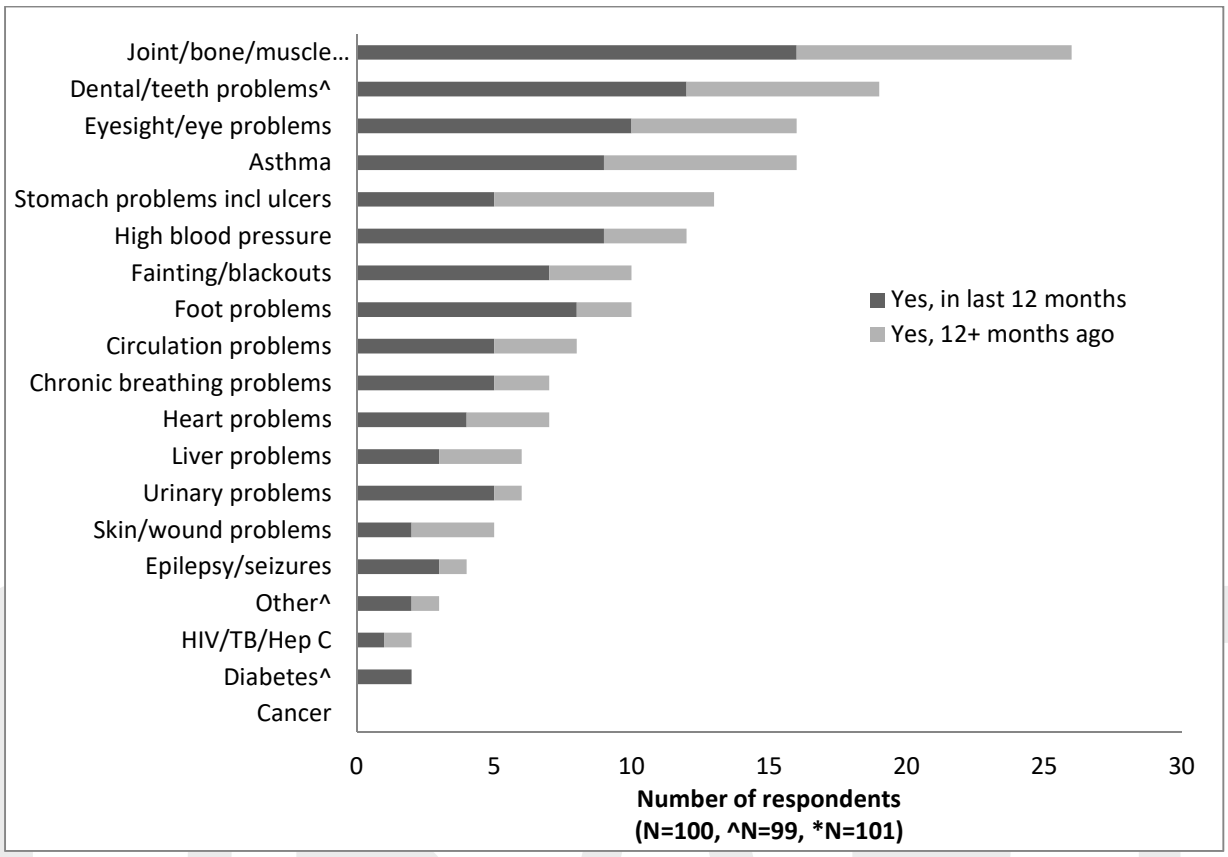
Forty-eight of those participating in the audit reported being supported by HHOS, 33 by Home Group and 19 by SHYPP (numbers include one respondent who reported receiving support from both Home Group and SHYPP). Three participants reported that they were not receiving support from any of these agencies. There was a difference in average age of participants supported by organisations which reflects their primary client groups: SHYPP 19.5 years, Home Group 35.4 years and HHOS 39.8 years.

6.3. Physical Health

6.3.1. Physical health problems and conditions

Participants were asked 'Has a doctor or health professional ever told you that you have any of the following, during the last 12 months or more than 12 months ago?', followed by a list of conditions. Figure 6 gives the breakdown of these conditions and shows the most common physical health problems to be joint/bone/muscle problems, dental problems, eyesight/eye problems and asthma. Whilst 44 respondents did not identify any physical health problems, 19 reported one single health problem and 38 respondents reported two or more.

Figure 6. Physical health problems or conditions



Comparison with general population show the prevalence of many health problems to be higher in the homeless population. For example, 14% of the general population report joint/bone/muscle problems compared with 26% in this audit. The Herefordshire results, although reasonably consistent, suggest some physical heath aspects which may be poorer than identified nationally for the homeless population, for example dental problems (Homeless Link report which analysed health needs data from 2,500 people). This does however, need to be treated with some caution due to the smaller number of participants in the Herefordshire audit.

Figure 7. Comparison of prevalence of physical health problems in the Herefordshire homeless population with national data and general population

Joint & muscle problems

Herefordshire Audit = 26%
(101 responses = 26 people)

Homeless Link Audit = 22%

General population = 14%

Dental problems

Herefordshire Audit = 19%
(100 responses = 19 people)

Homeless Link Audit = 15%

General population = unknown

Eye problems

Herefordshire Audit = 16%
(100 responses = 16 people)

Homeless Link Audit = 14%

General population = 1%

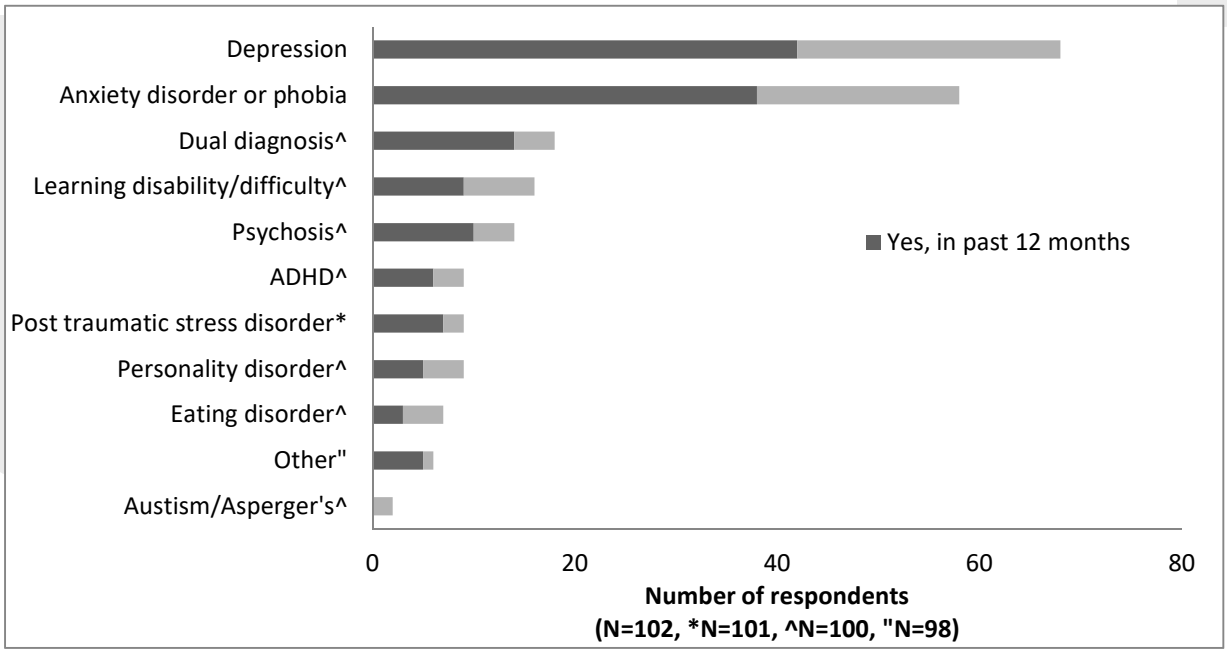
6.4. Mental Health:

6.4.1. Mental health problems and conditions

Participants were asked 'Has a doctor or health professional ever told you that you have any of the following mental health or behavioural conditions?', followed by a list of conditions.

Figure 8 shows the reported diagnoses. Two-thirds of respondents reported ever having had depression and 57% ever having anxiety. Only 24% reported no mental health issues. Dual diagnosis (severe mental health issue and substance misuse) was reported by 18% (18 people, 78% of whom were told in the last 12 months) and 14% reported psychosis (of whom 71% were told in the last 12 months).

Figure 8. Mental health problems or conditions



Whilst comparisons are difficult and should be treated with caution, Table 1 presents mental health prevalence amongst the Herefordshire homeless population, Homeless Link's Health Needs Audit data and general population data. It can be seen that mental health issues are considerably more prevalent in the homeless population, both common mental health disorders such as depression and anxiety and severe mental health illness (e.g. psychosis).

Table 1. Prevalence of mental health and behaviour conditions amongst Herefordshire Homeless population compared to other groups

	Percentage of population		
Mental health condition/behaviour	**Herefordshire Homeless Health Needs**	**Homeless Health National Data**	**General population**
Depression in the last 12 months	41%	36%[10]	19% (those aged 16y+)[11]
Anxiety disorder or phobia in last 12 months	37%	41% (Anxiety)[12]	6.6% England[13]
Psychosis, schizophrenia & bipolar disorder in last 12 months	10% in last year 14% ever	6% schizophrenia 6% bipolar disorder[10] 11% psychosis[14]	1% over a lifetime[15]
Dual diagnosis	14% in last year	12%[16]	6-15% in substance misuse settings; 20-37% in secondary mental health services[17] [18]

6.5. Drugs and alcohol use

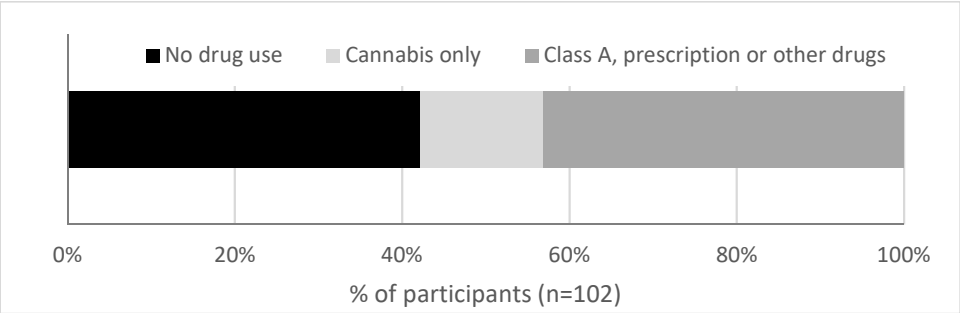
6.5.1. Drug use

43 (43%, N=102) respondents reported no drug use and 15 respondents (15%, N=102) reported use of cannabis only. Overall (i.e. alone or with other drugs), 34 respondents reported using cannabis (34%). Reported drug use by respondents is given in

Figure **9**.

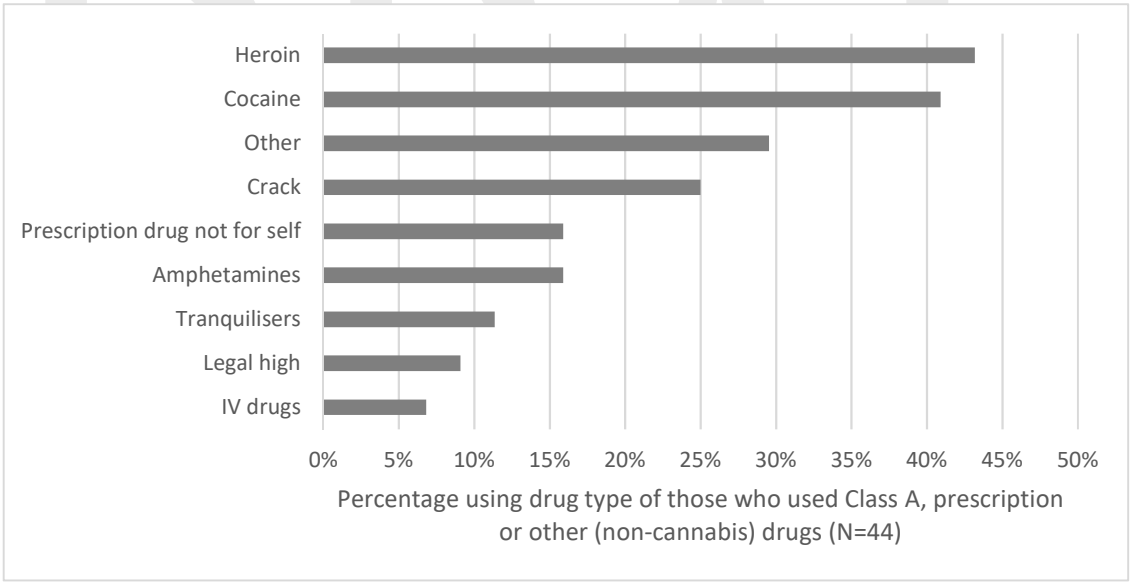
Figure 9. Reported drug use by respondents (%)

[10] Unhealthy State of Homelessness, Homeless Link, 2014
[11] ONS Measuring National Well-being: Domains and Measures 2016
[12] Mental Health and Wellbeing Guide, Homeless Link, 2011
[13] Mental Health Foundation, the one week prevalence of generalised anxiety in England
[14] Schizophrenia in homeless persons: as systematic review of the literature, Folsom, D., Jeste, D. 2002
[15] Psychosis & schizophrenia in adults, NICE Guidelines, 2013
[16] Turning Point, Dual Dilemma, July 2016
[17] Quoted in Severe mental illness and substance misuse (dual diagnosis), NICE, 2016
[18] It should be recognised that methodological challenges, including differing definitions of dual diagnosis and other issues means that national data should be treated with caution.



Drug use in the 44 respondents (44%, N=102) who reported using Class A, prescription drugs or other (non-cannabis) drugs in the past 12 months are given in Figure 10. 60% of participants who reported using these drugs, reported use of one type, 20% reported use of 2-3 different types and 18% reported use of 4 or more different drug types.

Figure 10. Drug use by those reporting Class A, prescription or other (non-cannabis) drug use (%)



Whilst comparison should again be treated with caution:

- **36 people** (36%, N=99) in the Herefordshire Audit said that they used drugs or alcohol to help them cope with their mental health (self-medicating). In the Homeless Link Audit national data almost 50% reported such use.
- The Homeless Link combined health needs audit[19] found that **64%** of participants used Cannabis. This is higher than the Herefordshire results at

[19] The Unhealthy State of Homelessness: Audit Results, Homeless Link as reference 11 above.

34% of participants, although, overall, it is the most commonly used drug by single homeless people taking part in Herefordshire the audit.

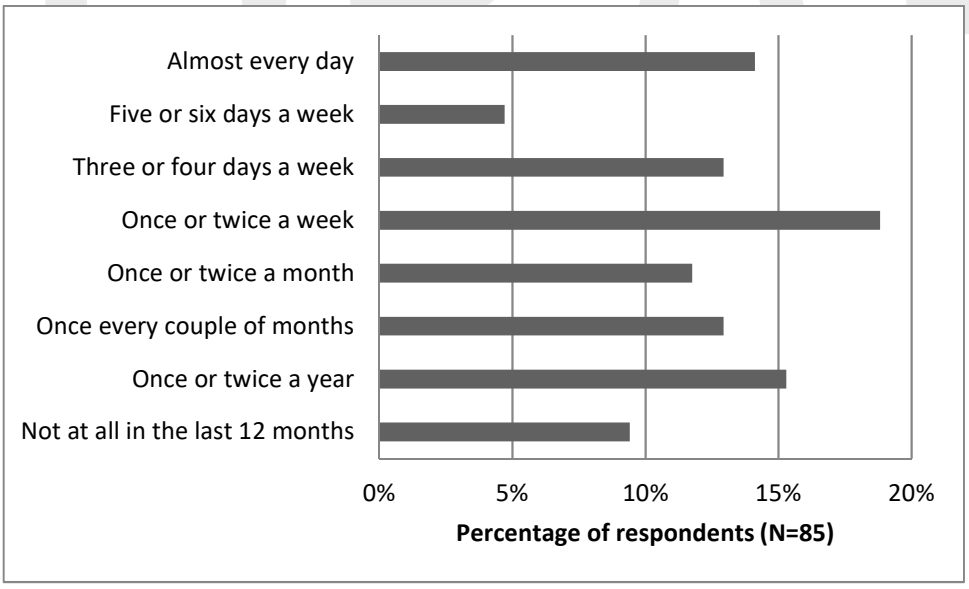
- **19%** of Herefordshire participants reported using heroin, again lower than the **27%** in the combined Homeless Link audit.

6.5.2. Alcohol Use

29%, of the 99 participants who answered the question, 'do you have or are you recovering from an alcohol problem, stated either that they did have (19 people) or that they were in recovery from an alcohol problem (10) people. This is broadly consistent with the 27% finding from the combined Homeless Link Audit results.

Participants were asked about how often they had an alcoholic drink in the past 12 months. Figure 11 shows the detailed frequency of alcohol consumption reported by respondents (17 people did not answer question).

Figure 11. Frequency of alcohol consumption



The data suggest that the frequency of alcohol consumption amongst participants is fairly uniformly split between those people who drink frequently, from almost every day to once or twice a week (43 people, 51%) and those who only drink once or twice a month to not at all in the last 12 months, (42 people, 49%).

However, participants reported high consumption on a typical day when they are drinking: average of 10.7 units per day. Excluding those that reported zero units,

the average was 14.8 units per day. The UK Chief Medical Officer's guidance on safe levels of drinking advises not to drink more than 14 units a week on a regular basis.

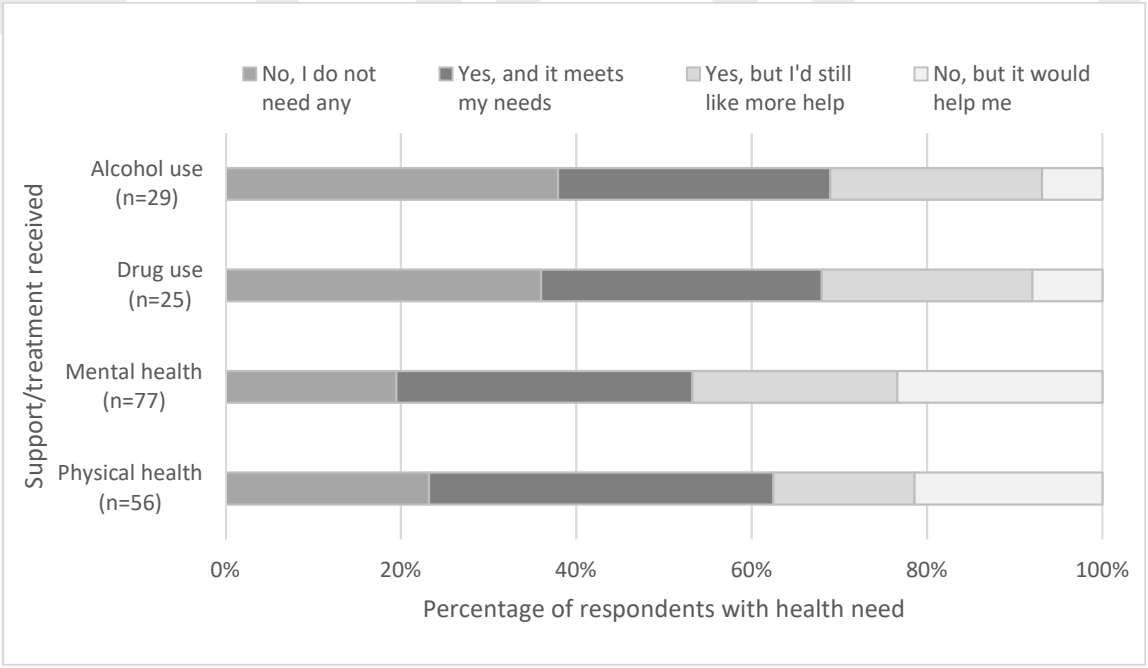
A third (33%) of those reporting their typical drinking day units, drank more than 10 units of alcohol a day. This is similar to the results of the Homeless Link audit data, which found that 35% of participants drink more than 10 units of alcohol per day.

6.6. Access to Services

6.6.1. Treatment and support for physical and mental health problems and drug and alcohol use

Figure 12 shows the support and treatment received by respondents for physical health, mental health, drug and alcohol problems. The greatest unmet felt need (i.e. those that were receiving treatment but reported they would benefit from more and those that were not in treatment but reported that it would help them) was for mental health problems with nearly half of respondents (47%) being in this category, compared to approximately one-third for physical health (38%), drug (32%) and alcohol (31%) problems.

Figure 12. Respondents' report on receipt and sufficiency of treatment/support for physical health, mental health, drug and alcohol problem.



- ***Treatment and support for mental and physical health problems***

Nearly half of respondents reported that they would like, or would like more, treatment/support for their mental health issues. The reported gap in treatment/support was identified in those with serious mental health issues as well as those with common mental health problems: of the 10 people reporting being diagnosed with psychosis (including schizophrenia or bipolar disorder) in the last 12 months, all reported receiving care although five (50%) would like more. Of the four diagnosed with psychosis more than 12 months ago, two were receiving treatment/support that they felt met their need, one was in treatment but would like more and one was not receiving treatment/support but felt they would benefit from it.

As shown in Table 2, overall the results would suggest that fewer people are receiving the mental health support that they feel they need than was the case in the results from the combined Homeless Link Audits.

Table 2. Comparison of respondents' views of sufficiency of care compared to national data

Herefordshire Audits		Homeless Link Audits
Receiving support that meets needs	33.3%	44.3%
Receiving some support but would like more	23.0%	28%
Not receiving support but it would help	23.0%	17.5%
Not receiving support and don't need it	19.2%	10.0%

27 (27%) of the 102 respondents were receiving professional talking therapy, support from a specialist mental health worker and/or a service that deals with dual diagnosis. Whilst the majority of participants had support from only one of these (8 in talking therapy, 8 with specialist mental health worker and 5 in service for dual diagnosis), 6 participants had support from more than one of these services. 25 of the 102 respondents (25%) reported that they received medication for their mental health. Of these 25, 10 received no other support/treatment.

Twenty respondents (20%) stated that there was a time in the last 12 months when they reported that they did not get the assessment or treatment they felt they needed for a mental health problem. This is higher than the comparative figure of 11% for physical health. The most common reason was wanting to wait to see if the problem got better on its own (n=6). Perhaps more concerning however, three reported being unable to get an appointment, two were refused

treatment/examination and two had a change in GP resulting in either cancellation of a referral to mental health services or loss of counselling service. For physical health, this was most commonly due to fear of medical institutions/treatments (n=4) or not being able to get an appointment (n=3). No respondents reported that they had been banned from services, travel was inhibitory or they were refused treatment/examination for a physical health problem.

- ***Treatment and support for drug and alcohol problems***

25 people reported that they had a drug problem, 19 people (18.6%, N=102) said that they had a drug problem and six that they were in recovery from a drug problem. Overall 14 of these reported receiving treatment.

Eleven of these 14 respondents reported taking Methadone, Subutex or another substitute drug, which was prescribed for them. In addition, two respondents who stated they did not need any treatment/support) reported taking substitute drugs, one that were prescribed for them and one prescribed for someone else.

Of the 29 people who reported that they have an alcohol problem or are recovering from an alcohol problem, one third stated that they did not need any help:

6.6.2. Primary Care Services

Data from the Herefordshire audit showed that:

- **78%** (80 people) of participants were registered with a GP[20]. This is lower than the combined data for the 'Unhealthy State of Homelessness' audits which found that 90% of people were registered with a GP. No respondents reported being refused GP registration in the past 12 months.
- **Only 29%** (28 people, N=97) were registered with a dentist in their local area.[21] Two people said that they had been refused registration during the last 12 months (due to waiting list and no NHS patients).

[20] Includes GP or homeless health service

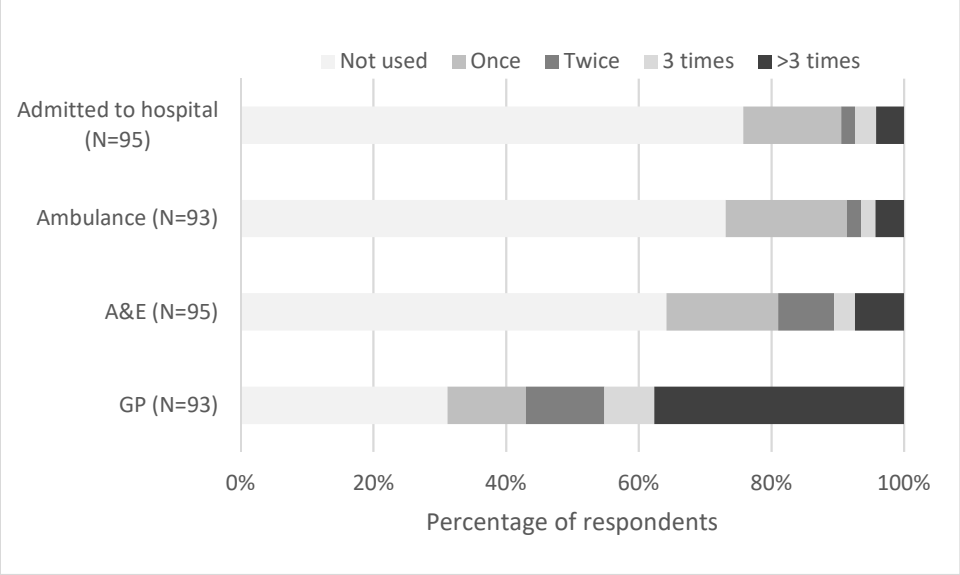
[21] An equivalent national statistic could not be identified, but 'Access to Dental Service' data NHS Outcomes Framework 2016/17 states that 94.6 who tried to get a NHS dental appointment over the previous two years did so.

Those who were being supported by HCOS, and therefore likely to be experiencing some of the most extreme forms of homelessness were significantly less likely to be registered with a GP than those supported by SHYPP and Homegroup (35.4% HCOS supported individuals not registered with GP compared to 9.3% of SHYPP or Homegroup supported individuals). This likely reflects the different homelessness experience of these groups.

6.6.3. Acute care services

Frequency of use of healthcare services in the past year are shown in Figure 13. Of the participants who answered the question, 69% had visited a GP during the last 12 months and 38% had visited more than 3 times. 36% had used A&E in the last year, and a quarter of participants (24%) were admitted to hospital. In total, the 95 respondents made a minimum 69 visits to A&E and had 43 admissions to hospital in the previous year.

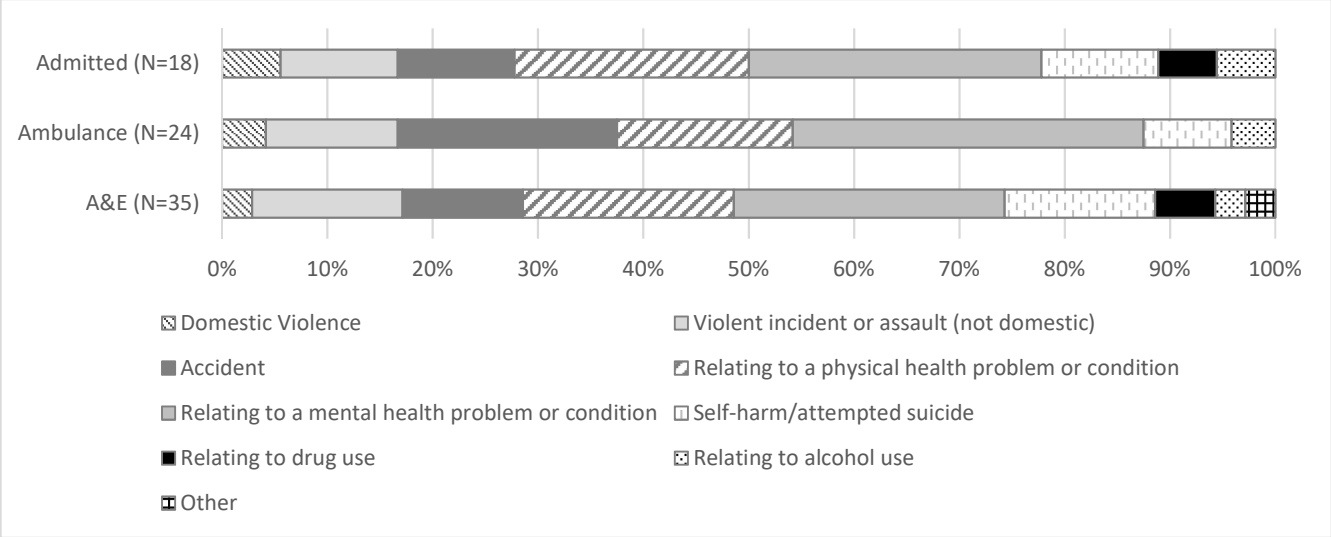
Figure 13. Use of acute health services in last year



Respondents were asked for the main reason for their use of each of the services A&E, ambulance and hospital use in the past year (i.e. only one reason could be given for each service even if there had been multiple use of the service).As can be seen in Figure 14, mental health problems and self-harm/attempted suicide

contribute to approximately 40% of the use of each of these services. Violence and accidents were the main reason for approximately 30% of use.

Figure 14. Main reason for use of acute health services



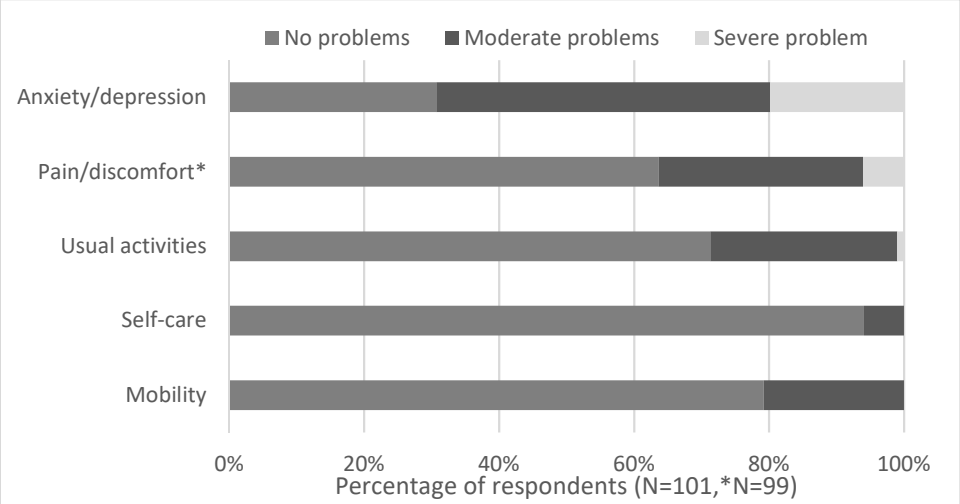
Of the 23 respondent who had been admitted to hospital, 16 were discharged into accommodation suitable to meet their needs, three could not remember where they were discharged to, one did not answer admission, however, three were discharged back onto the street (13%).

6.7. Wellbeing

6.7.1. Self-reported wellbeing

Whilst the majority of respondents reported no problems with mobility and self-care, ~70% of respondents reported moderate or severe problems with anxiety or depression and nearly 40% reported problems with pain and discomfort (Figure 15). 68% reported a long-standing illness or disability (LSI).

Figure 15. Description of own health state



Participants were asked to rate their health state on a scale from 0 to 100, where 100 is the best state they could imagine and 0 the worst. The mean score was 58, with a minimum of 4 and maximum of 100.

The majority of respondents (n=49) felt their health to be about the same as it was 12 months ago, with equal numbers reporting better and worse health (26 and 27 respectively, out of 102 respondents).

Self-reported long standing illness, disability or infirmity: 68% (67 people) report a long-standing illness or disability (LSI) of 99 respondents to this question.

6.7.2. Life Style

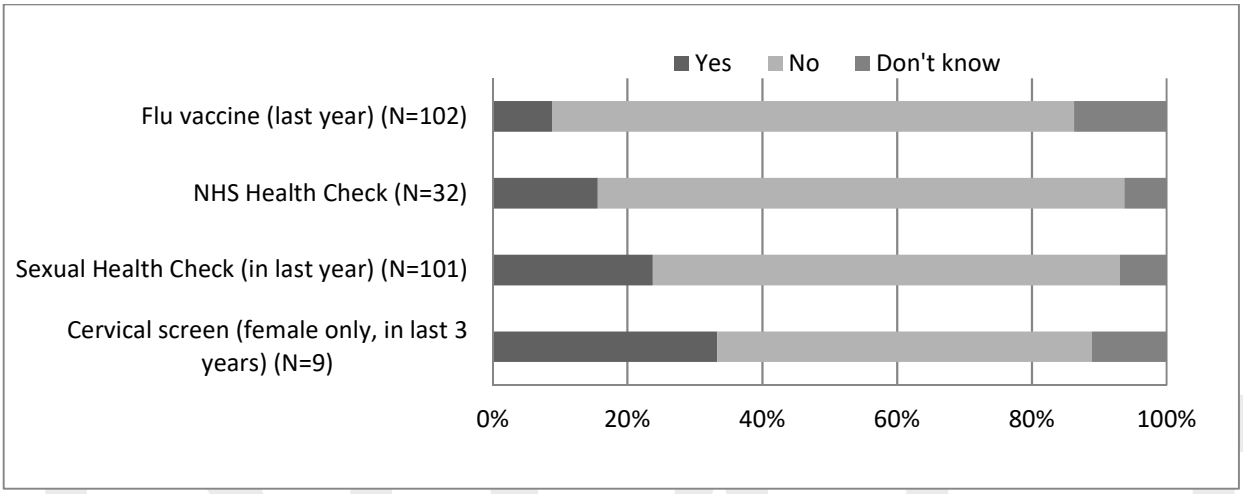
Smoking: 82%, of participants (84 people) smoke tobacco, which is more than five times higher than the national population at 16%.[22]

- 23% of participants said that they would like to give up altogether.
- 33% did not know whether or not they want to give up altogether.
- 74% had not been offered help by a health professional to give up smoking.
- 19% had been offered help to give up but did not take it.

[22] Office for National Statistics, 2016

Prevention: There was low uptake of preventative health services, including health checks and vaccinations (Figure 16). For example, fewer than 10% of respondents received flu vaccine last year.

Figure 16. Uptake of preventative health interventions



Nutrition: 44% of respondents reported eating an average of one meal a day, 37% reported eating two meals a day. Only 19% of respondents reported eating, on average, 3 or more meals a day. One respondent reported an average of no meals a day (N=101).

27% respondents reported consuming less than one fruit or vegetable a day, 33% reported 2-3 portions a day and only 9% four or more portions a day (N=101).

Exercise: 21 respondents (21%, N=101) reported exercising for 30 minutes five or more times per week, thereby meeting the recommended exercise levels. However, the vast majority never exercised (56%).

7. Conclusion

The results presented here highlight the poor physical and mental health, and substance misuse, of the homeless population in Herefordshire. These factors can be both the cause and consequence of homelessness.[23]

Self-reported health in this population is considerably worse than that of the general population: here 68% reported a long-standing illness or disability (LSI)

[23] Royal College of Physicians (1994). Homelessness and ill health.

which compares to 36% of the general population nationally[24] and is only marginally lower than the 69% of general population aged over 75 years who report having a LSI.

The Homeless Link 'Unhealthy State of Homelessness'[25] report found that almost all long-term physical health problems are more prevalent in the homeless population that in the general public. The data for Herefordshire would support this.

Mental health problems were extremely prevalent in this population.

Drug and alcohol abuse, especially when combined with a mental illness, are linked to homelessness as causal risk factors and triggers, but also as the consequence of being homeless.[26]

[24] Adult Health In Great Britain, Office for National Statistics
[25] The Unhealthy State of Homelessness, Health Audit Results 2014, Homeless Link.
[26] Evidence Review of the Costs of Homelessness, DCLG, August 2012

There is a growing awareness that individuals with dual diagnosis experience some of the worst health, wellbeing and social outcomes, and are among the most vulnerable in society.'[27]

Accessing the right health care early can prevent problems deteriorating to a point where they become critical and, therefore, significantly more costly both to the individual and to health care services.

Homeless people if not supported, treated effectively and given appropriate access to healthcare services are one of the most costly populations to the NHS. They consume eight times more NHS resources than that of the housed population, with 'homelessness' being an independent risk factor for experiencing emergency department and inpatient admissions high usage status.[28]

According to a Department of Health study, which provides estimates based on 40,500 rough sleepers or those living in a hostel, homeless people are 3.2 times more likely than the general population to be an impatient admission, at an average cost 1.5 times higher.[29]

Research has shown that that people who experience homelessness for three months or longer cost on average:

- £4,298 per person to NHS services.
- £2,099 per person for mental health services.
- £11,991 per person in contact with the criminal justice system.[30]

Hospital admissions and accident and emergency attendances are likely to represent only a small fraction of the total costs to health services. The Evidence Review of the Costs of Homelessness suggest that, due to the high prevalence of drug and alcohol dependency and mental health problems amongst this population, the more significant costs to health are likely to come from drug and alcohol treatment and mental health services.[31]

[27] Severe mental illness and substance misuse, prepared for NICE, December 2015
[28] Health of Homelessness, John S Bradley ,NHS Principal Public Health Practitioner Wales, the bmj, February 2018
[29] Department of Health (2010) Healthcare for single homeless people.
[30] Better than a Cure? Nicholas Pleace and Dennis Culhane, University of York, 2016.
[31] Department for Communities and Local Government (2012). Evidence review of the costs of homelessness. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/7596/2200485.pdf

Being homeless can cause or intensify social isolation, and create barriers to education, training and paid work.

There is also a substantial body of evidence that being homeless can make it extremely difficult to have a healthy lifestyle. It has a major detrimental impact on personal wellbeing and can cause significant long-term health problems or exacerbate those which are pre-existing. The longer a person is living on the streets, is sofa-surfing or living without a safe and stable home, the more these problems multiply and the harder they are to overcome.

8. Recommendations

- The Health and Wellbeing Board sign up to the 'Charter for Homeless Health' and implement its commitments, including identifying need, providing leadership and commissioning for inclusion;
- The Health and Wellbeing Board members review within their organisations access to services, including mental health services, primary and secondary health care and preventative services for homeless people with the aim to improve health and reduce first-line use of A&E and ambulance services;
- The Health and Wellbeing Board seeks assurance from lead agencies (including Herefordshire Council, Herefordshire Clinical Commissioning Group, Wye Valley NHS Trust and 2gether NHS Trust) on the actions they are taking to address this inequality and considers these in a future session together with local consideration/adoption of the national memorandum of understanding on health and housing "Improving health and care through the home: A National Memorandum of Understanding";
- The Homeless Health Needs Audit be undertaken again in 3 years' time (2022; completing the audit cycle) and reported to the HWBB.

9. Appendix 1.

Homeless Health Needs Audit Survey Questions