

Gateshead Homelessness and Multiple and Complex Needs Health Needs Assessment



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Contents

Executive Summary	<i>page 6</i>
Key findings and recommendations	<i>page 7</i>
Chapter 1: Introduction and Background	<i>page 19</i>
1.1 Introduction	<i>page 19</i>
1.2 HNA Policy Background	<i>page 21</i>
Chapter 2: Aims and objectives of the Health Needs Assessment	<i>page 23</i>
2.1 Aim	<i>page 23</i>
2.2 Objectives	<i>page 23</i>
Chapter 3: Scope	<i>page 24</i>
3.1 Identifying the target population and challenges in defining the population of interest	<i>page 24</i>
3.2 Domains of Homelessness: Including the overlap with multiple and complex needs	<i>page 24</i>
3.3 Dynamic nature of homelessness	<i>page 27</i>
Chapter 4: Methods	<i>page 28</i>
4.1 Methods	<i>page 28</i>
Chapter 5: Data Sources	<i>page 29</i>
5.1 Data Gaps	<i>page 29</i>
5.2 Identifying Key Vulnerable Groups in Data Collections	<i>page 30</i>
5.3 Limitations in Quantifying Homelessness	<i>page 31</i>
5.4 Key Sources of Local Data utilised for the HNA	<i>page 31</i>
5.5 HNA Coordination and Accountability	<i>page 33</i>
Chapter 6: Gateshead Headline Data	<i>page 33</i>
6.1 Population	<i>page 34</i>
6.2 Socio-Economic Circumstances	<i>page 34</i>
6.3 Health	<i>page 34</i>
6.4 Housing	<i>page 35</i>
Chapter 7: Pragmatic Review of the Literature – Understanding Homelessness and Multiple and Complex Needs	<i>page 37</i>
7.1 Housing and Health	<i>page 37</i>
7.2 Home – The Main Setting for Health	<i>page 38</i>
7.3 Multiple and Complex Needs	<i>page 39</i>
7.4 The Link between Homelessness and Multiple and Complex Needs	<i>page 40</i>
7.5 Clusters of Multiple Exclusion Homelessness	<i>page 40</i>

7.6 Multiple and Complex Needs and the Interaction with Housing Vulnerability	<i>page 41</i>
7.7 Unstable Accommodation and the Relationship between Health, Wellbeing and Recovery	<i>page 42</i>
Chapter 8: The Financial Costs of Homelessness and Severe and Multiple Disadvantage	<i>page 43</i>
8.1 Costs of Homelessness	<i>page 43</i>
8.2 The Cost of Fragmentation	<i>page 43</i>
8.3 Local evidence of fragmentation: Fulfilling Lives Client's Interaction with Services in Gateshead	<i>page 45</i>
8.4 Homeless Prevention - Potential Savings	<i>page 46</i>
8.5 Newcastle Gateshead Fulfilling Lives - Cost Calculator	<i>page 47</i>
Chapter 9: Roots and Pathways into Homelessness	<i>page 48</i>
9.1 Supply of affordable housing	<i>page 49</i>
9.2 Poverty	<i>page 49</i>
9.3 Psychological Understandings	<i>page 51</i>
9.4 Lifecycle transitions/leaving an institution	<i>page 51</i>
9.5 Immediate triggers	<i>page 52</i>
9.6 Sequencing of MEH experiences	<i>page 52</i>
Chapter 10: Meeting Specific Needs	<i>page 53</i>
10.1 Gender	<i>page 53</i>
10.2 Ex-Service Personnel Homelessness	<i>page 54</i>
10.3 Care Leavers	<i>page 54</i>
10.4 Offending and Leaving Prison	<i>page 56</i>
10.5 Lesbian, Gay, bisexual and transgender homelessness	<i>page 57</i>
10.6 Migrant and Immigrant Homelessness	<i>page 58</i>
Chapter 11: The Extent of Homelessness in Gateshead	<i>page 59</i>
11.1 Statutory Homelessness Prevalence	<i>page 60</i>
11.2 Homelessness Prevention	<i>page 61</i>
Chapter 12: Quantifying multiple needs within the homeless population	<i>page 70</i>
12.1 Hard Edges Report – Mapping Severe and Multiple Disadvantage	<i>page 70</i>
Chapter 13: Housing Support and Supported Housing in Gateshead	<i>page 72</i>
13.1 Supported Housing Portal Data	<i>page 77</i>
13.2 Supported Housing Providers Registered with the Portal	<i>page 77</i>
Chapter 14: The Health and Wellbeing Needs of Single Non Priority Homeless Population	<i>page 85</i>
14.1 Health Inequalities	<i>page 86</i>

14.2 Health Need and Homelessness	<i>page 87</i>
14.3 Mortality in Homeless Population	<i>page 89</i>
14.4 Maintaining a Healthy Lifestyle and Homelessness	<i>page 89</i>
14.5 Smoking Prevalence and Homelessness in Gateshead	<i>page 89</i>
14.6 Nutrition and Homelessness	<i>page 91</i>
14.7 Oral Health and Homelessness	<i>page 92</i>
14.8 Sexual Health and Homelessness	<i>page 93</i>
14.9 Health Protection – Public Health Risks and Homelessness	<i>page 95</i>
14.10 Cognitive impairment, learning difficulties, literacy and Homelessness	<i>page 97</i>
14.11 Substance and Alcohol Misuse and Homelessness	<i>page 97</i>
14.12 Mental Health Problems and Homelessness	<i>page 100</i>
14.13 Dual Diagnosis and Homelessness	<i>page 105</i>
14.14 Access to health services by Homeless people	<i>page 108</i>
Chapter 15: Stakeholder Consultation	<i>page 111</i>
Chapter 16: Peer Research – Qualitative Findings	<i>page 114</i>
Chapter 17: Making Homelessness a rare event and effectively supporting those with Multiple and Complex Needs	<i>page 115</i>
17.1 Focusing on What Works and Harnessing the Power of Data	<i>page 115</i>
17.2 Preventing Homeless	<i>page 116</i>
17.3 Primary, Secondary and Tertiary Prevention	<i>page 117</i>
17.4 What should good service design for people who have complex needs look like?	<i>page 120</i>
17.5 Improving access to appropriate accommodation and support for people with multiple and complex needs	<i>page 120</i>
17.6 Peer Support	<i>page 122</i>
17.7 Integrating Housing, Health and Care	<i>page 122</i>
Reference List	<i>page 123</i>
Appendix A – Gateshead Drug Related Deaths Annual Report 2015	<i>page 134</i>
Appendix B – Key Policies, Frameworks and Guidelines	<i>page 148</i>
Appendix C – Limitations of the Supported Housing Portal Data	<i>page 157</i>
Appendix D – Public Health Bid	<i>page 159</i>
Appendix E – Map of Supported Housing in Gateshead	<i>page 169</i>
Appendix F – Qualitative Feedback from Supported Housing Providers	<i>page 170</i>
Appendix G – Themes and Key Messages from Homelessness Health Needs Assessment Consultation Event	<i>page 172</i>
Appendix H – Stakeholder Consultation Event Programme	<i>page 190</i>
Appendix I – Peer Research Report	<i>page 191</i>

Executive Summary

Introduction

Gateshead Health and Wellbeing Board requested the undertaking of this Health Needs Assessment (HNA). A HNA is a tool for change that is used to identify the health needs of a particular population, with similar characteristics, or a population in a particular geographical area. The focus of the HNA is on vulnerable, homeless adults (18 years and over) who are enduring multiple and complex needs. This typically includes vulnerable single person households for whom the local authority does not have a statutory duty to accommodate. This encompasses those who are rough sleeping, living in supported accommodation, such as hostel or night shelter or receiving floating support to help sustain an independent accommodation option. It also includes those living in insecure accommodation, 'sofa surfing', squatting, people at risk of homelessness and those who have a history of episodic homelessness. They often have repeated experiences of homelessness or vulnerable housing as well as a wide range of other support needs which include substance misuse, physical and mental health issues, chronic poverty, social exclusion, cycles of physical and emotional abuse and involvement with the criminal justice system. They do not fit neatly into existing service compartments and frequently struggle to navigate a complex system where they either receive help late or not at all. This is not acceptable or sustainable. This HNA takes place against a backdrop of ongoing work.

Aim

The Gateshead Homelessness and Multiple and Complex Needs HNA will assess the scale, nature and impact of homelessness combined with complex and multiple needs in Gateshead in order to provide information which can be used to address the wider determinants of health and influence strategies and actions to prevent and alleviate homelessness and reduce health inequalities for this group

Objectives

- Identify the extent of the vulnerably housed and homeless population in Gateshead – specifically those not considered to be statutory homeless and for whom the local authority does not have a statutory duty to accommodate.
- Identify where and how homelessness overlaps with other issues associated with deep social exclusion and poor health and wellbeing outcomes.
- Identify the current and future health and wellbeing needs of people with lived experience of homelessness (main burdens of morbidity and mortality).
- Identify the triggers and pathways to vulnerability and protective factors across the life course and explore what successful support should look like by including the views of those with lived experience of homelessness.
- Understand the system and service response to homelessness and multiple and complex needs in Gateshead. (including access, utilisation, health outcomes, quality – identify gaps/challenges and opportunities)

Inform what might be done to ensure more comprehensive ways of working that are better able to tackle homelessness and meet people's overall needs and aspirations for recovery and well-being.

Methods

The HNA employed a range of collaborative methods to assess the scale and nature of adult homelessness in Gateshead. This involved reaching out to those with lived experience of homelessness, directly through peer research and stakeholder consultation and indirectly by seeking information from the people and services that they were in contact with. Methods included; **Epidemiological methods** to describe health need using estimates of incidence and prevalence of homelessness and to pragmatically review the literature. **Corporate methods** to undertake peer led qualitative research and a HNA Stakeholder Consultation Event; **Comparative methods:** to

consider current provision in Gateshead and compare what current understanding suggests is important to help make homelessness a rare event and to effectively support those experiencing multiple and complex needs.

Data Collected

Adequate baseline data is necessary to help understand and address health inequalities. The HNA identified a number of data gaps and data limitations in relation to quantifying and understanding the needs of homeless adults with multiple and complex needs and how they are currently using services. The HNA found variation in how homelessness is defined and understood and therefore measured and the same issues apply to multiple and complex needs. Data, at Gateshead level on homeless adults' use of primary and secondary care was unavailable, it was not retrievable for mental health service use or adult social care and attempts to obtain data from the criminal justice system were unsuccessful. Limitations were identified in the available data for supported housing. Key sources of local data that was available for the HNA is detailed in the main report. Primary data was also collected for the HNA through peer research methods and through deliberative stakeholder consultation.

Headlines

- Homelessness is not inevitable and is rarely a housing issue alone.
- This HNA has identified local and national evidence of a strong overlap between homelessness and other support needs such as substance misuse, physical and mental ill health, cycles of physical and emotional abuse and involvement with the criminal justice system.
- Homelessness is evidence of inequalities and is a late marker of exclusion and disadvantage.
- Current evidence suggests that homelessness results from the impact of structural, institutional, relationship and personal risk factors and triggers which have a cumulative impact, and are often underpinned by poverty and structural inequalities.
- The HNA highlights the difficulties in quantifying homelessness in Gateshead from the various information sources available (see Chapter 11):
 - Gateshead has seen an increase in the number presenting to the Housing Options service for advice. In 2010/11 the figure stood at 1,759. The following year, the number increased to 3,144 and since then annual numbers have remained fairly static with 3,322 presentations in 2015/16.
 - Whilst the number presenting for support has increased, the number presenting as homeless saw a step change from 756 in 2010/11 to 493 in 2011/12 followed by a progressive decline to 335 in 2015/16.
 - The level of homeless prevention activity increased year on year. In 2010/11 there were 1,437 preventions and during 2015/16 3,411 households were prevented from becoming homeless as a result of activities carried out by the local authority and partners working with those identified as vulnerably housed.
 - Those assessed as being homeless and in priority need has remained relatively stable between 2010/11 and 2015/16 with around 200 households annually.
 - Those assessed as homeless but not in priority need has seen more variation, with numbers declining from 334 in 2010/11 to 110 in 2015/16.
- We do not know the exact numbers of homeless people in Gateshead experiencing multiple and complex needs but the national Hard Edges Report (Fitzpatrick 2015) estimates that in Gateshead there are 3,325 people facing any one of three problems of homelessness, substance misuse and crime. The number of people experiencing all three problems was 245, for this group alone that equates to an annual public spending cost of £5,576,895 based on a national model (see Chapter 8).

- Spending on homelessness and multiple and complex needs is still largely reactive but preventing and rapidly resolving homelessness always costs less public money than allowing homelessness to become sustained or repeated (Pleace 2015).
- The prevalence of problematic childhood experiences among those with multiple and complex needs points to a need for more improved understanding within children and family services of routes in to multiple exclusion homelessness and more targeted work with children who are experiencing issues that may relate to later homelessness (McDonagh 2011).
- The HNA identified evidence to suggest that our current system is weakest where it needs to be strongest. The way services are funded, commissioned, monitored and measured often requires homeless, vulnerable individuals with multiple and complex needs to navigate a complex system that requires them to engage and manage relationships with numerous different agencies in order to address their needs.
- The presence of vulnerabilities such as a history of anti-social behaviour, substance misuse and criminal activity can act as a barrier to accessing a suitable and stable home. People with such vulnerabilities may be forced to seek accommodation in temporary accommodation that can be counterproductive for individuals with complex and challenging needs. Evidence suggests that 'drug taking, threatening behaviour, poor living conditions and disruptive residents often do further damage to the wellbeing of a group of people who may already have precarious lives, volatile relationships and health problems' (Rose and Davies 2014).
- The HNA Peer Research interviewed 27 people in Gateshead with lived experience of homelessness and multiple and complex needs. They identified a number of factors that contributed to their homelessness experiences these included: not being heard in childhood, childhood trauma, mental health and substance misuse, debt and job loss. Respondents raised issues of missed opportunities to intervene, particularly between the ages of 16 and 20, and they talked about the impact of being provided with accommodation and/or support that was sometimes inadequate and even detrimental to their health and wellbeing. Gaps in support were identified across housing, physical, social and mental health. Respondents highlighted a need to listen to people earlier and to listen well, to address issues around transitions and how appropriate help and support can be accessed, to remove postcode barriers and to ensure staff are appropriately trained to recognise and support multiple and complex needs (see Chapter 16).
- The HNA stakeholder consultation event engaged with 30 organisations and 83 people (including those with lived experience). Some powerful key messages emerged from the participants: these were targeted at policy makers, commissioners, service providers and front line staff. Key themes were around a need for system leadership, integration, co-production, prevention and earlier intervention, improved accessibility and workforce development (see Chapter 15).
- The HNA identified evidence locally and nationally of significant and long standing health inequalities faced by people experiencing homelessness. Gaps in our understanding of how local health services are accessed by homeless groups is a barrier to tackling health inequalities that could be addressed. Mental health as a cause and consequence of homelessness and the significant barriers faced in trying to get the right help and support, particularly for individuals with multiple needs, emerged across a number of local data sources. (see Chapter 14).
- It is essential to take the multiplicity of the needs of this population in to account because it is the co-occurrence of the individual factors which makes the way people experience them, and the solutions to them, very different to if any one factor was present as a stand-alone issue (Duncan & Corner 2012).
- To respond effectively to multiplicity of need there is a need to cut across policy areas, funding streams, geographical boundaries, organisations, departments and expertise and knowledge areas.

Key Findings and Recommendations

The following key findings and recommendations have emerged through the HNA process. They are presented with an ambition that they are translated into actions which make a genuine and enduring difference to those at risk of or experiencing homelessness and multiple and complex needs.

To make homelessness a rare event in Gateshead and effectively support people with multiple and complex needs.

Key finding 1:

The HNA had demonstrated the considerable overlap between homelessness and a wide range of other health and support needs - homelessness is not just a housing issue. Homelessness is not inevitable but the HNA shows we are still not solving it, we still have occurrences in the Borough: 3,322 presentations to Housing Options, 211 homeless in priority need, 110 homeless not in priority need, 457 referrals to Supported Housing, Fulfilling Lives: 14 rough sleepers, 50 Hidden Homeless, Basis@363: 163 rough sleepers, 578 hidden homeless, Hard Edges Report: 3,325 in multiple and severe disadvantage

Recommendation 1:

Establish system wide leadership & governance of homelessness prevention

What do we need to do differently?

Coordinate homelessness prevention and support to include preventing all domains of homelessness (statutory homeless, single homeless, rough sleepers, hidden homeless, multiple exclusion homeless, severe and multiple disadvantage) across Gateshead Council and partners.

How?

- System Leadership – Identify and implement a system wide governance system for homelessness prevention and support: Workshops to take this forward:
 - **Gateshead Council Workshop for Strategic & Service Directors and Portfolio Leads** : Care Wellbeing & Learning, Communities & Environment, Public Health, Commissioning & Quality Assurance, Adult Social Care and Independent Living, Council Housing Design & Technical, Development & Public Protection, Benefits and Financial Assessments, Learning & Schools, Economic & Housing Growth, The Gateshead Housing Company, Portfolio Lead (Health, Community Safety, Housing & Economic Development).
 - **External Stakeholder Workshop** with Gateshead Council, CCG, NTW, PHE, Housing Providers, Experts by Experience, Criminal Justice/Probation, Community and Voluntary Sector, Fulfilling Lives.
- Identify an existing forum, or convene a new group to oversee implementation of the Health Needs Assessment and review links with the Housing Intervention Work Plan
- Review the role of the Health & Wellbeing Board in this agenda.
- Visible/genuine involvement of those with lived experience of homelessness and multiple and complex needs within the governance system and policy making process.

Key finding 2:

Spending on homelessness and multiple and complex needs is still largely reactive rather than tackling the root causes (structural, institutional, relationship, personal). Gateshead recorded 3441 cases of homelessness prevention - this figure represents those helped when presenting in housing difficulty. However, we know that visible forms of homelessness are a late marker of disadvantage and often occur after hidden forms of homelessness such as sofa surfing as well as after contact with non-housing services (e.g. criminal justice system, mental health services, treatment agencies). The numbers of people facing all three problems of homelessness, substance misuse and crime in Gateshead equates to an annual cost of £5,578,895 for 245 people (chapter 8). The Peer Research (chapter 16) and review of the literature (Chapter 9) indicates that to tackle the root causes of homelessness and multiple and complex needs we need to build on and continue approaches in Gateshead which address poverty, tackle inequalities and offer help much earlier and when it is first needed (make every contact count) across the life course (many problems start in childhood) and across the wider determinants of health.

Recommendation 2:

Tackle the root causes of homelessness within all policy areas.

What do we need to do differently?

Re-orientate spending towards tackling the root causes of homeless and multiple and complex needs. Make this an explicit goal across all policy areas that contribute to the wider determinants of health in Gateshead (e.g. economic, environment, education, health, social care, housing, welfare services and criminal justice) and offer help when it is first needed across the life course.

How?

- Health and Wellbeing Board to identify how they include and engage with the Housing Sector and the wider determinants of health on the Health and Wellbeing Board. [Health and Wellbeing Board](#)
- The Gateshead Housing Strategy 2013-18, satisfies the requirement to publish a Homeless Prevention Strategy. The Housing Strategy promotes the principle of 'making every contact count' to prevent homelessness. The current strategy is due for a review. This process will involve key stakeholders and provider services and will be informed by policy (Homeless Reduction Act 2017) and evidence which will include the Homelessness and Multiple & Complex Needs HNA. It will also need to read across other policy areas, and links with wider service delivery across the Council. ([Lead: Director Development & Public Protection](#))
 - Work is already underway to review the work of the Council's multi-agency, Vulnerable Persons Housing Working Groups, VP Housing Panel, and the Vulnerable Persons Housing portal; which have been key tools in preventing homelessness.
 - Ensure that the reviewed Housing Strategy and Action Plans formally recognise the relationship between health, housing and homelessness.
 - Ensure that the Housing Strategy and Action Plans formally link to and influence other policies across the Council which address the wider determinants of health and can contribute to homelessness prevention across the lifecourse (e.g. links with Early Help) to address the root causes of homelessness, key transition points, and routes out of homelessness.
 - Ensure actions enable a shift of resources from managing homelessness and 'crisis' problems towards primary prevention of homelessness.
 - Ensure that the Housing strategy and Action Plan links to and influences policies which address the pervasive role of poverty as a root into homelessness and a barrier out of homelessness (e.g. recognition that poor financial circumstances are increasingly the reason why people are struggling to maintain tenancies/obtain tenancies supported or otherwise). We need to identify shared objectives and actions within the refresh of the Financial Inclusion Strategy 2012-15 and ongoing development of Gateshead Anti-Poverty Strategy.
 - Build an evidence base to demonstrate shared measures of success and cost effectiveness of re-orientation of resource towards prevention.

Key finding 3:

The HNA identified that there were gaps in the current approach to recording of housing status across a range of services. Identifying those who are homeless or at risk of homelessness when they first come into contact with a non-housing service, or are being reviewed is key to improving the support and health care that they receive and will enable more effective prevention and/or early intervention and support. This is not happening across all key services.

Recommendation 3:

Establish a system wide Identification of those who are homeless or at risk of homelessness to enable all services to contribute to homelessness prevention and support.

What do we need to do differently?

The Homeless Reduction Act 2017 places a new duty on public services to notify a local authority if they come into contact with someone they think may be homeless or at risk of becoming homeless. In Gateshead we need to establish a system wide approach to assess, record, respond and review the housing circumstances of those in contact with health, social care, housing, criminal justice and welfare services in a timely manner and take appropriate action to prevent homelessness or enable move-on to a suitable home.

How?

- Through the review of homeless prevention actions within the Housing Strategy Action Plan, develop and agree a consistent methodology to identify the different domains of homelessness including those with multiple and complex needs.
- To improve the identification, assessment and recording of the different domains of homelessness – and embedding the methodology across services in Gateshead via, services signing up to it and through staff training and development
- Prioritise services working with groups identified by Public Health England (2016) who are at a particular risk of inappropriate or unsuitable housing:
 - children and their families
 - people with long term conditions
 - people with mental health issues
 - people with learning disabilities
 - people recovering from ill health
 - people who spend a lot of time at home e.g. carers
 - low income households (this is widespread and implications to be reflected in Housing Strategy).
 - people who experience a number of inequalities (homeless, sex workers, vulnerable migrants, Gypsies, Travellers, Roma).
- Early identification of those who are at risk of losing suitable accommodation or the current situation is causing concern and costs.

Key finding 4:

The HNA found gaps in routine and/or comprehensive data to be able to quantify single adult homelessness and to understand their health and care needs and health inequalities. There is also a gap in how we capture multiplicity of need. Data which captured service outcomes for this group was limited. The HNA also identified circumstances where data was being collected but not in a useable format for analysis either because of poor quality information systems or capacity issues. Stakeholders during the HNA Consultation highlighted wasteful data collection as an issue.

Recommendation 4:

Establish good quality & useful data on homelessness and multiple & complex needs.

What do we need to do differently?

Address gaps in local data collection about homelessness and multiple and complex needs and remove any unnecessary and wasteful data collection requirements, and identify systems for analysis and reporting (linking with Recommendation 1, regarding governance arrangements).

How?

- Through the review of homeless prevention actions within the Housing Strategy Action Plan undertake a review of data requirements:
 - Agree what data is needed to effectively quantify homeless adults with multiple and complex needs?
 - Agree what data is required to monitor health, social and economic outcomes related to this group?
 - Aspinall (2014) identified the following as particularly important for the vulnerable homeless: use of services (primary and secondary care); mental health status and use of psychiatric services; drug/alcohol misuse and use of related treatment services; sources that capture dual or sets of co-existing medical conditions.
- Then undertake an audit of data currently being collected by the Local Authority and its partners and benchmark this against agreed data requirements.
- Address gaps in Health data (primary care, secondary care, sexual health, mental health) to ensure that health inequalities relating to homeless adults with multiple and complex needs are monitored and addressed.
- Address limitations identified in the supported housing portal database (e.g. develop a solution in Northgate and/or work sub regionally with other housing providers to develop and implement on a sub-regional basis)
- Improve retrievability of data collected by The Gateshead Housing Company on Non-statutory Homeless (e.g. develop a solution through Northgate)
- Ensure data is collected and utilised pertaining to the vulnerable persons housing panel
- Gateshead Council and its partners to agree and resource a unified data set/system for homelessness and multiple and complex needs.
- Commissioners to enable flexibility in the development of outcome measures for homeless adults with multiple and complex needs to recognise the importance of service providers co-producing outcome measures that matter to the individual and also the need to enable short, medium and long term outcomes to be captured.
- Ensure outcome data that is collected on services commissioned to provide supported accommodation is retrievable and utilised.
- Review and update the JSNA based upon the Health Needs Assessment
- Explore how mapping tools can be utilised to portray housing tenure and links to communities of interest at a population level.

Key finding 5:

Evidence from the HNA (e.g. Peer Research, Fulfilling Lives service data, HNA Stakeholder Consultation Event) indicates that the way services are currently planned commissioned and delivered is in silos which rarely address all of the issues an individual may be experiencing. Those with multiple and complex needs are required to navigate a complex system and multiple professionals are working with the same individual. For example, data used in the HNA from Fulfilling Lives showed that on average each client was referred to 5.3 different services and 10% of their clients were referred to more than 10 different services. This means that in Gateshead vulnerable individuals are expected to be able to meaningfully engage and manage relationships with multiple services and multiple staff in order to have their needs addressed. This is an unrealistic expectation, it is unlikely to be effective and it is an inefficient use of resources.

Recommendation 5:

Join up commissioning processes to address homelessness & multiplicity of need

What do we need to do differently?

Join up across the system to commission and deliver coordinated, preventative services which are designed to understand and respond to the whole person and are able to work effectively with multiplicity of need.

How?

- Build on good work in Gateshead (The HNA Stakeholder Consultation Event – chapter 15, identified many assets across people and place in Gateshead) to join up assets, budgets and resources within Gateshead to make the most of the Gateshead pound. Led by Health and Wellbeing Board.
- Build on existing good practice to integrate and join-up commissioning processes across health, care, housing and the criminal justice system in Gateshead to jointly address homelessness and multiple and complex needs. Health and Wellbeing Board
- Build an evidence base for what works and develop a local model for working with homeless adults with multiple and complex needs (system thinking - take a cohort of homeless adults with multiple and complex needs and learn how to be effective for each individual what does this tell us about root causes, what help is needed/works, learn from this, implications for how we do things) – See recommendation 6.
- Meeting the health needs of homeless people requires a shift in performance management from accountability for results towards practice improvement ‘how do we help people to do the right job well’ (Lowe 2016).

The Stakeholder Consultation Event Told Us To:

- Ensure a single point of access and single ‘assessment’ /understanding process for those with multiple and complex needs (for example learning from CYP Common Assessment Framework)
- Ensure we address need through positive transitions (e.g. hospital discharge, children to adult services, prison release, leaving care) Mental Health Programme Board
- Develop a lead practitioner role with the ability to marshal resources and act as a bridge across health, care housing and criminal justice and support smooth transitions between services and encourage services to be flexible for those with multiple and complex needs.
- Review service thresholds and remove any barriers to support to enable prevention and early intervention.
- Senior level strategic commitment from statutory and voluntary agencies to offer flexible responses for homeless adults with multiple and complex needs.
- Ensure services are assertively accessible and available 24/7
- A fast-track single ‘assessment’/understanding process for those identified as vulnerable/multiple and complex needs.
- Ensure services are personalised and able to work with multiplicity of need
- Ensure services are equipped to address the issues that caused or put the individual at risk of homelessness (e.g. poverty, social exclusion, trauma, mental ill health) building on strengths and capabilities over the long term.
- Genuine involvement of those with experience of homelessness and multiple and complex needs.
- Access to mental health and dual diagnosis support.

Key finding 6:

The HNA Consultation Event and the Peer Research identified a need for staff from all sectors working with homeless adults with multiple and complex needs to have the appropriate skills, knowledge and attitudes to be able to support vulnerable people to achieve recovery and good health and wellbeing.

Recommendation 6:

Ensure the workforce are equipped and supported to effectively understand & support multiplicity of need.

What do we need to do differently?

Have a strategic approach across Gateshead to ensure that staff working with homeless adults with multiple and complex needs are equipped and supported to deliver person centred and inclusive care which facilitates recovery and good health and wellbeing.

How?

- Gateshead Council and Key Partners to develop a system wide workforce development strategy/action plan to ensure that the workforce has the appropriate skills, attitudes and knowledge to prevent homelessness and to support homeless adults with multiple and complex needs. To be achieved through:
 - Formation of a multi-agency (integrated) training sub group for multiple and complex needs – reporting to Gateshead Health and Wellbeing Board with agreed terms of reference, membership, aims and objectives.
 - Training sub group for multiple and complex needs to undertake a training needs analysis to enable services/professionals to identify training needs and priorities informed by those with lived experience.
 - Training sub group for multiple and complex needs to develop a system wide workforce development strategy/action plan ensuring this builds on and develops models of good practice in Gateshead and is informed by the training needs analysis.
 - Ensure links with the refresh of the Financial Inclusion Strategy and ongoing development of an Anti- Poverty Strategy around workforce development so that staff have access to financial inclusion training.
 - Staff working with homeless adults with multiple and complex needs to access brief intervention (Making Every Contact Count) training to support healthy lifestyle behaviours.

Key finding 7:

Public Health England (2016) is leading a programme of work that recognises and promotes the home as the main setting for health. In Gateshead the HNA found evidence that housing provision is often weakest where it needs to be strongest eg; drug related death no emergency couple accommodation; Overview and Scrutiny Committee no direct access accommodation; multi – occupancy hostels not conducive to health, Portal data; only 27% -33% of referrals to supported housing are accommodated with no follow up information for those vulnerable homeless who were not housed, fulfilling lives data found individuals with high numbers of moves.

Recommendation 7:

Ensure that those with multiple and complex needs have homes that are able to be 'a main setting for health'.

What do we need to do differently?

Ensure that in Gateshead we recognise and promote the home as a main setting for health by ongoing work to ensure that there is a sufficient supply and range of suitable emergency and settled accommodation for those with multiple and complex needs. This needs to be linked to appropriate and good quality support which is matched to individual needs to facilitate and sustain recovery and good health and wellbeing.

How?

- Commissioners, service users and providers to agree a definition of 'suitable' home – use Homelessness (Suitability of Accommodation) (England) Order 2012 as a minimum.
- Use the planned Housing Support Workshop (emerging from the Housing Intervention Plan, being led by the Housing Growth Unit) to map services that are in direct contact with residents and have a duty to carry out property condition inspections, mandatory and selective licensing, and immigration inspections (Private Sector Housing Team; TGHC staff).
- Need to build an evidence base to develop local solutions; for example much evidence pointing towards Housing First Approaches. (Recent paper by York University). The Council's Housing Solutions for Care & Wellbeing Meeting provides an appropriate forum to review the evidence and make recommendations.
- Ensure that we develop an integrated model of accommodation with support that is an opportunity to address the issues that caused or put the individual at risk of homelessness and is flexible and tailored to support those with short, medium and long term needs and has monitoring in place to fully understand the impact of the support on health wellbeing and recovery and enable ongoing practice improvement.
- Understand and reduce barriers to housing stability which emerge from poverty and social exclusion (e.g. Implications of welfare reform agenda - housing benefit cap, Universal Credit, Under Occupancy) through shared objectives within the refresh of the Financial Inclusion Strategy and Housing Strategy and input from the Employment & Enterprises Service in integrated models of support.
- Remove barriers to accessing suitable accommodation faced by some groups of adults with multiple and complex needs (e.g. Portal Data and feedback from Mental Health and Housing Workers indicate that for those with past history of arson, antisocial/challenging behaviour, substance misuse and high mental health needs it is difficult to find accommodation) by reviewing referral criteria and the accommodation offer.
- Ensure that we have sufficient emergency and settled accommodation for those people with mental health needs/complex problems.
- Review Council Housing Stock that is not being used.
- Build on existing evidence and Gateshead Fulfilling Lives Pilot around the value and effectiveness of Psychologically Informed Environments particularly in projects working with people with histories of complex trauma.

Key finding 8:

Homeless adults are not a homogenous group and some subgroups among homeless people may experience specific risks and needs profiles. The HNA highlighted some groups that have been identified within the literature who may have specific needs within Chapter 10. These groups included; women, ex service personnel, care leavers, those offending and leaving prison, lesbian, gay, bisexual and transgender homeless and migrant and immigrant homeless. The HNA also identified gaps in our understanding of the needs of some subgroups of homeless people in Gateshead.

Recommendation 8:

Meet specific needs within the homeless population – personalisation and equalities.

What do we need to do differently?

Need to ensure that in Gateshead we have robust ways to identify subgroups among homeless people to ensure that the prevention activity and the support and services commissioned and available to them is tailored to meet their specific needs.

How?

- Need to ensure that data collection systems are able to distinguish subgroups within the homeless population to better understand their routes into homelessness, their presenting needs and short, medium and long term outcomes. [See Recommendation 4.](#)
- Build on existing evidence and gaps in knowledge about the needs of specific subgroups within the homeless population in Gateshead to inform commissioning and service development. [See Recommendation 2.](#)
- Commissioning Processes in Gateshead need to identify and better understand the needs of vulnerable subgroups of homeless people to ensure that homelessness solutions are tailored to meet specific needs. [Commissioning and Quality Team, Newcastle and Gateshead CCG](#)
- Expedite responsibilities under the Public Sector Equalities Duty

Key finding 9:

Homelessness is evidence of health inequalities. Data was not available from primary and secondary care for those identified as homeless in Gateshead however, the HNA was able to draw on other service data sets to highlight health issues faced by local homeless adults with multiple and complex needs and consider this in light of national/international evidence. Chapter 14 of the HNA has highlighted inequalities in access to health services by homeless people (e.g. 69% of health drop users not registered with a GP), inequalities in healthy lifestyle behaviour; oral health, sexual health, substance and alcohol misuse, significant levels of expressed mental health need, dual diagnosis and undiagnosed learning difficulties.

Recommendation 9:

Demonstrate a reduction in health inequalities experienced by homeless people with multiple and complex needs.

What do we need to do differently?

Demonstrate a reduction in health inequalities experienced by homeless people with multiple and complex needs in Gateshead via a coordinated approach between health, housing and care to improve care pathways and address gaps in provision, and access to preventative and treatment services.

How?

- Agree what data (primary and secondary care) to monitor access to health service and wellbeing of this group. See recommendation 4. [Newcastle Gateshead CCG](#)
- Identify a link GP and resource nursing input to enable re-launch of NHS Health Drop-In Pilot at Basis@363 to include physical health assessment, screening for dental/oral problems, Blood Borne Viruses, smoking, drug and alcohol problems, TB screening, screening for mental health problems. Formal Evaluation [Newcastle Gateshead CCG](#).
- Identification of those not registered with a GP and promotion of GP registration – Staff (Housing Support staff/Fulfilling Lives Navigators) to continue support with GP registration and continued use of Basis@363 as address for those without permanent address.
- Navigation model to support individuals to attend appointments and engage in treatment.
- All hospitals should have protocols for discharge planning for excluded groups (guidance developed by St Mungos and Homeless Link). [Newcastle Gateshead CCG, Northumberland Tyne and Wear NHS Foundation Trust, Gateshead Health NHS Foundation Trust](#)

Reduce the Inequalities in Healthy Lifestyle Behaviours:

- Develop a plan for housing and resettlement services to become health promoting environments/settings. [Public Health and Commissioning and Quality Team](#).

Reduce nutritional health inequality of Homeless People

- Supported Housing to have a role in promoting good nutrition link to Health Promoting Environment Plan. [Public Health and Commissioning and Quality Team](#)
- Ensure homeless groups included in strategies to promote healthy eating/good nutrition. [Public Health](#)

Reduce the inequalities in smoking prevalence for homeless people by:

- 10 Year Strategy – target to reduce inequality in smoking prevalence for vulnerable groups and need to identify homeless population to enable monitoring of access and uptake of smoking cessation services. [Public Health](#)
- Staff working with vulnerable groups to be targeted to undertake Active Intervention Training. [Public Health](#)
- Substance Misuse Strategy Action Plan to include requirement for recovery and treatment service, Housing and Fulfilling Lives Navigators to undertake Active Intervention Training. [Public Health](#)

Reduce inequalities in dental health

- Audit access to dental services and identify how access to dental health services can be improved for homeless groups with local NHS/Community Dental Services– [Public Health](#)
- Dental care for excluded groups to be included in Gateshead Oral Health Strategy [Public Health](#).
- Ensure that obtaining data about the homeless population is prioritised within any future oral health needs

assessment undertaken in Gateshead – Public Health

- Self-Assessment of Gateshead arrangements for dental care for homeless/vulnerable groups against The Faculty for Homeless and Inclusion Health: Standards for commissioners and service providers (2013)
- <http://www.pathway.org.uk/wp-content/uploads/2014/01/Standards-for-commissioners-providers-v2.0-INTERACTIVE.pdf>
- Supported Housing support workers to support dentist access.
- Fulling Lives Navigators to support dentist access
- Oral Health promotion through supported housing/Basis@363. (link to plan for Health Promoting Environments/Queens Nursing Institute Guidance for promoting oral health).
- NHS Health Drop-In at Basis@363 – an opportunity to review dental health/support dental registration

Reduce Inequalities in sexual health

- Homeless groups to be identifiable within Sexual Health Provider data sets and their access and uptake of sexual health services to be monitored and reviewed. Public Health.
- Access to sexual health services/STI screening to be improved (e.g. via Homeless Service Settings, Basis@363 Health Drop-In) Public Health
- Sexual health to be included within Health Promoting Environments Plan – (e.g. free condoms n Homelessness set). Public Health & Commissioning & Quality Team

Reduce Inequalities in Mental Health

- Homeless People to be identifiable with Mental Health Service Provider data sets (primary and secondary) and their access and uptake of mental health services to be monitored and reviewed (how can this be achieved?)
- Accommodation options for homeless people to be mental health promoting (e.g. through Psychologically Informed Environments) link to Health Promoting Environment Plan.) Commissioning & Quality Team
- Housing Support Staff to have access to mental health training and supervision to support them to understand and respond to the interaction between mental health issues and behaviours leading to homelessness – See Recommendation 6.
- Review the range of mental health services available to those with multiple and complex needs (co existing mental health and substance misuse problems, experience of complex trauma, personality disorder). Do we currently have the right choice of support and treatment options for people with the most complex needs in Gateshead including crisis support? Are there any Gaps? (The Faculty for Homeless and Inclusion Health 2013 Standards for commissioners and service providers p.25 could provide a baseline to review against) [.file:///C:/Users/jill/AppData/Local/Microsoft/Windows/INetCache/IE/1VUVHUA3/Standards-for-commissioners-providers-v2.0-INTERACTIVE.pdf](file:///C:/Users/jill/AppData/Local/Microsoft/Windows/INetCache/IE/1VUVHUA3/Standards-for-commissioners-providers-v2.0-INTERACTIVE.pdf)
- (This includes standards for community mental health services, in-patient psychiatric services, personality disorder services, psychological services, Counselling Services).
- Ensure that referral pathways and criteria for the range of services is clear and available to support staff working with this group and does not exclude those with dual diagnosis, experience of complex trauma, personality disorder and unreliable attendance and those who do not wish to engage with substance misuse services.
- Ensure that mental health support is a core part of an integrated model of support to those with multiple and complex needs (able to work with multiplicity of need) See Recommendation 5.

Reduce inequalities in substance misuse

- Use data already being captured by treatment and recovery services to review uptake and access of support and outcomes by homeless groups. Public Health
- Review Substance Misuse Action Plan against PHE Good practice prompts for planning comprehensive alcohol and drug prevention, treatment and recovery for adults 2015-2016. Public Health
- Review Substance Misuse Action Plan against The Faculty for Homeless and Inclusion Health Standards for Commissioners and Service Providers. Public Health
- Ensure that treatment and recovery support for substance misuse is a core part of an integrated model of support to those with multiple and complex needs (able to work with multiplicity of need) see recommendation 5. Public Health

Chapter 1: Introduction and Background

1.1 Introduction

Gateshead Health and Wellbeing Board (HWBB) requested the undertaking of this Homeless Health Needs Assessment (HNA). A HNA is a tool for change that is used to identify the health needs of a particular population or a population in a particular geographical area. It is an important tool in tackling inequalities as it encourages deeper inquiry into why health and well-being outcomes of the population of interest differ from the wider population and what can be done to close the gap. The focus of this HNA is on homeless adults who are enduring multiple and complex needs. This was prompted by ongoing awareness that some homeless people in Gateshead are experiencing more complex and numerous health and social harms than others leading to great personal, social and economic cost. This is not acceptable or sustainable.

We do not know the exact numbers of homeless people in Gateshead experiencing multiple and complex needs. The HNA process demonstrates why examining the numbers is difficult and needs to be improved because those falling within this category of homelessness are among the most vulnerable and excluded groups in Gateshead. They are typically those who are single and whom are judged as not being in priority need therefore the council does not have a statutory duty to accommodate. They often have repeated experiences of homelessness as well as a wide range of other support needs which include substance misuse, physical and mental health issues, chronic poverty, social exclusion, cycles of physical and emotional abuse and involvement with the criminal justice system. The multiplicity of their disadvantage means that although they are homeless they require more than a housing solution however, they do not fit neatly into existing service compartments and there is evidence that providing effective and long

Why focus on homelessness & multiple and complex needs? Key trigger 1:

North East Homeless Health Needs Audit 2015

During February 2015, Gateshead participated in The North East Health Needs Audit - commissioned by the North East Regional Homeless Group to develop an understanding of the health and wellbeing of individuals who are homeless or working with homelessness services across the north east. The Health Audit is a questionnaire designed to be completed by a service user with help from a support worker. Of the 600 participants who took part in the survey from the 12 North East Local Authorities, 69 of the sample were interviewed from Gateshead. A local overview report was presented to the HWBB in June 2015. This provided some important insights into the health of the homeless population in Gateshead and the Board proposed that further research be carried out to understand and build upon some of the messages in this baseline survey.

<http://youthhomelessnortheast.org.uk/wp-content/uploads/Homeless-Health-Needs-Audit-2015-Gateshead1.pdf>

Why focus on homelessness & multiple and complex needs? Key trigger 2:

St Mungo's Broadway Charter for Homeless Health

In June 2015, Gateshead HWBB demonstrated its commitment to improve the health of homeless people and signed up to St Mungo's Broadway Charter for Homeless Health

www.mungos.org/documents/5391/5391.pdf

This commits the HWBB to:

- **Identify Need:** identifying and including the health needs of homeless people in the JSNA.
- **Provide leadership:** providing leadership on addressing homeless health.
- **Commission for Inclusion:** the local authority working with the CCGs to ensure that local health services meet the needs of people who are homeless.

term solutions for this group is a challenge. This has led to the people most in need of support having to struggle to navigate a complex system and either obtain help late or not at all. This has not been helped by a national policy environment (defined by funding, outcomes and accountability channels) which has created a tendency, within official responses to homelessness, to attend to only one aspect of an individual's predicament and ignore the overlapping health and social issues they face.

It is essential to take the multiplicity of the needs of this population into account because it is the co-occurrence of the individual factors which makes the way people experience them and the solutions to them very different to if any one factor was present as a stand-alone issue (Duncan & Corner 2012). It is also important when discussing 'needs' to recognise that this can suggest that the problem lies with the person, rather than in the

relationship between the person and the services and systems that are meant to help (Lankelly Chase Foundation 2016). Consequently the imperative for the HNA was to improve our understanding of populations in Gateshead experiencing a clustering of health and social harms from a number of perspectives and to do this by viewing them through the analytical lens of homelessness.

To achieve this data has been scrutinised (locally and nationally) in order to help build a profile of the homeless population with multiple and complex needs including their health and wellbeing outcomes. The HNA has also considered how this is linked to their housing circumstance and broader service responses. The HNA recognises that while rigorous and robust data is the first step to understanding people's lives and where systems go wrong the case for change is best made through people telling their own stories (Lankelly Chase Foundation 2016). Consequently, peer research approaches were used to gather more in depth qualitative information from people with lived experience of homelessness and multiple and complex needs.

In addition to the analysis of data a stakeholder consultation event was held which provided an opportunity to hear from a range of local and national speakers who between them had direct experience of receiving, commissioning and delivering services and

studying the issues within academia. Attendees representing a wide range of sectors from across Gateshead were in attendance and were then invited to contribute to the HNA process by sharing debating and exploring the current service response in Gateshead to homelessness and multiple and complex needs and to share their aspirations for more effective approaches and how these may be realised. These reflections and contributions have helped to shape the recommendations and conclusions which are detailed in Chapter 13 of the HNA.

Through a combination of these methods, the HNA has made some progress in understanding the picture for this group, however there is still much more to do. The process has identified some gaps in the way we collect and use information about housing circumstances and homelessness and the processes of investigation has raised further questions that would be helpful to explore. These have been captured and are expressed through a number of

recommendations which have arisen from the HNA process.

Why focus on homelessness & multiple and complex needs? Key trigger 4:

Health Inequalities

Homelessness is evidence of health and wider inequalities (Public Health England 2016). Health Inequalities are avoidable, unfair and unjust. The intent and commitment to tackle health inequalities in Gateshead is expressed in the Council Plan and across a wide ranging number of Gateshead policy documents (See Appendix B).

The HNA may also contribute to broader efforts concerned with how we translate knowledge about the lives of homeless people experiencing multiple and complex needs into effective and shared responses to reduce inequalities and improve health and wellbeing outcomes.

Why focus on homelessness & multiple and complex needs?

Key trigger 3:

Drug Related Deaths in Gateshead

In 2015, there were 17 drug related deaths (DRD) in Gateshead. This was an increase from 6 in 2014. A review of the DRDs undertaken by the multi-agency DRD panel highlighted a number of important themes (Appendix A). Across these themes a pattern emerged of individuals experiencing multiple and complex needs, particularly linked to drug and alcohol misuse, mental health issues and involvement with many services including the criminal justice system. Vulnerable housing was a common experience and 2 of the individuals were actually homeless at the time of their death. A number of actions were recommended following a review of the DRDs. The actions included;

- Undertake a needs assessment of most vulnerable people known to DRD agencies
- Investigate the possibility of funding to work with people with complex needs, based on the needs assessment
- Identify a different way of working with people with dual diagnosis

Why focus on homelessness & multiple and complex needs? Key trigger 5:

Integrating Health, Care and Support and Housing Solutions

Across the public sector the imperative to maximise the impact of limited public resources has never been stronger. The impact of welfare reform and reductions to public sector budgets has inevitably reduced the capacity of front line services and the support available to homeless people and those with multiple and complex needs. In Gateshead the Local Authority, Housing, NHS, Criminal Justice and the Community and Voluntary sector are having to work harder than ever before to protect some of the most vulnerable people living in Gateshead. This is within the context of an unfavourable socio-economic climate which sees growing demand for help and support. To address these challenges there are a number of policy drivers (See Appendix B) which call for a shared vision and culture of cooperation and coordination across health, public health, social care and local authority roles. Working together to prevent homelessness and protect those affected by its causes and consequences can improve health and save money. There are also likely to be mutual benefits across policy areas. It is anticipated that the knowledge and insights provided by this HNA process will reinforce why such an approach is important for the population concerned and for our aspirations to address health inequalities and improve the wider determinants of health.

1.2 HNA Policy Background

The HNA takes place against a dynamic policy backdrop which reflects the wider, social, economic, cultural and political context where experiences of homelessness and multiple and complex needs occur.

Public policy is a critical wider determinant of health and can present unintended risks to health and wellbeing, as well as assets and resource which may be harnessed to achieve particular public health goals. To address issues of homelessness and severe and multiple disadvantage, change is needed not only in the design and delivery of services. Collective action is required on the wider determinants of health, including the wider economic and fiscal policies, that in the UK, as elsewhere contribute to gross inequalities.

Within Appendix B. of this document the HNA identifies some of the key policies, outcomes frameworks, guidance and guidelines which are influential to the overall health and wellbeing of those who are homeless with multiple and complex needs. The list is not intended to be exhaustive but does seek to highlight some of the key drivers to addressing the health, care and support needs. A list of policies considered in Appendix B is provided in Box 1.

List of policies, guidelines, frameworks discussed in Appendix B

Acts of Parliament

- The Statutory Homeless System in England
- The Localism Act 2011
- Welfare Reform Act 2012
- Health and Social Care Act 2012
- The Care Act 2014
- The Housing and Planning Act (2015-16)
- The Homelessness Reduction Act 2017

National Strategies

- Laying the Foundation: A Housing Strategy for England (2011)
- No Second Night Out (2011)
- Making Every Contact Count (2012)
- Social Justice Strategy: Transforming Lives (2012)
- No Health Without Mental Health (2011)
- Reducing Demand, Restricting Supply, Building Recovery (2010)
- NHS Five Year Forward View (2014)
- NHS Five Year Forward View for Mental Health (2016)

Local Strategies

- Vision 2030
- The Council Plan 2012-2017
- Gateshead Housing Strategy 2013 – 2018
- Gateshead Preventing Homelessness Strategy 2013-2018
- Active, Healthy and Well: A Health and Wellbeing Strategy for Gateshead 2013/14 to 2015/16

Outcomes Frameworks

- The Public Health Outcomes Framework. Healthy Lives, Healthy People: Improving Outcomes and Supporting Transparency
- The NHS Outcomes Framework 2015-2016

National Guidelines

- NICE Guidelines

National Guidance

- Health and Housing Memorandum of Understanding
- The Cost of Homelessness (2012)
- The Gold Standard Programme (2013)
- Issues and best practice in lesbian, gay and bisexual housing and homelessness (2005)
- Work it Out Barriers to Employment for Homeless People.
- Public Health England - Improving Health Through the Home.

Local Guidance

- Gateshead Housing Company – Lettings Policy
- North East Homeless Think Tank

Commissioning Guidance

- Standards for Commissioners and Service Providers (2013)
- Improving access to healthcare for Gypsies, Travellers, homeless people and sex workers (2013)
- Public Health England – Co-existing alcohol and drug misuse with mental health issues: guidance to support local commissioning and delivery of care (2014)
- Housing First Guide Europe (2016)
- NHS Alliance: Housing: Just What the Doctor Ordered (2016)

Chapter 2: Aims and objectives of the Health Needs Assessment

2.1 Aim

The Gateshead Homelessness and Multiple and Complex Needs HNA will assess the scale, nature and impact of homelessness combined with complex and multiple needs in Gateshead in order to provide information which can be used to address the wider determinants of health and influence strategies and actions to prevent and alleviate homelessness and reduce health inequalities for this group

2.2 Objectives

- Identify the extent of the vulnerably housed and homeless population in Gateshead – specifically those not considered to be statutory homeless and for whom the local authority does not have a statutory duty to accommodate.
- Identify where and how homelessness overlaps with other issues associated with deep social exclusion and poor health and wellbeing outcomes.
- Identify the current and future health and wellbeing needs of people with lived experience of homelessness (main burdens of morbidity and mortality).
- Identify the triggers and pathways to vulnerability and protective factors across the life course and explore what successful support should look like by including the views of those with lived experience of homelessness.
- Understand the system and service response to homelessness and multiple and complex needs in Gateshead. (including access, utilisation, health outcomes, quality – identify gaps/challenges and opportunities)
- Inform what might be done to ensure more comprehensive ways of working that are better able to tackle homelessness and meet people's overall needs and aspirations for recovery and well-being.

Chapter 3: Scope

3.1 Identifying the target population and challenges in defining the population of interest.

The target population for this inquiry is not straight forward because homeless people with multiple and complex needs do not constitute a homogenous group, and the term covers a big territory with no single standard definition.

It has been argued that how and whether homelessness is measured is caught up in ideological, cultural and policy differences centred on understanding, prejudices and beliefs about homeless causation (Pleace and Bretherton 2013). This can lead to variation in what is measured, variation in definitions and even variation in whether any attempt is being made to measure homelessness. The same issues arise when considering how to identify who has multiple and complex needs. Again a plethora of terms are linked with the concepts of 'complex' and 'multiple' needs and they are used by various disciplines sometimes interchangeably and sometimes specifically (Rosengard et al 2007).

For the purposes of this HNA it is necessary to consider definitions that allow the population of interest to be counted and described. However, it is also important to recognise that when applying definitions different people within those categories may have differing and unique experiences of homelessness and differing health and social care needs. Categorising too tightly can limit understanding of the true nature and extent of homelessness and may not concur with an individual's own perception of their circumstances.

The focus of the HNA is on a vulnerable subgroup of adult (18 years and over) homeless households who experience multiple health and psycho-social issues and whose needs extend beyond the provision of housing alone. This typically includes vulnerable and excluded single person households for whom the local authority does not have a statutory duty to accommodate. The HNA will concentrate upon this group:

Adults experiencing multiple health and psycho-social issues who are homeless or vulnerably housed and who the local authority does not have a 'duty' to accommodate.

This encompasses those who are rough sleeping, living in supported accommodation, such as hostel or night shelter or receiving floating support to help sustain an independent accommodation option. It will also include those living in insecure accommodation, 'sofa-surfing', squatting, people at risk of homelessness and those who have a history of episodic homelessness.

3.2 Domains of Homelessness: Including the overlap with multiple and complex needs

The UK defines homelessness by referencing legal frameworks that centre on a lack of housing that someone could reasonably be expected to occupy, ranging from a lack of any housing, through to housing that is too insecure, overcrowded or otherwise unfit for occupation. The legislation in England can be found in Part 7 of the Housing Act 1996, as amended by the Homeless Act 2002.

This places responsibilities on local authorities to consider housing needs within its area including the needs of homeless households. There is a statutory duty to provide a homeless service and housing advice with 24 hour access. Two populations are distinguished;

- The statutory homeless who have access to full assistance under the terms of the laws.
- Groups to whom there is not a full housing duty which includes single homeless and rough sleepers. These will be considered below. In addition four other domains of homelessness which fall within the group to whom there is not a full housing duty will be discussed: These domains have been described as rough sleepers, hidden homeless, multiple exclusion homeless and severe and multiple disadvantage.

3.2.1 Statutory Homeless (Priority Need)

Local Authorities have a duty to secure accommodation for an applicant if they are considered to be statutory homelessness. This refers to an applicant who meets the following criteria;

1. They are homeless (or threatened with homelessness in 28 days)
2. They are eligible for support (mainly related to immigration status)
3. They are in priority need
4. They have not become homeless intentionally
5. They have a local connection

The criteria for determining vulnerability, intentionality and local connection are quite broadly defined in the homelessness laws and associated guidance, leaving considerable scope for local authorities to exercise discretion. An in-depth overview of the criteria is set out in the Homelessness Code of Guidance for Local Authorities:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/7841/152056.pdf

3.2.2 Single homeless or non-statutory homeless.

Single homeless or non-statutory homeless people are those who are not owed a duty by local authorities therefore they are not entitled to an offer of settled accommodation. Some have not applied to be rehoused, while others have had their application refused. They either fall outside of the definition of priority need or are found ineligible for support. They may live in supported accommodation, e.g. hostels and semi-independent housing projects, sleep rough, sofa surf or live in squats. The local authority currently has a duty to provide basic advice and information to this group, however, the housing legislation itself goes into very little detail about how this duty should be met. People within this group may be more likely to experience complex problems and have significant support needs which are often not met. A recent report of the Select Committee Inquiry into homelessness (Department for Communities Local Government 2016) concluded that the service offered to homeless non-priority need applicants 'is unacceptably variable'. The Committee supported the Homelessness Reduction Bill which was introduced by Bob Blackman MP. The Bill which sought to amend Part 7 of the Housing Act 1996 has now passed into Law as the Homeless Reduction Act 2017. The Act represents an expansion of the rights of single homeless people, with a new duty to relieve homelessness for all eligible applicants regardless of priority need. It also extends the definition of those considered 'threatened' with homelessness to encompass people likely to lose their home within 56 days, rather than 28 days at present. Other provisions in the 2017 Act cover enhanced advisory services, the establishment of personalised housing plans, and a new duty on public services to make a referral to a local housing authority if they come into contact with someone they think may be homeless or at risk of becoming so.

3.2.3 Rough Sleepers

Rough sleeping is the most visible form of homelessness. For the purposes of counting rough sleepers they are defined as:

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

The definition does not include people in hostels or shelters, people in campsites or other sites used for recreational purposes or organised protest, squatters or travellers. (Department for Communities and Local Government 2013)

3.2.4 Hidden homeless

The hidden homeless are those homeless people not known to local authorities or services and are not recorded in official statistics. The 2015 report of The Homeless Monitor, an annual analysis of the impact of recent economic and policy developments on homelessness in England, revealed that official homelessness figures mask the true scale of the problem (Fitzpatrick et al, 2015). Increasingly, potentially homeless households don't show up in those statistics as they are encouraged to choose informal 'housing options' such as financial assistance and debt advice, help to stay in tenancy or family mediation – instead of making a statutory homeless application.

Some hidden homeless people may be 'unseen' because they do not wish to be seen. In other cases individuals remain unseen because they are in residency arrangements that make it difficult for them to be found. They include situations such as residing in squats, sleeping on the floors or sofas of friends and families, or sleeping rough in concealed locations. In a study commissioned by Crisis which involved a survey 437 single homeless people across 11 towns and cities in England, 62 per cent of those surveyed were hidden homeless (Reeve 2011). This study categorises the hidden homeless into two main groups:

- People who could have exited homelessness promptly with the right assistance, but who are at risk of joining the population of long-term homeless people with complex needs if their hidden homelessness endures.
- Vulnerable people with high support needs for whom a system of support exists (rough sleeper teams, supported housing, hostels for particular client groups) but who are not accessing this assistance.

The consequence of being 'hidden' is that a substantial number of the single 'non priority' homeless population are hidden from view and are not accessible to research and policy and may not feature within this HNA.

It is important to note that hidden forms of homelessness may become 'visible' in different ways such as through the use of services like hostels or applying to the council as homeless. This often occurs after contact with non-housing agencies, for example mental health services, drug agencies, the criminal justice system and social services or after periods of 'invisible' homelessness such as sofa-surfing (McDonagh 2011). Measures relating to welfare reform may be contributing to hidden homelessness and are discussed within Appendix B.

3.2.5 Multiple Exclusion Homelessness (MEH)

For the homeless population targeted by this HNA, homelessness can be as a result of a number of overlapping issues which housing alone will not solve. Issues and experiences may include homelessness, drug and alcohol misuse, mental and physical health problems, cycles of violence and abuse, and chronic poverty. A term that has been used to distinguish those with multiple and complex needs from the broader homeless population is 'Multiple Exclusion Homelessness' This term was defined by Fitzpatrick et al (2012);

People have experienced MEH if they have been 'homeless' (including experience of temporary/unsuitable accommodation as well as sleeping rough) and have also experienced one or more of the following other domains of 'deep social exclusion':

- Institutional care (prison, local authority care, mental health hospitals, or wards);
- Substance misuse (drug, alcohol, solvent or gas misuse)
- Participation in 'street culture activities' (begging, street drinking, 'survival shoplifting' or sex work).

MEH reflects a combination of complex needs and chaotic lifestyles which reaches right across health, public health, social care and into related areas such as housing and justice.

3.2.6 Severe and Multiple Disadvantage (SMD)

The term Severe and Multiple Disadvantage has been adopted by the Lankelly Chase Foundation as a way to describe the clustering of serious social harms such as homelessness, substance misuse, mental illness, violence and abuse (Duncan & Corner 2012). The term is used to describe a type of disadvantage that most others do not experience and which recognises the social nature of disadvantage by emphasising its relativity. For this group it is essential to take into account this multiplicity because it is the co-occurrence of the individual factors which makes the way people experience them and the solutions to them very different to if any one factor was present as a stand-alone issue.

Lankelly Chase Foundation is an independent charitable trust that works to bring about change that will transform the quality of life of those experiencing SMD. Their website explains their use of the term SMD in the following way:

Why 'Severe': When people struggle to get the support they need, there is a strong chance that the disadvantages they face will become more severe. This means that when they do present to support agencies, the focus is on managing problematic behaviours and the risks these present rather than addressing the person's underlying issues. This can escalate the severity of their problems even further.

Why 'Multiple': There is rarely ever one problem in isolation. People are usually hit by a number of linked problems at once, including homelessness, substance misuse, mental illness, extreme poverty and violence and abuse. Rather than responding to what the person is experiencing, a range of disconnected services each tackle individual problems. This means that people who most need support find it difficult to navigate a complex structure of help, meaning they access services late or not at all.

Why 'Disadvantage': A much more common term is 'needs', as in 'multiple and complex needs'. However 'needs' suggests that the problem lies in the person, rather than in the relationship between the person and the services and systems that are meant to help. We want to stress that people have more severe problems than they should in part because they have been disadvantaged by the response of services and society.

See Lankelly Chase Foundation website: <http://lankellychase.org.uk/multiple-disadvantage/>

3.3 Dynamic nature of homelessness

It is important to note that the domains of homelessness are not mutually exclusive and people experiencing homelessness may move in and out of these domains as their circumstances and needs change. Homelessness may also be differentiated by broad duration of homelessness. Longitudinal data from the USA (Khuln & Culhane 1998) highlighted the dynamic nature of homelessness, with the majority of people both entering and exiting homelessness relatively speedily. Three broad subgroups of the homeless population were identified:

- The transitional homeless, who rapidly exited and did not return to homelessness
- Those who had ongoing episodic bouts of homelessness
- The chronic homeless who were long-term users of emergency services and/or rough sleepers.

Chapter 4: Methods

4.1 Methods

Health needs assessment has been defined as a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities (Health Development Agency 2005). This HNA has drawn upon a combination of approaches which are commonly used to undertake health needs assessments:

1. **Epidemiological methods** have been employed to describe health need using estimates of the incidence and prevalence of homelessness in Gateshead, and other surrogates of health impact derived from data available locally and elsewhere. A pragmatic review of published reports and available literature has been undertaken to establish what is known about homelessness and multiple and complex needs, roots into homelessness, morbidity and mortality rates. Consideration of the ways in which existing services are delivered and the effectiveness of interventions intended to meet the need.
2. **Corporate methods:** the corporate approach to needs assessment is based on the demands, wishes and alternative perspectives of interested parties including professional, political and public views. These methods were employed to:
 - Undertake peer led qualitative research to elicit the experiences and views of those with direct experience of homelessness and severe and multiple disadvantage. The research was a collaborative process with Newcastle Gateshead Fulfilling Lives Programme, Gateshead Council Public Health and Fuse: Fulfilling Lives led on the peer research processes and research output.
 - Undertake a HNA Stakeholder Consultation Event with guest speakers and round table consultations with representatives from across the system with an involvement/interest in the issues of homelessness and multiple and complex needs. Questions posed during the consultation were based upon the aims of the HNA.
3. **Comparative methods:** have been used to compare current provision in Gateshead with what happens in other areas and settings.

Chapter 5: Data Sources

Where available the HNA has drawn upon routine health data and homeless statistical figures. In addition the HNA refers to other sources of data from national research, surveys, and reports and local service level data and surveys to build a picture of homelessness and complex and multiple needs.

5.1 Data Gaps

Adequate baseline data is necessary to help us understand health inequalities and to help identify appropriate targets and interventions to reduce them. It is also important for keeping the issue on the policy agenda and for monitoring the effect of agreed strategies and interventions. Currently there is no clear data strategy for vulnerable groups (Aspinall 2014).

5.1.1 Health and Social Care Data

It has proved difficult to obtain comprehensive or routine data for health issues affecting local homeless people and how they are currently using local NHS health services.

Newcastle Gateshead Clinical Commissioning Group (NGCCG)

NGCCG were approached and a request was made for any data about the homeless population from routine health data sets used in primary care and secondary care. NGCCG advised this group were not currently an identified priority group for NGCCG. Due to limited coding of homelessness within both primary and secondary care data sets this population is not explicitly identified within current 'data flows' used by the Clinical Commissioning Group and was not something currently being considered or readily available for the HNA.

Northumberland Tyne and Wear NHS Foundation Trust (NTW)

Data on the prevalence of mental health problems and use of mental health services by homeless people was identified as a gap in the HNA process. This was discussed with NTW which provides mental health inpatient, community and specialist services to the local population. They advised that people who are vulnerably housed or homeless are identified within mental health services via the core assessments and data is captured on an individualised basis, for inpatient services the SHARE document is used at the point of admission. This data was not retrievable for the HNA. However, as part of some planned changes NTW are currently seeking to extend their existing NTW Homeless Service which currently provides services in Newcastle into Gateshead this will include an additional two Dual Diagnosis therapists. Once the service is operational data will be collected on homeless clients and also if Gateshead residents are accessing services in Newcastle this will be captured.

Talking Therapies Service

The Talking Therapies Service for Gateshead did not have any data to share for the HNA and they advised that it is an exceptional circumstance in the service where a client is homeless. The service advised that they were planning to start to capture information on those who were homeless and vulnerably housed and were amending their electronic system and codes to be able to capture this.

Sexual Health Provider Services

Data to identify homeless groups using sexual health services was not being captured and was not available for the HNA.

Adult Social Care

Gateshead Adult Social Care operational client data is held on the Care First System. Data identifying those who are homeless or vulnerably housed was not held on this system or available for extraction.

5.1.2 Supported Housing Data:

Gateshead Council - Supported Housing Data for Commissioned Supported Housing

Supported housing providers commissioned by Gateshead Council provide monthly returns to the Health and Social Care Commissioning and Quality Assurance team. This data was readily made available to the HNA, however, it was not possible to interrogate the data in any great depth due to the way that the data is currently stored. Gaps in this data were identified including demographic information; presenting needs; interventions provided through supported housing and the immediate, intermediate and long term outcomes of the support. It was identified that we are unable to determine the statutory homeless status of those currently living in supported housing from the data that was available to the HNA. A range of data is held by individual supported housing providers. This may be rich in insights about the roots into supported housing and what happens during the supported housing episode however, this is currently not being collated routinely in a way that can be efficiently accessed and interpreted. This is something that the Health and Social Care Commissioning and Quality Assurance Team are reviewing.

Gateshead Housing Company – Supported Housing Portal

The Supported Housing Portal was introduced by Housing Services in December 2011 to act as a single point of contact for referrals to supported housing. Three years of portal data and annual reports were made available and have been used within the HNA process. However, there were a number of limitations identified. For example, the HNA process identified that only 12 of the 18 commissioned supported housing services were on the portal and receiving referrals through the portal route. This was identified as a data gap. The portal has the potential to be a rich source of data, current limitations of the portal data are discussed with Appendix C.

Vulnerable Persons Housing Panel

The Vulnerable Persons Panel is a subgroup of the Strategic Housing Group. The panel aims to try and find accommodation outcomes for those clients who are excluded from the standard housing pathways and likely to be the population of interest to the HNA. The Panel were unable to provide figures on numbers of cases reviewed over time or outcomes in relation to cases that had been referred to the panel for the HNA. This is a gap because information about those referred into the panel is potentially an important and rich source of data in relation to a vulnerable population in Gateshead. The Panel have advised they are looking to introduce a system to record and monitor activity and outcome data which may in future contribute to needs assessment processes.

Criminal Justice

This is a Gap in the HNA – attempts to obtain data from police and probation services were made but unsuccessful.

5.2 Identifying Key Vulnerable Groups in Data Collections

The local difficulties in accessing data on the homeless population echo findings from a report commissioned by the national Inclusion Health Programme which reviewed what data was available and the gaps for homeless people and three other of the most vulnerable groups in our society (vulnerable migrants, sex workers, gypsies and travellers) where the burdens of ill health and untimely death are greatest (Aspinall 2014). The

Sources of data identified as particularly important for the vulnerable homeless (Aspinall 2014):

- Use of services (primary and secondary care),
- Mental health status and use of psychiatric services
- Drug/alcohol misuse and use of related treatment services
- Sources that capture dual or sets of co-existing medical conditions

report found that it was difficult to obtain a comprehensive national or local level picture of health needs because of the lack of capture of these groups in standardised datasets for measuring and monitoring access to health care and in denominator datasets. It was noted that if we are to make real inroads into improving the health of the poorest fastest, then we must first create the tools for measuring the inequity reliably now and over time. We also need to provide local as well as national intelligence to support health and wellbeing strategies, commissioners, providers, and communities. A number of recommendations were made within the report with respect to improvement in data collection and coding and the use of existing data.

See the Inclusion Health Report for further details (Aspinall 2014):

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/287805/vulnerable_groups_data_collections.pdf

5.3 Limitations in Quantifying Homelessness

Quantifying the numbers of homeless people and understanding their health needs is known to be difficult. Some of the problems that arise when trying to estimate numbers of single 'non priority' homeless people include;

- Single homelessness is a dynamic state in which people will join and leave the population and experience change in accommodation status.
- Official statistics do not give a full picture of homelessness in England. The figures exclude those who are homeless who do not approach the local authority and those who do not meet the statutory criteria
- Data on single homelessness incidence and trends are hard to source
- Definitions of homelessness vary between agencies and areas therefore it is not comparable between authorities or across different agencies.
- Data on those who are homeless often focuses on those who are in contact with services and therefore underestimates the true number of people who are homeless. In particular the single homeless population, is invisible to many services
- Where comparisons between local and national data are made, national data may be skewed due to the specific circumstances and levels of homelessness in London.
- Data collected by agencies and services varies, and tends to be limited in what it tells us about the needs of the population.
- Data sets from services which may be a source of information about need cannot be compared with each other as data may overlap if an individual has been seen by multiple services.
- There is no universal system for recording the housing needs of people approaching advice and support agencies for help and some count the number of enquiries rather than the support needs of the enquirer.
- Data may be available on the housing status of service users at an individual case note level but the way it is collected and stored means that it is not easily accessible to enable broader assessment for trends and quantification.

Lack of Adequate Data Sharing Across Health Services

Some of the consequences of data that is not joined up between hospitals, GP practices and community nursing services were recently highlighted by the London Network of Nurses and Midwives in Homelessness. These included issues around:

- duplication
- significant safeguarding failures in our extremely transient population
- lack of clinical effectiveness
- potential risks to health care professionals.

<http://lhf.org.uk/blog/homelessness-and-health/>

5.4 Key Sources of Local Data utilised for the HNA

As part of the HNA process attempts were made to obtain data from a range of sources. The table below provides an overview of the key local sources of data used within the HNA.

Sources of Local Data Utilised by the HNA

Local Data Source	What is it	Rational for use
Annual Homeless monitoring data from Gateshead Council – Housing Options	Records numbers presenting to Housing Options for advice and number of homeless applications opened and outcomes.	Captures the scale of homeless applications and those assessed as not in priority need.
Homelessness Health Audit 2015	A self- report survey designed by Homeless Link and completed by 68 homeless service users in Gateshead in 2015.	This survey provides a snapshot of the health and wellbeing status of homeless population in Gateshead and responses can be compared to other sources of data about health and wellbeing.
Fulfilling Lives Newcastle Gateshead – operational client data available from May 2014 – July 2016	Fulfilling Lives Newcastle and Gateshead is one of twelve Big Lottery funded programmes working with multiple complex needs across England. The programme is seeking to help people with complex needs to better manage their lives by ensuring that services are more tailored and better connected to each other. The service made their anonymised activity data for Gateshead clients available to the HNA.	Target population similar to HNA. Collects demographic data, presenting needs including health needs and referrals to health and support services. Collects data on accommodation status over time. Collects data on financial status.
Basis@363 Activity Data 2013/14 2014/15 2015/16	Basis@336 is a resource centre run by Oasis Aquila which is for those who are street homeless or at risk of homelessness in Gateshead. The service operates a direct access drop-in between 9am and 2pm Monday to Friday where there is access to advice, guidance, shower and laundry facilities. The service made their activity data from there three latest annual reports available to the HNA.	Due to the open/accessible nature of this service may provide an insight into those who are homeless with multiple and complex needs who are not been reached by mainstream services. The individuals seen most often are single homeless young men not in priority need
Gateshead Evolve	Gateshead Evolve is a single, integrated drug and alcohol recovery service for all adults in Gateshead.	Provides an insight into the overlap between drug and alcohol misuse/mental health and homelessness.
Gateshead Supported Housing Portal	The Supported Housing Portal collects and processed referrals for supported housing in Gateshead. It is managed through Gateshead Council's Housing Options Service which offers free, confidential and impartial advice for people in housing need, in a potentially homeless situation or simply wishing to apply for different types of housing. Data for three years of referrals to the Supported Housing Portal was made available to the HNA.	Individuals unable to sustain an independent tenancy are likely to have multiple and complex needs the portal provides an insight into those being referred into supported accommodation and how this need is currently been met in Gateshead.
Housing Mental Health Service	A pilot project, funded jointly by the Northumberland Tyne and Wear NHS Foundation Trust and Gateshead Council. Set up to address the housing needs of people who have severe and enduring mental health problems, and who are or have been in contact with secondary mental health services and/or Adult Social Care mental health teams.	Provides an insight into individuals in contact with secondary mental health services with a housing need.

5.5 HNA Coordination and Accountability

A working group has overseen and provided the governance for this HNA process. The working group has agreed the scope and methods of the HNA and has provided 'expert' support, advice and scrutiny during the HNA process. The working group representatives were from Homeless Link, Gateshead Council Housing Services, Gateshead Council Public Health Team, Newcastle and Gateshead CCG, Oasis Aquila Housing, Fulfilling Lives and Changing Lives and fuse.

Chapter 6: Gateshead Headline Data

6.1 Population

The population of Gateshead reduced in size throughout the 1980s and 1990s, but began to recover from around about 2006 onwards. Since that time there has been an increase in the population of more than 10,000 people. The current population stands at around 200,500 (ONS MYE 2014) living in 90,600 households (DCLG 2012 Based Projections for 2015). The growth in the population has been most significant for older age groups with an 11% increase in 45-64 year olds and an 11% increase in those aged 65 and over. In contrast, the number of 0-24 year olds fell slightly by 0.7% over the decade. Population projections from the Office for National Statistics (ONS) predict that this ageing population trend will continue into the future. By 2030, Gateshead's population will grow to 212,312, nearly 90% of the anticipated growth is expected to be in the 65+ age group.

It is estimated that around 3.7% (7,500) of the population are from a Black or Minority Ethnic (BME) group (Census 2011). The BME population has increased from around 1.6% in 2001 (Census 2001).

Based on the 2014 mid-year population estimate Gateshead has a gender profile of 98,447 (49.1%) male and 102,058 (50.9%) female (Mid-Year Population Estimates 2014, ONS cited in 'Equalities Profile Jul 2015').

6.2 Socio-Economic Circumstances

Within Gateshead, socio-economic inequalities exist as illustrated by the 2015 Index of Multiple Deprivation (DCLG). Gateshead is ranked 73rd most deprived out of 326 local authorities in England. Within Gateshead there are 15 areas which fall within the 10% most deprived areas in England, equating to almost 23,600 people or 12% of the population of Gateshead. Much of this deprivation is based within the central and eastern urban areas of the borough. 22.6% of children aged 0-15 are in poverty in Gateshead (Public Health Fingertips Tool).

Around 89,400 or 70% of working age (16-64) Gateshead residents are in employment which compares with an average of 72% for England as a whole (ONS Annual Population Survey Y/E Sep 2014), and around 3,700 or 2.9% are unemployed claiming jobseekers allowance (DWP Dec 2014).

The average income in Gateshead is just under £31,000 per year, compared with a national figure of just under £40,000p;,(Acxiom, 2012). A recent survey of residents indicates that whilst half of residents believe their personal financial circumstances will stay the same over the next year, 34% believe they will get worse and just 9% feel they will improve (Gateshead Residents Survey 2012).

58.5% of pupils in Gateshead schools achieved 5 or more A*-C GCSEs including English and Maths in 2014, which is higher than the national average of 53.4% (DfE School Performance Tables 2014).

6.3 Health

At 77.4 years for males, and 81.2 years for females, life expectancy is lower than the England averages of 79.4 years and 83.1 years respectively. However, life expectancy is improving and has increased by 2 years for women and more than 3 years for men in the last decade (ONS 2011-13).

Despite these increases in Gateshead, life expectancy for men is 9.2 years less in the most deprived compared to the least deprived areas; for women, the difference is 7.8 years. In recent years the difference has been decreasing for men but increasing for women (Public Health Outcomes Framework ONS 2012-2014).

In the 2011 Census, around 22% of people in Gateshead reported that their health limits day to day activities compared to around 18% nationally, but only 8% reported they are in bad health (Census 2011).

6.4 Housing

In Gateshead's 2012 Residents Survey, 73% of residents were satisfied with Gateshead as a place to live, and in line with that, 70% felt strongly that they belong to the area.

Gateshead has a total housing stock of approximately 93,300 (2016) and there are around 90,000 households.

Private Sector Stock

The largest housing tenure in Gateshead is owner occupation; and the number of Gateshead households owning their property (either outright, through a mortgage or loan, or by shared ownership), has been increasing. In 2016, 57% of the housing stock was in owner occupation. Owner occupation is now in line with national rates for England, which have been falling.

Private rented sector (PRS)

In 2016 approximately 14,600 (16%) of the Borough's homes were in the private rented sector. The PRS in Gateshead grew by 70% between 2001 and 2011 (much higher than the national rate of growth), but now appears to have levelled out. However, demand for private rented properties may increase again in the light of the impact of recent Government policy changes and measures that are expected to lead to a reduction in the supply of social housing. The proportion of households living in private rented accommodation in Gateshead is still lower than the England average.

Principle reasons for the significant increase in the PRS between 2001 and 2011 included:

- an increase in buy to let as investment; and
- the decline in people's ability to afford to own their own home (rising prices; employment uncertainty; squeezed incomes).

In 2016 the highest concentrations of private rented stock in Gateshead are in Saltwell (36%) and Bridges (31%) Wards.

There still remains a relatively high level of poor housing in the private sector, with the private rented sector (PRS) showing the highest percentage of properties in the poorest condition; and this disproportionately affects vulnerable households. (Housing Health and Safety Rating System failure: Private rented sector 11%, owner occupied sector 10%, social housing sector 7%) (Gateshead Council 2013).

Social rented sector

Over the period 2001-2011 the social rented sector (including the Council's own housing stock and other social housing providers) declined by 6.3% (34.3% to 28%) (Gateshead Council and Newcastle Council 2013) and it has since continued to decline to around 26%: 6% private social housing, and 21% Council owned homes (HCA SDR Survey data, and Council Tax data at 2014).

The percentage of the population renting from the Council is still higher in Gateshead than for the average for council's in the North East (15%) and England (9%). Census data shows there were almost 5,000 fewer households renting from the Council in Gateshead in 2011 than there were in 2001, and this trend of decline has continued (ONS 2011).

Whilst the condition of social housing has improved over recent years to meet the Government's decent homes targets (Gateshead Housing Strategy 2013-18) the Government's July 2015 Budget, and subsequent Government measures and ongoing commitments, including extension of Right-to-buy, the requirement to reduce social rents by 1% p/a, and changes to social housing funding models, will lead to radical changes in the sector, put at risk the ability

of social housing providers to maintain the decent homes standard across their stock, and lead to further decline in supply.

Under and over-occupation

There is a significant level of under-occupation within our housing stock. 64,889 (73%) households in Gateshead are under-occupying properties; having at least one more room than the statutory standards require. Conversely, nearly 5,500 (6%) households are classified as overcrowded (in terms of space and room standards) (ONS 2011) half of which are in the social housing sector. This clearly shows that there is mismatch in relation to providing the right housing for all of Gateshead's residents and making best use of the housing stock.

Chapter 7: Rapid Review of the Literature – Understanding Homelessness and Multiple and Complex Needs

Given the breadth of research across the areas of housing, homelessness, multiple and complex needs, it has not been possible to produce an exhaustive review of research. The search parameters were guided by strict time constraints. The research method involved numerous combinations of search terms using web-based search engines and the Athens portal to access electronic journals. Searches were also undertaken of UK government websites and homelessness organisations to identify relevant research at the UK and, where available, international level. Accepting these limitations the aim of the rapid review of the literature is to reflect on some of the key learning from research and policy areas on the subject of homelessness and multiple and complex needs.

7.1 Housing and Health

To fully appreciate homelessness it is important to emphasise within this HNA why achieving a good quality and stable home is important to health. The link between housing and health at both the individual and population level is well established. Decent affordable housing is a cornerstone of good physical and mental health and the home is a critical determinant of health (Marmot 2010, Dahlgren and Whitehead 1992). The wider determinants of health include the physical, social and economic conditions in which people are born, raised and live. The Institute of Health Equity's 2013 report 'Working for Health Equity' (Allen et al 2013) identifies how the healthcare system and those working within it have an important role to play in tackling the wider determinants of health.

Badly designed and poorly built houses with inadequate heating, damp, lack of space, poor lighting and shared amenities are a major contributor to poor health. The exact causal relationship between poor housing and health is complex and the causal links between different dimensions of housing, neighbourhood environment and health operate at a number of interrelated levels (Taske et al 2005). However, it is accepted that associations do exist. Examples of key housing-related health risks include: respiratory and cardiovascular diseases from indoor air pollution; illness and deaths from temperature extremes; communicable diseases spread because of poor living conditions, and risks of home injuries (WHO 2010).

The home is a wider determinant of health



The Determinants of Health (1992) Dahlgren and Whitehead

There is no single source of information about the scale and nature of risks to health and wellbeing from the home, however, a useful summary of the key issues surrounding health and housing in the UK was published by the Parliamentary Office of Science & Technology in 2011;

The links between housing and health in the UK – Parliamentary Office key issues

Overview	<ul style="list-style-type: none"> • Poor housing conditions have a detrimental impact on health, costing the NHS at least £600 million per year. • Social sector housing has improved, but less than 50% of private rented homes housing people on benefits were considered decent in 2008. • Councils that have successfully improved private sector housing stock employed multiple local departments/funding sources. • There are concerns about the future condition of private housing stock as it is not included in the new initiative. This could have adverse health implications. • A wide range of central and local agencies is involved in housing. There is a need for co-ordination between these groups and comprehensive guidance to help local authorities to improve housing stock.
Evidence for health problems relating to housing	Sources of Data: Housing: English House Condition Survey Health: Fire and Rescue Service Returns; British Crime Survey; Home Accident Surveillance System; Hospital Episode Statistics; General Practice Research Database; Morbidity Survey in General Practice; Statutory Notification of Diseases; Office for National Statistics
Conditions Associated with Non-decent Housing	Cardiovascular diseases; respiratory diseases; rheumatoid arthritis; depression and anxiety; nausea and diarrhoea; infections; allergic symptoms; hypothermia; physical injury from accidents; food poisoning.

7.2 Home – The Main Setting for Health

“Homelessness has a human cost. The unique distress of lacking a settled home can cause or intensify social isolation, create barriers to education, training and paid work and undermine mental and physical health. When single homelessness becomes prolonged, or is repeatedly experienced, there are often very marked deteriorations in health and well-being.”
 (Pleace 2015)

Home as a main setting for health



Source CIEH 2015

Public Health England (PHE) have recently developed a multi-stranded programme of work which sets out to reduce the impact of poor, unsuitable housing and homelessness on both physical as well as mental wellbeing. The PHE programme has emphasised the home as the main setting for health throughout people's lives. This is because of the key role the home plays in enabling people to achieve good health and wellbeing and a good quality of life (Public Health England 2016). One strand of PHE's programme includes a housing and health toolkit which has been developed for PHE by the Chartered Institute for Environmental Health (CIEH). The toolkit can be accessed at:

<http://www.cieh-housing-and-health-resource.co.uk/>

This resource is designed to help develop a better awareness of the link between housing and health outcomes and inequalities and an understanding of how housing can influence physical and mental health and well-being. The resource sets out how having a decent home enables access to other health improving opportunities, for example employment, social networks, essential services and amenities such as green space as shown in the diagram to the right. Also discussed is how home can also influence access to healthcare, education, employment, transport, social care and more. In respect to this it is noted that the relationship between housing and health cannot be fully considered without also considering features of a person's neighbourhood or the 'place' where that person lives. It is recommended that 'local public service organisations with strategic and/or service delivery responsibilities need to move beyond simply seeing housing, and the potential needs that arise from it, simply through the lens of physical housing conditions and consider the role it plays in enabling people to achieve good health and wellbeing, and a good quality of life'.

7.3 Multiple and Complex Needs

A literature review undertaken by Rosengard et al (2007) identified a plethora of terms linked with the concepts of 'complex' and 'multiple' needs, used by various disciplines, sometimes specifically, and often interchangeably. They include: 'multiple disadvantage', 'multiple disabilities', 'multiple impairment', 'dual diagnosis', 'high support needs', 'complex health needs', and 'multiple and complex needs'. This multiple usage was confirmed by preceding reviews carried out by Rankin and Regan (2004) and Keene (2001). Rankin and Regan identified the essence of complex needs as implying both breadth of need (more than one need, with multiple needs interconnected) and depth of need (profound, severe, serious or intense needs).

More specifically related to the issue of homelessness, Homeless Link (2002) provide a definition of multiple needs where homeless people have at least three of the following:

1. Physical health problem
2. Mental health problem
3. Substance misuse problem
4. Vulnerability because of age
5. Personality disorder
6. Offending behaviour (previous contact with criminal justice system)
7. Borderline learning disabilities
8. Disability
9. Challenging behaviour.

A very wide range of people were identified within the review by Rosengard et al (2007) as having multiple and complex needs

- People with mental health problems, including 'severe and lasting' problems
- Those disadvantaged by age and transitions - young and older people
- Those fleeing abuse and violence - mainly women and refugees
- Those culturally and circumstantially disadvantaged or excluded - minority ethnic groups; travelling people
- People with a disability, including profound, severe or long term impairment or disability and those with sensory disabilities with 'additional needs'
- People who present challenging behaviours to services, for example in schools, within residential services/ hostels or in their own neighbourhoods
- People who are multiply disadvantaged by poverty, poor housing, poor environments or rural locations which mean they are distant from services
- People who are 'marginal, high risk and hard to reach', who may be involved in substance misuse, offending and at risk of exclusion (Watson, 2003)
- People who have a 'dual diagnosis' of mental ill health and substance misuse, or of other combinations of medically defined conditions

7.4 The Link between Homelessness and Multiple and Complex Needs

The strong overlap between homelessness and other support needs has been evidenced in a number of recent studies and has significant implications for the way services respond to homelessness. From 2009 to 2011, the Economic and Social Research Council commissioned four research projects as part of a ‘Multiple Exclusion Homeless Research Programme’ with the aim of informing government policy and practice and finding solutions to bring the most vulnerable homeless people in from the margins of society. The projects employed multiple methods including a survey and worked across 13 sites across England, including urban and rural areas.

An evidence review of these four projects was published by McDonagh (2011) in which the following key findings are highlighted from across the studies:

- There is a strong overlap between experiences of more extreme forms of homelessness and other support needs, with nearly half of service users reporting experiences of institutional care, substance misuse and street activities (such as begging), as well as homelessness.
- Visible forms of homelessness – including the use of services like hostels or applying to the council as homeless – commonly happen after contact with non-housing agencies, for example mental health services, drug agencies, the criminal justice system and social services. They also occur after periods of ‘invisible’ homelessness such as sofa surfing.
- Traumatic childhood experiences, such as abuse, neglect and homelessness are part of most street homeless people’s life histories. In adulthood, the incidence of self-harm and suicide attempts is notable.
- Most complex needs were experienced by men aged between 20 and 49, and especially those in their mid-thirties.
- Where homelessness and housing support agencies take on primary responsibility for supporting people with multiple and complex needs, workers can often feel isolated and out of their depth.
- People with complex needs are at serious risk of falling through the cracks in service provision. There needs to be an integrated response across health, housing and social care.

For those experiencing long term homelessness, analysis highlighted by Pleace (2017), showed that support needs and behaviours associated with long term homelessness do not always predate homelessness but can arise during homelessness. People who do not have high support needs, or indeed any support needs, when they first become homeless, develop support needs in association with experiencing sustained or recurrent homelessness.

7.5 Clusters of Multiple Exclusion Homelessness – Levels of complexity

The Multiple Exclusion Research Project included a quantitative survey (Fitzpatrick et al 2012) which surveyed users of low threshold services working with people experiencing deep social exclusion. The services included not only homelessness services but those targeting other aspects of deep social exclusion such as; drug problems; alcohol problems; street based sex work. 1,286 questionnaires were returned. This identified specific clusters of experiences among those experiencing multiple exclusion homelessness. These clusters are listed below and highlight potential sub-groups of those experiencing multiple exclusion homelessness as defined by the level and complexity of their experiences. Complexity was assessed by the overall number of experiences reported from a pre-defined list, and experiences were grouped under subheadings. The group with least complexity reported an average of five experiences, while the group with the most complexity, cluster 5, reported an average of 16 experiences.

Clusters of Multiple Exclusion Homelessness

Cluster 1 Mainly Homeless	<ul style="list-style-type: none"> • Least complex (5 experiences) • Majority male and over 35 • Disproportionate number of migrants without recourse to public funds
Cluster 2 Homelessness and mental health	<ul style="list-style-type: none"> • Moderate complexity (9 experiences) • Disproportionately female • High levels of anxiety or depression and attempted suicide

Cluster 3 Homelessness, mental health and victimisation	<ul style="list-style-type: none"> • High complexity; ‘severe’ version of Cluster 2 (15 experiences) • Lower average age • Defining characteristic was mental ill-health with high levels of experience of being victims of violent crime or sexual abuse
Cluster 4 Homelessness and street drinking	<ul style="list-style-type: none"> • Moderate complexity (11 experiences) • Older and mainly male • Defined by street drinking and almost all were sleeping rough with problematic alcohol use
Cluster 5 Homelessness, hard drugs	<ul style="list-style-type: none"> • High complexity (16 experiences) • Mostly in the 30s • Defined by use of hard drugs (denoting heroin and crack cocaine) with high levels of mental ill health including anxiety/depression, attempted suicide and self-harm • Strong theme of violence, both as a victim and perpetrator

Source: Fitzpatrick et al (2012)

7.6 Multiple and Complex Needs and the Interaction with Housing Vulnerability

“Having multiple and complex needs pushes people to the weakest corners of the UK housing market” (Rose and Davies 2014)

For people with multiple and complex needs good housing can help them maintain good health and independence for longer (Kings Fund 2016) however, the population covered by this HNA often experience a range of complex needs which can act as a barrier to good housing. This may be because they do not meet the threshold for statutory support or are denied help because of their substance misuse, offending or chaotic behaviour.

Often the private rented sector is an essential means to help people escape and avoid homelessness. However, a report by Crisis, ‘Home: No less will do’ (Gousy 2016) found that for many single homeless people financial barriers and instability of tenancy are too great. In addition the analysis highlighted that only 45 per cent of landlords in their analysis were willing to let to tenants in receipt of housing benefit and only 18 per cent were willing to let to homeless households. Reasons included a perceived greater risk of rent arrears, and requirement for more intensive management. Welfare reform, in particular changes to direct payments brought in by Universal Credit and caps to Local Housing Allowance Rates were making landlords much less likely to let to homeless people and people in receipt of benefits.

The challenges of the private rented sector are further exacerbated by a shortage of social housing. This was outlined in a Department for Communities and Local Government Committee Report on Homelessness (2016). The report sets out emerging evidence which indicates that financial pressures on social landlords has led to a more risk adverse approach to lettings which favours the economically active household who are able to pay their rent. Landlords are becoming much more selective over which tenants they take on. One contributor to the report indicated that this threatens a large number of people on lower incomes with homelessness and that for rough sleepers with multiple and complex needs their housing options were close to zero.

A research report by Rose and Davies (2014) found that those with multiple and complex needs were being driven towards the weakest corners of the English housing market as a consequence of their existing vulnerabilities which then compounded their problems further. The study identified that those without a reference or deposit, or with a history of antisocial or criminal activity or substance abuse had limited access to private rented properties with assured tenancies and that their difficulties could also act as a barrier to access properties held by registered social landlords or local authorities. This led to them seeking accommodation in temporary accommodation destinations which were mostly in the private sector such as bed-and-breakfast accommodation and ‘houses in multiple occupation’, hostels or refuges. Although such premises may be seen as a response to sudden episodes of homelessness and as an alternative to rough sleeping the report concluded that they were deeply counterproductive for individuals with complex and challenging needs; ‘drug taking, crime, threatening behaviour, poor living

conditions and disruptive residents often do further damage to the wellbeing of a group of people who may already have precarious lives, volatile relationships, addictions and health problems’.

7.7 Unstable Accommodation and the Relationship between Health, Wellbeing and Recovery

Research from the North East has raised awareness of the hidden lives of those living in unsupported accommodation and the detrimental impact of unstable accommodation on health, wellbeing and recovery. A study undertaken by Northumbria University in the North East (Irving 2015) focused upon privately run hostels and found several properties occupied by vulnerable men with high incidences of alcohol dependency and poor physical and mental health. The study identified frequent complaints of insufficient heating, broken door locks and damp. Such conditions were reported as exacerbating residents’ health problems. Of further concern were the psychological and social conditions, including feelings of insecurity, high levels of noise, theft, violence and unorthodox management practices. In an another study also undertaken in the North East, Spencer and Corkhill (2013), detailed unacceptable standards in various aspects of premises management, including poor security and poor buildings maintenance and repeated incidents of drug-related violence on the premises. The research also identified widespread abusive management practice, including tenants having their cash cards and benefit books confiscated by proprietors, being forced to share rooms with strangers, being locked out of the premises for long periods, and being charged for services that were not provided.

A report on Homelessness across Europe (European Commission 2013) highlighted some of the consequences of long term shelter living and in particular the observation that long term stayers lose their ability to lead an independent life. For want of adequate income and follow up support they may not be able to maintain permanent housing. Thus, Individuals with long term complex needs can often habituate the homelessness system and make up a significant entrenched and often intractable group who more often than not circulate in the system for a number of years.

The North East Regional Housing Group (NERHG) have set up a forum across the North East, now coordinated by Homeless Link and Clinks as part of the Making Every Adult Matter (MEAM) initiative. In a response provided to the CLG inquiry into roots into homelessness the group explored the journeys and needs of homeless people with multiple and complex needs, within their response it was highlighted that:

- Multiple/complex needs can be a considerable barrier to resolving housing needs
- There is a growing incidence of multiple needs among young homeless people
- Poor access to mental health assessments and services, and the complexity of the mental health system, compound problems experienced by people in this group
- Access to mental health services for people with dual needs of substance misuse and mental health is extremely difficult, meaning that some people remain with both problems, and in housing need for many years. (NERHG 2016)

Chapter 8: The Financial Costs of Homelessness and Severe and Multiple Disadvantage.

“There is growing evidence that public expenditure on homelessness rises in parallel to the human costs of single homelessness” (Pleace 2015)

8.1 Costs of Homelessness

There is international concern that failures to prevent and reduce homelessness are causing significant, but potentially avoidable increases in public expenditure. However there are also limitations in the quality of evidence on costs of homelessness, both in the UK and comparable European countries (Pleace et al 2013).

In 2012, the Department for Communities and Local Government undertook an evidence review of the costs of homelessness. The findings of this review are summarised in the box opposite. The review showed that a number of research studies have attempted to calculate the total costs to government of homelessness. These studies have a number of methodological limitations and concern different groups of homeless people. Estimates of the annual costs to government from these studies range from £24,000 - £30,000 (gross) per person, anything up to circa £1bn (gross) annually. The net cost is likely to be lower.

DCLG Evidence Review Costs of Homelessness

Department of Work and Pensions: Costs are likely to arise to DWP as a result of benefit payments, employment programmes, associated administration costs and payments to Local Authorities for administering housing benefit. In August 2011 the average weekly amount of benefit paid was £84 to an Income Support claimant, £80 to an Employment Support Allowance claimant and £64 to a Jobseeker’s Allowance claimant.

Department of Health: Health problems, in particular mental health problems, substance misuse and alcohol dependency are more prevalent among the homeless population, especially among rough sleepers with potentially significant costs for health and support services. Unfortunately there is a lack of evidence of the numbers of homeless people who use these services. Case study evidence suggests the costs to the public services of people with multiple needs can be considerable. Overall health service use by homeless people is between four and eight times that of the general population at an excess cost of £85 million.

Ministry of Justice: Research evidence suggests that homelessness and offending behaviours are interwoven and mutually perpetuating. Costs to the criminal justice system and policing may be significant. For example the total costs for a drug offence conviction is estimated at around £16,000.

English local authorities’ current expenditure on homelessness in 2010-11 totalled almost £345m. Of this around £100m is providing temporary accommodation; £70m homelessness prevention and the remainder the administration of homelessness functions.⁶ The Department for Communities and Local Government (DCLG) is currently exploring the scope for combining this information with activity data collected from local authorities to enable unit costs to be estimated for particular aspects of local authority activity.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/7596/2200485.pdf Source: DCLG (2012)

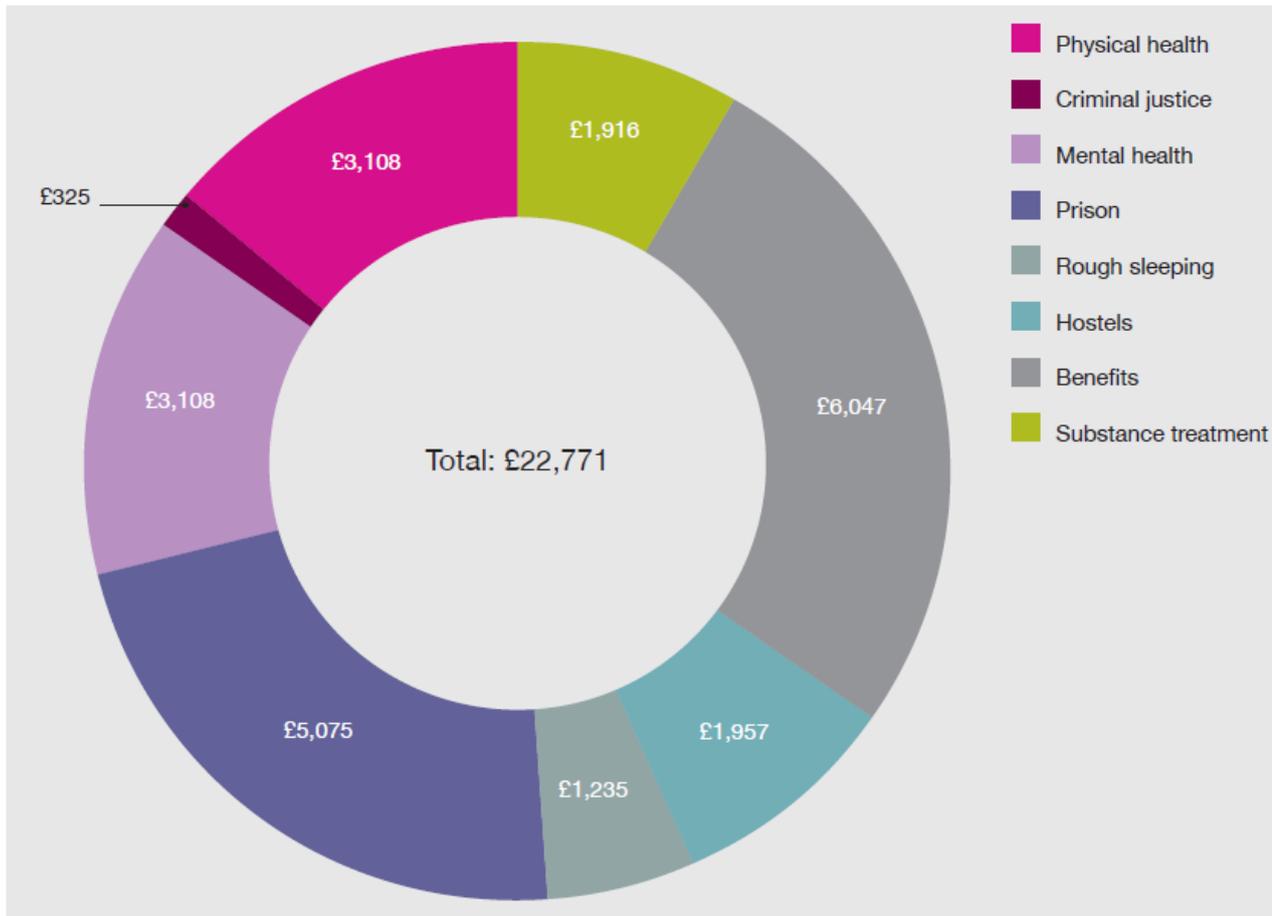
8.2 The Cost of Fragmentation

‘The numbers of people facing all three problems of homelessness, substance misuse and crime (245) in Gateshead equates to an annual cost of £5,576,895’

Providing services to support people with multiple and complex needs is expensive (Harwich et al, 2017). The Hard Edges Report (Bramley et al 2015), discussed in Chapter 12 of the HNA, identified that 3,325 people in Gateshead (as at 2010/11) fall into the ‘severe and multiple disadvantage group (face problems caused by at least one of the three issues of homelessness, substance misuse and crime). A 2017 report, published by Reform, an independent Think Tank, on the state of public-service commissioning (Harwich et al 2017) also used the Hard Edges research to

highlight evidence from HM Treasury which shows that each person facing all three problems will cost taxpayers £22,771 a year (see figure below). These costs further accumulate the longer people require services. In the Hard Edges report the average person receiving help for three SMDs had cost the Exchequer close to £250,000 over the course of their lifetime (to the date they were interviewed). If this model was applied to the numbers of people with all three SMD in Gateshead as identified by the Hard Edges report, it would equate to an annual public spending cost of £5,576,895 for just 245 people. Reform (Harwich et al, 2017) highlight that this creates a clear and compelling case for integration of services for people who require assistance from numerous different providers.

Annual public spending for those with three severe and multiple disadvantage profiles, per person



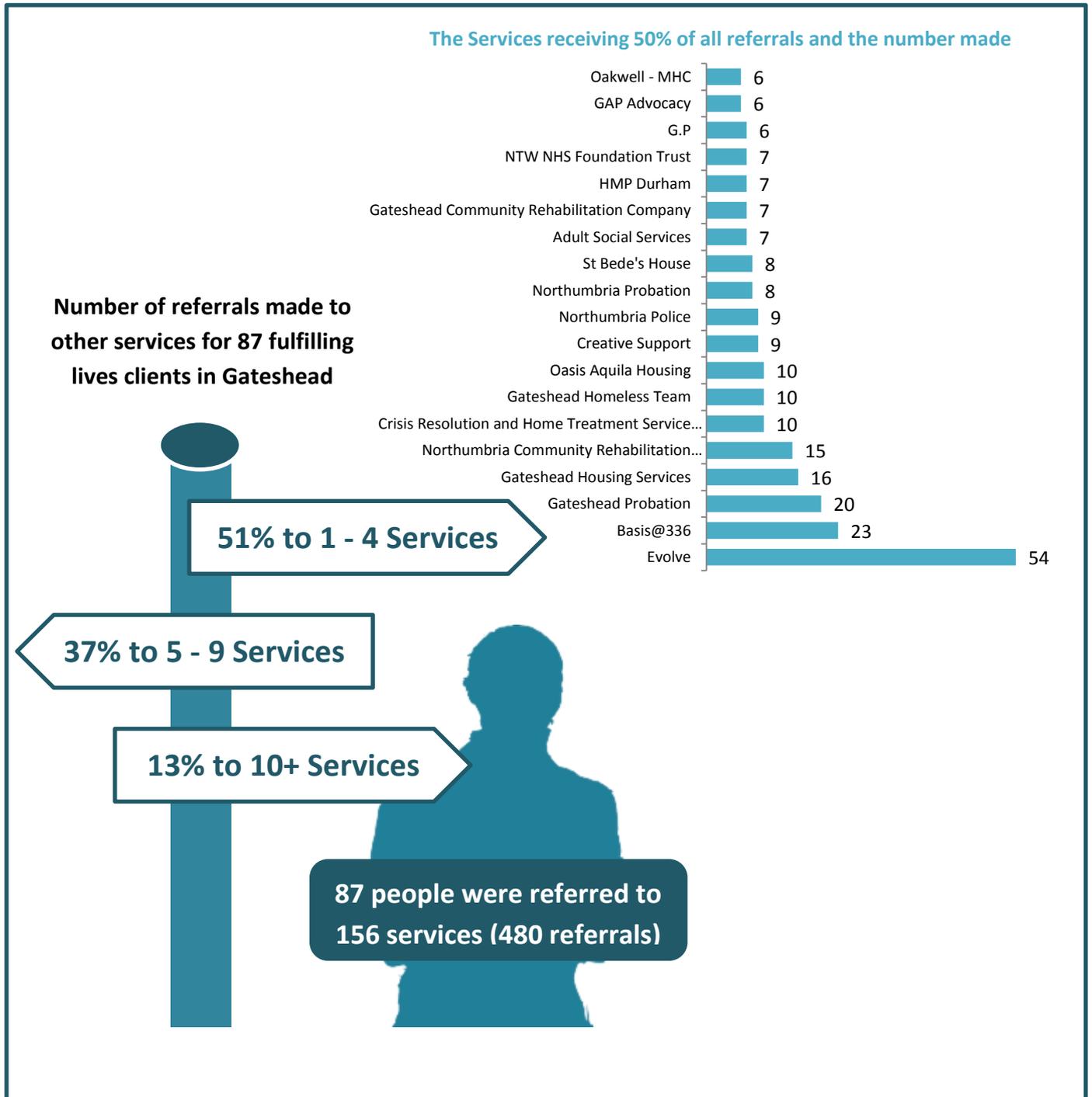
Source: Glen Bramley and Suzanne Fitzpatrick, *Hard Edges: Mapping Severe and Multiple Disadvantage, England* (Lankelly Chase Foundation, 2015).

Note: These figures have been updated to reflect 2016-17 prices.⁶¹

8.3 Local evidence of fragmentation: Fulfilling Lives Client’s Interaction with Services in Gateshead.

Data from the Fulfilling Lives database for their Gateshead clients provides evidence that homeless people with severe and multiple disadvantage are having numerous and repeated interactions with services in Gateshead.

On average the 98 Fulfilling Lives clients were each referred to 5 different services. The infographic below details the percentage of people receiving 1-4, 5-9 and 10+ referrals and the services receiving 50% of all referrals and the number made.



What does this data tell us?

The Fulfilling Lives data suggests a need to assess and monitor the resource implications of vulnerable individuals having to navigate multiple services rather than have their needs met in one place.

The data suggests that the 19 services receiving more than 5 referrals may have clients in common and it may be useful to consider how these services are currently working together around individuals who they share a responsibility.

It also poses questions about a system that appears to require homeless, vulnerable individuals with multiple and complex needs to engage and manage relationships with numerous different agencies in order to address their needs. For example, is this the most effective approach to addressing complex and multiple needs? What is the impact on the individual of having to engage with multiple services and a complex system? How is information being shared? This data prompts lots of questions.

8.4 Homeless Prevention - Potential Savings

A report undertaken by Crisis and the University of York (Pleace 2015), explored available data to produce four illustrative vignettes based on estimations of the additional costs of homelessness. In the first illustrative vignette, preventing homelessness costs the public sector an additional £1,558, while allowing it to persist for 12 months costs £11,733. For the second vignette, the figure for resolving homelessness quickly is £1,426, rising to £20,128 if homelessness persists for 12 months (see table below). For the third vignette, the figures are £4,726 compared to £12,778 and for the fourth, £1,554 compared to £4,668. The report highlights that the additional financial costs of homelessness vary by the location, type and nature of support provided by homelessness services. For the NHS and criminal justice system, the additional costs centre on the greater likelihood of more frequent and sustained contact with some single homeless people compared to other citizens.

Estimated additional costs of homelessness prevention and failure to prevent homelessness – Vignette 2

Table 3: Vignette 2, Estimated additional costs of homelessness prevention and failure to prevent homelessness

Scenario 1: Successful prevention	Cost
Preventative intervention by Housing Options Team ¹	£826
Floating support (mean support cost, 12 weeks) ²	£600
Total	£1,426
Scenario 2: Homelessness persists for 12 months	Cost
Processed by Housing Option Team, refused assistance ¹	£558
Visits to A&E department (20) ⁴	£2,340
Non-elective long stay in hospital (2) ³	£5,432
Anti-social behaviour (6 incidents) ⁴	£4,038
Arrested and detained (four times) ⁴	£2,876
High intensity accommodation-based service (mean support cost, 12 weeks) ²	£4,884
Total	£20,128

1. Based on median unit costs reported in Acclaim Consulting (undated) op. cit.

http://www.crisis.org.uk/data/files/publications/CostsofHomelessness_Finalweb.pdf

Source: Pleace (2015)

The illustrative vignettes within the report show that different experiences of single homelessness cause a diversity of public expenditure, varying in type and in level. However, there is a very clear message, preventing and rapidly resolving homelessness always costs less public money than allowing homelessness to become sustained or repeated. The report indicates that public expenditure on single homelessness is likely to rise in parallel to the duration and frequency of homelessness. The longer someone is homeless, or the more often they experience homelessness, the more they will cost the tax payer (Pleace 2015).

8.5 Newcastle Gateshead Fulfilling Lives - Cost Calculator

Newcastle Gateshead Fulfilling Lives Research and Evaluation Team have developed 'The cost calculator' which they describe as an easy and accessible tool which aims to build an understanding of an individual, or a group's, costs to the system that they interact with and how costs for the individual move through different parts of that system. People with multiple and complex needs interact with lots of different services across many different sectors and the cost calculator is intended to help improve understanding of the economic case by looking at the overall costs and make cost modelling more accessible. The box below provides a link to the cost calculator and details about how the cost calculator works.

How does the cost calculator work?

The cost calculator is a web based tool accessible here:

<http://www.fulfillinglives-ng.org.uk/resources/cost-calculator/>

The unit costs for the sector were compiled using a number of open sources referenced on the website.

The cost calculator adds up unit costs of a client, or aggregated clients over a set period of time and the total is how much the client has cost the various services over the period calculated; adding up the costs over a quarter period. Further developments will look to offer different time scales of calculator.

Comparative costs can be made pre and post an intervention but the cost calculator does not make an assumption about attribution of costs saved or provide a cost benefit ratio.

The cost calculator is very easy to use. Add the relevant numbers to the specified boxes, or slide the scale to the appropriate number. The cost of that unit will be shown in the right hand column.

You can add as many, or as few, unit costs as you would like. If you only want to include, for example, criminal justice costs then the calculator total will only show those costs. If there is nothing entered against a unit then the value returned will be zero.

The total cost is shown at the bottom of the right hand column. For a copy of your entries just copy all, and paste into a spreadsheet.

NB. The two columns do not scroll in unison so if you can't see your value for a unit just entered please check that you're scrolled to the right point in the column.

Chapter 9: Roots and Pathways into Homelessness

Knowledge of the roots and pathways into homelessness is necessary to be able to understand what causes it and/or to have the ability to predict in advance when, or to whom, it will happen. This also improves the odds of designing effective interventions and strategies to mitigate social risk factors and to target at risk groups. Research has identified many antecedents of homelessness that can serve as predictors, but these do not predict homelessness with certainty. In this section of the HNA the report highlights the main roots into homelessness that have been identified.

These issues have been considered in a comprehensive report prepared by the European Commission (2013) which highlights the structural, institutional, relationship and personal factors which can act as risk factors and triggers for homelessness across Europe. These are presented in the table below. It is important to note that not all people who experience these risk factors will have complex lives or become homeless. It is therefore important to understand each individual's unique experiences and the underlying issues that they may present with.

Communities and Local Government Committee Homeless Inquiry 2016-17
<https://www.parliament.uk/business/committees/committees-a-z/commons-select/communities-and-local-government-committee/inquiries/parliament-2015/inquiry1/>

In December 2015, amid a series of reports suggesting homelessness is on the rise, the Communities and Local Government Association (CLG) launched an investigation to examine the root causes behind the issue. In 2016, the Department for Communities and Local Government produced their third report of session 2016-17 the report identifies how roots into homelessness are complex and may relate to a number of factors, some of which are linked to the economy and the housing market, and others which are personal to the individual or family.

Risk factors and triggers for homelessness

Cause	Factor of vulnerability	Trigger
Structural	Economic process (poverty, unemployment)	Rent or mortgage arrears Eviction from rented or owned housing Loss of tied accommodation
	Housing market processes	Change of place for job search
	Social protection and welfare	New arrival Change of status
	Immigration and citizenship	Access to affordable housing and social protection blocked
Institutional	Shortage of adequate mainstream services and lack of coordination between existing services and to meet demand or care needs	Support breakdown or no adequate support in case of emerging need
	Allocation mechanisms	
	Institutional living (foster and childcare), prison, long-term hospital	Discharge Loss of home after admission
Relationship	Institutional procedures (admission, discharge)	
	Family status	Leaving family home
	Relationship situation (abusive partners or parents)	Domestic violence
Personal	Relationship breakdown (death, divorce, separation)	Living alone
	Disability, long-term illness, mental health problems	Illness episode. Support breakdown or problems in getting adequate support
	Low educational attainment	(Increased) substance misuse
	Addiction (Alcohol, drug & Gambling)	

Source: European Commission (2013)

Current thinking suggests that homelessness and exclusion are the result of the cumulative impact of a number of factors (some of which are considered below), but often underpinned by poverty and structural inequalities).

9.1 Supply of affordable housing

In a House of Commons Briefing Paper prepared by Wilson & Barton (2016), they identify the overall supply of affordable housing as a key structural factor. Affordable housing includes social rented and intermediate housing, provided to specified eligible households whose needs are not met by the market. This can be used to prevent and reduce homelessness if it can be rapidly and easily accessed by people facing homelessness (Pleace et al, 2015). The House of Commons Briefing Paper (Wilson & Barton, 2016), notes the decline in the social housing sector as a proportion of housing in recent years. The paper highlights that there are over one million fewer homes owned by local authorities and housing associations now than in 1977, with social housing falling over the period from 31% to 20% of all housing. This limits local authorities' scope for housing homeless families and families in need.

In addition, even when social housing is available obstacles may prevent individuals with more complex needs from accessing it. This population may have low levels of educational attainment and poor self-esteem and may find social housing allocation systems difficult to navigate, particularly web based social housing allocation systems (Pleace et al, 2015). Evidence submitted to the CLG Inquiry on Homelessness by the North East Regional Homeless Group (NERHG) and the North East Homelessness Think Tank (NEHTT) highlighted further issues (NERHG and NEHTT 2016). They described obstacles such as rejection from housing waiting lists for people with offending backgrounds as a problem. Sometimes this was regardless of an individuals' housing need or the fact that the offences in question did not relate to management of a tenancy or were a long time ago. Another barrier was cited as Housing Associations being increasingly likely to require rent in advance. Partnership working between social landlords and preventative services is therefore essential.

The private rented sector is the main alternative to social housing in providing affordable housing to both prevent and reduce homelessness. However, the appetite of private rental landlords to house vulnerable or high risk tenants has been questioned and for many the financial barriers and instability of tenancies is too great (DCLG, 2016). A longitudinal study undertaken by the Sustain Project (Smith et al, 2014) tracked the experience and wellbeing of 128 people who had been rehoused following a period of homelessness in the private rented sector. The research clearly indicated that the private rented sector is not providing a decent quality stable home for those who need it and that there is a need for improvement in the current enforcement and working practices. Moreover, a study commissioned by Crisis (Reeve et al, 2016) found that government policy was compounded rather than mitigating the difficulties faced by homeless people and benefit claimants trying to enter the private rented sector.

The potential impact of wider Government housing policies on levels of homelessness is discussed in detail in the Homelessness Monitor England 2016 report, an annual state of the nation report looking at the impact of economic and policy developments on homelessness (Fitzpatrick et al 2016). The report notes that housing market trends and policies have the most direct impact on levels of homelessness, with the influence of labour market change more likely to be lagged and diffuse, and strongly mediated by welfare arrangements and other contextual factors.

9.2 Poverty

“Primary homeless prevention – which combats the structural factors that contribute to economic disadvantage in the first place, offers the most effective means by which to counter both homelessness and poverty, and breaks the links between them” (Joseph Rowntree Trust 2014)

Unemployment or working in very low-skilled and unstable jobs are common risk factors for homelessness. A review of the European evidence by Busch-Geertsema and colleagues (2014) found that the overwhelming majority of homeless people have to live on low incomes. People who are not poor are more able to avoid homelessness because even if the experience a crisis they are able to afford temporary housing. The issue of poverty is also highlighted by the LankellyChase, Hard Edges Study (2015), which found that individuals with multiple and complex

needs have lives dominated by sustained experiences of poverty, with nearly half of people experiencing all three needs (homelessness, substance misuse, offending) reporting that they have been reliant on welfare benefits for most of their adult lives. The link between poverty and homelessness was the focus of a rapid evidence assessment undertaken by Johnson and Watts (2014). They found that the relationship between poverty and homelessness is bi-directional. Poverty was a precursor to homelessness for most of those who experience it (but not all) and for those with experience of homelessness the vast majority of people remain in poverty after they have been rehoused; with only a small minority participating in the paid workforce and those that do typically continuing to struggle financially.

A review of existing policy and research on social exclusion and poverty recently identified that the most intractable problems faced by those with complex needs tend to be their poverty and worklessness (Joseph Rowntree Foundation 2014). The review highlights how the poverty people face is complicated by their additional requirements for support with, for example, mental or physical health problems or various forms of social marginalisation. Stigma is a key issue and concerns were also identified about the prevalence of debt and the disproportionate impact of welfare benefit sanctions on homeless people, especially those with complex needs and young people. Homeless people and formerly homeless people were also identified as facing many barriers to accessing and retaining employment in the mainstream workforce, including: a lack of stable housing, work disincentives associated with welfare benefit system, vulnerabilities and support needs, low educational attainment, limited (or no) work experience, poor self-esteem and employer discrimination. These issues were identified as particularly acute for those with complex needs such as co-occurring substance misuse issues, mental health problems and /or experience of institutional care.

Primary prevention measures were also a feature of a report into homelessness by the Scottish Public Health Network (Hetherington & Hamlet 2015). Their report advocates for homelessness prevention policies that seek to address poverty and inequalities across the life course. They argue that this is necessary because poverty is such a pervasive factor for those experiencing homelessness. Their report supports actions to facilitate good parenting, life skills development, education, training and support for young people, and purposeful paid employment for youth and adults as key components of homelessness prevention.

A Joseph Rowntree Foundation review (2014) highlighted examples of initiatives which have attempted to break the links between poverty and homelessness. These include:

- Rent deposit schemes,
- Family mediation,
- Tenancy sustainment support
- Financial advice

Many such initiatives report positive psycho-social and other outcomes such as improvements in self-esteem and the acquisition of skills, qualifications and/or work experience. A number also reported cost savings to the state or broader social returns on investment via welfare benefit savings, tax gains, and/or savings in health and criminal justice provision. However, there was a lack of evidence that such interventions were successful in lifting homeless people out of poverty.

Evidence identified through the review showed that 'primary' homeless prevention – which combats the structural factors that contribute to economic disadvantage in the first place, offers the most effective means by which to counter both homelessness and poverty, and breaks the links between them. Primary prevention measures seek to reduce the risk of homelessness among the general population by improving housing supply, access and affordability, and or by reforming aspect of 'welfare settlement' (e.g. the level of income benefits, housing allowances and employment protection). The review showcases a need for the homelessness sector to redirect its focus from income maximisation, often reflected in a preoccupation with ensuring individuals receive all the benefits they are entitled to, to a more ambitious emphasis on poverty alleviation. This would direct attention to improve the accessibility of sufficiently well paid work or out-of-work benefits and/or strengthening of the wider welfare safety net (via provision of social housing and housing benefit, for example).

9.3 Psychological Understandings

Understandings of the relationship between poverty and homelessness are also compatible with psychological understandings which show how mental health issues are exacerbated and linked with economic, social and health deprivation. Emerging studies from neuroscience and neuropsychology on how poverty affects our cognitive abilities and reduces 'bandwidth' start to explain why the poorer you are, the harder it is to make what seem to be rational decisions over healthy behaviour and other decisions that affect our health (Marteau and Hall 2013). Recent evidence submitted to the CLG Homelessness Inquiry from research undertaken at the University of Southampton has highlighted that psychological factors can influence the way in which individuals behave given a set of environmental contingencies (Maguire 2016). This research has shown that there is a high level of childhood abuse and neglect in the homeless population, and that this is linked to attachment problems and difficulties in dealing with emotions, which in turn are linked to drug and alcohol use (methods externally changing the emotional state) and the asocial behaviours which led to tenancy breakdown. Other factors, found to be implicated are impulsivity, traumatic events in adult and childhood and emotions such as shame and guilt. A similar picture has also been found by other studies.

The Hard Edges study (Bramley et al 2015) pointed to a very close correlation between the extent of neglect and trauma suffered in childhood and the severity of disadvantage experienced in adulthood. For example, people in contact with all three systems (homelessness, criminal justice and drug treatment) were at least three times more likely than those in contact with just one system to have experienced growing up in a homeless family, a parent who was violent, a parent with a drug/alcohol problem or a parent who was mentally ill. 85% of people in contact with all three systems had experienced some form of childhood trauma. In the review of four studies undertaken by McDonagh (2011) it was noted that the prevalence of problematic childhood experiences among those with complex needs pointed towards a need for improved understanding within children and family services of routes into multiple exclusion homelessness and more targeted work with children who are experiencing issues that may relate to later homelessness. Shelton (2016) submitted evidence to the CLG Homelessness Inquiry based on 5 years of research undertaken at Cardiff University which investigated risk factors for homelessness experiences among young people. Her recommendations identify the apparent opportunities to reduce risk for first and recurrent experiences of homelessness among young people (aged 15-24 years). In particular, she notes that consideration should be given to how young people contending with intractable conflict, aggression, and abuse at home may be at increased risk of homelessness. Also of note were findings related to the relationship between disengagement at school and increased risk of homelessness suggesting additional avenues regarding the targeting of intervention and prevention activities.

9.4 Lifecycle transitions/leaving an institution

Research has described how lifecycle transitions may increase the risk of homelessness. Key transition points identified include during adolescence, leaving education, the parental home or a care institution including prisons, hospitals, mental health institutions and foster care (European Commission 2013). Recent data reported by Crisis (2016) from homelessness day centres and accommodation across England shows that of those living in direct access hostels, on average:

- 18 per cent of clients were prison leavers
- 8 per cent of clients were care leavers
- 3 per cent of clients were ex-service personnel

Many deinstitutionalised people do not have a family home to return to, have lost their own home during their care stay or cannot find suitable new housing and the importance of adequate preparation for after-care life and sufficient follow-up support. They are also vulnerable to social exclusion which can lead to homelessness (Wilson & Barton 2016).

9.5 Immediate triggers

Evidence from the Federation of European Organisations Working with the Homeless (Busch-Geertsema et al 2014) on the immediate triggers for homelessness were eviction (mostly after rent arrears) and relationship or family breakdown. In England the immediate homelessness triggers for families and vulnerable people housed by local authorities has remained fairly consistent in percentage terms over recent years. In 2011/12, the main cause was eviction by parents, relatives or friends at 34%. In 19% of cases households were unable to find alternative accommodation when their tenancy ended (Wilson & Barton 2016). In the different pathways to and through homelessness 'hidden homelessness' particularly staying with friends and relatives is a frequent episode, not only for young people and women, but also men who have lost their permanent home and are trying to secure temporary accommodation in an informal way before resorting to official support.

9.6 Sequencing of Multiple Exclusion Homeless experiences

An important research finding by Fitzpatrick et al (2013), highlights that there are critical intervention points in a person's journey into multiple exclusion homelessness. By the time an individual has got to more visible forms of homelessness they may have already had contact with a range of non-housing services such as mental health, substance misuse and criminal justice and have fallen between the gaps in policy and services. This study, which implemented a three stage survey in seven cities across the UK, was able to identify an order in which people encountered various aspects of multiple exclusion homelessness. They identified four broad phases as shown in the box on the right.

This finding highlights critical points in the persons journey into multiple exclusion homelessness and also points to how there are opportunities for services to intervene much earlier and across the life course. At the same time however, the study authors note that pathways in to multiple exclusion homelessness should not be conflated with pathways out and while housing-related problems may not be the starting point for MEH, the provision of stable housing is likely to be an essential element in ending it.

Stage 1 Substance Misuse: The experiences which tend to happen to people earliest, if they happened at all, were abusing solvents, glue or gas; leaving home or care; using hard drugs; developing a problematic relationship with alcohol; and/or street drinking.

Stage 2 Transition to street lifestyles: The next set of experiences then tended to occur included: becoming anxious or depressed; survival shop lifting; being the victim of violent crime; sofa surfing; and spending time in prison.

Stage 3 Confirmed street lifestyle: Next, there was a closely interlinked set of experiences which seemed to confirm transition to a street lifestyle, including sleeping rough, begging and injecting drug use.

Stage 4 'Official' homelessness: Finally, the experiences which tended to happen late in individual MEH sequences included applying to the council as homeless and staying in hostels or other temporary accommodation.

Source: Fitzpatrick et al (2013) - Based on 452 interview surveys

10. Meeting Specific Needs

10.1 Gender

Homelessness is an example of a gendered phenomenon where the majority of the disadvantaged are middle aged single men (European Commission 2013). Women are present in greater numbers in the statutory homeless systems throughout the UK, but these systems are explicitly designed to support homeless lone women parents with dependent children and other women with support needs (Pleace et al 2008). In the UK, research

by Crisis (Mackie 2014) suggests that in the single homeless population, women are in the minority and only make up approximately 17 per cent of clients of homelessness services. However, the profiles of homeless people have been changing and the number of women exposed to homelessness is growing (European Commission 2013). Women appear more frequently in some subgroups of homeless people than others, and the causation of their homelessness and their reaction to homelessness appears to exist in patterns that are distinct from those of men (Busch-Geertsema et al 2014). Research from the UK by Smith (2008) found that the most common triggers for men becoming homeless are relationship breakdown, substance misuse, and leaving an institution. While for women the most common are physical or mental health problems and escaping a violent relationship. Interviews with homeless women conducted by Crisis showed that over 20 per cent became homeless to escape violence from someone they knew (Mackie, 2014).

Women suffer from 'hidden homelessness' and engage in coping strategies such as sleeping rough in parks, sofa surfing or returning to a relationship to avoid being homeless (FEANTSA 2016). The CLG Homelessness Inquiry (DCLG 2016), received evidence that 28 per cent of homeless women have formed an unwanted sexual partnership to get a roof over their heads, and 20 per cent have engaged in prostitution to raise money for accommodation. The evidence identified high levels of vulnerability within the female homeless population, mental ill health, drug and

Female users of Local Homelessness Services

- 2015/15 32% of referrals to supported housing in Gateshead were for females
- Between May 2014 – July 2016 43% (42) of the individuals accessing Fulfilling Lives Programme were female.
- Basis@363 – 2015/16 25% (740) of all clients were female
- Basis@363 – Nurse Led Health Drop-In Pilot. NHS Health Check – Of the 29 respondents 5 (18.52%) were female.

alcohol dependencies, childhoods spent in care, experiences of sexual abuse and other traumatic life experiences are all common place. The Inquiry also identified that services do not always cater for the specific needs of vulnerable females so women may be less likely to engage with services. The enquiry recognised that women who have been victims of domestic violence as being particularly at risk of becoming homeless.

Gender remains a lesser-explored area of homelessness-related research and policy. Bush-Geertsema (2014), have called for further investigation of how homelessness is differentiated by gender. Key issues for exploration include the role of gender-based/domestic violence in causation, the use of informal arrangements with friends,

Gateshead – Domestic Abuse and Homelessness

Domestic Abuse is one of the single biggest reasons for homelessness in Gateshead:

- 2015/16 - 263 applicants presenting as homeless because they were fleeing Domestic Abuse.
- 2015/16 - 312 reported incidents of Domestic Abuse through the Neighbourhood Relations Team (a 13% increase from the previous year and 5% of those cases didn't want to engage with services offered).
- In 2015/16 - the Refuge in Gateshead received 183 referrals and accommodated 31 referrals. Of those referrals received, 9% of referrals changed their minds, deciding they no longer wanted refuge accommodation.

Gateshead Council's IDVA Service - Independent Domestic Violence Advisory Project received 1344 referrals in 2015/16.

<http://www.gateshead.gov.uk/People%20and%20Living/CommunitySafety/domestic/SaferFamiliesProject>

family and acquaintances, and the differential responses of welfare systems to homeless and potentially homeless lone women with children, compared to lone adults without children.

10.2 Ex-Service Personnel Homelessness

Homeless ex-service personnel are a group of significant policy interest in the UK. Johnsen et al (2008) identified that the extent to which homelessness is causally related to prior military experience varies significantly at the individual level: some personnel encounter difficulties during military service which continue to affect them after discharge; others carry vulnerabilities from childhood or adolescence into the Armed Forces and later life; some find post discharge adjustment to civilian life very difficult; whilst for yet others homelessness is triggered much later in life by apparently unrelated crisis (e.g. bereavement or bankruptcy). In relation to multiple exclusion homelessness a quantitative survey undertaken amongst 1,286 users of 'low threshold' services in seven UK cities

Gateshead Armed Forces Outreach Service

The Armed Forces Outreach Service helps veterans make the transition from military life back into civilian life and also supports serving members of the Armed Forces and their families. No information from the service was shared with the Health Needs Assessment however.

The service is available Monday to Friday, offering help with:

- **Benefits** – We can check that you or your family member has accessed all of the benefits available to you from the MOD.
- **Employment** – Support and advice on employment can also be provided by our Armed Forces Community Outreach Worker.
- **Housing** – Your time in military service will be taken into account if you apply for housing with Gateshead Council. Supported housing is also available for ex-service people through care and support.

identified a total of 14% of people experiencing MEH had served in the Armed Forces (Johnsen & Fitzpatrick 2012). Ex- service personnel reported similar levels of experience of homelessness, substance misuse, institutional care, and street culture activities as that of other members of the MEH population. However, they were more likely than the other MEH service users to have experienced specific adverse life events (notably redundancy), and less likely to report some experiences of extreme distress (particularly deliberate self-harm, suicide attempts and having being the victim of violent crime).

10.3 Care Leavers

“Housing is a vehicle for stability for care leavers and affects a wide range of other outcomes” (Demos and Barnardo's 2010)

The terms 'looked-after children' or 'children in care' refer to all children under the age of 18 being looked after by a local authority. It includes both those subject to a care order under section 31 of the Children Act 1989; and those looked after by a voluntary agreement with their parents under section 20 of that Act. Care leavers are those who have been in 'care' for at least 13 weeks from the age of 14 onwards and therefore qualify for services to support them once they leave. This support should be provided up to the age of 21 or until they have completed their education if this is longer.

Many young people leaving care do have successful transitions to adulthood, going on to achieve in education, gain skills and qualifications through training and having careers. However, a report by Whalen (2015) highlights that there are a significant proportion of young people leaving care aged 16, 17 or 18 who experience a range of difficulties,

Financial Education for Care Leavers – Gateshead Pilot

A recent report by the Children's Society (2016) has highlighted the shortcomings of local authorities when it comes to preparing care leavers for independent living. Gaps in financial education are identified and the lack of any meaningful knowledge around managing money that would allow them to live independently.

http://www.childrensociety.org.uk/sites/default/files/pcr073_care-leavers-financial-exclusion-final.pdf

In response to this report Gateshead Council are working with Clean Slate Financial Wellbeing Services on a Financial Education for Care Leavers pilot which will be an accredited OCN level 2 programme targeted at groups of young people who are due to leave the care of the local authority.

often over several years, as they make their transition to adulthood. One of the most common features of a poor transition to adulthood is housing instability, risk of homelessness and actual homelessness.

Overall, research indicates that leaving care services are effective in assisting most care leavers to access housing (Stein 2009). A report by the National Audit Office (2015) states Department for Education figures that judged in 2014 that 93 per cent of care leavers live in suitable accommodation at aged 19. However, there is no reliable information to monitor the lives of care leavers over time. The National Audit Office (2015) highlights that there are no official statistics on some aspects of care leavers' lives, such as whether they have timely access to health services, whether they feel they left care at the right time, or the extent to which they have poor social outcomes such as unemployment, homelessness, mental illness or criminal activity.

Supporting Gateshead Care leavers into Sustainable Accommodation

The Local Authority has a Care Leavers Accommodation and Support Panel which is held each month. The panel monitors the progress of young people who are due to leave care and plans are put in place regarding their accommodation needs including any risks posed to tenancies such as rent arrears and anti-social behaviour. All of the young people and their accommodation are assessed and RAG rated. When the process was introduced with leaving care services most were rated RED due to tenancy problems, this is now reversed and most are rated GREEN. The Panel have also been able to identify gaps in provision such as accommodation for young people with convictions, those with challenging behaviour and have been able to inform commissioning services of these gaps, we are now working towards commissioning services to meet these needs.

Care leavers needing tenancy support are given priority, so are picked up very quickly. The Housing & Independent Living Outreach Service workers work closely alongside the Personal advisors and Social workers in the Looked After Children team. A peer-led service for vulnerable care leavers who are offending or at risk of offending was commissioned as a 6 month pilot in December 2016. The tailored support service is provided directly to 3 young care leavers who are living independently in a taster flat supplied by the Gateshead Housing Company. The service offers

- A peer-led approach to support;
- Outcome focussed recovery through a diverse menu of activities;
- Tailored, person centred care;
- Fulfilling duties under relevant legislation, i.e. Children (Leaving Care) Act 2000;
- Employment, training and apprenticeship opportunities;
- Tackling social exclusion;
- Promoting community engagement and integration;
- Reducing offending or re-offending;
- Strengthening partnership working with key stakeholders, i.e. Northumbria Police;
- Reducing the cost of out of borough and unsuitable placements;
- Promoting a co-production approach to commissioning services;
- Piloting a new approach to support for looked after children in Gateshead.

Research by Stein (2009) identified that about one third of young people with care backgrounds experience homelessness at some stage between six months and 24 months after leaving care. Homelessness in this context includes 'sofa surfing, staying at homeless hostels or refuges, sleeping rough and spending short periods in B&B accommodation. The National Audit Office Report (2015) identified that in 2010, 25% of those who were homeless had been in care at some point in their lives.

In March 2013, a survey conducted by Youth Homeless North East's into Youth Homelessness in the North East (YHNE 2013) found that 77, (9%) of young clients engaged with homelessness providers were care leavers. 34 responses were received from the 12 local authorities and 29 responses were received from projects delivered by 21 homelessness providers.

Research conducted by Barnardo's (2014), with over 60 care leavers and support workers across a range of Barnardo's services throughout England found that vulnerable care leavers worry about the risk of becoming homeless and are experiencing severe difficulties with finding appropriate accommodation, having choice in their housing and managing living alone for the first time.

10.4 Offending and Leaving Prison

There is a close relationship between offending and homelessness. Prison can be both a cause and effect of homelessness. Nacro, the crime reduction charity, submitted evidence to the CLG Inquiry into homelessness, which identified one in five individuals being released from prison as having no home to go to on release they also cited one survey which found that almost half of homeless people had been in prison or a young offenders institute at one point (Nacro 2016). There evidence also highlighted that 15 per cent of newly sentenced prisoners reported being homeless before custody and 12 per cent of prisoners depend on housing benefit to help with their rent before they enter custody. A study by Reeve (2011), which surveyed 437 single homeless people, found that 28 per cent of respondents had committed a crime in the hope of being taken into custody for the night, 20 per cent had avoided bail or committed an imprisonable offence with the express purpose of receiving a custodial sentence.

Evidence of the health vulnerabilities of the prison population are highlighted in report by the Prison Reform Trust (2016); From a health perspective 36% of prisoners are estimated to have a physical or mental disability compared to 19% of the general population, 18% of prisoners were considered to have a physical disability, 20-30% of people in prison are estimated to have a learning disability or difficulties, 25% of women and 15% of men in prison reported symptoms indicative of psychosis and 46% of women report having attempted suicide at some point in their lives, more than twice the rate of male prisoners (21%) and higher than in the general UK population (6%).

The CLG inquiry into Homelessness (DCLG 2016) found that ex-offenders and those leaving prison do not always get the support they need and that there was a lack of coordination between the Ministry of Justice and the Department for Communities and Local Government. In 2014, Transforming Rehabilitation reforms commenced which replaced the previous 35 Probation Trusts with a single National Probation Service (NPS), responsible for the management of high risk offenders; and 21 Community Rehabilitation Companies (CRCs) responsible for the management of low to medium risk offenders across England and Wales.

Nacro state that acknowledging the link between stable accommodation and preventing re/offending is vital (Nacro 2016). NERHG submitted evidence to the CLG Inquiry (NERHG 2016). Their submission highlighted that the

Offending History of Gateshead Service Users

- Basis@363 2015/16 of 740 clients 57 (8%) reported an offending history
- Fulfilling Lives 2014-2016 of 98 clients 84(86%) reported an offending history
- Supported Housing Portal 2015/2016 of 286 (63%) of 457 referrals reported an offending history
- Homeless Health Audit – 11 (16%) were prison leavers.

Through The Gate Plus

The housing difficulties of people leaving prison in the North East region have been the focus of work undertaken by the North East Regional Housing Group (NERHG). They identified a significant proportion of rough sleepers across the region, and those users of multiple services had previously been in custody and had a history of inappropriate temporary accommodation. NERHG were awarded funding to develop a project called, Through The Gate Plus, to help offenders most at risk of homelessness and rough sleeping to find and sustain their home, and to help people going into prison for short sentences to keep their homes. The service is now provided in all North East prisons and compliments the Shelter housing advice provision that works with all prisoners needing advice with housing related issues. An evaluation of Through the Gate Plus was undertaken in 2014 (Harding et al 2014) and RHG have commissioned a further longitudinal evaluation.

<http://nrl.northumbria.ac.uk/24944/1/Through%20the%20Gate%20Plus%20Evaluation%20Final%20Report.pdf>

Reforming Rehabilitation initiative could enable all offenders in prison to have their housing needs identified and a resettlement plan formulated to address those needs. However, the following concerns were raised:

- There is less flexibility to deal with housing issues as they arise, and a lack of action on Housing Benefit claims between reception and 12 weeks prior to release.
- Not tackling a need for accommodation until 12 weeks before release
- Registering on Council and Housing Association waiting lists in good time
- Making arrangements to pay off past rent arrears
- Applications for private rented housing
- Homeless applications and referrals to supported housing provider
- Availability of places in resettlement prison
- Reserving beds in supported housing
- Different models of provision

The following recommendations were made as part of the RHG submission:

1. The Government should require CRCs to provide housing advice and other actions to resolve housing needs and plan for release as needed between reception into prison and 12 weeks before release.
2. The service offered to prisoners should be the same in all areas and for all CRCs.
3. All prisons should offer the facility of repaying an amount every week from rent arrears.
4. It should be the norm for beds in supported housing to be reserved in advance of release and for funding to support this, in order to prevent homelessness and uncertainty.

Multi Agency Public Protection Arrangements (MAPPA)

Gateshead Housing Services represents Northumberland Tyne and Wear on the regional Strategic MAPPA Board. Arrangements to secure appropriate housing for ex-offenders are agreed through this route. The Homelessness Prevention Team (Housing Options) accepts ex-offenders as priority need where they are considered to be at risk, for example due to substance misuse issues, mental health issues and institutionalisation. It is unusual for an ex offender not to be re-housed. Where there are issues the Single Gateway within Housing Services works with the client to broker support, establish a positive reference and then move over to general needs housing within council housing stock.

10.5 Lesbian, Gay, bisexual and transgender homelessness

Guidance developed by Shelter and Stonewall Housing (Gold 2005) has identified how issues related to sexuality and sexual identity can play a key role in the onset of homelessness. The report highlights some of the key problems people face related to housing:

- young people thrown out of home because of their sexuality
- young people suffer physical and verbal harassment inside and outside the home
- older people needing care or sheltered accommodation and finding themselves marginalised or ostracised
- all ages subjected to homophobic harassment and violence inside and outside the home
- people suffering same-sex domestic violence, with no appropriate emergency housing provision

A 2014 UK wide study into youth homelessness (aged between 16 and 25 years) with people who identify themselves as lesbian, gay, bisexual or transgender surveyed 261 individuals using survey methods (Albert Kennedy Trust 2015). The study found that LGBT people make up 24% of the youth homeless population. It also found that they are over represented

LGBT Data from Gateshead services

- Fulfilling Lives 2014 -2016 of 98 clients 79 reported they were heterosexual, 5 described themselves as other and the status of 14 was unknown.
- Supported Housing Portal 2015/2016 of 457 referrals 78% reported they were heterosexual, 2% were gay women, 1% were gay men, 1% were bisexual and 19% did not answer the question.

because many are rejected by families unable to come to terms with their gender identity or sexual orientation. A United States study (Kattari and Begun 2016), found that transgender individuals experience homelessness at higher rates than the broader population with many directly attributing homelessness to their transgender identities.

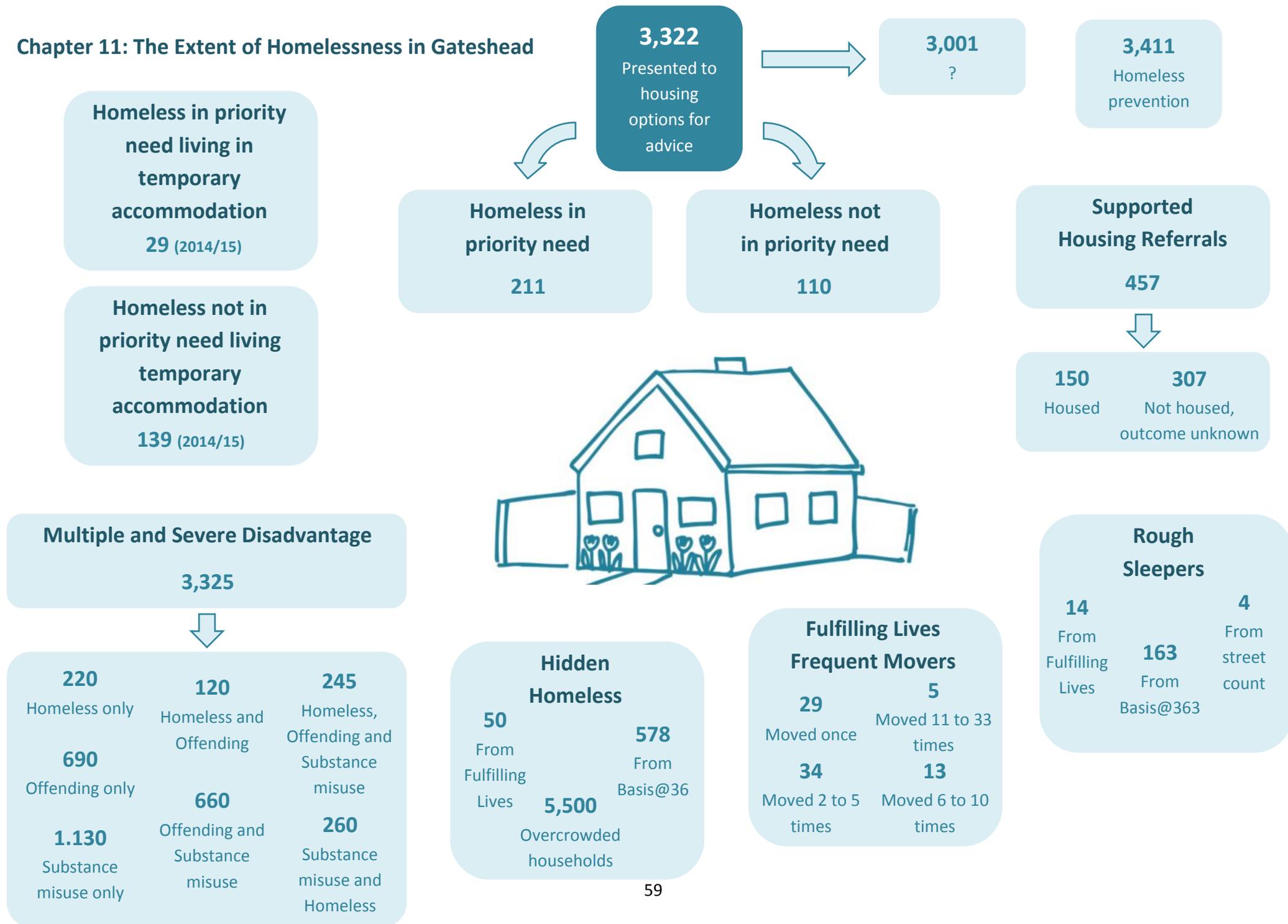
A paper by Roche (2006) raises concern that there is often a failure to identify issues of sexuality and for single homeless people to be defined by their homelessness, overlooking the more complex aspects of identity such as personal preferences and experiences. The paper also highlights that while there is some attention directed towards the experiences of young people who are LGBT the same is not true of adults or older people. The failure to recognise sexuality within systems of care means that the assumption is one of heterosexuality.

10.6 Migrant Homelessness

A literature review on migrant homelessness across Europe, undertaken in 2016 (Open Society Initiative for Europe 2016), reveals a heterogeneous group within the homeless population that form their own sub populations according to immigration status, whilst also sharing particular welfare needs, experiences of social exclusion or fundamental characteristics with the wider homelessness population (such as gender and age). The review found that homelessness most often results from adverse life events, such as eviction and relationship breakdown coupled with structural conditions that put individuals and families in financially vulnerable situations. For settled populations, interventions can draw on the broader support of the welfare state and the potential of labour markets, however for migrants excluded from such services or rights, a limited number of policy tools are at the disposal of cities and their partner agencies. As such, interventions tend to focus on the provision of advice and a number of specialised services have been developed across Europe to meet the needs of this sub-group of the homeless population.

A UK study comparing the experiences of multiply-excluded homeless migrants and those from the settled population found that the causes of homelessness amongst migrants were much less likely to be associated with deep social exclusion, such as experiences of childhood trauma or other complex support needs and much more likely to be associated with structural issues, including exclusions from welfare benefits and housing-related services and practical barriers such as poor English language skills or limited knowledge of local welfare systems (Fitzpatrick et al, 2012). Understanding migrant homelessness therefore requires a consideration of different dimensions of need. The Fitzpatrick study concludes that bespoke services tailored to the specific needs of homeless migrant groups are required, and that it is inappropriate to expect 'traditional' homelessness agencies – set up to deal with a fundamentally different social problem – to be able to cope with these emerging and distinctive needs.

Chapter 11: The Extent of Homelessness in Gateshead



11.1 Statutory Homelessness Prevalence

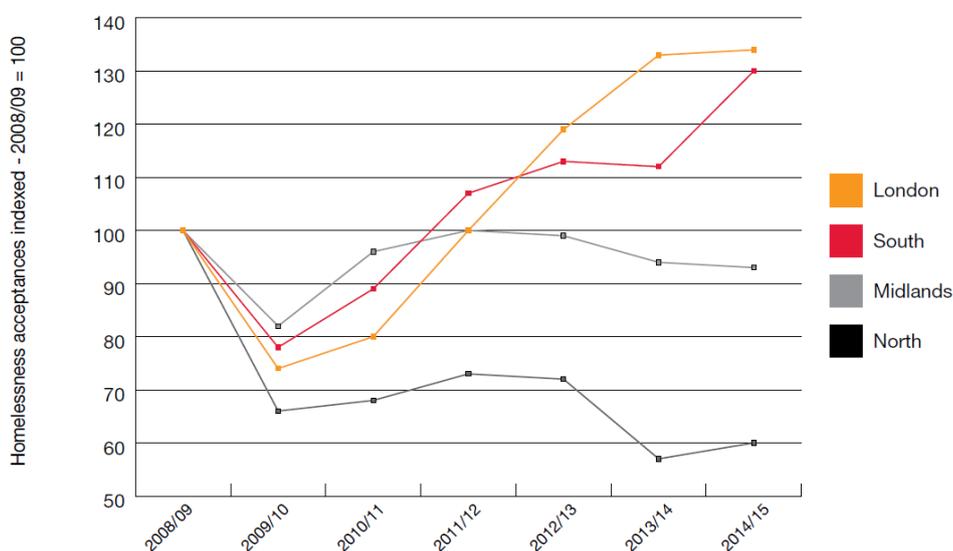
The Department for Communities and Local Government (DCLG) publishes three sets of data on homelessness; statutory homelessness, prevention and relief and rough sleeping.

National Statutory Homelessness

DCLG statistics suggest that homelessness is increasing however the scale of homelessness is greater than that captured in statistics (DCLG 2016).

Data from the Homelessness Monitor: England 2016 (Fitzpatrick et al 2016), describes how between 1997 and 2003 homeless acceptances by local authorities rose year on year. The yearly figures then fell until 2010. It is largely understood that these decreases were a product of the Government driven roll out of a more proactive homeless prevention (Housing Options) approach by local authorities across the country. The financial year of 2010/11 saw an increase in homelessness acceptances of 10%, representing the first financial year increase since 2003/4. The statistics on statutory homelessness published on 30 June 2016 showed that the number of households accepted as homeless and owed the main homelessness duty (permanent re-housing) for the financial year 2015 -16 was 57,750, up 6% from 54, 430 in 2014-15. Of these 19,180 were in London, up 9% from 17,530 during 2014-15. The London acceptances represent 33% of the England total. In the rest of England the 2015-16 figure of 38,570 is up 5% on the 2014-15 figure of 36,900. The chart to the right shows the homelessness trends at broad region level between 2008 and 2015.

Homelessness acceptances 2008/09-2014/15: trends at broad region level indexed



Source: DCLG Homeless Monitor (June 2015), Fitzpatrick et al (2016)

Gateshead – Statutory Homelessness

The majority (66%) of people who are assessed as homeless in Gateshead are those classified as officially homeless and for whom the local authority does have a duty to accommodate. In Gateshead the majority of households that approach the Housing Options team are recorded initially as a housing advice case and a caseworker will investigate opportunities to prevent homelessness. This can be either working with clients who are not yet homeless but are threatened with homelessness to enable them to remain or assisted them into alternative accommodation which prevents them becoming homeless. The number of households recorded as presenting as homeless are those households where the low threshold of evidence has been attended that satisfies the local authority that the household may be homeless under the legislation and investigations commence.

Data available for 2015 to 2016 shows that 3322 households in Gateshead approached Housing Options for advice. 335 of those assessed presented as homeless. Of these 211 households were accepted as unintentionally homeless and in priority need. The table below shows the number of households presenting to Housing Options for advice and as homeless from 2010/11 to 2015/16. Since 2010/11 there has been an increase in those presenting for advice since 2010/11 but the number of households presenting as homeless has decreased since 2010/11.

Presentations to Housing Options and Priority Need Acceptances - Gateshead 2010–2016

Data set	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Number presenting to Housing options (advice)	1,759	3,144	3,590	3,675	3,375	3,322
Number presenting as homeless to Housing options	756	493	508	461	420	335
Advice activity (Advice contacts)	7,312	14,616	23,900	24,910	23,570	24,870
Housing Advice cases threatened with homelessness prevention work failing homeless assessment opened	207	410	449	369	390	284
Total number of households found eligible, unintentionally homeless and in priority need	248	158	204	188	196	211

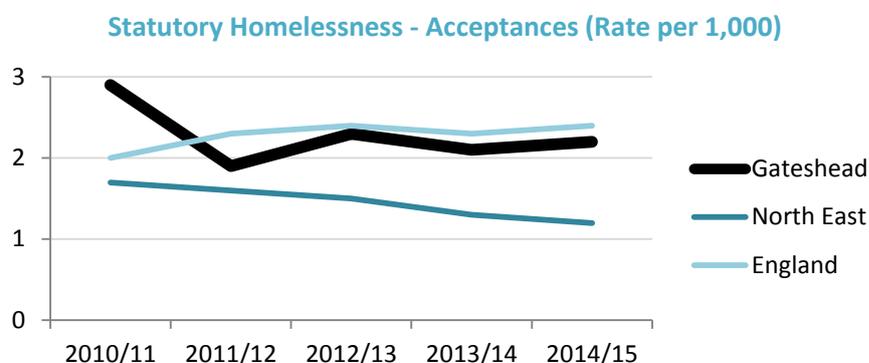
Data available from Public Health England (Public Health Outcomes Framework) provides details of trends in homelessness acceptances. By comparing the number of acceptances to the population size in an area a comparison can be made between the rates for Gateshead, the North East and England. Gateshead's homeless acceptance rate reduced substantially in 2011/12 and has remained relatively stable since. The 2013/14 rate of 2.1 per 1,000 households continues to be significantly higher than the North East rate as a whole (1.3 per 1,000 households) but when compared nationally it has been the same or slightly lower than the England rate since 2011/12.

In 2016 the 'homelessness acceptances' indicator in the public health outcomes framework was replaced with 'eligible homeless people not in priority need'. Data is therefore only available up until 2014/15. Further details are in Appendix B.

Rate per 1,000 of priority need acceptances – Gateshead, North East and England

	Gateshead				North East				England
	Number	Rate per 1,000	Lower CI	Upper CI	Number	Rate per 1,000	Lower CI	Upper CI	Rate per 1,000
2010/11	248	2.9	2.6	3.3	1,860	1.7	1.6	1.8	2
2011/12	158	1.9	1.6	2.2	1,800	1.6	1.5	1.7	2.3
2012/13	204	2.3	2	2.7	1,740	1.5	1.6	1.6	2.4
2013/14	188	2.1	1.8	2.4	1,520	1.3	1.3	1.4	2.3
2014/15	196	2.2	1.9	2.5	1,395	1.2	1.2	1.3	2.4

A separate request was made to provide data on the makeup of priority need acceptance households. This was not made available until 31 January 2017 and therefore figures do not sum to the table above due to changes in the status of cases that can occur following a review. The total number of cases at 31 January 2017 for the period 2015/16 of those homeless but not in priority need was 219. The tables below show a breakdown of household composition and age as well as the top 12 reasons for homelessness.



Household and Age Composition of homeless priority need acceptance households 2015/16

Couple with dep. children	Lone female, no dep. children	Lone female with dep. children	Lone male, no dep. children	Lone male with dep. children	Other
29	50	81	42	6	11

16-24	25-44	45-59	60-64	65-74	75+
44	133	34	<5	<5	<5

Top 12 reasons for homelessness

Violent breakdown of relationship, involving partner	94
Termination of AST	16
Other	12
Parents no longer willing to accommodate	11
Non-violent breakdown of relationship with partner	11
Friend Relative no longer willing to accommodate	11
Leaving national asylum support service accommodation	9
Other forms of violence	9
Violent breakdown of relationship, involving associated person	9
Refugee(s) or Asylum Seekers	7
Leaving hospital	7
Loss of tied accommodation other than AST	6

11.2 Homelessness Prevention

Under the Homelessness Act 2002, local housing authorities must have a strategy for preventing homelessness in their district. The approach taken to homeless prevention in Gateshead is expressed within the Preventing Homelessness Strategy 2013 -18 and resulting action plan.

Gateshead Preventing Homelessness Strategy 2013 -18:

<https://www.gateshead.gov.uk/DocumentLibrary/housing/strategy/homeless-strategy-consultation/Homelessness-Strategy-2013.pdf>

Homelessness prevention and relief activity may be carried out by local authorities on behalf of households whether they are in priority need or not. Prevention refers to positive actions taken by Gateshead Council and its partners to provide assistance to households who consider themselves to be at risk of homelessness, which enable them to remain in their existing property or to obtain an alternative for at least the next 6 months.

A recent assessment by the UK Statistics Authority (2015) concluded that the official Homelessness Prevention and Relief and Rough Sleeping Statistics do not currently meet the required standards of trustworthiness, quality and value to be designated, as national statistics.

National Homeless Preventions

An estimated total of 212,600 cases of homelessness prevention or relief took place outside of the statutory homelessness framework in England during 2015/16, this was down 4% on 2014/15 (Homeless Monitor 2016, Fitzpatrick et al)

Gateshead Homeless Preventions

Homeless prevention data is produced by the Housing Options team to demonstrate where supportive interventions have prevented a person from becoming homeless.

In Gateshead the level of homeless prevention activity has increased year on year. In 2010/11 there were 1,437 preventions and during 2015/16 3,411 households were prevented from becoming homeless as a result of activities carried out by the local authority and partners working with those identified as being vulnerably housed. The table below shows the homeless preventions from 2010/11 – 2015/16.

Homeless Prevention in Gateshead 2010/11 - 2015/16

		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Homeless prevention outcomes	Housing Options service	240	676	564	687	802	680
	LA partners	1,197	1,400	1,530	2,766	2,870	2,731
	LA and partners total	1,437	2,076	2,094	3,453	3,672	3,411

Households Accommodated in Temporary Accommodation

Temporary accommodation (TA) may be used by local authorities as an interim solution for statutory homeless households until suitable accommodation becomes available. The TA offered to a homeless household must be suitable for them and the local authority will take a number of things into account when considering this, including:

- How much rent the household can afford to pay;
- The condition of the accommodation; whether the accommodation is the right size for the household; the location of the accommodation;
- Any health needs in the household and other social factors (such as whether the household need to be close to support services, family or special need schools).

National

The number of statutory homeless acceptances placed in TA has risen sharply since 2010/11 with the most recent figures for 2014/15 showing a rate of 2.8 per 1,000 population.

Local

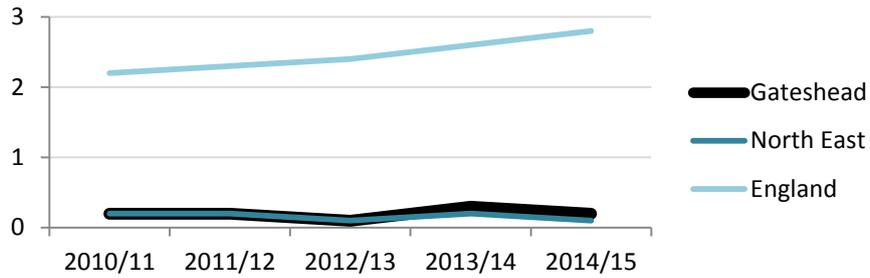
Since 2010/11 the rate of TA placements has been relatively stable. In 2014/15 22 households in Gateshead were placed in temporary accommodation the rate per 1,000 was 0.2 which is higher than the North East rate (0.1) and significantly lower than England (2.8). TA placements for Gateshead include B&B placements, Hostels and Women's Refuges. In 2014/15 the majority of TA placements in B&B placements and Hostels were from the non-statutory homeless population the trends in placements can be seen in the table below.

Rate of Temporary Accommodation Placements – Gateshead, North East, England

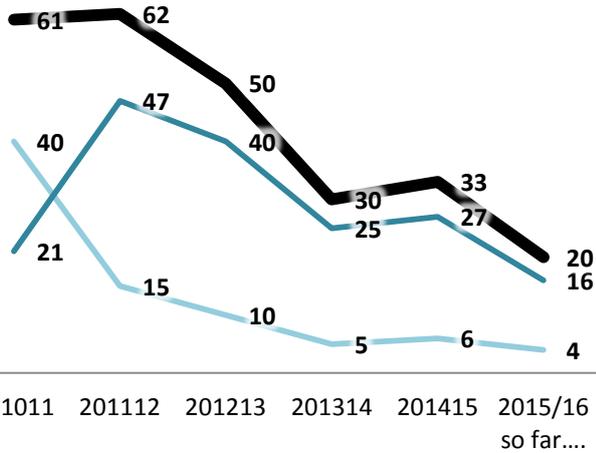
	Gateshead				North East				England
	Number	Rate per 1,000	Lower CI	Upper CI	Number	Rate per 1,000	Lower CI	Upper CI	Rate per 1,000
2010/11	17	0.2	0.1	0.3	220	0.2	0.2	0.2	2.2
2011/12	13	0.2	0.1	0.3	210	0.2	0.2	0.2	2.3
2012/13	8	0.1	0	0.2	170	0.1	0.1	0.2	2.4
2013/14	28	0.3	0.2	0.4	180	0.2	0.1	0.2	2.6
2014/15	22	0.2	0.2	0.4	155	0.1	0.1	0.2	2.8
2015/16	19	0.2	0.1	0.3	150	0.1	0.1	0.2	3.1

Source: DCLG (2015/16)

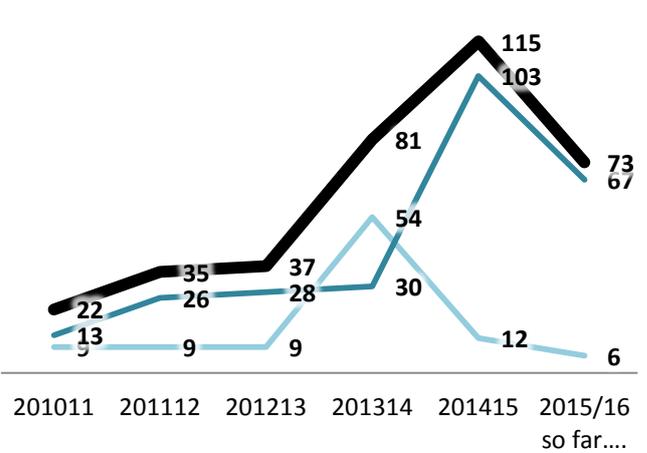
Statutory Homelessness - Households in Temporary Accommodation (Rate per 1,000)



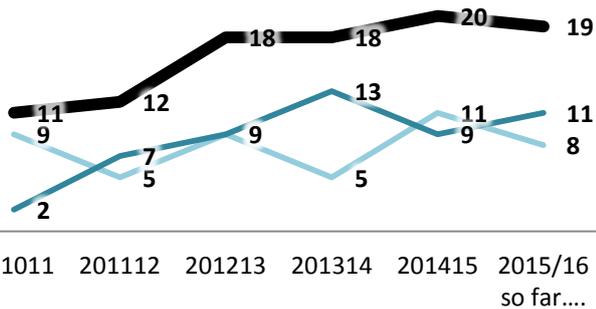
Gateshead B&B Admittance 2010 to 2015/16



Hostel Admittance in 2010 to 2015/16



Womans refuge admittance 2010 to 2015/16



Rough Sleeping

Exact numbers of rough sleepers are unknown. Rough sleeping counts and estimates are single night snapshots of the number of people sleeping rough in a local authority area. Local authorities decide whether to carry out a count or an estimate.

National – Rough Sleeping

According to the data, the autumn 2015 total of street counts and estimates in England was 3,569, an increase of 30 per cent from the 2014 figure of 2,744. In 2015, 44 local authorities conducted a count and 282 provided an estimate. London’s total in 2015 was 26 per cent of the figure for England with a count of 940 rough sleepers.

Gateshead – Rough Sleeping

The 12 local authorities in the North East, as part of the NERHG, agreed to adopt the ‘No Second Night Out Standard’ (See Appendix B) for helping people who are sleeping rough. This tries to make sure that anyone new to sleeping on the streets gets help so they do not have a second night out there. To report rough sleeping in Gateshead there is a dedicated telephone number and email which is provided through Oasis Aquila Housing. Anyone found sleeping rough can get help to access somewhere to stay, an assessment of their other needs and referral to other agencies which can meet these needs, and help to come in off the street while they are waiting for accommodation. All reports of rough sleeping are recorded on the regional database with outcomes.

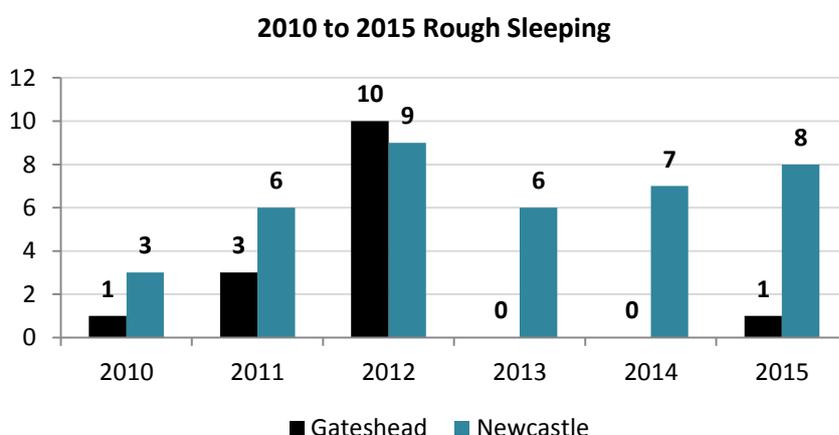
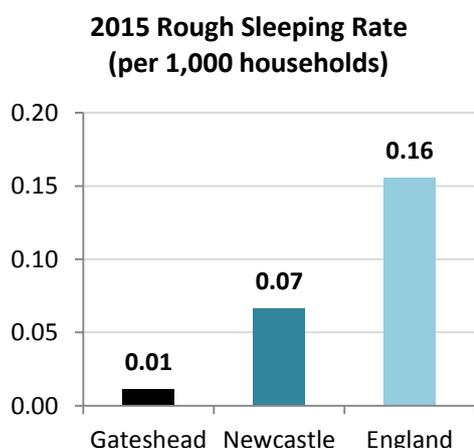
In the North East, there are a small number of recorded rough sleepers in most areas. In Gateshead, no one was identified as sleeping rough in 2013 and 2014. In 2015 one individual was identified. Most rough sleepers are people who have been in and out of services for some time and either cannot currently be found anywhere suitable, or do not want to accept what is currently on offer. In addition some are migrant workers who have no recourse to public funds so cannot be accommodated without a loss of income to the provider.

Most North East Councils have access to emergency accommodation for rough sleepers. Gateshead does not have emergency accommodation.

Street counts and estimates of rough sleeping in England

	2010	2011	2012	2013	2014	2015	Number of Households 2015 ('000s)	2015 Rough Sleeping Rate (per 1,000 households)
Gateshead	1	3	10	0	0	1	90.583	0.01
Newcastle	3	6	9	6	7	8	120.134	0.07
England	1768	2181	2309	2414	2744	3569	22940.022	0.16

Note: Figures in red are estimates
Source: DCLG GOV.uk website (Autumn 2010-15)

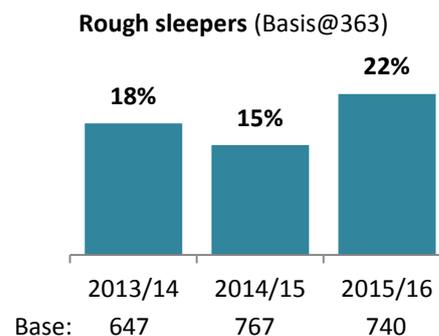


Basis @ 363 Data on Rough Sleeping/vulnerably housed/sofa surfers

Basis @ 363 record the reported housing status of individuals accessing the drop-in service. This shows that the prevalence of rough sleeping in Gateshead may be much higher than the DCLG street counts and estimates data shows. This merits further investigation.

Fullfilling Lives Rough Sleeping

Client data from May 2014 to July 2016 shows that for 14 of the clients had 20 episodes of rough sleeping recorded. Again this suggests a much higher prevalence of rough sleeping than the street count and estimate.



Non – Priority Single Homelessness Prevalence

Data on single homelessness incidence and trends are hard to source. Local Authorities log non-priority cases and this provides one possible benchmark as most of these cases are likely to be single people assessed as not having a priority need.

National

Data from The Homeless Monitor England (Fitzpatrick et al, 2016), shows that nationally, across England, annual ‘non-priority’ homelessness decisions have been running at around 20,000 in recent years with no clear sign of any upward or downward trend.

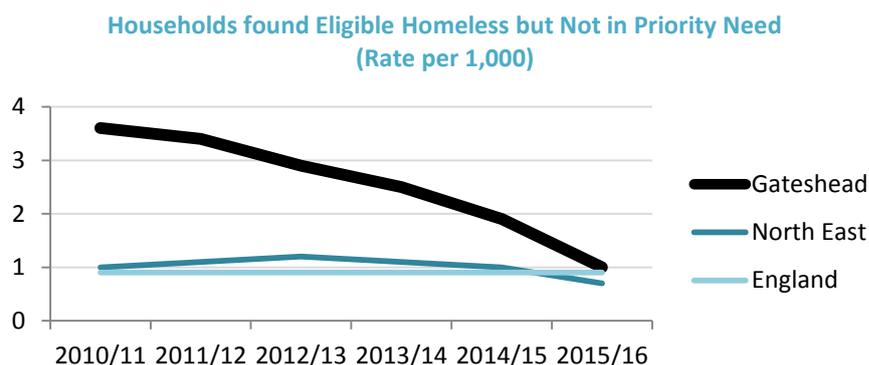
Gateshead

Data to quantify the number of households found eligible homeless but not in priority need was provided through the housing options service which was collated as part of their P1E returns. This was not reported as part of the public health outcomes framework until 2015/16. The data from the housing options service is detailed in the table below.

Total Number of Households found eligible, homeless but not in priority need

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Number of households found eligible, homeless but not in priority need	309	289	260	221	171	90
Ineligible households	3	5	11	8	4	7
Eligible, homeless and in a priority need but intentional so	22	18	15	12	7	13
Total number of households non statutory homeless decision	334	312	286	241	182	110

From 2015/16 indicator 1.15i was introduced as part of the public health outcomes framework to report on eligible homeless people not in priority need (See Appendix B). Data from the public health outcomes framework enables comparisons to be made at regional and national level. This is detailed in the chart to the right.



A separate request to the housing options service was made to provide data on the makeup of the households found eligible homeless but not in priority need. This was not made available until 31 January 2017 and therefore figures do not sum to the table above due to changes in the status of cases that can occur following a review. The total number of cases at 31 January 2017 of those homeless but not in priority need was 100. The tables below show a breakdown of household composition and age as well as the top 6 reasons for homelessness.

Household and Age composition of those homeless but not in priority need 2015/16

Couple with dep. children	Lone female, no dep. children	Lone female with dep. children	Lone male, no dep. children	Lone male with dep. children	Other
<5	15	5	72	<5	6

16-24	25-44	45-59	60-64	65-74	75+
25	64	11	0	0	0

Top 6 reasons for homelessness

Parents no longer willing to accommodate	24
Non-violent breakdown of relationship with partner	13
Friend Relative no longer willing to accommodate	11
Termination of AST	9
Other	9
Loss of tied accommodation other than AST	6

Hidden Homeless

National

The Homelessness Monitor, England (Fitzpatrick et al, 2016), provides an estimate of hidden homelessness. This was based upon a number of large scale household surveys which enabled measurement of two particular categories of hidden homelessness: concealed households; households who are sharing accommodation and overcrowded households.

Concealed households are family units or single adults living within other households, who may be regarded as potential separate households that may wish to form given appropriate opportunity. The report estimates that there were 2.35 million households containing concealed single persons in England in early 2015. The number represents broad stability alongside the estimates presented in the previous two Monitors, but a rise of 40 per cent since 2008. Concealed single individuals living with others, when they would really rather live independently, thus increased markedly after 2008.

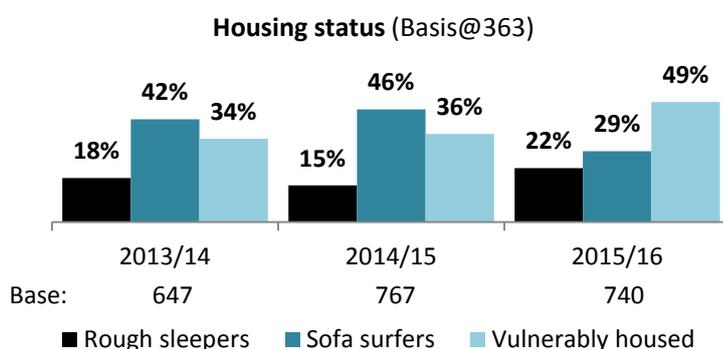
'Sharing Households' are described within the Homeless Monitor report as those households who live together in the same dwelling but who do not share either a living room or regular meals together. Sharing can be similarly considered to concealed households, namely an arrangement people make when there is not enough affordable separate accommodation. The report identified that in 2015 1.43 per cent of households in England were in shared accommodation. Sharing was identified as particularly rare in the North East, East Midlands and East of England (0.1-0.2%). The Homeless Monitor Report highlights that in England the most recent figure for overcrowding shows that 701,000 (3.1%) of households were overcrowded. This is at its highest level in recent years. Recent trends in overcrowding are downward in northern regions, but upwards in southern regions and London. Overcrowding can be a persistent experience for the households affected.

Local

It is not possible to quantify the exact levels of households that are 'hidden' in Gateshead however the data below may provide some indication of the scale of the issue in Gateshead. It is not possible to total figures as people may fall into multiple categories.

Basis@363

Basis@363 client records identified 42% were sofa surfing 13/14, 46% during 14/15 and 29% during 15/16. In 2015/16 49% of their clients identified as being vulnerably housed.



Fulfilling Lives

For the period from May 2014 to July 2016 98 Gateshead clients were seen by Fulfilling Lives. Indications of hidden homelessness were apparent, with 19 clients reporting episodes of sofa surfing (26 episodes) and 31 clients reporting episodes of staying with family or friends (43 episodes).

Overcrowded Households

Overcrowding is associated with increased physical and mental health problems and poor educational achievement in children (ODPM 2004).

In Gateshead nearly 5,500 (6%) of households are classified as overcrowded in terms of space and room standards, half of which are in the social housing sector.

Satisfaction with housing choice and quality

The 2012 Gateshead Resident's Survey indicated householder satisfaction with the quality of their home, and choice of housing across the Borough varied. There were significantly lower levels of satisfaction in a number of central wards (the Central Area of Gateshead includes Wards with the highest concentrations of private rented accommodation), together with Chopwell and Rowlands Gill in the West (Gateshead Residents survey 2012).

The 2016 You and Your Local Area survey also sought feedback on housing choice and quality. The responses are detailed in the table below. A third of respondents to the survey found it difficult to find a home they could afford, and 20% identified a lack of choice in size and type of housing as an issue.

Satisfaction with housing choice and quality (2016 You and Your Local Area Survey – Gateshead Council)

Question asked (Base 478)	Number	%	CI % (+/-)
There is not enough housing on the market	70	14.7	3.2
A lot of the housing is in poor condition or state of repair	96	20.0	3.6
There is not enough choice of size and type	98	20.5	3.6
There is not enough housing in the area I want to move to	125	26.2	3.9
It's difficult to find a home I can afford	160	33.6	4.2
It is fairly easy to find the right home at the right price	178	37.3	4.3

Condition and Quality of Existing Housing Stock

Poor quality housing has a significant negative impact on health and wellbeing. The housing stock in Gateshead has been improving, however it is predicted 9% of the total stock is likely to fail the Housing Health & Rating System. The housing health and safety rating system (HHSRS) is a risk-based evaluation tool to help local authorities identify and protect against potential risks and hazards to health and safety from any deficiencies identified in dwellings. It was introduced under the [Housing Act 2004](#) and applies to residential properties in England and Wales. A range of hazards are present within homes, in Gateshead the most prevalent reasons for homes failing the HHSRS are excess cold (threats to health from poor low indoor temperature) and presence of hazards likely to cause falls.

Levels of Housing Mobility and Instability – Fulfilling Lives Gateshead Data

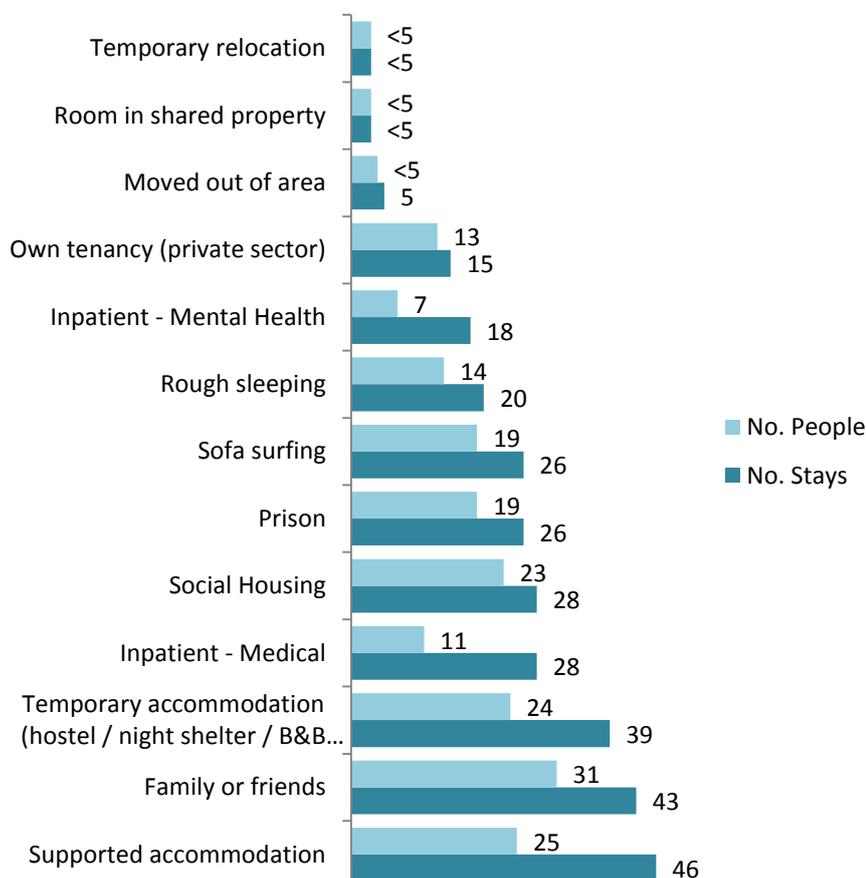
The Fulfilling Lives Programme monitors an individual’s housing status on an ongoing basis. Data related to this was available for 81 of the 98 Gateshead clients. This data highlights the dynamic nature of homelessness for those with multiple and complex needs living in Gateshead and the extremes of experience.

Overall there were 303 accommodation changes recorded for the 81 individuals where full data was available. 52 (64%) of the individuals had more than one accommodation change over the period they were receiving support from Fulfilling Lives. 19 (23%) of the individuals had 5 or more accommodation changes with some moving as many as 33 times.

The levels of housing mobility identified within this group are very likely to present major barriers in terms of meeting their care and support needs and may have reduced their opportunity to access consistent care and support and to establish support networks in the community.

Base=81

Number of people and number of stays in accommodation by type - Fulfilling Lives Clients



Numbers of people experiencing number of changes to accommodation – Fulfilling Lives Clients

No. Changes	No. People
1	29
2	17
3	10
4	6
5 to 6	7
7 to 33	12

Chapter 12: Quantifying multiple needs within the homeless population

There is a critical gap in information about the scale of homeless people with multiple and complex needs however, a number of recent studies have sought to quantify the extent to which individuals with complex needs habituate the homelessness system. In 2009, The Making Every Adult Matter Coalition (MEAM) provided a conservative estimate that there were 140,000 individual's in the UK who met their definition of people with multiple needs and exclusions;

“Experience a combination of issues that impact adversely on their lives are routinely excluded from effective contact with services they need tend to lead chaotic lives that are costly to society” (MEAM 2009)

Of this group the study identified that 81,162 such individuals were in prison, 42,000 individuals were in the non-statutory homeless sector and 15,000 were in statutory homeless temporary accommodation (MEAM 2009).

12.1 Hard Edges Report – Mapping Severe and Multiple Disadvantage

More recent research, published by the LankellyChase Foundation, builds upon these earlier estimates in a report entitled ‘Hard Edges’ (Bramley et al 2015). The study, which has been cited as the first robust statistical profile of multiple and severe disadvantage in England, triangulated data from three national sources:

- Supporting People Client Database (SP)
- Offender Assessment System (OA)
- National Drug Treatment Monitoring System (NDTMS)

The report differentiates between various categories of severe and multiple disadvantage (SMD) as detailed in the box below. This means that the individuals face at least one of three issues of homelessness, substance misuse and crime – the report found that poverty and mental health problems were nearly universally present.

SMD 1	SMD 2	SMD 3
Experiencing one disadvantage domain only (i.e. ‘homelessness only’, ‘offending only’, or ‘substance misuse only’)	Experiencing two out of three disadvantage domains (i.e. ‘homelessness + offending’; ‘substance misuse + offending’; ‘substance misuse + homelessness’)	Experiencing all three disadvantage domains (i.e. ‘homelessness + offending + substance misuse’)

It found that 58,000 people in England face all three problems of homelessness, substance misuse and offending in any one year. 164,000 people experience an overlap of any two of these and 364,000 people were found to experience one of the problems. The average local authority in England has 1,470 people falling within the SMD 2 and SMD 3 profiles, including 385 with disadvantage in all three domains over the course of a year. This did vary across the country. The study found that the profile of disadvantage was much more prevalent in northern areas, particularly post-industrial towns, whereas statutory homelessness clusters in London. The report suggest this difference underlines how rooted multiple disadvantage is in economic deprivation and decline, as distinct from other factors such as the housing market. The figures for each local authority are presented within the Hard Edges report. The table below details the absolute figures and rate per 1000 provided for Gateshead for 2010/11 compared with England. Of the 151 local authorities, Gateshead was ranked 28th highest for estimated rate of cases at a rate of 26.1 per 1000 compared to England’s rate of 17.4. Compared to the 14 CIPFA nearest neighbours (areas of similar demographic profile), Gateshead was ranked 7th highest, with Rochdale having the highest rate of cases at 35.9 per 1000 and Rotherham having the lowest rate at 22.2.

Estimated Number of Cases by SMD Category for Gateshead - rounded number in touch with relevant agencies over year, all-purpose and county authorities (Rate per 1000 working age population)

	H'less only	Offend only	Subst only	Offend + Subst	H'less + Subst	H'less + Offend	SMD3 (SP)	SMD3 (OA)	Total SMD1-3
England	1.9	3.4	5.4	3.0	1.4	0.8	1.7	1.4	17.4
Gateshead	1.7 (220)	5.4 (690)	8.9 (1,130)	5.2 (660)	2.0 (260)	1.0 (120)	1.7 (220)	2.1 (270)	26.1 (3,325)

The total is the sum of the average of SMD3 (SP) and SMD3 (OA) plus all other categories.

Source: 'Hard Edges' - LankellyChase Foundation (2010/11)

Having presented the numbers by SMD category and level, the Hard Edges report then went on to present an estimate of the number within each category who have mental health problems. The figures provided for Gateshead are presented in the table below. The report suggests there are some grounds for believing that the incidence of mental health problems may be greater than recorded here. Nevertheless they believe local practitioners may find these initial estimates of value in giving a feel for a conservative estimate of the overlap between mental health problems and the SMD groups. The report did not present the rates so a comparison with other areas has not been possible for the HNA.

Estimated Number of Cases with Mental Health problems by SMD Category for Gateshead (rounded number in touch with relevant agencies over year, all-purpose and county authorities)

	H'less + MH	Offend + MH	Subst + MH	Offend + Subst +MH	H'less + Subst +MH	H'less + Offend +MH	SMD3 (SP) + MH	SMD3 (OA) +MH	Total SMD1-3 +MH
Gateshead	30	270	650	390	130	60	80	140	1,640

Source: 'Hard Edges' - LankellyChase Foundation (2010/11)

From the national data, most of the individuals identified by the study were men (78% are male; 85% are white and 59% are aged 25-44) but the research also highlighted that other data sets are likely to reveal quite different profiles and further studies are to follow. This is welcome as there may be lessons to be shared that may lead to preventing and reducing homelessness more effectively. For example women with multiple needs probably appear in other data sets (e.g. domestic abuse and sexual violence service data) and are therefore under-represented.

The Hard Edges report demonstrates that in Gateshead, as nationally, homelessness is rarely the only difficulty in an individual's life and that when health and social problems are present they can act in a mutually reinforcing way. This suggests that while housing remains an essential element in ending homelessness it will not, on its own resolve, the strong degree of overlap with other social problems.

Chapter 13: Housing Support and Supported Housing in Gateshead

In Gateshead responses to adults identified as homeless with high support needs centre on programmes designed to reduce rough living and on providing housing related support. This is similar to findings from the Multiple Exclusion Research Programme (McDonagh 2011), which found that housing related support services have become the mainstay of support for people experiencing multiple exclusion homelessness. However, the research also found that such services often work in parallel with health and social care services with little evidence of integrated assessment and support planning.

Housing Support provided by Gateshead Council covers a broad spectrum of help given to people (across all tenures) to access and sustain a home which promotes their independence and wellbeing. It has been about considering the varying needs of residents and providing the solution that best fits, within the budgetary and resource constraints faced by the Council.

Alongside having the right type and quality of homes, providing sufficient and proportionate investment in the right advice and support services, helps saves money in the long run, by minimising the need for repeat intervention, facilitating self-help, and reducing the demand on more expensive services including primary care, social care, emergency and crisis services such as A&E, specialist housing (including care homes), preventing homelessness or even preventing time spent in prison.

Social care services, and health care providers and commissioners, have an important role to play in signposting and making referrals to the Council's range of housing services where the home environment is affecting the health and wellbeing of residents. Social Services Assessment of Need, under Fair Access to Care, could also be used to consider the impact of the home and the condition of the home on health, and how independence in the home can be sustained.

The Council's Private Sector Housing Team

Gateshead Council's Private Sector Housing Team provides advice and guidance to residents, across all housing tenures, to promote good housing conditions, and has a statutory duty to act where any premises fails the Housing Health and Safety Rating System. The Service provides support to private tenants and landlords, to assist them recognise and meet their responsibilities in relation to their tenancies; using enforcement powers and regulation as appropriate to ensure good property management practices and achieve sustainable tenancies.

The Strategic Vulnerable Person's Housing Group

Gateshead has an established "Strategic Vulnerable Persons' Housing Group" made up of partners who can positively impact upon vulnerable people in housing need. The group branches into sub groups which each specialise in a particular area of vulnerability. Each of these groups has created an action plan highlighting the most pressing issues affecting the people whose lives they are working to improve. Collectively these plans make up the "Homelessness Prevention Strategy", which is a statutory document. The actions are "fluid" and change to reflect new pressures. Systems are in place to manage vulnerable persons with housing needs with specific work targeting domestic abuse, offenders and those with substance misuse issues, ex forces and persons with mental health problems.

Vulnerable Persons Housing Panel

One of the subgroups of the Strategic Housing Group is the Vulnerable Persons Housing Panel which aims to try and find accommodation outcomes for those clients who are excluded from the standard housing pathways and likely to be the population of interest to the HNA. This is a multidisciplinary group which meets on a monthly basis to consider cases where an appropriate solution to an individual's accommodation needs has not been found. Membership of the panel includes the supported housing providers, commissioning, the police, tenancy support

services, treatment agencies and The Gateshead Housing Company. The case and their individual needs may be discussed and considered by the panel to try and find a solution that will be appropriate to meet the individual's needs.

Gateshead Multi-Agency Safeguarding Hub (MASH)

The MASH is a pilot programme which commenced in November 2014 and is led by Gateshead Council, Northumbria Police and Northumbria Police and Crime Commissioner. The aim of the pilot is to provide a single gateway for all safeguarding, domestic abuse and vulnerable victim referrals; to expedite the sharing of information in an efficient and consistent manner and to protect and safeguard the most vulnerable within the Borough. From November 2014 up until November 2016 a total of 1175 referrals have been received. 23 referrals have been made for individuals identifying as homeless or no fixed abode.

The Gateshead Housing Company (TGHC) & Housing Options Service

Council Housing in Gateshead is managed on behalf of the Council by TGHC which aims to provide a quality council housing management service, which represents best value for Council tenants and the Council, and which supports the prevention agenda and aims to reduce high cost expenditure in adult and children's services. TGHC also delivers a housing options service which acts as a single point of assessment that directs potentially or newly homeless household to the required services (from either the Council, TGHC or its partners) to stop a loss of housing or immediately end their homelessness. The service also signposts advice and support regarding wider issues affecting a household's housing choices such education, employment and financial management.

Floating Support Services

Floating Support Services are designed to both prevent and reduce homelessness. In Gateshead this is currently provided by the 'Housing & Independent Living Outreach Service' as part of Housing Services (there is also the Homeless Support team who provide support to clients when they are placed in council dispersed accommodation temporarily – this is separate from the Portal Supported accommodation provision). The Housing & Independent Living Outreach Service receive referrals from a very wide referral source which are then allocated to workers who provide support in many areas with the aim of preventing homelessness and sustaining tenancies.

This is managed on an Access database and a report is produce annually demonstrating referral numbers and outcomes achieved for each client.

Housing Mental Health Service

The Housing and Mental Health Service is a pilot project, funded jointly by Gateshead Council and North of Tyne and Wear NHS. The service provides a dedicated housing mental health resource (via 2 housing and mental health worker posts) which is able to focus upon the housing needs of people who have severe and enduring mental health problems, and who are or have been in contact with secondary mental health services and/or Adult Social Care mental health teams. Housing need can include rent arrears, neighbour nuisance, homelessness, poor property condition, relationship breakdown, antisocial behaviour in area, feeling isolated in area, moving to be closer to support.

The need for the service was identified due to people presenting at Housing Options who had been discharges from psychiatric hospitals as homeless. Housing Options often had no prior information about the individual's needs/risks/vulnerabilities which would be a barrier to finding suitable accommodation. Also finding suitable accommodation was time consuming which could mean that individuals were homeless or in inappropriate accommodation such as a hostel out of the borough while waiting for appropriate accommodation to be identified.

The support offered is client led and has included attending 72 hour meetings and discharge planning meetings at hospitals to provide advice regarding housing options and to liaise with Housing Options where a temporary accommodation is required if agreed accommodation is not ready. In community settings home visits re offered to discuss and assess housing need and options available.

Public Health England and Changing Lives Capital Grant

Gateshead Council in partnership with Changing Lives, a national registered charity working in Gateshead to provide specialist support to vulnerable people and families, has been awarded a £280,000 grant to support the purchase and refurbishment of 14 empty properties to turn them in to homes for rent to people with complex needs including those in recovery from addictions. The properties will be part of Changing Lives' Homelife programme which provides affordable, long-term accommodation for people with histories of homelessness or housing problems. Homelife currently houses 93 people in safe and secure accommodation; 42% of these are defined as having complex needs including experience of drug and alcohol abuse. Everyone housed by Changing Lives in one of these 14 properties will be offered the opportunity to be supported to access 'Oaktrees', an abstinence based day treatment centre based in Gateshead and run by Changing Lives, or other local substance misuse services. Details of the bid and plans to be fulfilled through the grant are in Appendix D.

Supported Housing

Supported housing covers a range of different housing types, including group homes, hostels, refuges, supported living complexes and sheltered housing (Wilson 2016). People in supported housing have diverse and complex needs, requiring different levels of support in various types of accommodation. Rent levels in supported housing tend to be higher than those charged for similar accommodation in the private sector.

In Gateshead Supported Housing has predominantly included supported and transitional housing and tenancy support services. There is no direct access to emergency accommodation in Gateshead, although this is a feature of models elsewhere in the UK. Gateshead Local Authority within the Supported Housing Contract describes the Supported Housing offer as follows;

'Supported housing' is a solution for vulnerable people to maintain their dignity and be part of a community. It is made up of a variety of schemes designed to provide both housing and support to help vulnerable people live as independently as possible in their community. Hence tackling and preventing societal issues such as homelessness, poverty, mental health breakdowns, and risk of abuse. These schemes are designed to meet the needs of particular client groups, such as people with mental health issues, learning or physical disabilities, addiction issues, victims and women at risk of domestic abuse, young or inexperienced parents, ex-offenders, or older people'.

While living in Supported Accommodation, there is a variation of tenure depending on the scheme. Some schemes are able to offer an assured short-hold tenancy, whereas some admit people into the schemes on a license agreement – this is important due to the occasions where a person is asked to leave a scheme and the methods by which this must be done.

Prior to 2009, funding for accommodation-related homelessness services in the UK was largely provided through the Supporting People Programme. The Programme was ring-fenced within local authority funding to provide housing related support services to vulnerable adults, including single homeless people. In 2009, the ring fenced funding was removed and from 2011-12 funding was rolled into the Formula Grant – which is a single grant given by government to local authorities. Now local authorities including Gateshead have complete discretion over where to direct their funding best to meet local need.

Since Supporting People funding ended research undertaken by Homeless Link (2013) identified that changes to the funding regime had led to budget reductions in housing related support in all local authorities questioned. In

Gateshead this has been within the context of wider funding changes, welfare reforms and a changing homeless population.

Profile of Commissioned Supported Housing - 2015

Gateshead Council currently commissions 10 providers offering 18 contracts plus 1 joint contract with Newcastle. This equates to a total of 149 units. The Value of the contract is approximately £1.5 million per annum. Information was provided for the HNA about the type of services, the capacity (places or hours if floating support) the numbers supported and the numbers discharged for the 2015 calendar year. This is detailed in table below. A map of the location of Supported Housing across Gateshead is presented in Appendix E.

All supported housing, including floating support schemes, are subject to a commissioning-led review, within a co-production framework.

Co-production is: *“A relationship where professionals and citizens share power to plan and deliver support together, recognising that both have vital contributions to make in order to improve quality of life for people and communities.”*

A new model for the provision of supported housing services in Gateshead has been under development during 2016 with a projected service start date of 30 October 2017.

- The Council’s strategic commissioning objectives are outcome focussed and it is clear that the most sustainable, effective and cost efficient commissioning approach is by adopting a co-production partnership with experts by experience in the sector. This co-production approach has also complemented and enhanced the ongoing consultation with existing service providers.
- The co-production approach has resulted in the following:
 - A series of development meetings have taken place with experts by experience;
 - The first meeting was held at the Civic Centre but have subsequently been held at various supported housing centres across Gateshead;
 - Although there is a set agenda the discussions at the development meetings have been organic and experts by experience have offered ideas and critical appraisal in respect of the new models considered by the Commissioning Officer;
 - The development of alternative models of service delivery based on lived experience;
 - The various service models have been tested at an Experts and Provider Forum and also in smaller meetings with a larger group of experts;
 - Meetings and service visits have been completed with all existing providers, including consultation with service users.
 - A Community Interest Company has been developed by one of the experts by experience in partnership with others, to provide intensive floating support for vulnerable young people.

The procurement timeline has been shared with the experts and a core group will be involved in writing the specification and assisting with the tendering process, including submission evaluations.

Each of the development meetings have been evaluated using the 4 plus 1 technique and the following learning has been gleaned from the co-production approach:

- Inclusivity is the key to understanding the market;
- Many experts by experience have clear and articulate ideas about how their service, and other services, should function;
- The lived environment and geographical location are important factors in terms of support;
- Skilled and caring support staff can elevate support services and make a difference.

Comments made by the experts by experience involved in the co-production approach include:

“I feel professionals talk down on people. I think it is good that you are willing to listen to what we have to say about our experiences and our ideas.”

“Really good. We learn as we go and have to change things along the way to fit the service user. Change the way of working and dealing with the client.”

(Experts by experience – supported housing)

Types of supported housing provision and capacity and numbers supported/discharged in Gateshead 2015/16

Service	Type of Provision	Capacity	Number Supported	Number Discharged
Byker Bridge	Any gender residential housing & support. 3 Houses & satellite services in Newcastle and Whitley Bay	24 places	40	17
Changing Lives – Eslington House	Any gender residential housing & support for 16-25 year olds	20 places	77	64
Changing Lives-Gifford House	Male only residential housing & support for 18+. 24 hour service.	11 places	32	23
Creative Support- Floating Support	Floating support service for 16+ any gender, including mental health and risk of offending. Support daytime only	200 hours p/w	177	97
Haven – Floating Support	Floating support for 17+ any gender via 12 leased properties in Gateshead. Clients who are homeless and threatened with homelessness	12 places	23	13
Home Group – Juniper House	Mixed gender residential housing support service for people with mental health issues	8 places	16	8
Home Group – Gateshead Women’s service	Women only refuge includes services for children. Includes 2 community programmes for male victims of domestic violence.	6 places	32	25
Home Group – St Bede’s House	Any gender residential housing & support for 16+. 16 rooms plus 2 properties in community used for move on accommodation up to 2 years.	16	26	10
ISOS Tenancy and Outreach	Any gender 18+. Residential housing & support and outreach.	30 places	38	15
Mental Health Concern	Any gender adults with mental health issues. Rehabilitation and recovery units for adults with complex mental health needs.	7	8	1
Mental Health Matters	Any gender 18+. Residential housing and support for those who have a mental health diagnosis includes an out of office service.	6	6	0
Thirteen Care & Support	Any gender 16+ who are offending or at risk of offending. Residential and floating support services.	16	25	16
Oasis Aquila – Elizabeth House	Female parents or expectant mothers with children under 5 aged 16-25.	9	20	11
Oasis Aquila – Karis Project	Female 16-25 community based tenancy support for those homeless or threatened with homelessness.	7	12	8
Oasis Aquila – Naomi Project	Female 16-30. Residential housing & support for those with complex needs. 24 hour service	12	32	22
Richmond Fellowship	Female residential support for those with a mental health diagnosis and are homeless/threatened with homeless	6	10	5
SSAFA – Longside House Project	Stepping stone residential housing for people who have left the armed forces – women and children.	3	10	7
Zayis Raanon	Faith based floating support service – mainly elderly residents requiring help to live independently	15	17	3

13.1 Supported Housing Portal Data

The Supported Housing Portal data provides some insight into demand and availability of Supported Housing, and the presenting needs of those referred. This data is collected through the Supported Housing Portal which was introduced by Housing Services in December 2011 to act as a single point of contact for referrals to supported housing. Since 2013 data on the referrals and the outcomes of those referrals to supported housing providers registered with the Portal has been collected more systematically. This helps to build a better understanding of need. However, the system and process for collecting this information has some significant limitations. These have been acknowledged and are currently being reviewed (see Appendix C). Despite the limitations described the data is included within the HNA because it does add to the picture of the population of interest and may also prompt some further questions about the needs identified and how they are currently being supported.

13.2 Supported Housing Providers Registered with the Portal

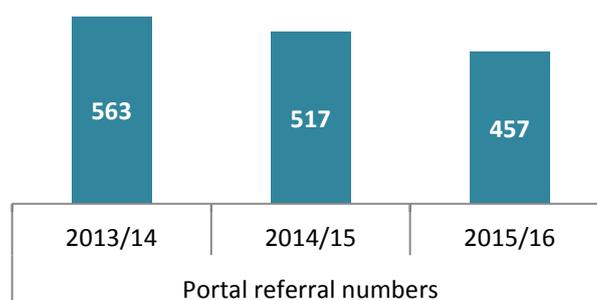
The portal is made up of the following Supported Housing Providers (not all Supported Housing commissioned by Gateshead Council is registered with the portal).

Provider	Scheme Name
Changing Lives	Gifford House
	Eslington House
Oasis Aquila	Naomi Project
	Elisabeth House
	Karis
Thirteen Care & Support	Gateshead Acc. Scheme
	Bibby House
Home Group	Juniper House
	St. Bede's House
Byker Bridge	Byker Bridge
Richmond Fellowship	Richmond Fellowship
Haven	Haven

In addition to the above in 2015/16, Phoenix Futures, a non commissioned service, also accepted referrals from the Supported Housing Portal.

Referrals to Portal

Over the three years of recording data there has been a downward trend in the number of referrals made. In 2015/16 457 referrals were received by the Portal which is an 11.6 percent reduction from the 517 received in 2014/15. This, in part, is a result of improvements within the Portal process. There was a focus on checking the quality of referrals. Applications were not registered until they were adequately completed by the referrer. Only those completed appropriately by referrers, detailing all vulnerabilities were forwarded to providers. This reduces the number of inappropriate referrals being sent to providers and maximises the chances for the person to obtain suitable supported accommodation.

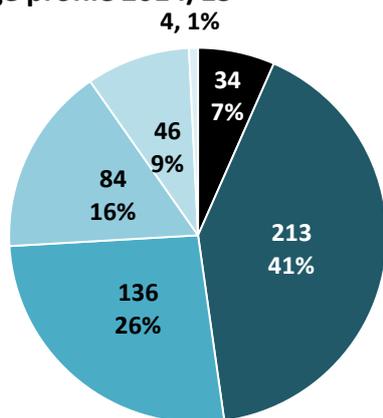


Demographic Profile of Referrals

Age

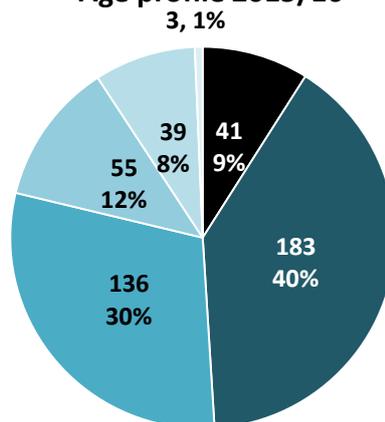
From 2014/15 to 2015/16 there has been a 14% reduction in the number of referrals received for 18-25 year olds and a slight increase in the numbers of 16-17 year olds referred, going from 34 in 2014/15 to 41 in 2015/16. For those in the 36-45 age band, there has been a 34% decrease in referral numbers. Overall, the percentage proportion split of each age category remains fairly consistent since 2014/15. Comparisons to the Gateshead population age profile are difficult to make because the national statistical information starts from birth and the age bandings are not consistent for comparison. The youngest person referred into the Portal was 16, the oldest 78.

Age profile 2014/15



16-17
 18-25
 26-35
 36-45
 46-60
 Over 60

Age profile 2015/16

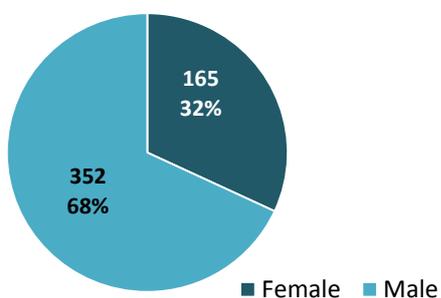


16-17
 18-25
 26-35
 36-45
 46-60
 Over 60

Gender

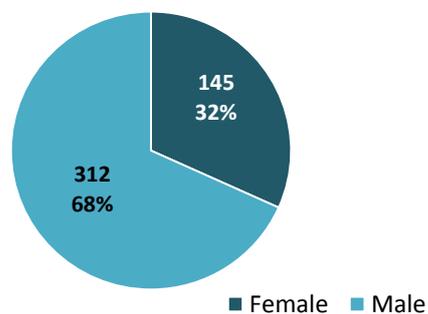
During 2013-14, 414 male referrals were recorded (77%) and 149 female referrals (23%) were received. The following two years have seen an increase in the proportion of female referrals with females making up 32% of all referrals for 2014/15 (165 females) and 2015/16 (145 females) although the actual count of female referrals decreased in 2015/16. There were no transgender applicants.

Gender profile 2014/15



Female
 Male

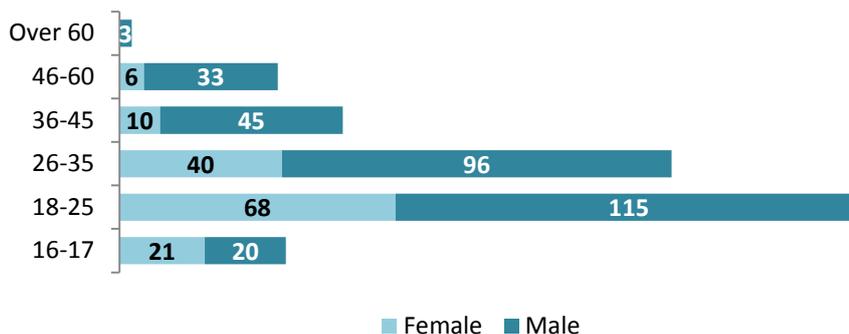
Gender profile 2015/16



Female
 Male

The greater number of male referrals to supported housing is consistent with other reports showing that women make up a smaller proportion of the homeless population. However, there are significant concerns that the true number of women who are homeless is higher than figures suggest with many more women experiencing hidden homelessness and living outside mainstream support. This gender imbalance highlights further work on how we capture reason for loss of last accommodation needs to be improved through the Portal referral process. The portal referrals have also been broken down into age groups and gender.

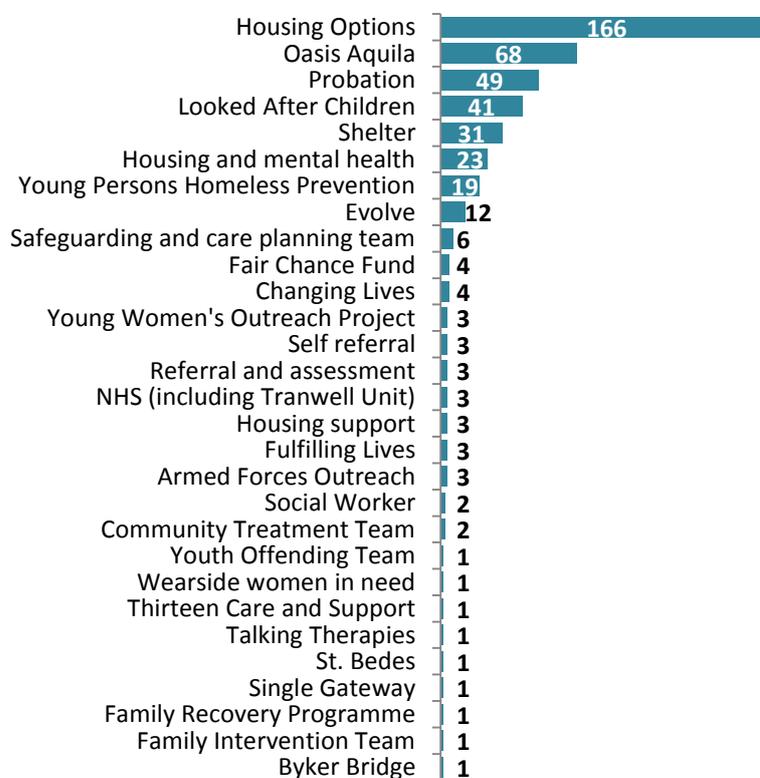
2015/16 Supported Housing Portal Referrals by age & gender



Agencies Making Referrals to the Portal

Agencies making referrals into the Portal have been shown in the chart below. The biggest referrer is the Housing Options team (36%). Oasis Aquila also make a high proportion of all referrals via the Basis@363 project (15%). External services have gone through many changes, resulting in services such as NECA being replaced by Evolve. The various elements of Probation have been combined into one category in this data as 'Probation', who are the third biggest referrer (49). A partnership between the NHS and Gateshead Council led to two Housing and Mental Health workers and they have made 23 referrals, improving appropriateness for vulnerable people with mental health difficulties.

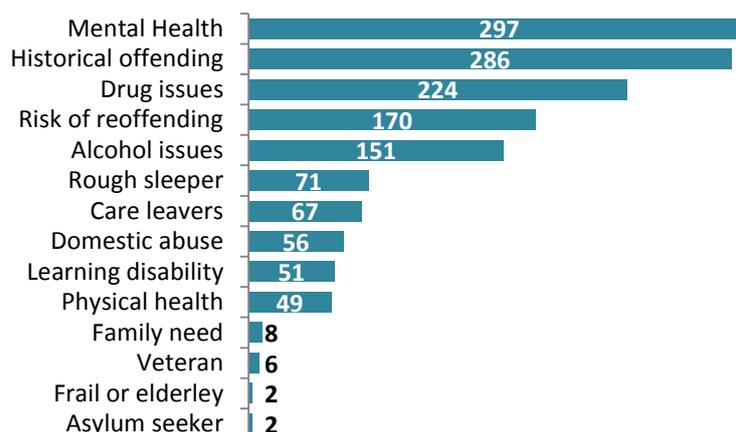
Referral Source and Numbers of Referrals Made 2015/16



Breakdown of need for Portal referrals received

This chart displays the needs identified by the referrer when they submit the referral form. Many clients present with multiple needs, and the dominant needs appear to be mental health, substance misuse and offending. Of the 457 referrals received, 65% had a need around their mental health. A high proportion of the people referred into the Portal had needs in more than 1 of the top 5 need areas.

Breakdown of need for referrals received



Accommodation Outcomes Following a Referral

Data from the three years of reporting shows that the majority of referrals made to the Portal do not result in an offer of accommodation. During 2015/16 of the 457 referrals made through the Supported Housing Portal, 150 people were housed this equates to 33 per cent of all referrals made.

This is a slight increase in the percentage of people housed compared to 2014/15 which saw 167 of the 517 referrals housed (32%) and during the period 2013-2014 which saw 150 of the 563 housed (27%).

Over the three years of Portal Data available 27%, 32% and 33% of referrals each year resulted in an offer of accommodation.

Since the first year of recording Portal data it is reported that there has been an improvement in the quality and appropriateness of referrals, reducing wasted administrative time on behalf of the providers.

It can take between 0 and 155 days for a person to be accommodated after being referred via the Portal. From the data available in 2015/16, people stay in schemes from between 7 and 258 days.

Accommodation Ceasing

For 2015/16 of the 150 people who went on to be housed, accommodation later ceased for 67 people within that year. This is 45% rate of accommodation ceasing, and is consistent with the previous year. Reasons can include eviction, leaving of own accord, planned move-on, moving back in with family and others. A full breakdown for each provider and scheme is below.

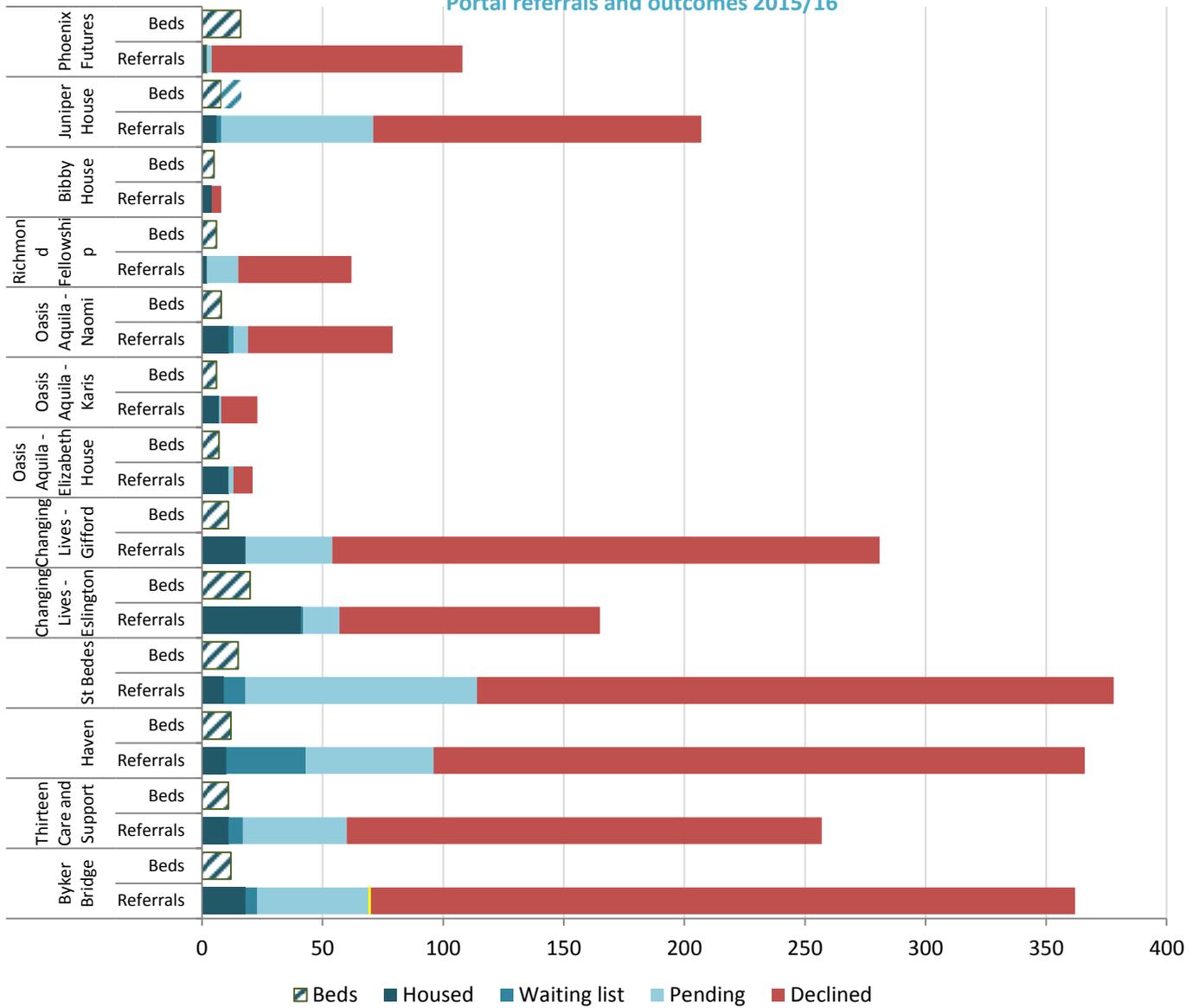
There are 2 protocols in place to try to ensure a positive move on. These are the 'move-on protocol' and the 'evictions protocol'. The Vulnerable Persons Housing Panel (VPHP) is also available which is set up to discuss solutions for those clients who may be rejected from all schemes. This panel is also available to discuss clients who may be at risk of eviction, inappropriately placed or vulnerably housed in some other way.

For the year, where supported accommodation ceased, 26 people had a planned move-on, moved in with parents or other family or found alternative accommodation.

Outcomes Data

The following chart represents providers/schemes, their bed spaces and referral outcomes at year end. For the 'Housed' data, this includes those referrals where a client was housed via the Portal and this later ceased. Portal data is evolving each day; therefore this is a snapshot of the end of the year 2015/16 position.

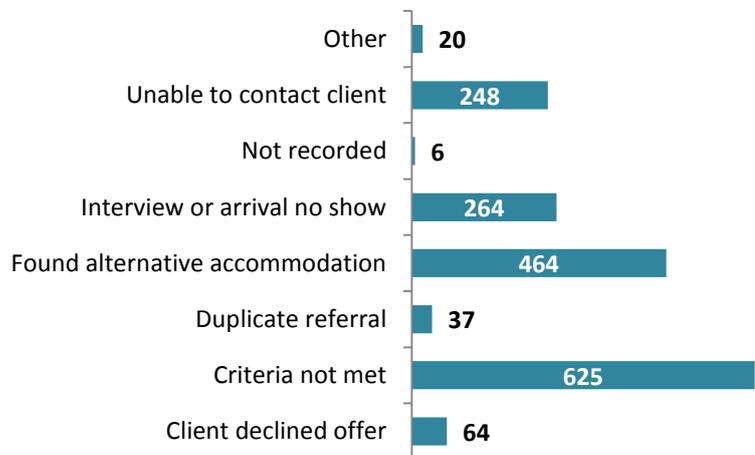
Portal referrals and outcomes 2015/16



Reasons for Declined or Cancelled Referrals

The chart below shows a breakdown of declined or cancelled referrals across all schemes. One of the largest areas for the declining or cancellation of referrals is 'Criteria not met'. When assessing suitability for a provider/scheme, this happens in two stages. Firstly, Portal admin put forward clients who may be suitable for a scheme based on criteria. Then, the provider considers the referral and offers an interview. From some of the data above, there are issues such as 'age criteria not met', 'no child' or 'child not at preschool' as examples. Another reason for referrals being declined is 'no local connection' which is also a factor in deciding whether a person should be referred to a Gateshead commissioned provider. These are areas where the Portal could more carefully consider the appropriateness of which schemes the referrals are forwarded to.

Reasons for declined/cancelled referrals across all schemes 2015/16



In 20 cases a reason for 'criteria not met' is 'other' this reflects the various individualised reasons that are given by all providers as to why the client did not meet the criteria for the scheme. There is a further summary breakdown of these 'other' reasons in the adjacent table.

Reasons 'other' criteria used (figures do not sum to 20 because an individual can have multiple 'other' reasons)	Number
Offence related - too long ago or offences not serious enough	14
Risks too high to manage	13
Overall support needs too high	11
No vacancy in scheme (Mainly Richmond Fellowship)	11
Client could be at risk from other offenders in scheme	4
Other family member/ex-partner already in project	3
Barred from project	2

Where a referral for supported accommodation is made a decision as to whether to accept the referral is made usually based upon the information on the referral form and any supporting information from other agencies

involved as well as the interview that the supported housing provider makes with a prospective tenant. The Portal records a reason for applications which are declined.

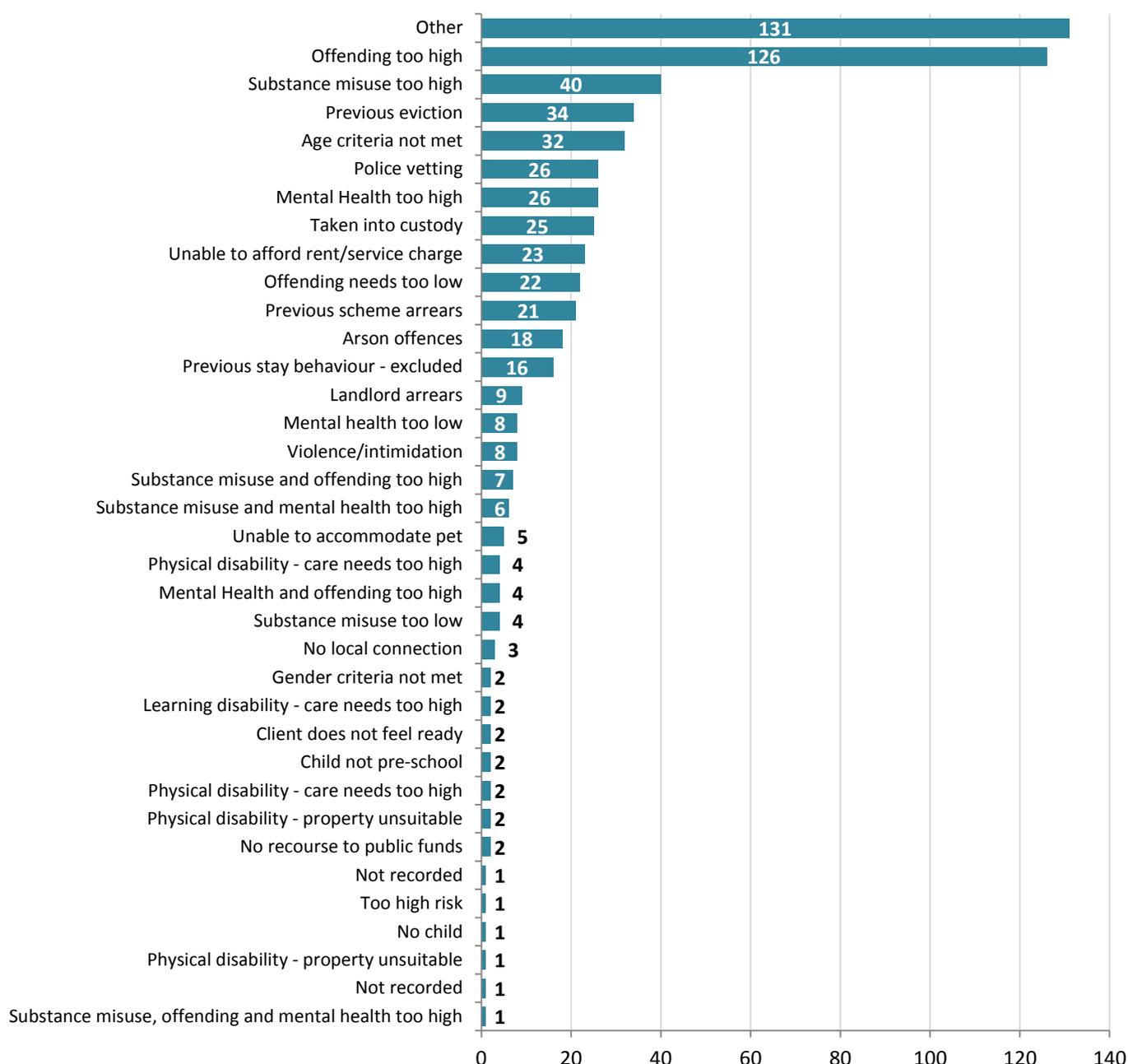
Declined Referrals for Supported Housing

The data provided through the portal suggests a spectrum of need a concern is that some referrals needs are deemed 'to high' and others are deemed 'to low' to be able to benefit from support. They therefore end up not meeting the threshold required despite being in need of support.

This information is potentially indicative of unmet need and a reflection of some of the barriers experienced by individuals with multiple and complex needs in relation to accessing supported accommodation. This data is a likely indication of gaps in the current housing pathways and provision of particular types of supported accommodation and accompanying support services and merits further assessment and understanding.

It is also important to view this information within the context of some of the challenges faced by supported housing providers in terms of ensuring that they can offer the appropriate environment and level of support required for an individual to succeed and benefit from a particular accommodation setting. This judgement may need to take into account the presenting need of the client, capacity within the accommodation, resources available, the skill mix of staff, the views of the local community where the accommodation is located as well as how any prospective resident may interact with existing clients and their mix of needs, vulnerabilities and expectations of the accommodation.

Reasons given by supported housing provider for referral being declined



Supported Housing – Employment Status

The HNA obtained a snapshot of the employment status of individuals living within Supported Housing for November 2016. This is detailed in the table below. Of the 316 individuals receiving either supported accommodation or floating support at the time of the request, less than 2% were in employment and less than 2% were undertaking some form of volunteering.

The qualitative feedback from Supported Housing Providers recognised some of the barriers to accessing and retaining employment in the mainstream workforce faced by their service users (See Appendix F)

“.....the rent for supported housing is quite a barrier to people gaining paid employment – we have in the past moved people out because they have secured employment and they simply cannot afford the rent, despite them still needing support. This makes an employment outcome quite difficult to achieve” (Gateshead Supported Housing Provider)

“Work is generally ‘Healthy’ for us all. To support and enable people to take what is often a huge step is difficult for staff, as the system is unclear; complex and can seem punitive. Staff therefore find it difficult to promote gaining paid employment or reassure service users about such a transition. Service users are often understandably reluctant to take a seemingly positive risk that potentially jeopardises their stability”
(Gateshead Supported Housing Provider)

Employment status of those residing within Supported Housing

Provider	Service	Number	No. of people supported	People volunteering	People working PT	People working FT
Mental Health Matters	Richmond Terrace	6	6	0	0	0
Home Group	Juniper House	8	8	0	0	0
Oasis Aquila	Elizabeth House	9	9	0	0	0
Mental Health Concern	Supported Housing	7	7	<5	0	0
Haven	Floating Support	12	17	0	0	<5
Home Group	Gifford House	11	16	0	0	<5
Byker Bridge	Durham Road	13	13	0	0	0
Creative Support	Floating Support	200 hrs	95	0	0	0
Changing Lives	Eslington House	20	20	0	0	0
Isos	Tenany	16	16	0	0	0
Oasis Aquila	Karis Project	7	7	0	0	0
Oasis Aquila	Naomi Project & flats	12	13	0	0	<5
Richmond Fellowship	Whitworth Close	6	6	0	0	0
SSAFA	Longside House	<5	6	0	0	<5
Home Group	St Bedes House	16	24	<5	0	0
13 Care & Support	Oban Terr & Floating	16	22	<5	0	0
Home Group	Women's Service	6	14	0	<5	0
Zayis Raanon	Floating Support	15	17	0	6	0

Source: Gateshead Council (2016)

Reflections on the Portal Data

Current monitoring system is not capturing outcomes, so how can we judge value for money/effectiveness. Data on presenting needs suggests that the provision is working with some of the most vulnerable and complex needs in the population – need to understand how health and care needs are being supported are there any missed opportunities to address health inequalities and explore integrated approaches to supporting this vulnerable population?

Moving on pathways - Visit to Juniper House – staff welcome more input and closer access to supervision from mental health appeared very committed had been worried about arbitrary time frames!

On the face of it the portal data suggests that there is some level of failure to keep up with current demand for supported housing. This requires further investigation within the context of the rest of the housing system and how Gateshead will manage future demand . Currently there is no data available which tracks what happens to those households who do not go on to be accommodated through the Portal route. This group may potentially be vulnerable and have additional support needs as indicated by the reasons for their referrals to the Portal. They may also present elsewhere within the housing and care and support system in Gateshead – are there opportunities to track this?

Chapter 14: The Health and Wellbeing Needs of Single Non Priority Homeless Population

Smoking

97% smoke (Basis@363)
79% smoke (Health Audit)

Drugs and Alcohol

22% of drug and alcohol clients have a housing problem (Evolve)
8% of drug and alcohol clients have no fixed abode (Evolve)
48% access substance misuse services (Basis@363)
24% report injecting drugs (Basis@363)
21% alcoholism and ongoing problem (Basis@363)
49% taking drugs or recovering (Health Audit)
9% taking so called 'legal highs' (Health Audit)
29% use cannabis (Health Audit)
61% of drug users were getting support (Health Audit)
9% weekly drinkers (Health Audit)
17 drug related deaths in previous 12 months (Gateshead)

Accessibility

35% not registered with a GP (Fulfilling Lives)
7% not registered with a GP (Health Audit)
66% not registered with a GP (Basis@363)
48% difficulty accessing GP services (Basis@363)
79% used A&E in previous 12 months (Basis@363)
38% used an NHS Walk-In centre in previous 12 months (Basis@363)
43% overnight stay in hospital in previous 12 months (Basis@363)
41% had a health check in previous 12 months (Basis@363)

Health Inequalities



Oral Health

50% dental problems (Health Audit)
40% not registered with a dentist (Basis@363)
97% not accessed dental services (Basis@363)
75% not registered with a dentist (Fulfilling Lives)

Mental Health

65% of referrals had a mental health need (Supported Housing Portal)
79% have depression (Health Audit)
18% have a dual diagnosis (Health Audit)
10% referred to Tranwell Unit (Fulfilling Lives)
44% have a mental health disability (Fulfilling Lives)
47% have a dual diagnosis (Fulfilling Lives)
7 people had 18 mental health hospital stays (Fulfilling Lives)
40% have mental health needs (Basis@363)
121 referrals (Housing and mental health service)
50% have multiple needs (Housing and mental health service)
27% have a dual diagnosis (Housing and mental health service)
650 people with mental health and substance misuse issues (Hard Edges Report)
7% of clients have mental health and drug/alcohol issues and housing need (Evolve)

Sexual Health

3% access to sexual health clinic (Basis@363)
52% engaged in unprotected sex (Basis@363)
9% Hepatitis C (Health Audit)
29% vaccinated for Hepatitis B (Health Audit)

Nutrition

73% eat two meals per day (Health Audit)

14.1 Health Inequalities

“Failing to prevent homelessness, leaving people on the streets or in temporary accommodation for long periods is an investment in disease and premature death” (Pathway and Faculty of Homeless Health 2016)

“Homelessness is evidence of health and wider inequalities” (Public Health England 2016)

Health inequalities is the term that describes the unjust differences in health, illness and life expectancy experienced by people from different groups of society (WHO 2000). It is important to recognise that Inequalities start before birth and generally the experiences that lead to becoming homeless are underpinned by poverty and structural inequalities that can be identified across the life course of individuals. (Hetherington & Hamlet 2015). Homelessness is a late marker of severe and multiple disadvantage (McDonagh 2011). The Marmot review estimated that the inequality of illness costs the economy between £56bn and £60.5bn a year in lost productivity, lost taxes, increased welfare and benefits payments and health costs of treating ill-health (Marmot 2010). Evidence relating to the health of homeless people tells us that it remains unacceptably poor compared with the general population and that these differences have proved longstanding and difficult to rectify;

- Homelessness causes multiple risk factors which have an immediate and long term detrimental impact on the health and wellbeing of homeless people. Risks include poor nutrition, poor access to hygiene facilities, personal safety, privacy, warmth, space, access to warm clothing, money, mobility, stability, supportive relationships and more (Queens Nursing Institute 2015)
- Single homeless people in particular experience significant health inequalities (Department Of Health 2010)
- Being homeless for even a short period of time increases the risk of long-term health problems (Deloitte Centre for Health Solutions 2012).
- The longer and deeper the exposure to homelessness and extreme exclusion, the more profound the likely health harms, both in the short and longer term (Mehet & Ollason 2015).

In 2010, The National Inclusion Health Board for England was established as part of the Department of Health’s broad strategy to tackle inequalities. The remit of the board was to improve access to health services and outcomes for the most vulnerable people. The board prioritised four groups as amongst the most ‘vulnerable’ and socially excluded in our society; vulnerable migrants, Gypsies and Travellers, homeless people, and sex workers. Two key dimensions of exclusion were identified:

1. The difficulty these groups experience in accessing health services generally and primary care in particular and the need to address prejudice, cultural and practical barriers faced by vulnerable people when accessing health services;
2. that these groups suffer multiple and enduring disadvantage, their health outcomes being amongst the worst of any groups: they are thus deprived of the opportunities available to the wider society and face discrimination and significant health inequalities. (Aspinall, 2014)

Many single homeless people may also fall into one or more of the other Inclusion Health groups, and may therefore face additional barriers that must be understood to be overcome. Approaches to improve the health of people who are homeless may be integrated into wider efforts to tackle health inequalities across all these groups (St. Mungos 2014).

Tackling Homelessness = Tackling Health Inequalities

- Tackling health Inequalities is a major priority for Gateshead Health and Wellbeing Board as expressed within the Health and Wellbeing Strategy.
- Tackling health inequalities is a major priority for Gateshead Council as expressed within the Council Plan.
- The NHS and Public Health have legal duties to address health inequalities in terms of access to health services and outcomes achieved following the introduction of The Health and Social Care Act (2012).
- The NHS Five Year Forward View, calls for a radical upgrade in ‘prevention’ and public health and action to tackle health inequalities (NHS England 2014).
- By improving the care of homeless patients, we may improve systems that benefit all of our patients (Meili & Hewett 2016).
- Given the high prevalence of chronic disease and co-morbidity amongst the population of people who are homeless, and the financial cost this has on the NHS, CCGs should be commissioning healthcare to work more proactively with people experiencing homelessness and the agencies that support them (NHS Healthy London Partnership 2016).
- Action to address homelessness as a significant health inequality requires action across all areas of the wider determinants of health as well as specific interventions to support the most vulnerable people and communities.
- There are common outcomes related to the wider determinants of health in the NHS, Social Care and Public Health Frameworks.
- Homeless prevention is a good downstream marker of attention to poverty and socioeconomic determinants of health (Hetherington & Hamlet 2015).
- A report by the Scottish Public Health Network (Hetherington & Hamlet 2015) highlights that action to address inequalities for homeless people requires a life course approach which acknowledges that there are opportunities for intervention at many points throughout life. Inequalities start before birth and generally homelessness is a late marker of complex and severe disadvantage. A life course approach shows that the greatest potential is for interventions targeted at children, as poverty and deprivation at an early age can have long-lasting effects.
- In order to reduce health inequalities, Marmot (2010) make a number of specific evidence-based recommendations, conceptualized around the life course which group around the following themes:
 - Giving every child the best start in life
 - Ensuring good education and enabling all to take control over their lives
 - Access to employment and “good jobs”
 - Ensuring a sufficient income for healthy living
 - Ensuring access to green and sustainable environments
 - Placing more focus on ill health prevention
 - The need to act across the whole gradient (proportionate universalism)
 - A focus on human rights and equality issues

14.2 Health Need and Homelessness

Health problems are particularly linked to homelessness both as a triggering factor and as a consequence. This may be influenced by a combination of risk factors including poverty, social exclusion, substance misuse and physical and mental health problems. The relationship between health and homelessness is multifaceted however, findings extracted from published reports and papers indicate that homelessness is associated with adverse outcomes in a number of ways. In 2010 the Department of Health presented an analysis of the health needs and relative healthcare costs of single people who are homeless or living in certain types of vulnerable accommodation (DOH 2010). The report highlighted the common health problems experienced by homeless people; these are listed in the table below.

Health Problem	Description
Mental ill Health	<ul style="list-style-type: none"> • Schizophrenia • Depression and other affective disorders • Psychosis • Anxiety states • Personality disorder
Physical Trauma	<ul style="list-style-type: none"> • Injury • Foot trauma – due to walking for long times in inappropriate shoes, standing or sitting for long periods leading to venous stasis, oedema and infection, frost bite, skin anaesthesia due to alcoholic peripheral neuropathy, lack of hygiene due to wearing unwashed clothing or overgrown toe nails. • Dental caries due to self-neglect
Drug/Alcohol dependence and adverse effects.	<ul style="list-style-type: none"> • Earlier onset of drug misuse. • Heroin-related death secondary to respiratory coma. Cocaine – case reports of toxic inhalation leading to pulmonary inflammation and oedema (Crack lung) agitation and paranoia due to acute toxicity and thromboembolic events. • Severity of alcohol use - • Cardiological – cardiomyopathy. • Neurological – peripheral neuropathy, erectile dysfunction, Wernicks encephalopathy, Korsakoffs psychosis, amnesic syndrome, cerebellar degeneration, alcohol withdrawal seizures • Gastrointestinal and hepatobiliary – hepatitis, liver cirrhosis, pancreatitis, gastritis, peptic ulceration, oesophageal varices, carcinoma of the oesophagus and oropharynx, cardiomyopathy. • Metabolic – vitamin deficiency (particularly thiamine), obesity • Psychosocial ill health – including depression and suicide, sexual dysfunction, alcoholic hallucinations, marital, family or employment breakdown.
Complications of injecting illicit drugs	<ul style="list-style-type: none"> • Blood borne virus infections - see below • Skin commensals or pathogens causing septicaemia, endocarditis, cellulitis and deep vein thrombosis (a combination of poor hygiene and repeated puncture) • Tetanus – possibly secondary to injecting contaminated drugs
Infections	<ul style="list-style-type: none"> • Blood-borne virus – hepatitis B,C or HIV • Hepatitis A • Skin Infections – cutaneous diphtheria, impetigo, viral warts • Secondary to louse infestations – typhus (caused by Rickettsia prowazekii), trench fever (caused by Bartonella Quintana) or relapsing fever (caused by Borrelia recurrentis) • Fungal – most commonly tinea
Inflammatory skin conditions	<ul style="list-style-type: none"> • Erythromelgia • Pediculosis • Seborrhoeic dermatitis • Acne rosacea • Eczematoid eruptions • Xerosis • Pruritus
Skin infestations	<ul style="list-style-type: none"> • Body louse • Scabies
Respiratory Illness	<ul style="list-style-type: none"> • Pneumonia – common pathogens Streptococcus pneumonia, Haemophilus influenza b, aspiration of anaerobes or Pneumocystis carinii (the latter occurring almost exclusively in immunocompromised patients). • Influenza • Minor upper respiratory tract infections • Tuberculosis (often latent)

14.3 Mortality in Homeless Population

Life expectancy in Gateshead is currently 77.8 years for men and 81.2 years for women. Due to the large number of variables it is not possible to state what the life expectancy of a person experiencing homelessness is, however it is likely to be lower for homeless people. This can depend upon a large number of factors including the age homelessness began, the length of time homelessness was experienced, experiences of episodic homelessness, the form of homelessness experienced, access to services and support networks (FEANSTA 2016).

The average age at death refers to the average a person who is homeless is likely to die in a shelter/hostel or sleeping rough. A widely reported study undertaken by Crisis (Thomas 2012) reports the average age of death for a homeless person sleeping rough was 47 years for men and 43 for women, respectively in significant contrast with 77 for the general population. The Crisis report revealed some key trends relating to mortality within the homeless population. The average age of death of homeless people due to drugs is 34. Though this is similar to that of the general population, the chance of a homeless person dying from drugs is 20 times higher. The report highlights the fact that homelessness itself is a factor in poor health and death and that homeless people are nine times more likely to commit suicide than the general population. Homelessness is an independent risk factor for mortality following a hospital admission (Morrison 2009) and homeless people die of treatable medical conditions (Mehet & Ollason 2015).

A review published in the Lancet of the health of homeless people in high income countries synthesized findings from several studies to show that mortality is substantially increased in homeless people (Fazel et al, 2014). This review found causes of excess mortality to include infections (HIV and Tuberculosis), Ischaemic heart disease, substance misuse and external factors including unintentional injuries, suicides, homicides and poisoning (from medication and illicit substances). The review found that the standardised mortality ratios reported vary between studies and countries, but for homeless people are typically 2-5 times the age-standardised general population.

14.4 Maintaining a Healthy Lifestyle and Homelessness

A Glasgow study undertaken by Collins (1997) found that despite their poor health homeless people did not prioritise their health as other daily living concerns were more immediate. The Crisis research into the mortality of homeless people found that homelessness precludes a healthy lifestyle. Poor sleep quality, inadequate diet, difficulty maintaining personal hygiene, and problematic access to health care and maintaining a treatment regime can lead to poor health (Thomas 2012).

Addressing inequalities in lifestyle behaviour

Over a decade ago Crisis produced a guide to promoting health and wellbeing among homeless populations (Hinton et al 2001). The Principles and approaches highlighted in the guide are targeted at housing and resettlement services and they remain relevant. The guide explores ways of working in traditional health promotion areas like access to services including health and housing, diet and nutrition, personal hygiene, exercise, alcohol, drugs and smoking, sexual health, women's health and positive mental health. It also explores broader issues to do with empowering individuals to take control of their own health and ways in which organisations as a whole can become healthier, health promoting environments. The guide may be a useful starting point to explore some of the key issues in developing strategies, policies and guidance to support effective health promotion work particularly within homeless accommodation.

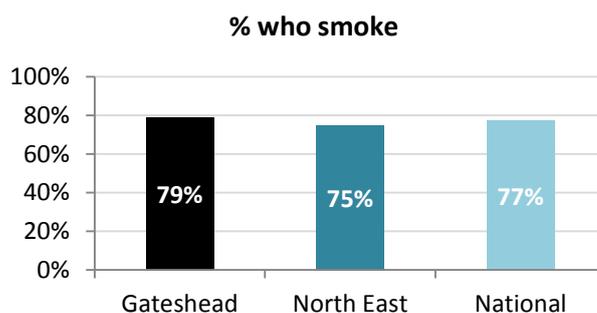
14.5 Smoking Prevalence and Homelessness in Gateshead

“Helping people to stop smoking is a good use of scarce resources and can save money for individuals, for the NHS and for society as a whole”
(PHE 2015)

Smoking is the main contributor to health inequalities in England and is increasingly concentrated in disadvantaged groups. Homelessness is independently associated with smoking and homeless individuals have higher rates of smoking-related diseases, including early onset cardiac disease, chronic obstructive pulmonary disease and smoking related cancers (Fazel et al 2014). Smoking is twice as high in people with long standing mental health problems (PHE 2015).

A recent BMJ editorial (Middleton et al 2016) on drug related deaths in England and Wales highlights that underlying respiratory disease exacerbates the respiratory complications of opiate use and leads to higher risk of death. The authors call for further research into the place of respiratory screening in older users and state that smoking cessation services need to be offered systematically.

In 2015, the smoking prevalence in adults in Gateshead was 18.3% which was similar to the England average of 16.9%. However, there is a marked social gradient in smoking rates. The gap between the proportion of smokers in the most and least deprived quintiles in Gateshead is 17.5%. The rate of smoking in routine and manual jobs in Gateshead is 25.6% which is much higher than the whole population average. There are also higher rates in the 18 to 24 age group at 31.4% (JSNA 2016).



Source: Homeless Health Audit

Homeless Health Audit 2015

79% of 69 respondents from Gateshead were smokers this was slightly higher than the national and north east survey responses. 44% of the smokers identified within the Health Audit reported a desire to stop smoking.

Data on smoking for homeless population in Gateshead
 Basis@363 Nurse Led Health Drop In Pilot – NHS Health Check Smoking Data
 97% of the 29 individuals accessing the drop-in and completing the survey were a smoker.

Addressing Inequality in Smoking Prevalence

There is a need to better understand barriers to smoking cessation and the ways in which vulnerable groups in Gateshead currently access stop smoking services and support. By 2025 Gateshead aims to reduce smoking prevalence from 18.3% to 5%. Public Health England (2015) suggests that services need to be targeted at those who need it most and that smoking cessation should be a priority in settings where the prevalence is high. Fazel et al (2014) found that several factors impede smoking cessation within the homeless population including higher rates of environmental exposure in shelters and other congregant living facilities, reduced access to health care and competing health needs which decrease health care providers opportunities to discuss cessation.

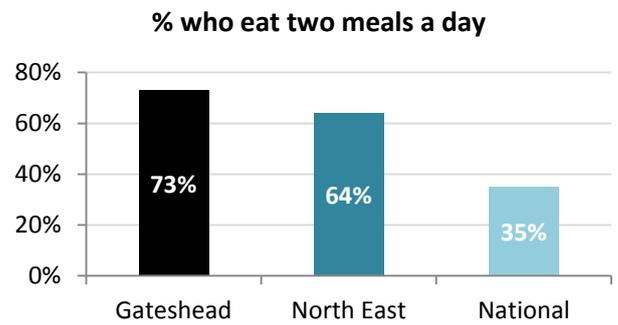
A systematic review undertaken by Twyman et al (2014) on perceived barriers to smoking cessation in vulnerable groups which included homeless, mental illness, substance misuse and prisoners identified stress management, high prevalence, acceptability of smoking and lack of support to quit as high priority areas. The review recommended:

- Interventions with vulnerable groups need to address wider social, community and cultural factors as well as individualised cessation support.
- Smoking cessation interventions should be designed to maximise participation by vulnerable groups, addressing the key barriers around acceptability and access to interventions.
- Utilising existing services and organisations that are highly accessed by vulnerable groups and are a trusted source of help for vulnerable groups is necessary.

- There is accumulating evidence that social and community service organisations are well placed to provide brief smoking cessation advice to highly vulnerable clients.
- The predictors of cessation found within the general population, such as nicotine dependence and enjoyment, remain important for vulnerable groups.

14.6 Nutrition and Homelessness

Evidence shows that inadequate food and nutrition intake is a contributory factor to ill health, and to a number of chronic health conditions and to premature death. For the general Gateshead population a 2014 survey showed that just 51.2% of those aged 16 years and over were eating the recommended five portions of fruit and vegetables every day. This compares with the England average of 53.5%. This figure may be even lower within the homelessness populations of Gateshead. Research carried out by Evans & Dowler (1999) to assess the diet of single homeless and marginalised in London highlighted that many did not meet current dietary recommendations. The diets of men and women were high in saturated fat and added sugars and low in fibre, vitamins and minerals, despite 70% reporting they wanted to improve their diet. The Homeless Health Audit undertaken in 2015 with a sample of 68 users of Homelessness Services in Gateshead found that only 73% of respondents were eating two meals a day. Poor nutrition can contribute to a number of chronic conditions over time and issues like fatigue and weakness in the short term (Homeless Hub 2017).



Guidance published by the Queens Nursing Institute (QNI 2012) on food nutrition and homelessness identified a limited amount of evidence in the UK as to the extent of malnutrition amongst the single homeless population. The QNI Guidance highlights some of the main barriers faced by single homeless people in maintaining a healthy diet, which may also apply to Gateshead;

Source: Homeless Health Audit

- Limited or no money to buy food
- No fixed abode
- Reliance on day centres for food. Not always possible to address cultural differences in food provision, for example availability of halal foods
- Drug/alcohol issues
- Eating for fullness rather than nutritional value
- Food is a low priority in life
- More likely to have health problems including physical (e.g. digestive problems) and mental health (e.g. depression, anxiety)
- Weight loss
- Irregular lifestyle
- Food insecurity
- Lack of knowledge about healthy eating
- Poor dental health and other health issues

Gateshead - Joe's Place

Based within St. Joseph's Church on Walker Terrace in Gateshead - Joe's Place is a drop-in run by a team of dedicated volunteers offering table service and a choice of free, hot and cold food and refreshments from a varied menu.

The drop-in is being accessed by some of the most vulnerable people in the area, including those who are homeless, experience social isolation, have little or no money, are living with addiction or have mental health issues.

As well as food and shelter, the volunteers also provide friendly conversation and a listening ear and are able to signpost anyone in need of additional support to agencies and organisations able to help. However, the main purpose of Joe's Place is to be a warm, welcoming, friendly place where anyone in need can call in and feel at home.

Addressing Food and Nutrition Inequality

There are significant gaps in our understanding of the food and nutrition status of the homeless population in Gateshead. This indicates the need for further study and to explore with homeless people the type of interventions that would be useful to them. The QNI guidance has been designed to raise awareness of the importance of nutrition amongst front line workers working with the homeless population, and to help identify needs that can then be addressed.

14.7 Oral Health and Homelessness

There is relatively little information available on the oral health needs of the homeless population in Gateshead. NICE Guidelines identify those who are homeless or frequently move as a high risk group for poor oral health. Key risk factors for poor oral health are hygiene, alcohol use, smoking, diet, trauma and stress, all which a homeless person may face (NICE 2014).

An extensive study of oral health and homelessness in East London found 99% of people accessing a dental service for homeless people between April 2009 and September 2011 needed treatment. Nearly two thirds of people (61%) completed their treatments (1 to 18 appointments) but only 28% did so with no failed or cancelled appointments. The study identified a significant need for oral healthcare services for this population and highlighted that flexibly delivered dental services, embedded in local health and social networks, seemed to promote uptake in these clients who normally find it extremely difficult to find dental care services elsewhere (Simons et al 2012).

General dental services are the main route to accessing primary dental care in the UK, however there can be access barriers for single homeless people, such as cost; difficulty keeping appointments; low sense of priority of oral health and a reluctance by dentists to register homeless patients due to a perception of them being problematic (DOH 2005).

Dental Health Data for Homeless People in Gateshead Fulling Lives

In Gateshead 74 (75%) of Fulling Lives Clients were identified as not registered with a dentist.

The Homeless Health Audit:

- 34 (50%) reported dental problems
- 27 (40%) were not registered with a dentist
- 29 (43%) had used a dentist in the past 6 months

Basis@363 Nurse Led Health Drop-in Pilot – NHS Health Check
Of those individuals completing the health survey only 3% had accessed dental services in the past 12 months.

Addressing Oral Health Inequality

There are gaps in our understanding of the oral health of the homeless population in Gateshead and how they currently access oral health advice and treatment.

Guidance from the Department of Health outlines that dental services should form an integral part of primary care for homeless people, for example through a 'one stop shop' approach involving multi-disciplinary working between GP's, mental health services, dentists, addiction services and podiatry (DOH 2005).

Oral Health and Homeless Guidelines from the Queens Nursing Institute (2015) recommends that professionals who are not oral health specialists could improve client's oral health by:

- Offering brief and simple advice at an appropriate time
- Offering toothbrushes and fluoride toothpaste as part of the service
- Encouraging limited sugar intake and good nutrition
- Encouraging reduction of tobacco and alcohol intake
- Hold health promotion days featuring oral health
- Explore ways to work collaboratively with local NHS/Community dental services
- Support clients to attend dental appointments and
- Support clients to regain choice, control and self-esteem and motivations towards self-care

The Faculty for Homeless and Inclusion Health's Standards for commissioners and service providers (Pathway 2013) includes standards for local NHS arrangements for dental care for excluded groups. These standards could be used to self-assess current arrangements in Gateshead and to identify further actions needed.

<http://www.pathway.org.uk/wp-content/uploads/2014/01/Standards-for-commissioners-providers-v2.0-INTERACTIVE.pdf>

14.8 Sexual Health and Homelessness

There is a gap in data pertaining to the sexual health of homeless people in Gateshead and their uptake of sexual health services. This reflects an evidence gap at the national level. A scoping review of research literature on the sexual health needs of vulnerable groups was undertaken in Scotland (Sim et al 2009). This highlights that data and evaluations relating specifically to the sexual health of homeless Scottish and other UK populations are almost non-existent. The review highlighted that the research that is available suggests unmet health need in terms of the supply of information about and testing for sexually transmitted infections, condom supply and use, contraceptive advice and cervical cytology. Homeless people are at increased risk of sexually transmitted infections and unintended pregnancies and can come under pressure to exchange sex for food, shelter, drugs and money.

Sexually Transmitted Infections Among Homeless Persons

A systematic review of homeless populations in the United States considered the intersection of homelessness and risk factors associated with sexually transmitted infections (Bryant et al 2012).

<http://homelesshub.ca/resource/sexually-transmitted-infections-among-homeless-persons-literature-review>

Findings which may have implications within the UK and highlight the need for local assessment of the homeless population included:

Lesbian, Gay, Bi-sexual, Transgender (LGBT)

- Homeless LGBT are more likely to participate in survival sex, more frequently victimized, use highly addictive substances and have more sexual partners.
- Studies have reported that among women self-identifying as lesbians, 15% reported being diagnosed with a Sexual Transmitted Disease (STD) at some time.
- STD risks among lesbian women can be exacerbated by a tendency among lesbian women's services to assume that they do not require regular screening tests.

Women

- Homeless women have more psychiatric problems, physical, emotional and sexual abuse than domiciled women

- Engage in multiple types of relationships and sexual behaviours; emotion and attachment play critical roles in risky sex choices
- High levels of unrecognised HIV infection (N=436, 9%) and recent STD diagnosis (33%) were found among women who had unprotected intercourse.
- Unprotected anal intercourse was associated with a large increased risk of STDs

Men

- Homeless men have higher rates of alcohol and substance use disorders, injection drug use, and risky sexual behaviours.
- Risky sexual behaviours were more frequent among those living on the street or in abandoned buildings
- Extended homelessness is associated with more risky sexual behaviours and a greater risk of contracting HIV

Lessons Learned

- STI prevalence data for homeless is limited
- Community-based screening can significantly impact STI risk:
 - Mobile services in areas where homeless people frequent
 - STI screening in homeless service settings
- Housing is a vital component of STI and HIV prevention
 - Housing stability can contribute to risk reduction
 - Persons whose housing status can be improved have been found to reduce their risk of drug use and unprotected sex
 - Supported housing can contribute to reducing risks associated with structural factors
 - However, further interventions are needed to address individual/relational factors associated with STIs

Addressing Sexual Health Inequality

The fact that sexual and reproductive ill health is concentrated in many vulnerable and marginalised communities is highlighted within Public Health England's Strategic Action Plan for sexual and reproductive health and HIV (Public Health England 2016). Consequently the plan highlights the need for universal approaches together with targeted interventions for key populations. Currently there is a gap in our understanding of the sexual health needs of the homeless population in Gateshead which indicates that this vulnerable group be included within future local sexual health needs assessments to inform local sexual and reproductive health promotion activities.

In a resource developed by the Queens Nursing Institute aimed at improving the health of homeless people (QNI 2011) they highlight that homeless people are less likely to access the sexual health promotion services if timing and appointment systems do not meet their needs, they are unaware of the service or unaware of the need to use it. The resource highlights some areas which should be considered in relation to addressing this:

- Reducing the under-18 conception rate – worth bearing in mind in homeless accommodation for young people.
- Increasing knowledge of safer sex practice and condom use – free condoms in homeless services can be helpful here.

Sexual Health Data for Homeless in Gateshead

Basis@363 Nurse Led Health Drop-In Pilot. NHS Health Check Of the 29 individuals who completed survey:

10% of individuals had accessed a sexual health clinic in the past 12 months

52% of individuals reported they had engaged in unprotected sex in the last 12 months, 17% preferred not to say and 31% had not.

The Homeless Health Audit:

Of the 69 respondents;

- 9% had tested positively for Hepatitis C
- 29% had received a Hepatitis B vaccination

Of the 43 male respondents;

- 25% reported they had received a sexual health check

Of the 25 female respondents;

- 33% reported they had received a health check
- 19% reported they had a cervical smear

- Increasing access to sexual health services – this can be done through information and outreach of sexual health services to homelessness venues.

14.9 Health Protection – Public Health Risks and Homelessness

Homelessness has an impact on the spread, severity and treatment of infectious diseases. Vulnerability arises because of compromised immune systems, reduced access to healthcare, the inability to maintain personal hygiene and inadequate nutrition (Homeless Hub 2016). The prevalence of transmissible diseases among the homeless varies greatly according to living conditions (Badiaga 2008). Staying in overcrowded and sometimes poorly ventilated spaces with other vulnerable people raises the likelihood of spreading infectious diseases. In addition, experiences identified within some homeless groups such as transitioning between prison and homelessness, engaging in sex work and using intravenous drugs also increases the risk for infectious diseases to spread which may then become serious public health concerns (Homeless Hub 2016).

In 2013, NICE published an evidence overview on infectious diseases within the homeless population (Nice 2013). This highlights that HIV, Hepatitis C and tuberculosis are the most heavily studied infectious diseases among homeless populations. However, high rates of other infectious diseases – such as hepatitis A and B, diphtheria, foot problems and skin infections – have also been reported in some studies. The evidence review references a systematic review and meta-analysis of 43 studies (4 were from the UK) undertaken by Beijer et al (2012). The review found that the UK prevalence of hepatitis C viral infection is reported to be approximately 50 times greater in the homeless population than in the general population. HIV prevalence has been found to be 1-20 times higher in homeless populations in the United States compared to the general population, but no UK studies were identified. A review by Badiga (2008) highlights that the risk for HIV infection is higher in the following homeless people; those engaged in sexual behaviour such as sex work, receptive anal sex, and having multiple sexual partners, those who find it difficult to obtain condoms and those who use drugs in shooting galleries or who share needles or other drug paraphernalia.

Tuberculosis TB

In the UK, the prevalence of tuberculosis is reported to be 34 times greater in homeless people than in the general population (Beijer et al 2013). Homelessness can be a risk factor for TB as sleeping on the streets or inadequate living conditions combined with reduced access to a good diet and appropriate medical care all impact on a person's physical and mental health and can make vulnerability to infection more likely. Lifestyle factors can sometimes mask symptoms of TB (i.e. smokers often have coughs anyway and can have frequent chest infections; those with a drug habit may not notice additional weight loss very quickly; people reluctant to see Doctors may delay accessing help) so it's important that those working with vulnerable groups have an awareness of the symptoms of TB and know when to seek advice. If disease is detected earlier it is easier to treat and if it is infectious further spread can be better contained.

Gateshead Specialist Health Visitor TB and Migrant Health:

In Gateshead the Specialist Health Visitors for TB and Migrant Health based at Low Fell Clinic are also available for advice on: 0191 2834660. Work is underway to look at introducing basic TB screening and TB awareness into healthcare assessments for the homeless through Basis@363 in Gateshead and to support TB awareness raising among staff working with vulnerable groups.

Homeless individuals who have presented with TB in the past in Gateshead have tended to be part of the hidden homeless group: those without their own fixed address who are staying with friends and can be moving between houses often. They have been a mixture of both white British and migrants with no recourse to public funds. At this point in time TB is treated free of charge by secondary care for anyone regardless of employment / migration status. This includes free prescriptions for TB medications when issued from a hospital pharmacy for anyone on treatment.

In addition NICE (Tuberculosis in Vulnerable Groups 2013) now recommends that homeless people with TB should be housed

by Local Authorities during and on completion of treatment:

- Commissioners of TB prevention and control programmes should fund accommodation for homeless people diagnosed with active TB who are otherwise ineligible for state-funded accommodation. Health or public health resources should be used. Strategic housing leads and relevant services within local authorities should work with multidisciplinary TB teams to set up a process for assessing eligibility for people with TB for housing.
- Multidisciplinary TB teams should make people who would not otherwise be entitled to state-funded accommodation aware that they may lose this accommodation if they do not comply with treatment.
- Multidisciplinary TB teams should ensure plans are made to continue housing people once their TB treatment is completed.

Basis@363 Nurse Led Health Drop-In Pilot. NHS Health Check

The 29 respondents were asked:

- 'Have you had a blood borne virus check in the past 12 months?'
- 4(14%) of the individuals responded yes to the question.
- 21(72%) of the individuals responded no to the question.
- 4 individuals said they would rather not say.
- 7 of the 29 respondents reported they had injected drugs in the last 12 months.
- 15 (51.72%) individuals reported they had engaged in unprotected sex in the last 12 months, 5 (17.24%) preferred not to say and 9 (31.03%) had not.

Homeless Health Audit

Of the 69 respondents;

- 9% had tested positively for Hepatitis C
- 29% had received a Hepatitis B vaccination

Addressing Inequalities in Infectious Diseases within the Homeless Population.

The NICE evidence review (NICE 2013) highlights that it is recognised and accepted as standard practice to screen homeless populations for hepatitis, HIV and tuberculosis. NICE has pathways on tuberculosis, HIV testing and prevention, and hepatitis B and C testing which include recommendations for:

- Simultaneous screenings for TB, hepatitis C, and HIV
- Transportation and housing supports as well as ensuring adequate nutrition
- Active case-finding screenings (should not be restricted to symptomatic patients)
- Needle exchange programmes
- Free condom distributions
- Community health centres in large cities
- Better access to health care

The NICE evidence review (NICE 2013) also argues for the regular assessment of homeless populations, wherever they are found, in order to provide a locally adapted response. For this to be most effective it will need health organisations to have a 'memory', being able to monitor trends and the effectiveness of various interventions over time. While these are important recommendations, addressing the inequalities experienced by homeless people and their impact on social determinants of health is also a critical component of a wider public health strategy.

A research overview of a London based programme (University College London 2014) to improve control of tuberculosis in hard to reach groups includes some key recommendations including : mobile radiographic screening to expand to other higher incidence areas outside London; screening for TB in prisons; screening for latent TB in drug users; NHS to provide funds for housing of homeless TB patients with no other recourse to support; multidisciplinary teams to include social care workers to support care; directly observed therapy to become routine for homeless

people, prisoners and drug users; cohort review (a service quality improvement model based on international experience and the London TB profile) to become routine across TB services nationally.

14.10 Cognitive impairment, learning difficulties, literacy and Homelessness

Cognitive impairments are due to a variety of causes including schizophrenia, substance misuse, traumatic or acquired brain injury, progressive neurological disorders and developmental disabilities. Cognitive impairments can affect memory, attention and communication; they have an impact upon visual and spatial functioning, the ability to problem solve and perform unfamiliar tasks, overall awareness and the ability to organise and regulate behaviour (Backer & Howard 2007). Behaviours resulting from cognitive impairments could be an important factor in increasing the risk of becoming homeless and may also present barriers to exiting homelessness and living independently. For example, landlords may deny housing to people with cognitive impairment because their behaviours may be difficult to understand or be misinterpreted as being intentionally anti-social or disruptive. The presence of cognitive impairment also has major implications for case management in terms of the amount and type of support and accommodation that needs to be offered (HousinLin 2008).

Gateshead Example of Learning Difficulties impacting upon Housing

During the HNA process anecdotal evidence was provided in relation to clients within supported housing where staff were struggling to support desired behaviour change. An example was provided of a client who was preparing food in a way that presented a fire risk however, due to apparent problems with the client's understanding and capacity to retain information the individual was unable to maintain any change despite a number of tailored support sessions to demonstrate and help the individual learn about safer practices. This behaviour was putting his accommodation at risk because of concerns regarding fire safety to the property, himself and other residents.

Basis@363 Nurse Led Health Drop-In Pilot. NHS Health Check

Of the 29 respondents;

- <5 individuals reported a diagnosed learning disability
- <5 individuals reported undiagnosed memory loss

It is difficult to estimate the prevalence of cognitive impairment in the homeless population as people are infrequently assessed or when they are often treated for other conditions such as enduring mental illness or substance misuse (Backer & Howard 2007). Assessment may also be impaired by temporary conditions such as drug use or inebriation. However, there is evidence of a significant burden of cognitive impairment among adults who are homeless (Spence 2004) and one study suggested the prevalence may be as high as 80% (Solliday-McRoy et al 2004). Undiagnosed learning difficulties are also common in the homeless population and may go unidentified as sufferers have been out of school, and have begun to experience mental health difficulties and substance misuse conditions at an early age which may complicate the presentation. A study by St Mungos Broadway (2014), identified that 51% of homeless people lacked the English basic skills needed for everyday life, compared to 15% of the general population in England.

Addressing Inequalities in Cognitive Impairment, learning difficulties and literacy

The presence of cognitive impairment, learning difficulties and lack of basic literacy skills have major implications for case management in terms of the amount and type of health and social support and accommodation that needs to be offered. It may also have implications for the type of support needed to facilitate a route of homelessness and access to employment and education opportunities. The prevalence of cognitive impairment within the homeless population has led to recommendations for routine screening (Spence 2004). Training and support available to staff working with this population should consider how the presence of cognitive impairment, learning difficulties and low literacy levels can be identified and understood and best supported for each individual.

14.11 Substance and Alcohol Misuse and Homelessness

The relationship between substance and alcohol misuse and housing is well-documented. The 2010 National Drug Strategy (Home Office 2010), explicitly recognises that people who suffer from drug or alcohol dependence are at

greater risk of cycling in and out of homelessness, rough sleeping or living in poor quality accommodation. Evidence from an international review on effective substance misuse services for homeless people (Pleace 2008) confirmed that substance misuse can be a cause of homelessness. Addictive disorders disrupt relationships with family and friends and can cause people to lose their jobs. Homelessness can also be a risk factor for drug and alcohol use, with problems developing or increasing as a means to cope with the difficulties of homeless life and past trauma. These populations are in turn characterised by poor social supports, negative experiences during childhood, poor educational outcomes, and sustained worklessness.

Findings from a 2014 Homeless Link Health survey (Homeless Link 2014) using data from health audits completed by 2,590 people across the country illustrates the extent of substance misuse within the homeless population;

- The survey found that 39% of respondents said they take drugs or are recovering from a drug problem and 36% had taken drugs in the month prior to completing the audit. This compared to only 5% of the general public taking drugs in the past month.
- The survey found that 27% said they have or are recovering from an alcohol problem. 39% of homeless men who completed the survey and 25% of women drank twice or more a week and two thirds consume more than the recommended amount of alcohol each time they drink

For the general population in Gateshead, a local perception survey undertaken by Balance (2015) suggests that there may be 65,000 residents in Gateshead drinking at increasing and higher risk levels. Data on hospital episode statistics for Gateshead (HSCIC 2014/15) shows that the age standardised rate of alcohol related hospital admissions in Gateshead is 927 per 100,000 this is significantly higher than both the regional average (830) and the England average (641). Alcohol related mortality has been decreasing in recent years, narrowing the gap to England however, in 2014 there was a slight increase (110 deaths with a rate of 56.7 per 100,000) resulting in Gateshead being significantly worse than the national average (45.5 per 100,000) (ONS 2014).

From the general population in Gateshead, in the year to March 2015 there were over 1,000 opiate users and almost 250 non opiate users in treatment (NDTMS 2015). The proportion of opiate users that left drug treatment successfully (free of drug dependence), who did not then re-present within 6 months was 6.4% which is similar to the regional average (6.0%) and England (7.8%) (NDTMS 2013). The proportion of non-opiate users that left drug treatment successfully was 32.2% compared to 31.2% across the north east region and 37.7% for England (NDTMS 2013). There has been an increase in the use of non-psychoactive drugs across Gateshead (Drug and Alcohol Service Needs 2013).

The effects of drug and alcohol use have a strong and destructive effect on the physical and mental health of homeless people.

Gateshead Council's Review of Drug and Alcohol Treatment (2013/14)

The Gateshead Council's review of drug and alcohol treatment (2013/14) identified challenges with appropriate housing for people in recovery as an outstanding issue at the end of the review. The review process included an externally commissioned consultation process to enable people within the treatment system in Gateshead to give their views. In addition to this the review interviewed carers and other professionals who work with people with substance misuse issues. Through this consultation work housing was identified as a particular challenge which was negatively affecting people's chance of recovery. This led to the PHE Capital Recovery bid detailed on page x. There has also been continued engagement from a commissioning and provider perspective on the vulnerable persons housing panel.

Source: Gateshead Substance Misuse Strategy (2017-2022)

EVOLVE – Drug and Alcohol Data

Gateshead Evolve is a single integrated drug and alcohol recovery service for all adults in Gateshead. Data provided from April 2015 until April 2016 identified that from a total of 1100 service users 239 (22%) classed themselves as having a housing problem and 87 (8%) had no fixed abode/urgent housing problems. Service users will include those accessing support through their GP for drug misuse (shared care) as well as those receiving services directly through evolve. This data does not include those accessing their GP for brief advice relating to alcohol.

Basis@363 Nurse Led Health Drop-In Pilot

Of the 29 individuals completing the survey:

- 14 (48.28%) had accessed substance misuse services in the past 12 months.
- 17 (58.62%) reported drinking 20-30 units of alcohol per week
- 7 (24.14%) reported injecting drugs in the past 12 months
- 6 (20.7%) said they had an ongoing problem with alcoholism

Homeless Health Audit

Of the 68 individuals completing the survey:

- 49% are taking drugs or recovering from a drug problem
- 9% take legal highs
- 29% use cannabis
- 61% of drug users reported they were getting support
- 9% reported they were weekly drinkers
- 22% of the weekly drinkers consumed more than 10 units of alcohol

Addressing Inequalities in alcohol and drug misuse and homelessness

In 2008 a rapid evidence assessment of international literature on effective substance misuse services for homeless people was conducted to see if there were any lessons for Scotland these lessons may also be applied to other UK populations (Pleace 2008).

The review highlighted:

- Services that are aimed solely at promoting abstinence among homeless people with a substance misuse problem tend to meet with quite limited success.
- When services pursue harm reduction or harm minimisation policies, rather than insisting on total abstinence, there is evidence that they are able to engage with homeless people with a substance misuse problem more effectively. In particular, there is evidence that harm reduction based on floating support models used in the United States are able to promote and sustain stable living arrangements and ensure contact with services.
- Homeless people with substance misuse problems have a range of needs that can include support with daily living skills, a requirement for mental health services and a requirement for support in managing substance misuse. Their needs are often complex and services that focus on any one element of the need, be it substance misuse, mental health or housing related support, meet with less success than services designed to support all their needs.
- Three main models of resettlement for homeless people with a substance misuse problem were identified. The first, the Continuum of Care or 'Staircase' approach, uses a series of shared supported housing settings that are intended to slowly progress service users towards independent living and abstinence. The evidence is that this model meets with limited success. The second, which is referred to in the United States as the 'Pathways' Housing First model, uses intensive floating support to ordinary accommodation, with a strong focus on service user choice and a harm reduction approach to substance misuse. There is evidence that this is more successful than the first model. The final model is the package of floating support provided through case management and joint working this was identified as standard practice in Scotland which had a less developed evidence base.

<http://www.nta.nhs.uk/uploads/jsna-adult-alcohol-final-300914.pdf>

The guide recommends that local authority public health commissioners need to consider a range of questions in order to commission high quality, evidence-led alcohol and drug services based on outcomes. In relation to a home environment the following questions were recommended:

1. Have the housing needs of alcohol and drug users in the community and prison and residential treatment been identified in order to inform local commissioning plans for housing, homelessness and housing related services?
2. Are the housing needs of alcohol and drug users and their families (where appropriate) assessed in a timely manner to prevent homelessness and/or enable move-on to a suitable home? (This includes those in prison, in residential services and those living in their own home but at risk of homelessness)
3. Is good quality housing information and advice readily available?
4. Is there a range of suitable housing options to meet different needs including: emergency bed spaces; direct access accommodation; refuges for those fleeing domestic abuse; supported housing; floating support available to those in their own home; accommodation specifically for women or young people, housing for people with complex needs (eg Housing First).
5. Are alcohol and drug users who are rough sleeping able to access emergency accommodation and appropriate support?
6. Do housing services support homeless alcohol and drug users to access primary care?
7. Have commissioners, service users and providers agreed a definition for a 'suitable' home? Is the definition based on the description of 'suitable' found in the Homelessness (Suitability of Accommodation) (England) Order 2012, as a minimum? Is the local definition consistently applied in practice by staff working with alcohol and drug users when supporting them along the pathway? Are frontline housing staff working in local authority services, for social landlords and housing support providers) trained in working with alcohol and drug users to meet their housing and related needs?
8. Is there a hospital discharge policy and procedure in place for homeless alcohol and drug users (and others) to enable access to pathway suitable housing?

14.12 Mental Health Problems and Homelessness

Poor mental health is known to be both a cause and a consequence of homelessness. Mental health problems can range from common problems such as anxiety and depression to more rare problems such as bi polar disorder and schizophrenia. There is a higher prevalence of mental health problems in the homeless population, both for common mental disorders and more severe conditions. The Five Year Forward View for Mental Health (NHS England 2016), identified that common mental health problems are over twice as high among people who are homeless compared with the general population, and psychosis is up to 15 times as high. A systematic review of the literature undertaken by Maguire (2009) found that there are higher rates of mental health problems, both Axis I (anxiety disorders, depression, dementia and psychosis disorders) and Axis II (personality disorders) than non-clinical populations. Homelessness is also associated with higher rates of personality disorder, self-harm and attempted suicide (Rees 2009). It is estimated that 70% of single homeless people suffer from personality disorder (more recently called complex trauma), compared to 4% in the general population.

Data on the prevalence of mental health problems and use of mental health services by homeless people was identified as a gap in the HNA process. For the general population data is available at the Newcastle and Gateshead CCG level for numbers affected by anxiety and depression. In 2014/15 29,571 (7.2%) people in Newcastle and Gateshead were affected which compared to an England average of 7.3% (HSCIC, Quality Outcomes Framework Prevalence of Depression, 2014/15 - Common Mental Health Disorders website). For severe mental illness the 2012/13 data shows that 0.94% of the Gateshead population were affected (HSCIC, Mental health QOF prevalence, 2012/13 - Community Mental Health Profiles).

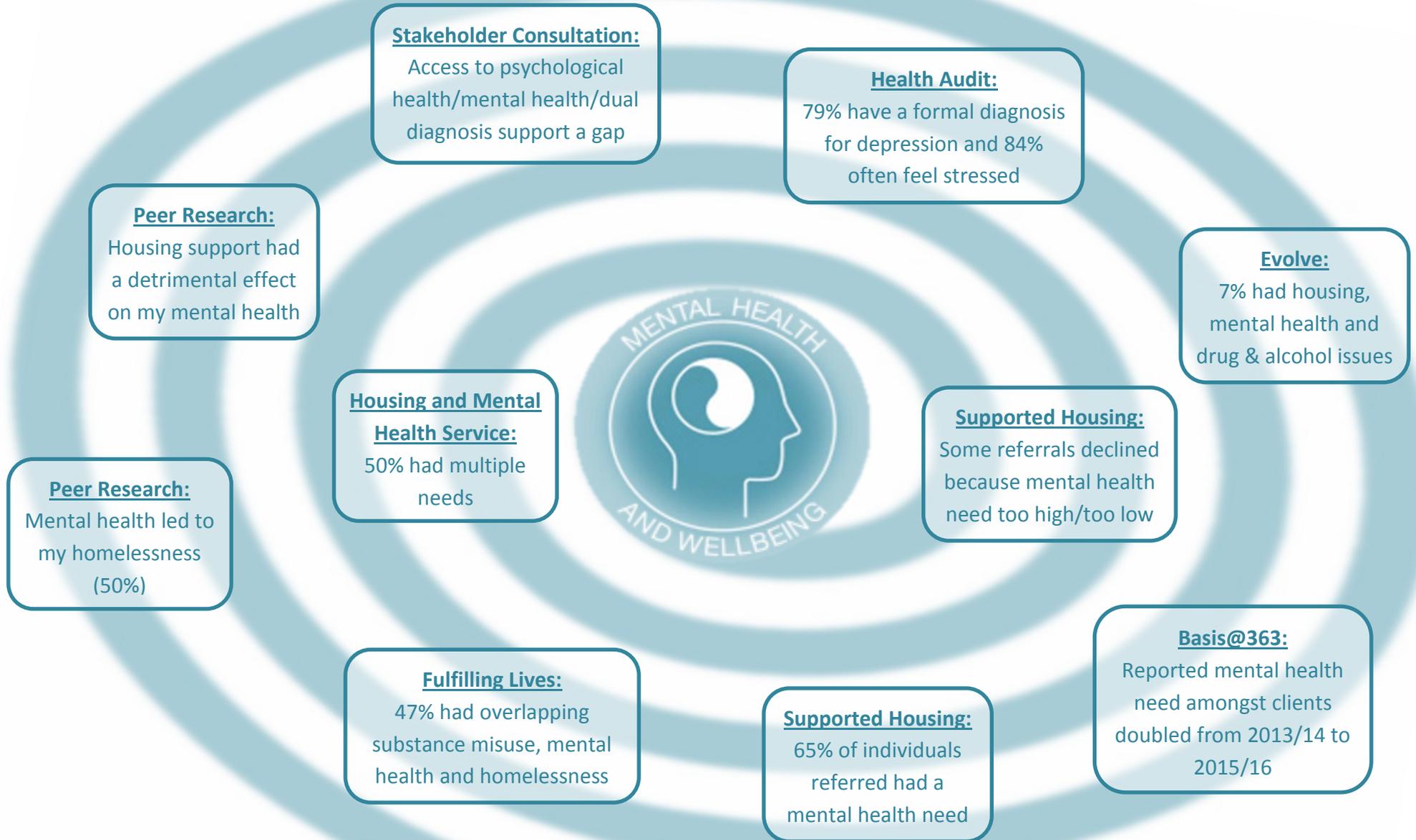
Although data on uptake of NHS treatment services by the homeless population in Gateshead was not available. The Homelessness Health Needs Audit and service level data indicates that the level of expressed mental health need is

significant among the single homeless population. The table below provides a summary of data reviewed in relation to mental health need and the infographic on the following page highlights some of the key findings from the health needs assessment process.

What local sources of data tell us about mental health need of those identified as homeless in Gateshead

Data Source	What did it tell us about mental health need in Gateshead
Supported Housing Portal Data 2015-2016	<ul style="list-style-type: none"> • 297 (65%) of individuals referred to supported housing had a mental health need • 23 referrals were made to supported housing by the housing and mental health team • 3 referrals were made by the NHS including the Tranwell Unit • 1 referral was made by Talking Therapies • 26 referrals were declined because mental health needs were too high • 8 referrals declined because mental health needs were too low • 6 referrals declined because mental health needs and substance misuse was too high • 4 referrals declined because mental health needs and offending was too high • 1 referral declined because mental health, offending and substance misuse too high
Homelessness Health Audit 2015 Self reported data Sample = 68	<ul style="list-style-type: none"> • 84% often feel stressed • 78% often feel anxious • 76% feel depressed • 49% have a formal mental health diagnosis • 79% have a formal diagnosis for depression • 18% have received a dual diagnosis
Fulfilling Lives – Operational Client Data 98 clients from Gateshead accessing programme during period May 2014 – July 2016	<ul style="list-style-type: none"> • 43 named mental health as a disability • 20 named mental health as long term condition • 5 had personality disorder as long term condition • 46 had overlapping homelessness, substance misuse and mental ill health • 33 had overlapping substance misuse, mental health and offending • 7 had overlapping homelessness, substance misuse and mental health • 6 had substance misuse overlapping with mental health • 2 had overlapping homelessness, mental health and offending • 1 had mental health as only issue. • 10 referrals were made to Gateshead Tranwell Unit (Crisis Resolution and Home Treatment Service) • 7 referrals to NTW NHS Foundation Trust • 6 referrals to Oakwell Mental Health Concern • 18 hospital inpatient (mental health) stays were recorded for 7 individuals.
Basis@363 Operational data 13/14 (647 clients) 14/15 (767 clients) 15/16 (740 clients)	<ul style="list-style-type: none"> • The numbers of clients reporting mental health needs has increased over the three years of reporting 19% (13/14), 28% (14/15), 40% (15/16)
Basis@363 Nurse Led Health Drop-In Pilot NHS Health Check 29 patients surveyed	<ul style="list-style-type: none"> • 9 individuals (31%) had accessed mental health services in the past 12 months. • 9 individuals (31%) reported some form of mental health problem. • 2 individuals (7%) reported an undiagnosed problem of self-harm.
Housing and Mental Health Service Data from 2 nd Feb – 31 st December 2015	<ul style="list-style-type: none"> • 121 referrals were received – 80 were male/ 41 were female – 98 were single households. • 61 had multiple needs • 33 had a dual diagnosis • Of the 68 closed cases 71% had their housing need met through support from the service.

Evidence of Significant Mental Health Need Emerged from the Health Needs Assessment Process



Barriers to meeting mental health needs

A report by Homeless Link (2015) highlights how mental health problems can deepen exclusion and make it harder to escape cycles of poor health and homelessness. At the same time, homeless people often face significant barriers when trying to get the right help at the right time with their mental health needs. Mental health problems may go undiagnosed or untreated because of the chaotic and transient lifestyle of the population and because the presence of other issues such as substance misuse can act as a barrier to treatment.

The Housing and Mental Health Service in Gateshead have identified a number of barriers to meeting people's needs. Areas identified were:

- Accommodation has criteria that must be met upon referral – if this is not met it is no use submitting referrals.
- For supported accommodation there are often barriers such as an individual with a past history of arson, antisocial behaviour, substance misuse and high mental health needs.
- There are gaps in emergency provision for people with mental health problems and high needs/complex problems.
- Lack of hostel provision in Gateshead
- Lack of prevention services to support people who are at risk of going into secondary services. The Housing and Mental Health Service currently only has scope to work with people who are in secondary mental health services.
- Substance misuse is a major issue with clients and has a detrimental effect on their mental health

Within the HNA stakeholder consultation and the peer research many difficulties were identified for people accessing support for their mental health needs. These are documented in chapters 15 and 16 of the HNA. Anecdotal issues were also raised during meetings with key stakeholders. A briefing paper by HousingLIN (2008) suggests these issues are not unique to Gateshead. The main difficulties highlighted in relation to providing services by the briefing paper are summarised below;

- **Who is responsible** - Both primary care and specialist mental health services can be reluctant to take on the care of people who are homeless or living in secure accommodation.
- **Continuity of care** - Homeless people can often lose touch with services who know their often complex past history. Transferring patient between workers and teams, even in the same service can also cause difficulties in continuity of care.
- **Dual diagnosis** - Evidence from GPs and voluntary organisations of clients being turned away from mental health services because of their drug/alcohol problem but simultaneously declined by substance abuse services because of their mental health problem. Co-morbidity can still be a barrier to obtaining either any care at all or adequate care for both conditions, particularly in the most excluded groups such as homeless people who are difficult to engage with.
- **To admit or not to admit?** - When assessing a homeless person, mental health staff can be faced with a person who, if they were living in their own flat where they could be seen by a home treatment team, they would not consider admission. Some homeless people with chronic psychosis may appear so well adapted to their condition, albeit to living on the streets, that professionals are reluctant to undertake compulsory admission even when there is a clear sign of self-neglect and vulnerability.
- **Role of advocate** - The poverty and poor social networks associated with homelessness can make access to, and delivery of, services difficult. Homeless accommodation and support agencies are often in the position of acting as advocate or care navigator to homeless people. They consistently report problems with the delivery of mental health care, mainly in terms of obtaining access to care for their clients. Furthermore it may be difficult for non-clinicians to understand why a person who presents in obvious mental distress or with unusual behaviour may not be considered psychiatrically unwell and therefore may not need to access acute

psychiatric care. The value of engaging with voluntary sector hostel and outreach agencies as advocates and sources of vital information and practical support cannot be overemphasised.

- **Young homeless people** - The group under 25 present a particular challenge and there is a high overlap with care leaving services and youth offending teams. High levels of mental ill health and substance misuse are reported. Accommodation providers report difficulties in obtaining appropriate

Also the level of support provided by non-mental health professionals such as housing support workers may not currently be fully recognised or understood. As a consequence opportunities to understand this in greater detail should be considered and to explore how staff receive supervision and support when providing support to those with mental health needs

Addressing Mental Health Inequality

Addressing mental health inequality could be tackled through various measures both within and beyond housing policy. A starting point may be to consider and respond to some of the issues identified through this HNA process. A briefing by the Mental Health Network and NHS Confederation (2012) examines what considerations need to be made when planning, designing and delivering mental health services for single homeless people and highlights examples of good practice. The briefing highlights that access to mental health services for homeless people can be improved through improving staff awareness and the development of models of care better able to engage with complex presentations. The briefing recommends assertive outreach programmes, improved access to psychological therapies, effective joint working with partners and delivering services differently as key solutions.

Psychological Informed Environments (PIE)

The briefing by the Mental Health Network and NHS Confederation (2012) supports the psychologically informed environments (PIE) approach to providing therapeutic environments. The PIE approach stems from work by the Royal College of Psychiatrists which recognised the high levels of emotional

Local Fulfilling Lives Psychologically Informed Environments Pilot

<http://www.fulfillinglives-ng.org.uk/wp-content/uploads/2016/08/exec-summary-pie-v.3.pdf>

The Newcastle Gateshead Fulfilling Lives Programme recently published the results of a PIE pilot which was undertaken with two accommodation services delivered by Mental Health Concern and a drop in day centre delivered by Oasis Aquila (Fulfilling Lives 2016). The evaluation of the pilot noted that services involved had developed and changed their approaches to working with individuals with multiple complex needs leading to staff teams with more resource to problem solve, and to reflect and ensure their own self-care, and to improving outcomes for clients. The report suggested there was a strong case to be made for the value of expanding PIE throughout the wider multiple complex needs system and made the following recommendations:

1. Relative advantage is needed. This means services and staff need to see the immediate benefit to them over the status quo. Initial focus should therefore be on the services that have the most interaction with chaotic and challenging clients first and then extend backwards into services with less chaos as the model becomes more integrated across the system.
2. There needs to be a commitment from strategic and senior management and commissioners to allow for a PIE approach to embed. Services need to feel they have the permission to work outside of traditionally rigid performance structures.
3. Service level managers need to have visible buy-in - PIE will be more likely to fail if there is resistance at the service manager level. Time and resource must be invested to ensure this is in place before trying to establish PIE within services.
4. Service managers need support from senior management to ensure they can commit to the time and space needed for reflective sessions, and to consider physical changes if needed.
5. Resource needs to be given to ensure that the training is delivered by someone with expertise in PIE, and that the training materials are produced to a high standard
6. Consideration must be given to ensure that training retains a service-specific element tailored to the local service's needs.
7. A peer network of the trained facilitators from across the services should be established to support and ensure sustainability of peer facilitation.
8. To ensure capacity, quality, consistency and momentum in delivering PIE across the wider system a dedicated PIE training and facilitator position should be funded. This would be the most cost effective means of embedding PIE across the wider system.

trauma that accompany, and in many cases preceded, an individual becoming homeless. A good practice guide was produced in 2010 by the Department for Communities and Local Government (DCLG). Within the guide a PIE environment is described as 'one that takes into account the psychological make-up – the thinking, emotions, personalities and past experience – of its participants in the way that it operates' (DCLG 2010). A detailed background to PIE concepts, approaches and the state of the evidence base are discussed in a recently published literature review published by St. Mungos (2016).

<https://www.mentalhealth.org.uk/sites/default/files/pies-literature-review.pdf>

14.13 Dual Diagnosis and Homelessness

Dual diagnosis is a term used to describe people who have severe mental health problems and drug or alcohol problems. The government's most recent definition of dual diagnosis (set out below) is broad and encompasses different causal relationships between mental health problems and substance misuse (DOH 2009).

A primary mental health problem that provokes the use of substances

(As may be the case with someone suffering from schizophrenia who finds that heroin reduces some of his symptoms.)

Substance misuse and/or withdrawal leading to psychiatric symptoms or illnesses

(Emergence of depression post-detoxification – insomnia and low mood; also the emergence of a psychiatric disorder to which the individual was vulnerable pre-substance misuse.)

A psychiatric problem that is worsened by substance misuse

(For example, a person with heightened anxiety of danger from others who uses cannabis to relax, but finds that the cannabis can increase their paranoia, leading to increased alienation.)

Substance misuse and mental health problems that do not appear to be related to one another

(For example, someone who has an ongoing anxiety problem that is neither lessened nor worsened by drug or alcohol use.)

A considerable proportion of homeless people have a dual diagnosis, with both one or more mental health problems and a problem with drugs and/ or alcohol. Estimates of the prevalence of dual diagnosis among the homeless population vary from 10 to 50 per cent (St. Mungos 2009, Rees 2009).

Dual diagnosis can suggest that there are only two problems, however local experience suggests that in fact people may have multiple needs. This has also been highlighted by the mental health charity RETHINK who identified a range of other problems and consequences that are associated with dual diagnosis (RETHINK 2009):

- Family problems or problems in intimate relationships.
- Isolation and social withdrawal.
- Financial problems.
- Employment or school problems.
- High risk behaviour while driving.
- Multiple referrals to drug and alcohol services and rehabilitation units.
- Multiple admissions for psychiatric care due to relapse
- Increased casualty/accident and emergency admissions.

- Increase need for health care services
- Legal problems and possible incarceration.
- Homelessness
- Higher risk of self-harm and suicide

Over half of an estimated 58,000 people nationally experiencing severe and multiple disadvantages including substance misuse, also have a mental health condition (Bramley et al 2015). The National Inquiry into Suicide and Homicide by People with a Mental Illness (2015) identified that more than half of suicides (54%) nationally occur among patients with a history of alcohol or drug misuse. Alcohol misuse is a key predictor of suicide/premature death. Across 189 drug treatment services in England, more than one in five (22%) say that access to mental health services deteriorated over the 12 months to September 2014 (Drugscope 2015). 14% of alcohol dependent adults also receive treatment for a mental health issues. Alcohol dependent women (26%) were more likely to receive such treatment than alcohol dependent men (9%) (HSCIC 2007).

Gateshead – Dual Diagnosis and Homelessness Data

Hard Edges Report

650 people in Gateshead with mental health & substance misuse

Fulfilling Lives

46 (47%) Homeless & substance misuse & mental health & offending, 33 (34%) substance misuse, mental health & offending, 7 (7%) Homeless, mental health & substance misuse, 6% substance misuse & mental health.

Homeless Health Audit

18% of 68 respondents reported a dual diagnosis.

Gateshead Evolve drug and alcohol service

Of 1100 service users 73 clients identified as having a housing need as well as both mental health and drug/alcohol issues.

Concerns regarding the particular lack of support for people with a dual diagnosis of mental health and substance misuse were raised frequently during the HNA process. In 2016, a webinar was held with Fulfilling Lives Newcastle Gateshead and the University of Sheffield and CFE Research which is carrying out the national evaluation of the Fulfilling Lives initiative. The briefing has captured some of the key local challenges identified by the Fulfilling Lives programme locally in relation to dual diagnosis. These are detailed below;

- Lack of understanding of mental ill health within non-mental health services. In particular services commissioned to provide accommodation and support for people who are homeless find themselves dealing with substance misuse and mental ill health but are often not equipped for (or commissioned to provide) this support
- Mental health services not accessible to people with substance misuse: mental health services will not assess anyone who is under the influence of drugs or alcohol. In Newcastle and Gateshead the drugs related deaths panel has identified a number of cases where people who have died had an untreated mental health problem
- Performance management of services: Key Performance Indicators influence the way services behave and can make it less likely for services to engage with people with multiple and complex need. For example, the Improving Access to Psychological Therapies (IAPT) service has targets to get people through treatment within a six or twelve week period; this can be a significant barrier to engaging with clients exhibiting more complex needs.
- Tendency towards traditional practices and culture at service delivery level: While there is buy in at strategic level to take holistic, person centre and psychologically informed approach to individuals with dual diagnosis, this does not always translate to action on the ground. There is a gap between theory and practice.

Newcastle and Gateshead Fulfilling Lives – barriers to supporting people with dual diagnosis



Statutory Mental Health Services

Wont assess anyone who is under the influence.
CRISIS team appear to use deficit based approach
when DD people are in crisis.

Lack engagement techniques, struggle to track down
hard to reach clients.

People with multiple needs. Transient homeless. Street drinkers. Early years trauma. Undiagnosed mental health. Long term self medicating. Institutionalised within CJS. Sexually exploited. Isolated. A&E frequent Flyers. No access to GP.

Drug treatment often identify people are self medicating
to deal with MH

Staff often don't have the training to manage a MH crisis.

Staff don't always get the response they want



Front Line commissioned, 3rd sector and Charites

Gateshead Dual Diagnosis group

People with mental behavioural diagnosis and substance misuse problems have reported difficulty in accessing services to address their complex needs. Although guidance refers to 'diagnosis' it is vital that the focus is on the needs of people with dual problems. People with dual needs experience problems in many diverse ways with varying degrees of severity and may require different services to help them.

The Gateshead Dual Diagnosis group sets out to look at ways to help individuals, families, providers and commissioner's work together to respond to the complex and changing needs of individuals living with dual diagnosis and to look at ways to work together to meet the needs of the population.

The group comprises people from a wide range of organisations including; Gateshead Council staff from a range of specialties, Newcastle Gateshead CCG, Evolve (Gateshead Drug and Alcohol service), NTW Acute NHS Mental Health Trust, Gateshead Talking Therapies, Voluntary and Community Sector Mental Health providers, Fulfilling Lives, GP lead for Mental Health.

A key challenge faced by services supporting people with multiple needs is that of dual diagnosis, where people are affected by both mental ill health and substance misuse. People find themselves in the catch-22 situation of being unable to access mental health services while they are misusing substances but not being able to get help with their substance misuse due to underlying mental health problems.

The group has met for almost a year and is in the process of developing a Dual Diagnosis strategy and action plan to support the group and partners in developing appropriate support for their clients in the future.

14.14 Access to health services by Homeless people

All UK residents are entitled by law to access primary care services which are free at the point of need, as laid out by the NHS Constitution (DOH 2015). However for homeless people General Practice may not be the routine gateway to health services as it is for the general population. Research by Crisis identified a number of reasons for poor access including GPs requiring proof of address, inflexible services, and personal factors such as low self-esteem, stigma and discrimination. The social skills and lifestyles of homeless people mean that many find it difficult to book and keep appointments (Crisis 2002). People who are homeless also report that they regularly face a lack of understanding about their complex health needs when trying to access healthcare (St. Mungos 2014). Such barriers to health services mean people who are homeless often find it difficult to access primary care and preventative support, only seeking help when their condition has deteriorated to the point at which they need emergency hospital treatment St. Mungos (2014). Evidence suggests homeless people attend Accident and Emergency six times as often as the housed population, are admitted four times as often and stay three times as long (Three Boroughs Homeless Team 2008). Moreover, according to a 2010 report from the Department of Health: “There may be a disincentive for individual primary care trusts to provide good primary care for homeless people where they are a mobile population and the provision of a high quality, easily accessible service may attract users from other areas, putting additional strain on resources” (Department of Health 2010).

Access to health care in Gateshead

In Gateshead services working with homeless people have responded to some of these issues. In 2016 a workshop was delivered to General Practice reception staff in Gateshead to raise the profile of homelessness and challenges around accessing healthcare – an outcome of the workshop was that it was agreed that the Basis @363 service address could be given as an address for homeless people to be able to register with a General Practice. The limited data available for Gateshead suggests that some of the most vulnerable people in Gateshead are not registered with a GP. This needs to be better understood and it would be helpful to consider how those who are not registered can be better identified so that support can be offered for them to do so including addressing any barriers.

Basis@363 Clinical Space and nurse led health drop-in

Funding was identified through Gateshead Council, Public Health and the GP transformation team to develop a clinical space and to run a pilot health drop-in from the Basis@363 premises during their operating hours 9am-2pm one day a week. The aim of the pilot was to provide the opportunity for those who were homeless or in housing need to participate in a nurse led NHS health assessment and to assess the health needs of those accessing this provision.

The drop-in was led by a qualified nurse who was funded to run the health drop-in once a week during the pilot period and offer an NHS health assessment. The pilot commenced in January 2016, approximately 60 individuals were seen by the nurse and 29 completed a

health survey which has been utilised within the HNA. The nurse supporting the drop-in moved to a new post in the summer of 2016 and despite the promising results the health drop-in has stopped. The HNA is making a recommendation for a continuation of the health drop-in and a formal evaluation.

An Insight into accessibility of health services for homeless groups – Gateshead Data

- In Gateshead 34 (35%) of Fulfilling Lives Clients were not registered with a GP
- The Homeless Health Audit – 7% of 69 respondents were not registered with a GP
- Basis@363 Nurse Led Health Drop-In Pilot – NHS Health Check
 - 19 (66%) of 29 respondents were not registered with a GP
 - 14 (48%) reported difficulty in accessing GP services, 5 (17%) reported some problems, and 10 (34%) said it was easy.
 - 23 (79%) had used A&E services in the last 12 months
 - 11 (38%) had used an NHS Walk in Centre in the last 12 months
 - 16 (55%) had used a GP in the last 12 months
 - 12 (43%) had been admitted to hospital for an overnight stay (or longer) in the last 12 months
 - <5 (3%) had used podiatry service in the last 12 months.
 - 12 (41%) had a health check in the last 12 months

Addressing Inequalities in Access to Healthcare

Identification of homelessness is key to improving the healthcare that homeless people receive. However, there is evidence that health staff often remain unaware that a patient is homeless because the patient has not been asked, or fears admitting their homelessness.

A 2010 Department of Health report *Inclusion Health: improving primary care for socially excluded people* (Department of Health 2010) sets out an extensive case for change by outlining the poor health outcomes achieved by socially excluded groups and often high costs of their current patterns of access of services. The report's recommendations are summarised below:

- Acknowledge the issue and gain support at senior level
- Work with partners, including third sector, to:
 - better identify need
 - jointly reduce instability of individuals and make more use of resources
- Be pro-active and employ methods of 'outreach'. Including:
 - the use of advocates/support workers to improve navigation around the system
 - help individuals access treatment by keeping appointments, securing medication etc
- Integrate Services and/or service pathways
- Support (Primary Care) Providers to:
 - train frontline staff
 - make reasonable adjustments to services
 - build networks which support workforce
- Be opportunistic and build services around existing 'touch-points'
- Involve clients from start to finish
- Build in an ethos of continuous improvement for individuals wherever possible

Recent Guidance from Public Health England (2016) includes core principles for health professionals in relation to homelessness. The guidance also sets out some key interventions specifically linked to improving the accessibility of healthcare services. A summary of which is highlighted in the box below, but the full guidance may be accessed here:

<https://www.gov.uk/government/publications/homelessness-applying-all-our-health/homelessness-applying-all-our-health#core-principles-for-healthcare-professionals>

PHE Guidance Improving Accessibility of Healthcare Services

Population Level

- People with experience of homelessness being heard in local commissioning, service development.
- Local health needs audits of the homelessness population inform commissioning and services.
- Local data systems recording information about patients and service users housing circumstances, including homelessness, and this is used to inform integrated, person centred, commissioning and delivery across sectors and services
- Feeding back on access to services and outcomes to local commissioners, as experienced by homeless patients or other homeless service users.

Community Level

- Audit access to primary care by people experiencing homelessness, in partnership with people with lived experience and the local Healthwatch.
- Commissioning healthcare provision, including mental health care, that engages people who are experiencing homelessness, whether this is rough sleeping, insecure housing in the private sector and, is appropriate, through outreach to hostels.
- Commission integrated provision for people leaving hospital, other health institutions or prison, and/or putting in place protocols for timely referrals to services, to enable smooth transitions from institutions to safe and suitable housing in the community.
- Identifying and addressing missed opportunities for improving health, such as breaking the cycle of substance misuse
- Providing volunteer opportunities and/or employing people with experience of homelessness delivering services.

Family and Individual Level

- Enquiring about a households housing circumstances as a matter of course, and ensuring this is recorded
- Providing holistic screening and health assessment (using tools such as the QNI health assessment)
- Providing person centred interventions for an extended period of time for those who do not respond to brief interventions
- Supporting individuals to attend appointments and engage in treatment (this may benefit from involvement of peers)
- Ensuring that individuals with deteriorating health and increasing need are identified and receive adequate (social care) support.
- Checking homeless patients are registered with a GP and receive primary health care, vaccinations and screening programmes.
- Contributing to and providing holistic assessments for people at high risk of, or experiencing, homelessness
- Building trust with patients

15. Stakeholder Consultation

A stakeholder consultation event was held on 5th July 2016. It was targeted primarily at those with responsibility for policy making, commissioning, providing, delivering and evaluating services for those experiencing homelessness and multiple and complex needs in Gateshead. The event was also attended by service users and experts by experience who also delivered some of the presentations.

In total the event was attended by 83 individuals, representing 30 organisations from across academic, statutory, community and voluntary services. A full list of organisations attending the event is provided in Appendix G.



“Excellent event highlighting the need to see people as individuals and think creatively about how to support them”.

Aim of Stakeholder Event

The aim of the event was to provide insight into the system and service response to homelessness adults with multiple and complex needs and to contribute to the formulation of the Health Needs Assessment recommendations.

Methods

The consultation Event was planned and led via a sub group of the Health needs Assessment Working Group with representatives from Public Health, Housing Services, Fulfilling Lives, Local Authority Commissioning and Quality Assurance, North East Athletic and their experts by experience.

A deliberative consultation event approach was selected as an effective way of obtaining qualitative insights from representatives from the housing, criminal justice, community and voluntary and health and care system in Gateshead. The research involved a half day deliberative event where there was a mix of plenary speakers and round table discussions. The plenary speakers were chosen to reflect a range of national and local perspectives about homelessness and multiple and complex needs and between them they had direct experience of receiving, commissioning and delivering services and studying the issues within academia. A consultation event programme with details of the speakers and event format is available in Appendix H.

The deliberative event approach used for this part of the HNA had the advantage of providing people with information about accessing and delivering services from a range of perspectives. This helped to stimulate discussion and support reflection, debate and perspectives about the questions being posed.

Participants were organised in groups of 8-10 individuals sitting at round tables to facilitate discussion and each round table was supported by a facilitator who also documented responses as they emerged.

“Good event with a good range of participants giving perspective that will, if taken forward, make a huge difference to the lives of very vulnerable people”

Responses were then analysed and themes were identified and organised under the question headings. These themes are presented in Appendix G.

These themes were then reviewed and distilled further by the Health Needs Assessment Working Group at a session held on 30th November 2016. The working group also considered a number of reflective questions which had emerged from the Health Needs Assessment. The output of this session is presented in Appendix G. A number of key messages were then identified from the analysis process.



Consultation Questions

During the course of the event participants were asked to consider the following four key questions linked to the service response to homelessness and multiple and complex needs.

1. In relation to the current service response to this group, what is working well?
 - What assets do we have in Gateshead that can be used for the benefit of this group? (eg. Skills, provision, ways of working, physical environment)
 - Examples of good practice?
2. What challenges do you face in responding to the needs of individuals with multiple and complex needs?
3. What do we need to do differently – what would an effective ‘perfect’ response look like?
 - What opportunities are there to do this?
 - How do we find solutions in current climate of austerity and reducing budgets?
 - What principles are important for this client group?
4. What outcomes would you expect to see?
 - How will we know if we are being effective? The so what question
 - How do we capture what really matters to the individual?

Key Messages from the Consultation Process

Key Message for Policy Makers

1. Involve those with experience of homelessness and multiple and complex needs genuinely and explicitly in policy making, where it affects them.
2. Address the root causes of homelessness and multiple and complex needs by make prevention and early intervention explicit across all policy areas in Gateshead.
3. Develop a system wide workforce development strategy to ensure that the workforce has the appropriate skills, attitudes and knowledge to support the inter-related needs of individuals with multiple and complex needs.
4. Policy makers need to build on good work, and join-up assets, budgets and resources within Gateshead to mitigate the impact of austerity.

Key messages for Commissioners

1. Integrate and join-up commissioning processes across health, care, housing and the criminal justice system in Gateshead to address homelessness and multiple and complex needs.
2. Integrated commissioning needs to be co-produced and genuinely and explicitly involve those with experience of homelessness and multiple and complex needs as well as involving providers of services.
3. Commissioners need to be more flexible and long term about measures of success (Outcomes, KPIs and Targets) and create opportunities for service providers to co-produce and agree outcomes that matter to the users of their services.
4. Commissioners need to respond to gaps in local data collection about homelessness and multiple and complex needs as well as removing any unnecessary and wasteful data collection requirements.

5. Commissioners need to commission services that can respond to multiplicity of need and in particular address the gaps identified in access to mental health support.
6. Commissioners need to ensure the provision of a range of suitable and high quality accommodation choices within Gateshead which are integrated with care and support pathways to enable recovery and positive health and well-being.

“Systems that some of the most deprived people in our communities have to work their way through are so complex that they require people employed as Navigators to help them understand what’s on offer and then to access the services.”

Key Messages for Service Providers/Managers of Services

1. Develop a single point of access and single assessment process for those with multiple and complex needs
2. Develop a lead practitioner role which can bridge across health, care, housing and criminal justice and support smooth transitions between services.
3. Develop information sharing protocols across health, care housing and criminal justice.
4. Services need to be assertively accessible and available 24/7 not Monday to Friday 9-5.
5. Improve access to services and develop service thresholds which enable prevention and early intervention
6. Homeless individuals with multiple and complex needs require support that is flexible, consistent, and needs-led and is able to ‘stick’ with them for as long as they need.

“By moving away from a one size fits all delivery model and understanding that failure should be a learning opportunity for providers not a bridge burnt for service users. Too often a failed stay in accommodation marks the service users ‘chaotic’ when in reality it is the provider who has failed to give an opportunity for the client to succeed.”

Key Messages for Front Line Staff

1. Listen to the person you are there to support and develop interventions which respond to the aspirations, needs and potential of that individual.
2. Involve people with lived experience.
3. Work holistically by recognising the multiplicity of needs and build on the individual’s strengths and assets.
4. Be non-judgemental and create a no blame culture.
5. Be a reflective practitioner and access support and supervision to continually improve your practice.
6. Recognise and be proud of what you do well and be honest if you do not know something.



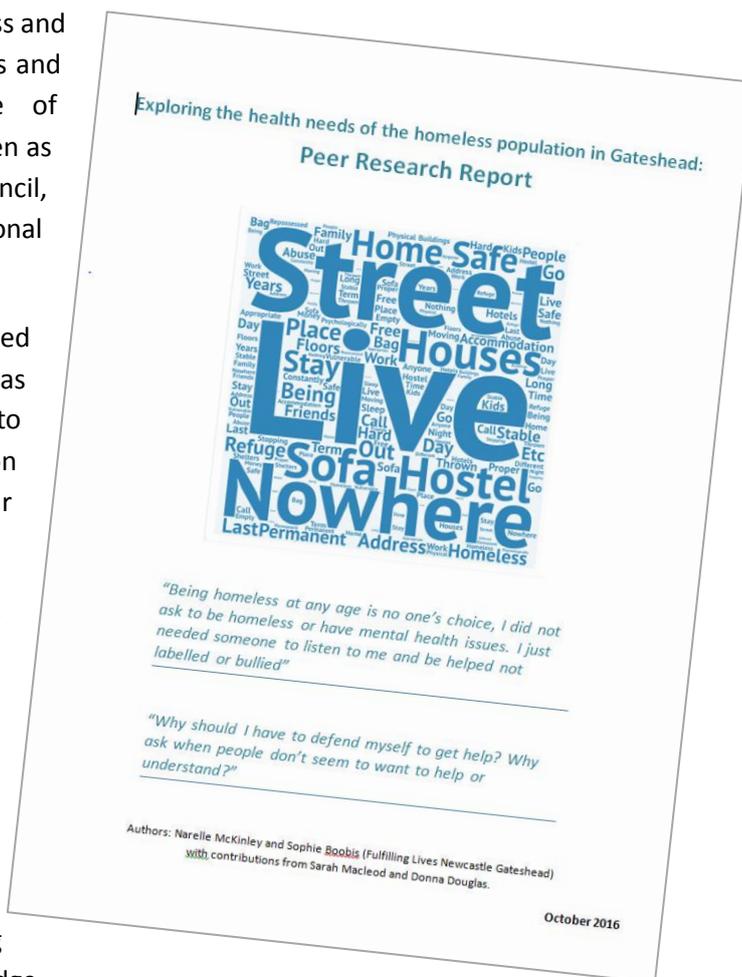
“Much needed event to share ideas, good and bad experiences to learn from as professionals. Looking forward to collated ideas and suggestions. Good for networking and to meet people”

16. Peer Research – Qualitative Findings

Peer Research was an integral part of the HNA process and was used as a method to help understand the views and perspectives of people with lived experience of homelessness. This aspect of the HNA was undertaken as a collaborative project between Gateshead Council, Fulfilling Lives and Fuse, the Centre for Translational Research in Public Health.

The approach was an entirely peer led and developed research programme which produced a report that has looked to identify the causes leading up to homelessness, and the barriers that this population encounters in accessing support with a particular focus around health services.

The solutions offered by those individuals interviewed directly during the research process relate to the themes identified through exploring the journey to homelessness. They identify certain practical recommendations such as easier access to health care services through reducing the need for permanent addresses and postcodes, or more diverse service locations but threading through the recommendations for both health care and housing services is the request for staff to listen and not to judge.



“They see a label and a complicated history and immediately see a problem not a person. People are scared by mental health and addiction but need educating not to judge”

The full peer research report is available in Appendix I of the HNA.

17. Making Homelessness a rare event and effectively supporting those with Multiple and Complex Needs.

There is no single magic bullet solution to homelessness and while there are numerous examples from across the country of good practice interventions, homelessness remains a serious and enduring issue in the UK. The aim of this section of the HNA is to highlight some key areas of understanding that may be important in order to make homelessness a rare event and effectively support those with multiple and complex needs.

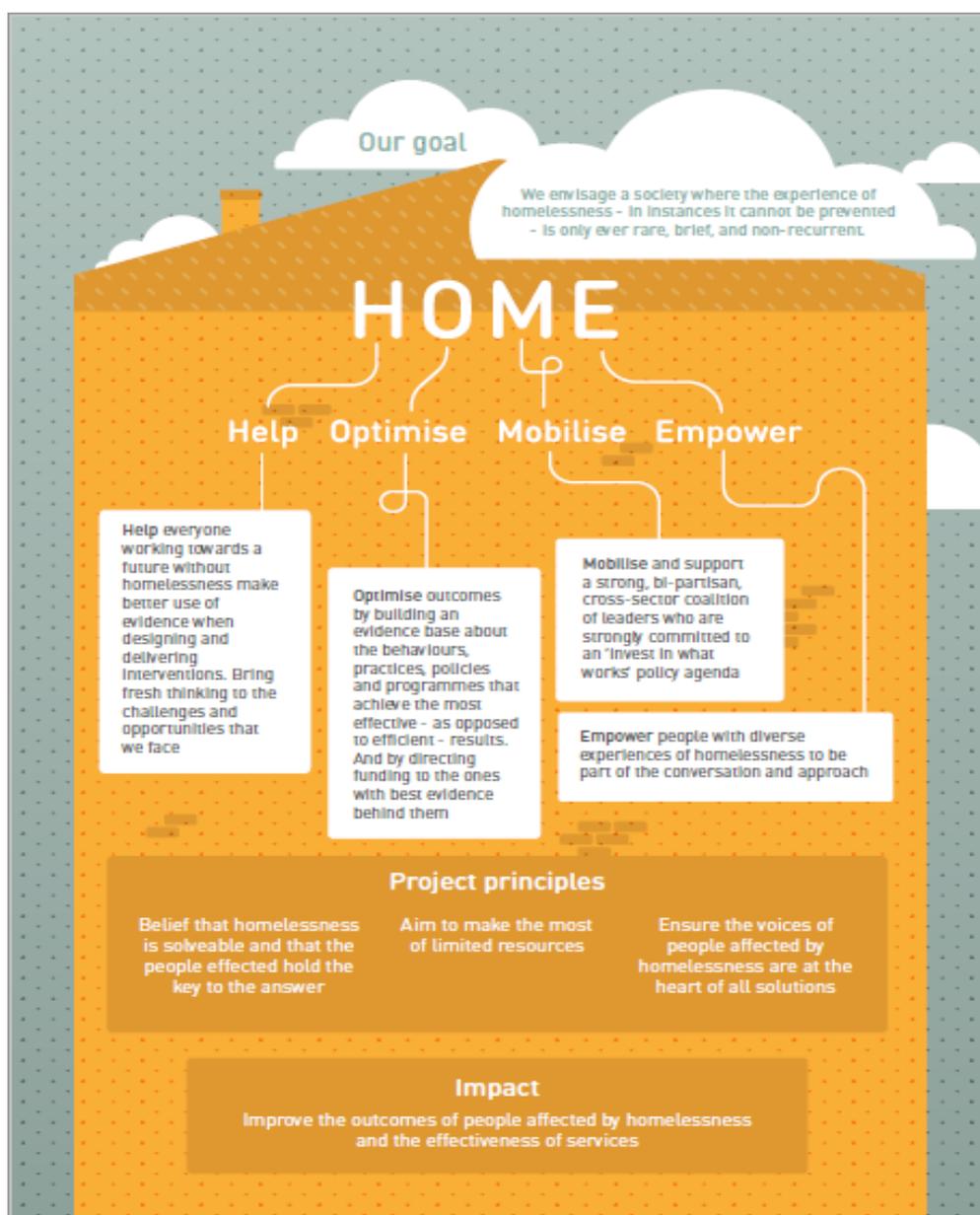
17.1 Focusing on What Works and Harnessing the Power of Data

Stakeholders and organisations working to address the issue of homelessness and associated health and social problems recognise that we need to get better at building and using the evidence base and focusing on what works. Harwich et al (2017), highlight that in order to deliver better value for money there is a need for greater development of the knowledge base and dissemination of expertise.

“A surprising number of people continue to experience homelessness despite a one billion pound infrastructure designed to deal with the problem.” (Teixeira 2017)

In Scotland, a new widely supported proposal, led by Crisis and Glasgow Housing Network is calling for a new Centre for Homelessness Impact which will provide a dedicated coordinating centre for homelessness research. The business case for this Centre (Teixeira 2017) acknowledges that finding effective solutions to end rather than manage homelessness, and changing ways of working is not going to be easy. However, the work to inform this proposal introduces some key principles that could be argued are worthy of consideration when developing local solutions to this issue. These are detailed in the infographic to the right.

It should be recognised that it will take time for commissioners and providers to be able to reap the full benefits of the research produced by ‘what works’ centres (Harwich et al 2017).



There is also a key place for developing a local evidence base and allowing time and space for learning and understanding to take place and influence accordingly. There is also an important opportunity to consider how the full potential of current data and analytics is harnessed. This includes increasing the quality of data and making better use of what is already available that could lead to more effective public services at lower costs to taxpayers (The Stationary Office, 2016).

17.2 Preventing Homeless

Prevention and early intervention are the most cost effective and harm minimising policies for confronting homelessness. The benefits of prevention are clear; averting issues before they occur not only increases the wellbeing of individuals but also reduces the demand for services (Department for work and pensions, 2011). Reintegration costs increase sharply after somebody becomes homeless (European Commission 2013).

Under the [Homelessness Act 2002](#), local housing authorities must have a strategy for preventing homelessness in their district. The strategy must apply to everyone at risk of homelessness, not just people who may fall within a priority need group for the purposes of [Part 7](#) of the Housing Act 1996. Authorities are also encouraged to take steps to relieve homelessness in cases where someone has been found to be homeless but is not owed a duty to secure accommodation under the homelessness legislation.

- ‘Homelessness prevention’ means providing people with the ways and means to address their housing and other needs to avoid homelessness.
- ‘Homelessness relief’ is where an authority has been unable to prevent homelessness but helps someone to secure accommodation, even though the authority is under no statutory obligation to do so.

Gateshead’s Homelessness Prevention Strategy is available at

<https://www.gateshead.gov.uk/DocumentLibrary/housing/strategy/homeless-strategy-consultation/Homelessness-Strategy-2013.pdf>

Despite the focus on homeless prevention strategies such as those in Gateshead and across the UK interventions are still not early enough to assist people before a crisis and before homelessness becomes entrenched (Mackie 2014). Such approaches are not orientated towards tackling the root causes of homelessness and the wider determinants of health. This is emphasised in the opposite diagram which is taken from the Homeless Hub, a Canadian research and information centre for Homelessness. The diagram is used to show how effort has been focused towards ‘managing’ homelessness through an investment in emergency services. A more

Prevention



strategic response will retain the emergency services (because people will still experience crises that lead them to lose their housing) but shifts the focus to prevention, and moving people out of homelessness. A key element of prevention is a willingness to invest in services today, to save money in the longer term however, Harwich et al (2017), highlight how the current commissioning framework acts as a barrier to prevention because different services are being designed by different commissioning bodies who are failing to act together and in the most effective manner. Their report suggests that fragmented responsibilities and the inability to reap the reward of interventions when they accrue elsewhere in the system has failed to incentivise commissioners to design services

which prevent problems within and across service areas. Contributing to this is poor information sharing, differing priorities and a lack of clarity as to who is responsible for interventions or outcomes.

The Health and Wellbeing Board acts as a key link between the local authority and the CCG and may be well placed to provide system leadership to consider the issues and challenges which need to be overcome in order for prevention to be enabled and incentivised. This is likely to require the joining up of different commissioning priorities and funding streams to enable the whole care needs of homeless adults with multiple and complex needs to be addressed. This is identified within the recommendation chapter of the HNA (Chapter 18).

17.3 Primary, Secondary and Tertiary Prevention

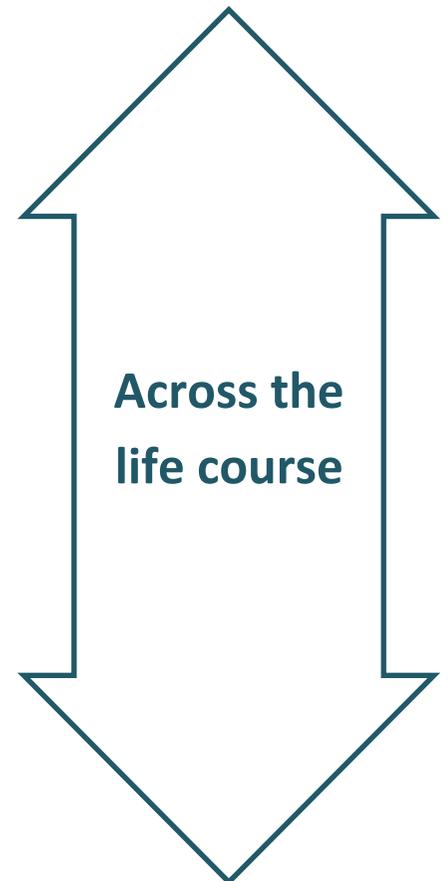
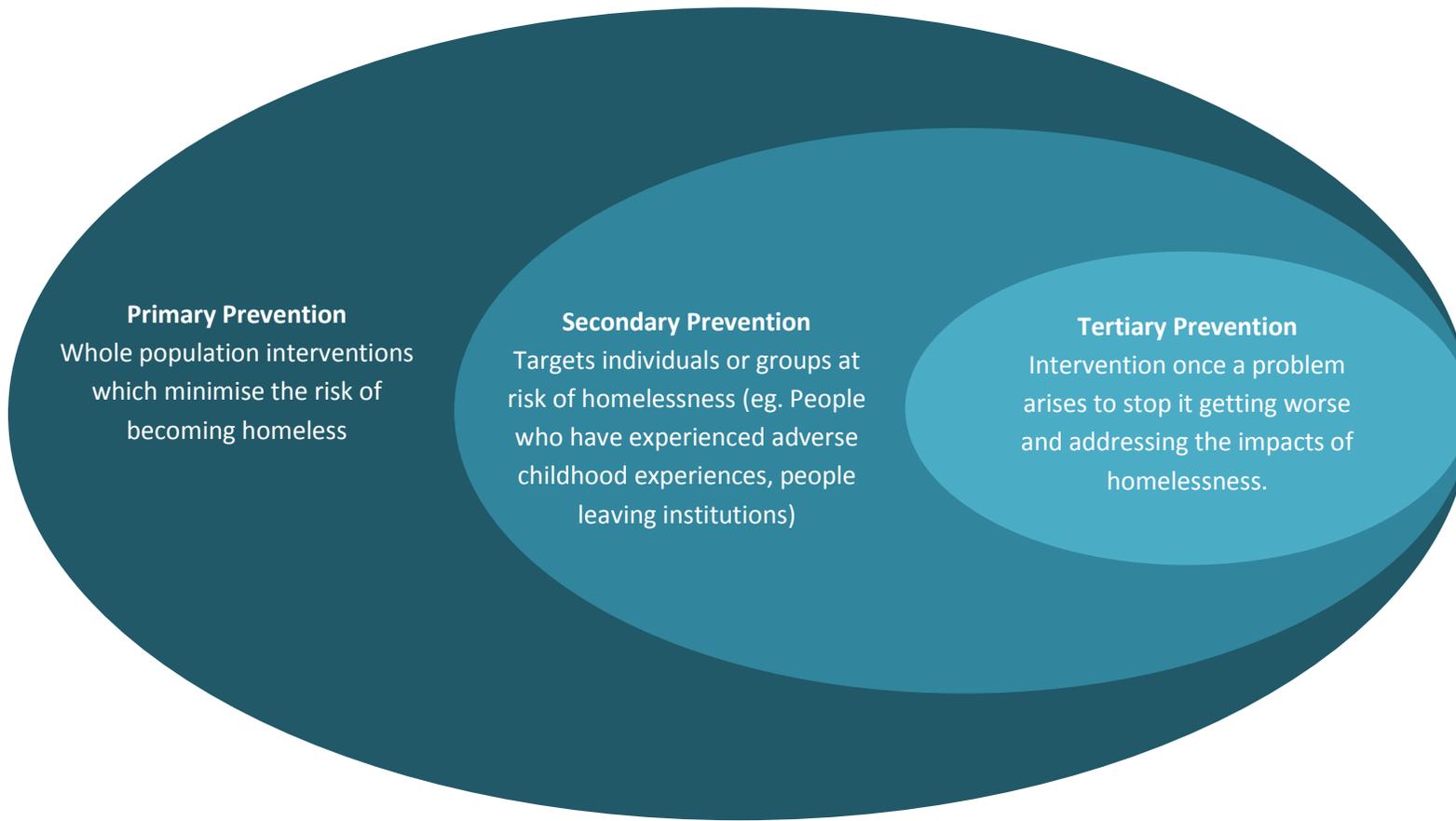
One way of understanding Homeless Prevention strategies is on a continuum with three levels; primary, secondary and tertiary prevention. The table below details how we may plot interventions at each of these levels and may be a helpful starting point in reviewing where activity needs to be emphasised and what this may look like. It can be hypothesised that if there was a successful shift in focus towards primary prevention there would be a reduction over time in those requiring secondary and tertiary interventions.

Primary Prevention	What does this look like?
Whole population interventions which minimise the risk of becoming homeless.	<ul style="list-style-type: none"> • General Prevention programmes to reduce the risk of homelessness through structural measures that are part of welfare, housing, employment, education and family related policies (European Commission 2013) • Affordable Housing in suitable locations (Mackie 2008). • Good coordination between welfare, housing and homeless policies (European Commission 2013) • Policies to tackle a lack of truly affordable housing, rising rents, cuts to benefits and local services (Teixeira 2017) • Poverty reduction strategies, mental health promotion, preventing tobacco/nicotine, drug and alcohol addiction, employment protection, skills and career development, life skills, financial skills, housing pathway planning, early childhood supports, housing education in schools. • Carers Support, Volunteer Programmes and asset based approaches that draw on community strengths and corporate social responsibilities (Diamond and others 2014) • National statistics and research must provide a better understanding of the scale and underlying causes of homelessness, and what actions are successful in achieving sustainable outcomes to avoid the on-going costs and damage of repeat applications for assistance (Shelter 2016).
Secondary Prevention	What does this look like?
Targets individuals or groups at risk of homelessness (eg. People who have experienced childhood disadvantage, people with mental health problems, people leaving institutions, families in poverty)	<ul style="list-style-type: none"> • Increased recognition of the childhood experiences that lead to homelessness and multiple and complex needs and understanding the critical intervention points (Peer Research Chapter 16). • Improved understanding within children and family services of routes into homelessness. Key services such as mental health and alcohol and drug treatment and recovery are critical to this approach (McDonagh 2011). • Timely family counselling and prevention of early school leaving can help avoid youth homelessness (European Commission 2010). • Early intervention for people with mental health problems (particularly by the age of 14) has also been proven to have significant health benefits for the individual and later costs associated to a person's mental ill health if support is not commissioned early enough for example through lost working days, poor physical health and potential substance misuse (Complex Needs and Dual Diagnosis All Party Parliamentary Group 2011) • Counselling, assistance with job seeking and finding housing as-well as follow up support may help to prevent homelessness among those leaving institutions (European Commission 2013)

	<ul style="list-style-type: none"> • Identifying tenants in difficulty and timely contact with tenants when they are starting to encounter problems (European Commission 2013) • Accessible housing options information and assistance for 'at-risk' groups (Shelter 2016) • Target individuals or groups at risk of homelessness, or in crisis situations which are likely to lead to homelessness (e.g. Loss of employment, serious health deterioration, relationship breakdown, risk of eviction) (Shelter 2016) • Early access to integrated, low intensity support, including personalised counselling and guidance, mediation between tenants and landlords, financial institutions and authorities are the cheapest ways to reduce evictions (European Commission 2013). • Early intervention to reduce the flow from other areas (e.g. hospital) (Shelter 2016).
Tertiary Prevention	What does this look like?
Intervention once a problem arises to stop it getting worse and addressing the impacts of homelessness.	<ul style="list-style-type: none"> • Housing First (Homeless Link 2016) • Individualised professional support for multiplicity of needs (Gateshead HNA Stakeholder Consultation 2016) • Address acute mental distress: Psychologically informed environments (Gateshead HNA Consultation Event 2016) • Mainstream healthcare provision could be adapted to better meet the needs of homeless people, so that unnecessary emergency care use can be avoided (FEANTSA, 2006) • Direct intervention to save the home or help with rehousing (Shelter 2016) • Must meet personal needs and include safeguards for the vulnerable (Shelter 2016)

The infographic on the following page illustrates what prevention may look like.

Making Homelessness a Rare Event in Gateshead



Poverty reduction strategies, mental health promotion, preventing tobacco/nicotine, drug and alcohol addiction, employment protection, skills and career development, life skills, financial skills, housing pathway planning, early childhood supports, housing education in schools.

Improved understand within children and family services of routes into homelessness. Key services such as mental health and alcohol and drug treatment and recovery are critical to this approach (McDonagh 2011).

Housing First (Homeless Link 2016)
Individualised professional support for multiplicity of needs (Gateshead HNA Stakeholder Consultation 2016)



Focus on what works... harness the power of data... listen early and listen well... outcomes focus... peer support... integration

17.4 What should good service design for people who have complex needs look like?

The HNA stakeholder consultation event and peer research have provided some important messages which should be taken into account when developing services in Gateshead (see chapter 15). These findings should contribute to the local evidence base and have been used to inform the HNA recommendations.

17.5 Improving access to appropriate accommodation and support for people with multiple and complex needs.

The ultimate solution to homelessness is getting access to permanent accommodation (European Commission 2013). However, it is also important to recognise that people with multiple and complex needs may require access to a range of different types of accommodation, whether on a temporary or more permanent basis which provide levels of support which are on a continuum according to need. A qualitative study undertaken by Revolving Doors Agency (Terry 2015), worked with participants with multiple and complex needs to explore key themes of 'a good life'. Housing and the home were identified by many participants as particularly important in their recovery journey. Basic shelter was important but most wanted more from their home and there was recognition that while independent living represented peace and respite for some, others were not yet ready for the responsibility.

In an international review, Pleace et al (2015) highlight some common findings that apply to a wide range of service models and contexts. These findings include a recognition that services that are holistic, highly flexible, able to directly respond to almost any practical, emotional or support need, or to arrange access to appropriate support via case management, are likely to be more effective. The findings show that for some groups, where support needs may be ongoing, or likely to reoccur, there is a case for services being open-ended, offering support for as long as it is needed. Some service models have the option of becoming dormant enabling formally homeless people to live entirely independently if they are able to, but capable of being reactivated if necessary and for some groups support needs may not always be ongoing in which case there may be scope to explore use of shorter-term service models.

Staircase Model of Transition to Independent Living

The current UK approach of transition to independent

Weaknesses of the Staircase Model (Shelter 2008)

https://england.shelter.org.uk/data/assets/pdf_file/0008/145853/GP_Briefing_Housing_First.pdf

- Not all stages in the model are consistently available, and in localities with no direct or quick access hostels there are long waits for housing. Those owed a homelessness duty by the local authority can gain immediate accommodation. However, due to the strict requirements of the legislation, this option will be unsuccessful for many homeless people with complex needs. Equally, this perceived lack of success can deter many of those people experiencing homelessness with complex needs from even attempting to secure accommodation in this way.
- Hostels tend to house a variety of people with widely differing support needs. The communal nature of hostels can create problems for particularly vulnerable homeless people. Conflict with other residents, or behavioural difficulties resulting from people's support needs, can end in eviction, or abandonment of the accommodation, and an inability or unwillingness to return.
- The housing readiness approach may involve continual movement of people through differing types of accommodation as their needs change both positively and negatively. Each stage of this transition can also trigger a recurrence of previous difficulties and create something of a 'snakes and ladders' pathway to independent living.
- Hostels can house problematic drug and alcohol users who are at varying points of addressing their substance use. It is best practice not to mix users at different stages of their support programmes within the same accommodation, because keeping them separate can help to avoid a negative impact of one person's substance use on any progress made by others. Any positive progress made to cease substance use may require a move to alternative accommodation. At best, relapsing back into substance use would result in a return to previous accommodation; at worst, and more likely, it would result in eviction and a return to homelessness. Hostels can be reluctant to house some of the more problematic substance users and being housing ready can often equate to being 'drug/alcohol free'. For some, achieving and maintaining a drug and/or alcohol-free life can take many years to achieve, if at all, and so settled independent housing can become an unachievable goal.

living for those with complex needs is described as a 'staircase model'. A briefing published by the charity Shelter (2008) provides detail of what the staircase model involves: initial contact with outreach workers or day centres; a move into direct-access hostels; a further move into second stage or specialist hostels (relating to support needs); progression to semi-independent or shared accommodation; and ultimately (once deemed 'housing ready'), taking an independent tenancy, with or without floating support. This model is noted to have helped large numbers of individuals with complex needs to attain independent living however, Shelter also identify a range of weaknesses.

There appears to be a general recognition that although the staircase model can work for some individuals it exposes those with multiple and complex needs to potential stress and dislocation on the different steps of the staircase as they have to readjust to new living environments with new rules, before they are eventually able to have a settled home, which may further reduce their capacity to live alone (European Commission 2013). The evidence reviewed by Pleace et al (2015) suggests that the idea that most long-term homeless people can be trained to live independently in their own homes in an institutional setting appears to be fundamentally flawed. This has led to a keen interest in alternative strategies and in particular Housing-Led policies which have gained inspiration from the Housing First concept, which was developed in the United States.

Housing First Strategies

"The evidence showing that Housing First is more effective and cheaper than the dominant linear treatment model is overwhelmingly positive.....and while Glasgow has recently won strategic commitment it is yet to be introduced on a grand scale anywhere in the UK." (Teixeira 2017)

Housing First are evidence based approaches which operate on the basis that having a home is a basic human right and involve the rapid re-housing of homeless people with complex needs with either secure independent or communal housing that they have been involved in choosing. In Housing First approaches housing comes 'first', without any expectations of the homeless person, ensuring that the homeless person can exercise the same controls as any other citizen can over their own home (Pleace 2012). Support is available to help people maintain a tenancy and to address any needs they identify but this adopts a choice-led approach, which fully respects the choices of each person and supports their self-determination (Homeless Link 2016).

There is no single definition of Housing First; however in 2016 Homeless Link launched principles for Housing First in England which drew on evidence from the USA Pathways to Housing Programme and the FEANSTA Housing First Guide Europe (www.housingfirstguide.eu). The Core Principles adapted for England are as follows:

1. People have a right to a home
2. Flexible support is provided for as long as it is needed
3. Housing and support are separated
4. Individuals have choice and control
5. An active engagement approach is used
6. The service is based on people's strengths, goals and aspirations
7. A harm reduction approach is used

The overall philosophy of Housing First is to provide a stable, independent home and intensive personalised support and case management to homeless people with multiple and complex needs (Homeless Link 2016).

Evaluations from the approach in Glasgow and Renfrewshire, support international evidence that Housing First provides the best model to resolve homelessness in 80% of those with complex needs (Johnson 2013). Figures from both the US and Canada have shown remarkable savings through applying the Housing First concept, in relation to emergency accommodation use, inpatient stays and less involvement with the police and criminal justice system (Pleace 2012). A recent evaluation undertaken by York University of nine English Housing First Services (Bretherton

and Pleace 2015) showed high levels of success in reducing repeated and long-term homelessness, which is associated with very high support needs:

<https://www.york.ac.uk/media/chp/documents/2015/Housing%20First%20England%20Report%20February%202015.pdf>

The successes of these English Housing First Services reflect positive evaluations in North America and Europe. Homeless Link (2016) recommends that providers adhere to the core principles as closely as possible in order to provide high quality and successful Housing First services.

17.6 Peer Support

A position paper produced by FEANSTA (2015), highlights that an increasing number of homeless services are developing peer support and peer worker roles. Peer support is well recognised by professionals in mental health and addiction services, where peer support has been widely used over the past few decades and considerable knowledge has emerged about the approach. The paper notes that the few studies into the effectiveness of peer support in the field of homelessness so far show the positive impact of peer support and benefits for service users, peer workers and both homelessness and health services. A review undertaken by Barker and Macguire (2017) assessed the effectiveness of peer support as an intervention with young adults and adult homeless persons. Ten studies were identified involving 1,829 participants. Peer support was found to have significant impacts on quality of life, drug/alcohol use, and social support. Common elements of peer support were identified, suggesting possible processes that underlie effective peer support. Shared experiences, role modelling and social support are suggested to be vital aspects of peer support and moderate changes in homeless clients.

17.7 Integrating Housing, Health and Care

Given the diverse, wide ranging causes of homelessness and multiple and complex needs integrated approaches which join up prevention, services and responses is needed. A report by The European Commission (2013) highlights why good cooperation between social and health services can reduce service and administrative costs and increase efficiency of outcomes. Integrated models can ensure coordination between relevant authorities and services and allow for the tracking of service take-up which can be used to calculate future spending. The report states that whilst this approach would contribute to tackling homelessness, mutual benefits of service improvement would be felt across policy areas.

The way in which different sectors can further integrate and work together on this shared issue has been the subject of renewed attention. In part this has been influenced by financial factors and ongoing pressing concerns regarding the costs of poor housing upon individuals, wider society, the economy and the public purse. The contribution of housing to the care and support system is formally recognised in the Care Act 2014 which came in to force on the 1st April 2015. The NHS five year forward view (NHS 2014) recognised that people's health and care cannot be met by the NHS alone and called for closer cooperation among services that support health and wellbeing. How this opportunity for integration is being translated on the ground is the subject of ongoing attention and is likely to be an important feature of effective solutions to address homelessness in Gateshead.

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Gateshead Drug Related Deaths Annual Report 2015

Contents

Overview	3
Gateshead Drug Related Death Process	4
Gateshead Deaths in Numbers	5
Themes	6
Key learning	7
Actions 2016/17	8
Implementation	10
Action Plan 2016/17	13

OVERVIEW

Drug use and drug dependence are known causes of premature mortality, with drug poisoning and overdoses accounting for nearly one in seven deaths among people in their 20s and 30s in 2013.

The latest figures from the Office for National Statistics (ONS) on deaths related to drug poisoning (involving both legal and illegal drugs) and drug misuse (involving illegal drugs) in England and Wales for the last five years (2009 to 2013) indicate that there has been an increase of 21% in reported DRDs.

Nationally male drug misuse deaths (involving illegal drugs) increased by 23% and female drug misuse deaths increased by 12%. Male mortality rates significantly increased in three substance categories: heroin/morphine, benzodiazepines and paracetamol. Conversely female mortality rates remained relatively stable except for a sharp increase in the cocaine-related death rate.

Heroin/morphine remains the substances most commonly involved in drug poisoning deaths, with over half (56%) of all deaths related to drug poisoning in 2013 involved an opiate drug. Deaths involving tramadol have continued to rise (2.5 times the number seen in 2009).

For the last ten years the North East mortality rate for drug related deaths (DRDs) has been consistently higher than the rate for England and Wales. The North East had the highest mortality rate from drug misuse in 2013 at 52.0 deaths per million.

The context in which an acute DRD happens is often complex and there are many contributory factors; however DRDs are preventable. Public Health England (PHE) and the former National Treatment Agency (NTA) have published guidance documents that provide a framework for the prevention of DRDs, which includes a process for reviewing and learning lessons from DRDs at a local level and on a case by case basis.

The DRD review process is recognised as an important component in preventing further DRDs.

GATESHEAD DRUG RELATED DEATH PROCESS

Gateshead has a robust DRD review process which is complemented by a multi-agency DRD Panel.

The purpose of the DRD Panel is to carry out case reviews following on from a DRD in Gateshead, to establish whether there are lessons to be learnt from the case about the way in which local professionals and agencies work and to make recommendations on both clinical practice and non-clinical policy and practice to reduce the risk of DRDs in the future.

The DRD Panel is a multi-agency group that meets bi-monthly and carries out inquiries into each death where drugs are suspected to be a direct cause of death of a person in Gateshead.

Key activities of the Gateshead DRD Panel are:

- To ensure agencies contribute to the collection of data when required for the purposes of Drug Related Death Inquiries.
- To receive summary reports from the Safer Communities Co-ordinator following on from a drug related death in Gateshead.
- To review questionnaires and reports provided by agencies as part of the Drug Related Death Inquiry.
- To draw conclusions relating to a drug related death in Gateshead.
- To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together.
- To identify recommendations on both clinical practice and non-clinical policy and practice to reduce the risk of drug related deaths in the future.
- To ensure the recommendations form part of the Harm Reduction Action Plan.
- To ensure recommendations and lessons learnt as part of the Drug Related Death Inquiry are cascaded to all relevant agencies.
- To ensure cooperation with any parallel investigations of practice, for example, a mental health homicide or enquiry by the Local Safeguarding Children's Board resulting from a drug related death in Gateshead.
- To review the process for carrying out Drug Related Death Inquiries, and where necessary as a result of this make changes to the protocol.
- To ensure that the group works effectively and reports to the Joint Commissioning Group and Community Safety Partnership.
- To ensure the production of an annual report summarising recommendations resulting from the reviews is produced and presented to the Community Safety Partnership.
- To deal with any emerging issues relating directly or indirectly to this work.

GATESHEAD DEATHS IN NUMBERS

17 Drug related deaths
Increase from 6 in 2014

The average age is increasing – 35 years (from 32 in 2014)
Oldest was 49
Youngest was 23
0 young people

13 Males
4 Females

15 people resided in Gateshead

8 lived alone
5 lived with someone else
2 were homeless
1 was in a bail hostel
1 was in a hostel

1 had recently been released from prison

The majority (6) died in the Central area of Gateshead
9 died at home
7 died at a friend's house
1 died in a tent

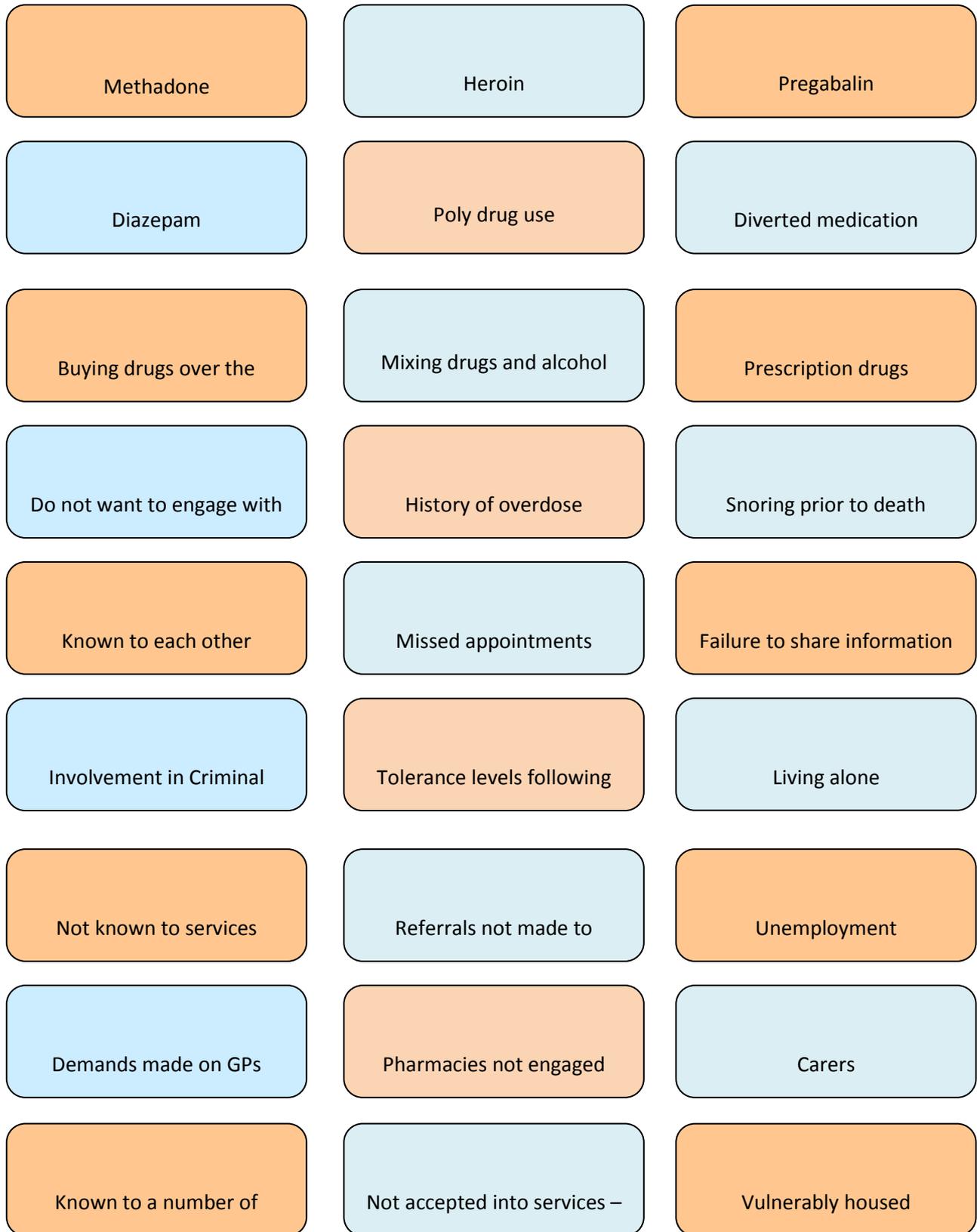
14 were unemployed

6 were in drug treatment
9 were known to drug treatment
8 were not known

1 died on a Friday
3 died on a Saturday
2 died on a Sunday
3 died on a Monday
4 died on a Tuesday
3 died on a Wednesday
1 died on a Thursday

THEMES

A review of the 2015 DRDs highlighted the following common themes.



KEY LEARNING

Duty Screening Tool

A referral was made to the Drug and Alcohol service (Evolve) on a Friday afternoon for poly drug use. The welcome appointment was made for the client for the following Wednesday. The client died before the appointment took place.

Evolve have since introduced a duty screening tool to ensure that new referrals have telephone contact at point of referral to discuss the reasons for referral in order to highlight any risks at time of referral. This is to allow for a brief intervention of harm reduction advice to be provided at initial contact and if the individual is highlighted as high risk at point of referral their assessment could be prioritised and arrangements made to make the assessment earlier.

Take Home Naloxone

In response to the number of drug users who had overdosed Gateshead treatment service began the roll out of take home Naloxone to service users.

Prenoxad Injection is the first presentation of naloxone to be licensed for emergency use in the community – in the home or other non-medical setting by appropriate individuals for the complete or partial reversal of respiratory depression induced by opioids. The process advocates use alongside the ambulance service call out and gives valuable intervention in this situation, alongside basic life support.

Drugs Management Policy

Partners recognised the links between homelessness, housing issues and drug related deaths and so, in response to this a Drugs Management Policy for support accommodation premises was implemented.

The policy provides staff in supported accommodation with the necessary tools and guidance to effectively deal with incidents involving drugs – rather than evict a person in the first instance.

The policy details what actions should be considered to prevent the loss of accommodation and how best to support clients with substance misuse problems and those in recovery. There is clear evidence to show the importance of stable housing in tackling addiction and to sustain recovery which is why it is important to try and prevent the loss of accommodation.

ACTIONS FOR 2016/17

Following the review of the cases and themes, the following actions for 2016/17 have been identified in order to prevent future drug related deaths:

DRD Process

- Gateshead Carers should be part of the DRD process
- Gateshead pharmacies should be part of the DRD process
- Refresh of the DRD inquiry process and questionnaires
- Review of information sharing processes to ensure there are no gaps between agencies

Communications

- Regular marketing campaign across Gateshead to promote treatment services and referral routes
- Publicise the dangers of buying drugs across the internet
- Appropriate publicity to raise awareness of the harms involved in taking cocktail of drugs and mixing drugs with alcohol
- Ensure agencies known who they can make referrals to when a client has multiple issues
- Be responsive to emerging drug trends and issues within the community
- Develop and promote referral pathways into Gateshead Carers

Harm reduction/Overdose awareness

- Regular safe injecting and overdose prevention sessions are available to all drug users in Gateshead
- All service users are given information about reducing the harms related to drug use and that the risks associated with mixing drugs are clearly explained including alcohol and drugs, poly drug use and diversion of medication with other drugs
- All service users are informed about the risk of using illicit methadone and other prescription drugs
- All service users are aware of the signs of overdoses in particular loud snoring
- Awareness raising with carers and community members about the dangers of diverting medication

Workforce Development

- Annual training session for supported accommodation providers
- Regular harm reduction and overdose awareness sessions for frontline professionals
- Regular overdose awareness sessions for frontline professionals
- Regular overdose awareness sessions for carers
- Ensure each service has a thorough disengagement process and be assured that this information is shared with all agencies involved

Dual Diagnosis

- Continue to highlight relevant cases to the dual diagnosis group
- Undertake a needs assessment of most vulnerable people known to DRD group agencies
- Investigate the possibility of funding to work with people with complex needs, based on the needs assessment
- Identify a different way of working with people with dual diagnosis
- Contribute the re-commissioning of mental health and treatment services

GPs/Prescribers

- Individual case summaries to be sent to the prescriber for review, wherever a prescriber is identified
- Re-establish regular Shared Care sessions to highlight cases and share learning where a prescriber has been involved
- Prescribers being aware of potential for misuse and diversion of medication by patients, especially when prescribing Pregablin, Gabapentin, Benzodiazepines and Opiates
- Work with GPs in order to understand the way in which they deal with patients who make demands for certain medications
- Work with GPs to understand how they would share concerns regarding a vulnerable drug user

Take Home Naloxone

- Evaluation of Take Home Naloxone pilot
- Roll out of take home Naloxone in prisons

Reflective practice

- Individual cases are shared with prescribers and GPs where they have been recently involved in a case prior to death
- DRD Panel has a regular slot at Time in Time out sessions to highlight cases and share learning
- Where an individual is not from Gateshead ensure that services in other areas are made aware of lessons learned

Near Misses

- Establish a near miss referral pathway so that those who have overdosed are referred into drug treatment and receive appropriate support

Implementation

The DRD Group will work in partnership with the Substance Misuse Group and others to deliver the actions outlined above. Gateshead Community Safety Board will be responsible for overseeing the delivery of the actions and will receive regular reports on progress.

Drug Related Death Panel Action Plan 2016/17

Ref	Action	Who	By when	Status/Update
1. Drug Related Death Process				
1a	Gateshead Carers should be part of the DRD process	Nicola Johnson	May 16	Complete
1b	Gateshead pharmacies should be part of the DRD process	Alice Wiseman	June 16	
1c	NTW should be part of the DRD process	Alice Wiseman	June 16	
1d	Job Centre/DWP should be part of the DRD process	Nicola Johnson	June 16	Complete
1e	Refresh of the DRD inquiry process and questionnaires	Nicola Johnson	February 17	
2. Communication				
2a	Marketing campaign across Gateshead to promote treatment services and referral routes – to services and potential clients	Racheal Taylor	July 16	
2b	Appropriate publicity to raise awareness of the harms involved in taking cocktail of drugs and mixing drugs with alcohol	Lee Hansom	July 16	
2c	Be responsive to emerging drug trends and issues within the community	All	As and when	
2d	Regular safe injecting and overdose prevention sessions are available to all drug users and carers in Gateshead	Rachael Taylor	As required	
2e	Ensure agencies known who they can make referrals to when a client has multiple issues	Nicola Johnson	June 16	
3. Harm Reduction				
3a	Awareness raising with carers and community members about the dangers of diverting medication	Helen Hughes	June 16	
3b	Annual training session for supported accommodation providers	Kate Stockdale	May 16 Annually	
3c	Review of Drugs Management Protocol	Mark McCaughey	September 16	
3d	Regular drug and overdose awareness sessions for professionals in Gateshead	Rachael Taylor	As required	
3e	All service users and carers are aware of the signs of overdoses in particular loud snoring	Rachael Taylor Faye Codling Helen Hughes	July 2016	
4. Workforce Development				
4a	Services to review disengagement process and ensure there are communication channels to appropriate agencies	All	August 16	
4b	Develop and promote referral pathways into Gateshead Carers	Helen Hughes	August 16	
4c	Highlight the role of carers to professionals, in particular GPs and Pharmacies	Helen Hughes	September 16	

Ref	Action	Who	By when	Status/Update
5. Naloxone				
5a	Extension of Naloxone	Jazz Chamley	November 16	
5b	Evaluation of Take Home Naloxone	Rachael Taylor Joy Evans	November 16	
5c	Roll out of take home Naloxone in prisons	Rachael Taylor Joy Evans	March 17	
6. Dual Diagnosis				
6a	Highlight relevant cases to the dual diagnosis group	Nicola Johnson	At each meeting	
6b	Identify a different way of working with people with dual diagnosis	Alice Wiseman	October 16	
6c	Undertake a needs assessment of most vulnerable people known to DRD group agencies	Alice Wiseman	October 16	
5d	Examine current pathways, protocols and policies for those needing both mental health and substance misuse services.	Alice Wiseman	October 16	
5e	Contribute to the re-commissioning of mental health and treatment services	Alice Wiseman	October 16	
5f	Explore the creation of a charter/agreement that no client can be closed for disengagement reasons, whilst they are still involved with (other) providers across the system.	Alice Wiseman Jazz Chamley	October 16	
7. GPs/Prescribers				
7a	Understand the way in which GPs deal with patients who make demands for certain mediations	Alice Wiseman	July 16	
7b	Understand how GPs would share concerns regarding a vulnerable drug user and ensure pathways to services are in place	Alice Wiseman	July 16	
7c	Re-establish Shared Care meetings	Rachael Taylor	August 16	
7d	Review take Home Methadone policy: <ul style="list-style-type: none"> Pharmacies to be trained in OD awareness. Pharmacies to hold Naloxone. 	Alice Wiseman	November 16	
7e	Undertake a Clinical Audit of Shared Care arrangements	Alice Wiseman	October 16	
8. Reflective Practice				
8a	Individual cases are shared with prescribers and GPs where they have been recently involved in a case prior to death	Alice Wiseman (Chair)	Following each case	
8b	Identify gaps in provision for vulnerable clients who require housing	Mark McCaughey	September 16	
8c	DRD to receive regular updates from the supported accommodation substance misuse and offending sub group	Mark McCaughey	At each meeting	
8d	Facilitate 2 x annual Time in Time out sessions re DRD process, cases and learning, misuse and diversion of mediation	Nicola Johnson	April 17	

Ref	Action	Who	By when	Status/Update
8e	Individual case summaries to be sent to the prescriber for review, wherever a prescriber is identified	Alice Wiseman	Following each case	
9. Near misses				
9a	Establish a near miss referral pathway so that those who have overdosed are referred into drug treatment and receive appropriate support (including clients who have disengaged)	Dale Healey Nicola Johnson Rachael Taylor	June 16	
9b	Explore system that allows GP's to be notified when someone has been admitted to hospital with suspected OD, with a view to a GP meds review for over medicated clients.	Alice Wiseman	November 16	

This appendix to the HNA identifies some of the key policies, frameworks and guidelines which are influential to the overall health and wellbeing of those who are homeless with multiple and complex needs and considers some of the key drivers to addressing their health and care and support needs.

Acts of Parliament

The Statutory Homeless System in England

The Housing Act (1977) introduced the duty upon Local Authorities to be responsible for the long term rehousing of some groups of homeless people. Today these duties are primarily laid out in part 7 of the England and Wales Housing Act 1996 as amended in the Homelessness Act 2002 (see section 4 of the HNA). The Homelessness Act (2002) requires local authorities to review homelessness and its causes in their area and develop a strategy for tackling it.

Change to the legislative model?

Currently there is speculation that the Government is looking to introduce a new duty to prevent homelessness, along the lines of that introduced in Wales (Wilson & Barton 2016). The Welsh Prevention Duty places a duty on local authorities to help prevent homelessness and to provide private rented accommodation to all households regardless of priority need, local connection or intentionality. In 2015 CRISIS established an independent panel to consider the strengths and weaknesses of the current homelessness legislation in England, with a particular focus on how single homeless people are supported by it. The Panels finding were published in 2016 and they recommended a new legislative model to:

- Place a stronger duty on local authorities to help prevent homelessness for all eligible applicants regardless of priority need status, local connection or intentionality.
- Extend the definition of threatened homelessness from 28 days to 56 days to provide local authorities with more flexibility to tackle homelessness at a much earlier stage and;
- Place a new relief duty on local authorities requiring them to take reasonable steps to help to secure accommodation for all eligible homeless households who have a local connection (CRISIS 2016)

Gateshead Council has strategic responsibility for meeting legislative requirements under the Homelessness Act 2002, with homelessness services provided by Gateshead Housing Company. This is an arms length company which delivers homelessness services, housing options and advice and operates the social housing register.

The Localism Act (2011)

The 2011 Localism Act introduced a raft of local government reforms across finance, planning, and governance as well as significant changes to the Housing Act 1996. The stated policy objective is to enable local authorities to better manage housing demand and access to housing within the context of local circumstances. Important reforms to social housing and homelessness include:

- The right for local authorities to grant fixed term tenancies
- Greater flexibility in the allocation of social housing which allows local authorities to set allocation policies appropriate to the local area
- Discharging homelessness duties by making use of available accommodation in the private rented sector.
- The Act also changed the statutory succession rights of new tenants, restricting the right to the partner of the deceased tenant.

The Homelessness Monitor is an annual report funded by Crisis and the Joseph Rowntree Foundation with the aim of providing an independent analysis of the impacts of policy on and economic changes on rates of homelessness. In

the 2015 Homeless Monitor Report (Fitzpatrick et al 2015) concerns were expressed that changes introduced by the Localism Act (2011) may weaken the sector's safety net function, and may also impact negatively on community stability and work incentives. For example there are concerns that the ability of landlords to issue time limited tenancies for as little as two years, could mean lack of security for tenants who need stability.

Welfare Reform Act (2012)

Since 2010 there has been considerable reform of the welfare system reducing the level of support for low income households and those at risk of homelessness;

- **Under occupancy charge or 'bedroom tax' – introduced 1 April 2013:** Council and housing association tenants and those in temporary accommodation of working-age who claim housing benefit get less housing benefit if the council decides they have 'spare' bedrooms. This will result in a shortfall between the rent due and the benefit paid. Local Authorities can provide a discretionary housing payment to cover the shortfall.
- **Benefit cap – Introduced from April 2013:** There is a cap on the total amount in benefits that people of working age can claim. The cap is £500pw for couples and lone parents, and £350pw for single adults. The cap applies to the combined income from the main out of work benefits plus Housing Benefit, Child Benefit and Tax Credits.
- **Shared room rate for under 35's – introduced January 2012:** The amount of housing benefit payable for single people under 35 was restricted and based on the single room rate – the rate of a room in a shared house. Any single tenants occupying a one bedroom flat and receiving housing benefit are required to meet any shortfall. Automatic entitlement to housing benefit will be removed for 18-21 year olds from April 2017.
- **Council tax benefit reduction – Introduced April 2013:** The amount of council tax benefit is no longer worked out according to a national formula and has been replaced by localised Council Tax Support Schemes. Those under the age for getting Pension Credit are not protected and may no longer receive a full rebate.
- **Universal Credit – Introduced from October 2013:** is a single means-tested benefit which will be paid to people of working age. It will replace most means tested benefits for people who are out of work and tax credits for people in work. It is expected to be delivered 'digital by default'. People will be responsible for paying their rent and council tax, which could see an increase in levels of rent arrears for registered providers and increased levels of eviction of tenants and homelessness as a result.
- **New conditions about looking for work – introduced from April 2013:** Those out of work or in work on a low income will be required to sign a new claimant commitment which will set out a number of work-related requirements to be met before benefit can be received. If these are not met sanctions can be applied in the form of stopping benefit payments for a period of time.
- **Personal Independence Payment replaces Disability Living Allowance – Introduced from June 2013:** Personal Independence Payment (PIP) is a benefit for people who have a long-term health condition that means they have trouble getting around or need help with daily living activities. This is based on how a person's condition affects them, not on the condition they have. It will eventually replace Disability Living Allowance for people aged 16 to 64.
- **Parts of the Social Fund abolished – Introduced April 2013:** parts of the social fund have been abolished, including Community Care Grants and Crisis loans. This funding stream has been a key component in the prevention of homelessness and the resettlement of homeless people, providing access to funds to purchase essential household items and assistance with removal costs. In its place, responsibility for this type of support has been devolved to local authorities who have been given a budget and may choose to spend on replacement schemes.

Measures relating to welfare reform continue to unfold however, many households' incomes have been reduced. Financial pressures can result in homelessness, particularly where these relate to rent or mortgage arrears. In addition the cumulative effects of a number of benefit cuts can impact upon households' ability to pay housing costs. The Homelessness Monitor report (2016) estimated that in overall terms the welfare reform programme took some £19 billion pounds a year out of the pockets of low income households and the economy in 2014/15. The areas most

affected include the older industrial areas of England. The Monitor also described findings of a survey of local authorities carried out in 2015 to identify whether the reforms of the 2010-15 Coalition Government had impacted on levels of homelessness: two thirds (67 per cent) of local authorities in England reported that these changes had increased homelessness locally, with no authorities reporting that homelessness had consequently decreased (Fitzpatrick 2016). Since April 2013, the North East Homeless Think Tank (NEHTT) have been gathering information about the implementation of welfare reform and its impacts on single homelessness in the North East. In May 2014 they published their initial findings which indicated a significant relationship between welfare reform and single homelessness. Evidence collected by the authors suggest that changes to housing benefits, the localisation of Council Tax benefit schemes and Social Fund, and the application of stricter requirements for work-related benefits are putting single households at greater risk of homelessness as well as reducing the likelihood of single homeless people achieving and sustaining independence (NEHTT, 2014).

Health and Social Care Act 2012

The Health and Social Care Act 2012 introduced the first statutory legal duties on NHS commissioning organisations to have regard to the need to reduce health inequalities in access to and outcomes achieved by services, and to integrate services where this will reduce inequalities. These are particularly relevant to service provision for marginalised groups such as the homeless population with multiple and complex needs.

Gateshead Health and Wellbeing Board is a statutory body introduced under the Health and Social Care Act (2012). The Board includes representation from the local health, public health and care system as well as related public services and it is responsible for leading locally on reducing health inequalities.

The Care Act 2014

The contribution of housing to the care and support system has been recognised in the Care Act 2014. This is a significant piece of legislation which came into force on 1st April 2015 replacing several existing laws with the aim of creating a single consistent route to establishing an entitlement to publically funded care and support in England. The Care Act aims to improve people's quality of life, delay and reduce the need for care, ensure positive care experiences and safeguard adults from harm. Part one of the Act and its statutory guidance set out the duties for Local Authorities and their partners which include new rights for service users and carers. The Act and its guidance clearly recognises the influence physical aspects of housing and socio-cultural sense of home and community have on the health and wellbeing of its population. The Act identifies the need for closer working and integration between housing, health and care and support services. The following points are of particular note in relation to this:

- A general duty to promote wellbeing makes reference to suitable accommodation
- Housing not just the 'brick and mortar' also includes housing related support or services
- Housing must be considered as part of an assessment process that may prevent, reduce or delay an adult social care need
- Information and advice should reflect housing options, as part of a universal service offer
- Care and support delivered in an integrated way with cooperation with partner bodies, including housing

The Housing and Planning Act (2015-16)

The Housing and Planning Act which became law on 12 May 2016 contains a wide range of measures to expand home ownership, reform housing management and the planning process and increase housing supply to tackle the housing crisis in England. The Act's main focus upon boosting home ownership may be at the expense of affordable and social housing and concerns have been expressed about the potential impact upon homelessness. The Act contains measures to extend Right to Buy discounts to Housing Association tenants. This policy will extend Right to Buy to 1.3m housing association tenants in England. Compensation to housing associations will be funded by the sale of high value council homes (through a charge levied on councils). The Act also makes provision for tenants with household incomes of £30,000 or over outside of London to pay market rate rents. This pay to stay policy will apply

to local authorities and housing association tenants. Councils will also gain the ability to apply for orders against private landlords. A database of rogue landlords and agents will be set up.

The policy towards more home ownership will not be a realistic option for many social housing tenants. Also by depleting social housing stock there is a risk of pushing the most vulnerable further towards homelessness.

The Homelessness Reduction Bill

- The Bill makes changes to the current homelessness legislation contained in Part 7 of the Housing Act 1996 ("the 1996 Act"), and to the Homelessness (Suitability of Accommodation) (England) Order 2012. It places duties on local housing authorities to intervene at earlier stages to prevent homelessness and to take reasonable steps to help those who become homeless to secure accommodation. It requires local housing authorities to provide some new homelessness services to all people in their area and expands the categories of people who they have to help to find accommodation. The Bills measures include:
 - An extension of the period during which an authority should treat someone as threatened with homelessness from 28 to 56 days.
 - Clarification of the action an authority should take when someone applies for assistance having been served with a section 8 or section 21 notice of intention to seek possession from an assured shorthold tenancy.
 - A new duty to prevent homelessness for all eligible applicants threatened with homelessness.
 - A new duty to relieve homelessness for all eligible homeless applicants.
 - A new duty on public services to notify a local authority if they come into contact with someone they think may be homeless or at risk of becoming homeless.

National Strategies

Laying the Foundation: A Housing Strategy for England (2011)

The Government's Housing Strategy presents the intended direction of travel for housing, its role in the wider economy and its contribution to social mobility. The strategy acknowledged the key challenges posed by tackling homelessness, through issues such as recession, welfare reform and rough sleeping and highlighted the importance of homelessness prevention. Two initiatives have arisen from this Strategy:

No Second Night Out (2011)

This report published by the Ministerial working group for Homelessness sets out the vision to end rough sleeping and a commitment to support the roll out of the principles of No Second Night Out nationally to help people off the streets, to access healthcare, into work and empowering local authorities. The report sets out the Government's approach to homelessness prevention by focusing on the contribution that a commitment around troubled families, health, crime prevention and employment and skills can make. The report calls for central Government, Local Authorities, Government agencies and the voluntary sector to work together to support those at risk of homelessness.

Making Every Contact Count (2012)

The second report by the Ministerial working group was produced to build on the progress made since 'no second night out' by encouraging better cross-service working between councils, health services and the police to focus on earlier support for people likely to become homeless. The aim of the report is to ensure that every contact local agencies make with vulnerable people and families really counts. The report brings together government commitments to:

- Tackling troubled childhoods and adolescence;
- Improving health;

- Reducing involvement in crime;
- Improving access to financial advice, skills and employment services; and
- Pioneering innovative social funding mechanisms for homelessness

Social Justice Strategy: Transforming Lives, 2012

Recognises homelessness has devastating long term effects such as poor mental health, lack of personal development, and contributes towards increasing propensity towards anti-social and offending behaviours. It promotes the principle of prevention where possible, and 'second chances' for those willing to accept help to lift them out of disadvantage.

No health without mental health (Department of Health 2011)

No health without mental health is a cross government outcomes strategy for people of all ages. The strategy identified addressing homelessness and the mental health needs of this group, as a priority for action. The strategy recognises the need to improve access to mental health treatments and support.

Reducing Demand, Restricting Supply, Building Recovery (2010)

This drug strategy recognises the clear association between mental illness and drug dependence. It stresses the importance of mental health and substance misuse services working together in relation to prevention and early intervention as well as in treatment and recovery. As such it recognises the complexity of the relationship between mental health and substance misuse.

NHS Five Year Forward View (2014)

The NHS Five Year Forward View is a wide ranging strategy for the NHS in England. It emphasises preventing ill health, coordinating and personalising services, engaging patients and communities and creating new more integrated models of care.

NHS Five Year Forward View For Mental Health (2016)

The report provides a comprehensive picture of the current priorities and problems in mental health. The report identifies that some groups and life situations are particularly connected with the risk of mental health problems. Employment and housing are identified as major factors in successful prevention and recovery. By 2020/21 Health and Wellbeing Boards should have plans in place to promote good mental health, prevent problems arising and improve mental health services, based on detailed local data for risk factors, protective factors and levels of unmet need. These should specifically identify which groups are affected by inequalities related to poor mental health and be co-produced with local communities to generate innovative approaches to care and improving quality.

Local Strategies

Vision 2030

<http://www.gateshead.gov.uk/People%20and%20Living/communitystrategy/Vison2030.aspx>

Vision 2030 is Gateshead's Sustainable Community Strategy which sets out a vision and programme of transformation for Gateshead based upon six big ideas:

- City of Gateshead
- Gateshead goes global
- Creative Gateshead
- Sustainable Gateshead
- Active and Healthy Gateshead

- Gateshead Volunteers

The Council Plan 2012-2017

The Council Plan 2012 – 17 describes our priorities for Gateshead over the next 5 years. It will focus on:

- Meeting the needs of Gateshead residents and reducing inequality
- Delivering our long term strategy, Vision 2030
- Delivering our ambition of sustainable economic growth and well being
- Focusing on our 'have to do', statutory functions (strategic, democratic, safety)

Gateshead Housing Strategy

<https://www.gateshead.gov.uk/DocumentLibrary/housing/strategy/Gateshead-housing-strategy-2013-18.pdf>

Gateshead Housing Strategy has been developed through a multidisciplinary group within Gateshead Council, involving services with an interest in housing. The Strategy is structured around THREE linked objectives:

- Support – to help residents access and sustain a home which promotes their wellbeing. Preventing Homelessness is a key element of this objective.
- Standards – to improve the quality, condition and management of housing so that all residents benefit from safe, healthy and well-managed homes.
- Supply – to ensure use of existing stock and supply of new housing best meets current and future needs and aspirations.

TEN key challenges have been identified under these three objectives; for each challenge a clearly defined guiding approach is proposed with a supporting set of coherent actions. The strategy will identify how the Council's land, property and financial resources will be used to overcome these challenges, will clarify roles and responsibilities and partnership arrangements and will set out the measures to be used to judge success.

There are a further THREE cross cutting challenges: (i) Establishing effective strategic partnerships; (ii) Moving to a commissioning model for both services and investments; and, (iii) Maintaining and sharing housing intelligence.

Taken together our actions to deal with these challenges will help deliver sustainable homes and communities in Gateshead.

Gateshead Council Preventing Homelessness Strategy (2013 – 2018)

<https://www.gateshead.gov.uk/DocumentLibrary/housing/strategy/homeless-strategy-consultation/Homelessness-Strategy-2013.pdf>

The 2013-2018 strategy has been formulated to continue to work towards the eradication of homelessness. The headline priorities within the strategy are:

- The Property: contributing towards 'increasing and maintaining the supply of good quality housing to meet the needs and aspirations of tenants and residents.
- The People: supporting people to secure and maintain a home and improve their quality of life.
- The Place: making Gateshead a better place to live, and doing so by making best use of our financial, staff and stock resources

Active, Healthy and Well: A Health and Wellbeing Strategy for Gateshead 2013/14 to 2015/16

<https://www.gateshead.gov.uk/DocumentLibrary/CBS/health/Active-Healthy-and-Well-Gateshead.pdf>

Our Health and Wellbeing Strategy 'Active, Healthy and Well Gateshead' sets out a route map on how Gateshead can work towards its ambitious vision for health and wellbeing based on evidence of local needs and evidence of what works. The Strategy has been informed by a wide range of information on local needs brought together by the Gateshead Strategic Needs Assessment (which incorporates the Joint Strategic Needs Assessment). This information was also used as a basis for engagement with partners and local communities. The priorities identified within the strategy are:

- Secure joined-up, person centred services across health and social care – address 'service fragmentation'.
- Make the most of available resources to secure better, higher quality services – shift more investment from expensive hospital care towards prevention, early intervention and community provision.
- Strengthen engagement and build capacity within communities, especially those with the poorest health. Make the most of community assets.
- Make the most of new working opportunities, including those across new geographies.
- Make the most of 'place shaping' opportunities to promote active and healthy lifestyles.

Outcomes Frameworks

The Public Health Outcomes Framework (PHOF) Healthy lives, healthy people: Improving outcomes and supporting transparency

The PHOF sets out a vision for public health, desired outcomes and the indicators that will help us understand how well public health is being improved and protected. The framework concentrates on two high-level outcomes to be achieved across the public health system;

- Increased healthy life expectancy
- Reduced differences in life expectancy and healthy life expectancy

Further indicators are grouped into four domains that cover the full spectrum of public health. The outcomes reflect a focus not only on how long people live, but on how well they live at all stages of life. The document recognises the link between health inequality and homelessness and sets out key indicators under Domain 1 'Improving the wider determinants of health' to meet the outcomes.

Two outcome indicators directly linked to homelessness:

- 1.15i Statutory homelessness – eligible homeless people not in priority need
- 1.15ii Statutory homelessness – households in temporary accommodation

Indicator 1.15i was introduced in 2016. The DOH provided the following explanation for the change:

"Homelessness Acceptances' indicator has been replaced with 'Eligible Homeless People Not in Priority Need'. This will help provide a rounded picture of single homeless people, who often have significant health needs and are not entitled to statutory housing support. Evidence suggests that this group can fall through the gaps of local service provision and their needs become more complex as a result. 'Homelessness Acceptances' was replaced as an indicator as it was difficult to demonstrate whether a high or low figure was good or bad in terms of public health outcomes. Homelessness Acceptance also overlaps with the 'households in temporary accommodation' indicator and broadly speaking measures the same household twice. In order to be placed in temporary accommodation a person will need to be accepted as homeless." (Department of Health 2010)

Outcome Measures Indirectly Related to Homelessness

Wider Determinants of health includes:

- school readiness (1.02)
- pupil absence (1.03)
- adults in contact with secondary mental health services who live in stable and appropriate accommodation (1.06)
- domestic abuse (1.11)
- first time offenders and re-offending levels (1.13)

Health Improvement includes:

- smoking prevalence in adults (2.14)
- successful treatment of drug treatment – opiate users (2.15i)
- successful treatment of drug treatment – non-opiate users (2.15ii)
- successful treatment of alcohol treatment (2.15iii)
- cancer screening coverage – breast cancer (2.20i)
- cancer screening coverage – cervical cancer (2.20ii)
- cumulative % of the eligible population aged 40 to 74 offered an NHS health check (2.22iii)
- cumulative % of the eligible population aged 40 to 74 offered an NHS health check who received an HNS health check (2.22iv)
- cumulative % of the eligible population aged 40 to 74 who received an NHS health check (2.22v)
- average Warwick-Edinburgh Mental Well-being Scale score (2.23v)

Health Protection includes:

- population vaccination coverage – Flu (at risk individuals) (3.03xv)
- people presenting with HIV at late stage of infection (3.04)
- treatment completion for TB (3.05i)
- incidence of TB (3.05ii)

Healthcare and premature mortality includes:

- mortality rate from causes considered preventable (persons) (4.03)
- mortality from communicable diseases (4.08)
- emergency readmissions within 30 days discharge from hospital (4.11)
- excess winter deaths (4.15)

NHS Outcomes Framework

The NHS Outcomes Framework sets out the outcomes and indicators that will be used to hold NHS England to account for improvements in health outcomes. The following domains are identified as having relevance to the HNA target population:

- domain two: enhancing quality of life for people with long-term conditions
- domain three: helping people to recover from episodes of ill health or following injury
- domain four: Ensuring that people have a positive experience of care Improving people's experience of outpatient care

Guidelines

NICE Guidelines

While there are no specific guidelines on homelessness, other guidelines do recognise that there is a relationship between homelessness and specific health conditions including:

- borderline personality disorder: treatment and management (CG78)
- antisocial behaviour and conduct disorders in children and young people: recognition, intervention and management (CG158)
- alcohol-use disorders: Diagnosis and clinical management of alcohol-related physical complications (CG100)
- alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (CG115)
- drug misuse – psychosocial interventions (CG51)
- quality standard for drug use disorders (QS23)
- tuberculosis (NG33)
- advice on HIV Testing (LGB21)
- severe mental illness and substance misuse (dual diagnosis) (in development, expected November 2016)
- NICE Clinical Pathway for Hepatitis B and C testing
- NICE Clinical Pathway for Oral Health Needs Assessment
- quality standard for transition between inpatient hospital settings and community or care home settings for adults with social care needs (QS141)

Guidance

The Gold Standard Programme

The Gold Standard Programme was launched in 2013 by DCLG with the intention of supporting local authorities to improve frontline housing services and increase opportunities for early intervention and prevention. The programme awards local authorities gold, silver or bronze status according to their progress in meeting certain challenges.

Health and Housing Memorandum of Understanding

A central part of the drive for more integration is a pioneering Health and Housing Memorandum of Understanding (MoU) which has been signed by government departments and agencies which include NHS England, professional and trade bodies, and leading learning networks. The MoU sets out a shared commitment to collaborate for health and wellbeing outcomes and details areas of improvement and actions that by working together aims to:

- Establish and support national and local dialogue, information and decision-making across government, health, social care and housing sectors;
- Coordinate health, social care, and housing policy;
- Enable improved collaboration and integration of healthcare and housing in the planning, commissioning and delivery of homes and services;
- Promote the housing sector contribution to: addressing the wider determinants of health; health equity; improvements to patient experience and
- Develop the workforce across sectors so that they are confident and skilled in understanding the relationship between where people live and their health and wellbeing and are able to identify suitable solutions to improve outcomes.

The MoU is linked to a delivery plan with all partners making specific commitments to actions to progress housing integration. This plan has tracked strong progress much of which is driven by Public Health England (PHE) and members of ADASS Housing Network.

Local Guidance

North East Homelessness Think Tank (NEHTT)

The North East Homelessness Think Tank (NEHTT) is a new regional group, comprising academics, researchers and policy officers (from Centrepoin, Youth Homeless North East, Homeless Link, Shelter, Barnardo's, Changing Lives, the Northern Housing Consortium, the Institute for Public Policy and Research North, and Northumbria University, as well as independent specialists). The NEHTT website publishes research outputs, resources and a range of recommendations to address homelessness in the North East.

<http://youthhomelessnortheast.org.uk/nehtt/#>

Commissioning Guidance

Improving access to healthcare for Gypsies, Travellers, homeless people and sex workers (2013)

Produced by the Royal College of General Practitioners and Inclusion Health this is part of the Department of Health's Inclusion Health Programme of work and provides an evidence-based commissioning guide for clinical commissioning groups and health and wellbeing boards.

Standards for Commissioners and Service Providers (2013)

This guidance document produced by the Faculty for Homeless and Inclusion Health sets clear minimum standards for planning, commissioning and providing health care for homeless people and other multiply excluded groups.

Housing First Guide Europe (2016)

FEANSTA, the European Federation of National Organisations have coordinated the production of a guide working with a range of international experts. It aims to support service commissioners, practitioners and policy makers who are implementing or interested in developing Housing First services and strategies. The guide has a dedicated website which includes additional resources and explanatory videos.

<http://housingfirstguide.eu/website/>

NHS Alliance: Housing Just What the Doctor Ordered

The NHS Alliance has recently produced a new resource to help commissioners understand and work with housing organisations (2016). The resource is intended to act as a guide for housing and housing support organisations through the process of developing a relationship with Clinical Commissioning Groups (CCGs), NHS providers and GPs but there are also ideas and resources targeted at CCGs.

<http://www.nhsalliance.org/wp-content/uploads/2015/10/sitra-what-the-doctor-ordered-brochure-print-1.pdf>

Limitations of the Supported Housing Portal Data

The HNA was unable to obtain a comprehensive picture of households referred into and/or accessing supported housing in Gateshead. A number of limitations with regard to the way data on supported housing use was collected was highlighted. In relation to the Portal data it is entirely dependent on which services are contributing data and currently not all supported housing providers are registered with the portal. Some Schemes which are being commissioned by Gateshead Local Authority chose not to be part of the Portal. There are other schemes who are not commissioned by Gateshead Council (e.g. Phoenix Futures) who do help the Portal by offering accommodation. This particular scheme will also take referrals from other sources as they are not commissioned by anyone. In addition to this, there will be supported housing providers in Gateshead and neighbouring authorities who are not commissioned by Gateshead who are also not part of the portal. Some of the main limitation of the Portal data were discussed with the Housing Options Team. This feedback is collated below:

- **Participation:** Some schemes are not part of the Supported Housing Portal. They deal with their referrals directly with referrers and clients therefore this valuable support and accommodation may not get offered to the vulnerable people that need it.
- **Direct referrals:** Schemes that **are** part of the Portal should never accept direct referrals outside of the Portal as this causes problems with the coordination of referrals and the maximisation of the chances of the person being referred into the most appropriate schemes to find accommodation. It also discourages fair access into the schemes and 'queue-jumping' if people have been waiting
 - **Referrers:** There are instances where professionals will contact the schemes directly and arrange admittance of a client. They will then send through a Portal referral as a courtesy. This causes problems due to other people who may be waiting for supported accommodation and it also allows an assumption that the scheme is suitable. The coordinating nature of the Portal allows referrals to be sent to all appropriate schemes, not just specific ones, with the aim of maximising the chances of someone finding appropriate accommodation. It would be unwise for commissioned supported housing providers to take referrals from both the Portal and directly – there would be no way of tracking outcomes reliably, or clearly demonstrating demand in Gateshead.
 - **People being referred:** Occasionally, clients will approach schemes directly – again, professional referral is n and clients should be advised of agencies that can work with them and make a referral on their behalf. The professional can then attempt to gather as much information as possible about their vulnerability and needs
- **Waiting Lists:** The Portal does not manage individual scheme waiting lists. The schemes themselves manage their own waiting lists and have their own methods of doing this. This is another reason why direct referrals and adhoc admittances are a problem.
- **Emergency housing:** Supported Accommodation is not intended to be emergency accommodation and it can often be thought of as such by both internal and external agencies out of desperation to find someone somewhere to live. The purpose of supported accommodation is to stabilise and hopefully prepare a client to be able to take on their own independent tenancy in the longer term. A planned approach to getting a person into Supported Accommodation is therefore needed, not a knee-jerk reaction. However, it is also acknowledged that sometimes there is a small window of opportunity to engage with a vulnerable person. Because of this, Portal referrals are dealt with as soon as they come in and immediately sent to the most appropriate providers.
- **Stand Alone Databases:** Outside of the portal each service provider operates stand-alone database/information systems. The data between the different service providers is not linked and there is no robust way of uniquely identifying service users across the different providers.

Limitations of the Portal Data Recording System

Since the implementation of the Portal in 2011 the problem of an adequate I.T. system and method of accurately tracking referrals and outcomes has been recognised. The Portal itself is currently recorded on annual Excel Workbooks which are used for recording various elements of data to track referrals and outcomes. Each of the individual supported housing schemes have their own methods of tracking referrals and their own waiting list. The lack of a common I.T. system causes problems with accuracy and excessive administrative communications. Referrals and updates are very time consuming and prone to error. There are also information security guidelines that must be followed. A referral pathway and monitoring I.T. system common to Council and all housing providers would present a more robust solution.

Application Process for Supported Housing via the Portal

Where it established an individual is unable to sustain their own tenancy a referral can be made for supported housing via the Portal System. Referrals can come from the Gateshead Housing Options Team following a Housing Options interview or directly from external services. The referral information will be considered by the providers registered with the scheme and a decision will be made as to whether the individual can be accommodated by each provider based upon their own admission thresholds and availability.



Public Health
England

Protecting and improving the nation's health

Drug and alcohol recovery capital grant Application Form 2015-2016

Section 1 – The Project

1.1 Project contact details			
Name of Project	Homelife		
Name of Project Coordinator	Rhiannon Bearne	E-mail	Rhiannon.Bearne@changing-lives.org.uk
Name of parent organisation	The Cyrenians Ltd trading as Changing Lives		
Job Title / Position in Organisation	Assistant Director		
Telephone Number	0191 481 3681		
Organisation Address and postcode	Central Office Textile House Dukes Way Team Valley Gateshead NE11 0LF		
Expression of interest approved by (name of Chief Executive)	Stephen Bell		

1.2 Local authority contact details			
Name of local authority submitting the bid	The Borough Council of Gateshead		
Name of commissioner	Carole Wood	E-mail	carolewood@gateshead.gov.uk
Job title / position in local authority	Director of Public Health		
Telephone Number	0191 433 3066		
Address and postcode	Gateshead Council, Civic Centre, Regent Centre, Gateshead, NE8 1HH		
Is this the local authority in which the provider is based?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
Expression of interest approved by (name of Chief executive)	Jane Robinson		
Expression of interest approved by (name of Director of finance)	Darren Collins		

1.3 Project details

Summary of the project

please make it clear how your bid is underpinned by overarching principles of recovery

Changing Lives, with the backing of Gateshead Council, is requesting capital funding to support the purchase and refurbishment of 14 empty properties to turn them in to homes for rent to people with complex needs including those in recovery from addictions. The properties will be part of Changing Lives' Homelife programme which provides affordable, long-term accommodation for people with histories of homelessness or housing problems. Homelife currently houses 93 people in safe and secure accommodation; 42% of these are defined as having complex needs including experience of drug and alcohol abuse. Everyone housed by Changing Lives in one of these 14 properties will be offered the opportunity to be supported to access 'Oaktrees', an abstinence based day treatment centre based in Gateshead and run by Changing Lives, or other local substance misuse services.

Changing Lives already plays an important part in the treatment and recovery system in Gateshead. We deliver the Oaktrees and Recovery Centre projects which together provide non-residential, abstinence-based help for people looking to move on from alcohol and substance misuse. Changing Lives understands that recovery is a **process** through which an individual is enabled to **move on** from their problem of drug and alcohol use through a **commitment to abstinence** and becoming an **active member** of society. We provide people with the tools to make this progress, giving them the support to maintain abstinence long-term (as an alternative to managed addiction). We recognise that there are a variety of areas that people in recovery need help with; finances, employment, relationships – and in particular housing in order to make that recovery sustainable.

Across Changing Lives we have 467 clients per annum going through our abstinence-based recovery programme at Oaktrees with 60.7% having a positive move on. In the year prior to treatment at Oaktrees on average each of our current cohort of clients:

- Had 14 interventions from acute NHS (ambulance &/or A&E) services and/or the police per year
- 3.4 alcohol related ambulance attendances per year
- 3.6 alcohol related treatments at A&E per year
- 1.6 arrests involving being detained per year

The range of costs per client is £3,256 - £11,411 per year prior to treatment.

We have a strong track record of supporting people with complex needs to live independently. Since 2012 we have refurbished and rented 89 homes, providing over 175 people and their families, with a safe and secure place to live. The programme is supported through a funding mix including; Homes and Communities Agency income, contributions from independent trusts and foundations, as well as match funding from Changing Lives. All properties are rented at the nationally defined affordable limit of 80% of market rates and the programme includes a small tenancy support team which prioritises people with needs related to Changing Lives' services including experience of addiction and recovery.

This proposal will build on the lessons learnt from Homelife tenancies to date, as well as Denmark St, Gateshead, a Changing Lives' four bed accommodation project which has been ringfenced for people in recovery treatment for the last five years. We are requesting £20k match funding per property to purchase 14 flats/houses in the Gateshead area. These will be made available to people in recovery. Based on experience to date we are confident that these tenancies will be filled by clients from our own services and those of similar agencies, including local social services teams. All referred tenants will undergo the Homelife assessment process to ensure they are fully prepared for independent living, and have the necessary networks of support to maintain a positive, long-term tenancy for at least 6 months. To date 79% of Homelife residents have maintained their tenancy for at least 6 months.

Changing Lives' focus on recovery actively advances the 2010 National Drug Strategy, the first wide-ranging policy attempt to put recovery at the heart of the substance misuse agenda. It makes clear that a life free from drug and alcohol dependency and prescribed alternatives should be a legitimate aim for everyone. This proposal specifically supports the Strategy's recommendation that housing services have a key role to play to 'increase ambitions for recovery' and address the need for housing

and homelessness providers to work jointly with drug treatment organisations to promote good practice.

What are the key milestones and deliverables?

Please note several of these deliverables are concurrent as the project will be based on a rolling programme of 3-4 purchases per quarter.

1. March - Sept 2016 – Property searches underway in local area. Changing Lives Trustee approves all decisions to purchase in line with the charity’s financial approval procedure.
2. April – Dec 2016 – Rolling programme of purchases underway, delivering 14 properties by March 2017
3. Jul 2016 – Mar 2017 - Properties passed to refurbishment partner Mears Group plc for renovations, decoration and kit out. Mears Group plc was contracted through an open tender exercise at the start of 15/16 for the Homelife programme.
4. Sept 2016 – Mar 2017 – Referrals received on a rolling basis from Changing Lives’ own services and those of other local recovery and treatment providers
5. Oct 2016 – Mar 2017 – 14 x families let Homelife properties and offered support from Changing Lives’ local recovery services
6. Mar 2017 – First 6 month reviews completed with project tenants, assessing progress with any areas of need during the initial phase of their tenancy

Please outline the delivery timetable for the project

This timetable assumes a rolling programme of 3-4 purchases per quarter. Based on Homelife experience to date the average time between identifying a property and it becoming available to let is 12 weeks.

	Mar 2016	Apr-June 2016	Jul-Sep 2016	Oct-Dec 2016	Jan-Mar 2017
Property search					
Appraisal and Trustee approval to purchase					
Offer including surveys and legal instruction					
Refurbishment					
Tenant referrals received					
Properties let and tenanted					

Please provide the value of capital funding you are bidding for

£280,000

Please provide details of any match funding from other sources

Homes and Communities Agency Affordable Home Round 4: £66,000 (confirmed)
 Homes and Communities Agency Affordable Home Round 4: £275,000 (anticipated)

Several bids for capital and revenue funding are also currently in progress to the value of £817,280 to programmes such as the Big Lottery Power to Change fund and the Monument Trust. The current Homelife scheme has been underpinned by a contribution from Changing Lives’ reserves and loan finance. Any shortfall in capital grants raised for the 14 properties will be supported in the same way.

Please provide a clear financial breakdown of how the funds will be used

Please use the embedded template and return with your application form



Budget Template.xlsx

Will the arrangement by the local authority (in order to have a clear oversight of the proposed asset created from the project) include a legal charge? If so please state the intended length of the charge. If not, please include what the arrangement will be (e.g. Memorandum of Understanding).

This bid has been jointly agreed and is endorsed by the Council. To ensure that there is robust governance in place, if the bid is successful, the Council will enter into a legally binding agreement with Changing Lives under which the grant terms and conditions will be passed down to Changing Lives. In addition the Council will take a legal charge over each property purchased using grant funds by Changing Lives.

1.4 Strategic approach to consultation, need and provision

Please provide evidence that the bid is needs-led and supported via service user consultation

The relationship between recovery and housing is well-documented. For example the 2010 National Drug Strategy states that ‘people who suffer from drug or alcohol dependence are at greater risk of cycling in and out of homelessness, rough sleeping or living in poor quality accommodation.’ Homelife properties fill an important gap in the market between over-subscribed social housing and expensive, and often poor quality, private rental provision. Gateshead Council’s review of drug and alcohol treatment (2013/14) identified challenges with appropriate housing for people in recovery as an outstanding issue at the end of the review. The review process included an externally commissioned consultation process to enable people within the treatment system in Gateshead to give their views. In addition to this the review interviewed carers and other professionals who work with people with substance misuse issues. Through this consultation work housing was identified as a particular challenge which was negatively affecting people’s chance of recovery. In response to this the output from the review acknowledged the gap in appropriate housing as part of a person’s recovery journey and on-going recovery capital.

Changing Lives uses a range of techniques to receive regular and meaningful feedback on its services. These include annual client surveys, service development focus groups and involving clients in activities such as staff recruitment. We have identified the need for this project via feedback from:

- The mutual aid network we have helped foster in Gateshead and Newcastle for the past 5 years. 11 twelve step groups are delivered from Changing Lives’ Oaktrees recovery project in Gateshead alone, giving us a rich insight into the needs of the local recovery community.
- Regular feedback from our four 12-week, full-time structured, abstinence-based day treatment centres. Although secure housing is often a pre-requisite of accessing the provision, work with clients has highlighted repeat problems around housing instability, and homelessness risks which can be present in early stages of recovery. Anecdotally we know that, due to the recent changes in the benefits system with the introduction of Universal Credit and increased use of work-related sanctions, need continues to grow.
- Evidence and learning from our abstinence-based housing at Denmark St, Gateshead. This highlights the importance of well-established referral pathways which match clients carefully to appropriate accommodation, based on clear assessment criteria as well as expectations around independent living and ongoing tenancy management.

As described above, 42% of current Homelife tenants are defined as experiencing complex needs, including histories of substance abuse.

Please describe how the project will address gaps in local provision by supporting capital investment in adult community or residential drug or alcohol services

Gateshead’s local Health and Wellbeing Board (HWB) has acknowledged the important relationship between health and housing. As outlined above, the drug and alcohol treatment review identified a

gap in appropriate housing for people in recovery. The need to further develop the Health and Wellbeing Board's understanding of this issue has led to the commissioning of the Homeless Health Needs Assessment (HNA). The HNA includes within its aims, to:

- Identify the overlap between homelessness and other issues associated with deep social exclusion and poor health and wellbeing outcomes.
- Identify the triggers and pathways to vulnerability, assets and what successful support should look like by seeking the views of those with lived experience of homelessness.
- Inform what might be done to ensure more comprehensive ways of working that are better able to tackle homelessness and meet people's needs and aspirations for recovery and well-being.

The above clearly highlights the desire by the HWB partners to understand and meet the needs of the homeless community and there is clear opportunity for the aims of this application to enhance this work.

The DPH Report of 2014, Rethink your drink highlighted:

- The total cost of alcohol-related harm in Gateshead is £82.98 million per year, with a cost to every resident of Gateshead of £433; 1 in 4 residents are estimated to drink at higher risk levels
- The priority to address health inequalities and preventable early death through reducing the use of tobacco and alcohol, improving diet and physical activity, underpinned by the promotion of good mental health and well-being.
- The need to continue to develop improved access to treatment services along with monitoring outcomes, treatment interventions and joining up elements of support across the wider system, including links with employment and housing.
- Housing and social care-related support a key area of plan around alcohol interventions
- The role of Changing Lives' Oaktrees project in the current treatment system

It is vital that this bid, if successful and the resulting housing and support given to those in recovery, would help address this identified need.

Within Changing Lives' own recovery services around 10% of clients at any one time are homeless.

However as the data from the wider Homelife tenant population indicates these figures are likely to be the tip of the iceberg. Addiction, and positive long-term recovery, is affects millions of people in the UK. By prioritising people with poor housing track-records, but with evidence of the ability to maintain affordable tenancies once their addiction issues are effectively managed, the Homelife properties will address these needs of the recovery community beyond shorter-term interventions, and will complement and enhance existing core services and the existing treatment system.

Please describe how the project will be embedded within the strategic commissioning approach and needs assessment of the local partnership

In 2013 Gateshead Council undertook an extensive review of its existing drug and alcohol provision. The result was the commissioning of an integrated treatment service provided by Gateshead Evolve, CRI. This single point of access, assessment and recovery and care co-ordination for all service users seeks to provide a seamless treatment journey. Gateshead Evolve play a significant part in building recovery capital, however, it also depends heavily on the contributions of other health and social care services, housing and employment. Referring to and actively supporting contact with other services and peer support groups is a key tenant of this. Changing Lives is central to this delivery. As outlined in the first section of 1.4 housing for people in recovery has been identified as a current gap.

In addition the recent HNA work has identified homelessness and housing responses as one of the key agendas supporting effective recovery in Gateshead. Housing providers are identified as important in this context and Changing Lives' Homelife proposal addresses both these aspects of need.

This application therefore demonstrates a clear link to the Council's priorities and a strategic commissioning approach which prioritise sustained, long-term recovery within a community context.

Please describe how the project will fit within the wider recovery system, delivering recovery focused drug or alcohol treatment for adults in community-based or residential service

Changing Lives works within the wider recovery services across Gateshead and has established partnerships with treatment providers Evolve, CRI. We will build on the existing pipeline of referrals from sources such as the local adult social care service, as well as our own local Changing Lives' recovery projects, to ensure the properties made available are meeting known needs. In particular,

our tenancy support team will work with existing local recovery providers such as Phoenix Futures to provide opportunities for move on accommodation from their client group.

Demand for greater affordable rental provision is evidenced by the current social housing waiting list in Gateshead. Whilst some of this population is historic and securely housed, work by Gateshead Council's Homelessness Needs Assessment Group suggests there is a population with recovery needs for whom stable housing is a priority. Homelife is already well integrated with the wider recovery system in the area; graduates from our own recovery services often secure Homelife tenancies, as do our peer volunteers from our complex needs services. We work closely with Evolve, CRI and associated support providers such as Aquila Oasis, as part of the local recovery system, so have several well-established referral routes which can be built upon.

1.5 Risks and monitoring

Please provide details of any possible risks to delivery and actions to mitigate these risks

Risk Identified	Mitigating actions
Lack of suitable empty properties available	Refining search based on previous experience and insights. The Homelife team already let 10 properties in Gateshead suggesting supply is good Existing relationships with Council's empty homes team and local property professionals to help identify appropriate properties quickly
Additional costs for property renovations	A full survey prior to completion with renegotiation of price as appropriate A realistic budget for renovations included in funding request
Insufficient capacity in the Homelife team to deliver the agreed milestones and maintain a rolling programme of purchases and lets	There is sufficient capacity within both the purchasing/buying and tenancy support sides of the team to deliver the commitment. All staff are effectively line-managed to ensure progress against personal and project objectives
Insufficient referrals of suitable tenants	The Homelife team has a strong network of referring partners and continues to build this through marketing activities with new recovery organisations and others
Objections from the local community	The privacy of Homelife tenants is a priority and is carefully safeguarded. The tenancy support team is experienced in positive community relation management e.g. networking with local residents and tenants associations where this is appropriate

Please identify the key performance indicators that will be used to measure the success of the project

- A minimum of 14 people with complex needs supported with a Homelife tenancy and offered ongoing recovery support
- 14 additional affordable homes made available for people/households in recovery from addiction
- 14 empty local properties brought back into use

Additional social value will come from the contribution to the regeneration of neighbourhoods in the local area, and increased beneficial relationships between Changing Lives' recovery services, the Homelife Team and local recovery providers in Gateshead.

1.6 Evaluation and sustainability

What processes will be put in place to evaluate whether the project has met its planned outcomes and has delivered value for money?

Gateshead Council has undertaken a homelessness needs assessment and set up a housing working group to monitor progress towards its supporting action plan. This is led by the public health team but is supported by other teams, such as housing. At part of the monitoring arrangements for this bid Changing Lives will provide quarterly updates to the group on project progress and outcomes. Anonymised client data/case studies will also be provided to this group to evidence the types of impacts stable, affordable housing is having for the tenants housed, and to share any lessons learnt. The Homelife team will also work with the Council's housing and growth team to share intelligence on opportunities for purchases to support the Council's wider regeneration and growth strategy.

Changing Lives will capture data on client progress in the following ways. At the start of a tenancy a new tenancy checklist is completed face-to-face with a client, which ensures the right financial and service support is in place to maintain a tenancy e.g. tenants are consistently and effectively engaged with Changing Lives' (or other agencies') support services etc. At six weeks and six month intervals post-tenancy visits are completed by the Tenancy Support team to ensure that the resident is coping well with the tenancy, happy with the property, and to identify if they require any additional support and help to maintain their home. This visit includes completing a satisfaction survey regarding the property, as well as our Client Progress Measure; the Changing Lives' bespoke outcomes measurement tool which provides an objective assessment of client's progress against eight domains of wellbeing, including financial stability. Data from these measures will then be collated and evaluated annually to provide a picture of client need, satisfaction and relative stability within Homelife properties. Finally Homelife will shortly issue its first bi-annual satisfaction survey to all tenants. This will give the Homelife team internal intelligence to inform what future services might be needed, as well as giving an indication of what wider needs Homelife is meeting in the community.

A significant proportion of match investment for this proposal is coming from the Homes and Communities Agency. Their Affordable Home Programme includes stringent assessment criteria around ensuring the properties purchased are; empty for a minimum of six months, refurbished to the national Decent Homes standard as a minimum; purchased in line with local markets rates (which are clearly evidenced in our supporting project plan) and let at the nationally defined affordable market rate (80% of the local rental average). All Homelife purchases continue to meet these criteria and ensure best value for the project.

What processes will be put in place to share learning and best practice emerging from the project?

PHE may wish to share examples of promising practice that emerge from this project. Please briefly outline how learning from this project may be made easily available.

Gateshead Council would be keen to share any learning from this work. Case studies will be distributed through the strategic and operational groups identified, as well as Changing Lives' own communications channels (digital, press and PR), with the HCA through our scheduled monitoring visits, and with treatment providers and others through a range of established panels and commissioning networks. Nationally the Council attends the Housing Associations Charitable Trust networking events for empty homes providers and will profile this work there.

In addition to this, a regional conference could be held, working with PHE, to share the findings of the local HNA on Homelessness with partner agencies and key stakeholders.

(if applicable) Describe how you will sustain the project after the grant funding has ended?

***Please describe how the work of this project will be sustained/supported in future?
Which measures will be taken to ensure that funding is committed to the project on a longer term?***

The Homelife programme is well-established and has a strong pipeline of secure and potential funding in place up until 2018. This includes the existing HCA Round 4 Affordable Homes match for this bid; an opportunity to bid for further Round 4 monies in January 2016; and restricted income from Trusts and Foundations including the Nationwide Foundation. The current project forecast and plan takes Homelife to 2020/21 and 225 properties.

Section 2 – Additional information about the recovery provider organisation

2.1 Organisational and Funding Details

Please briefly outline the aims and objectives of the organisation

Changing Lives is a national charity which provides specialist support services for thousands of vulnerable people and their families, every month. We work holistically, addressing the person, not the problem, and our non-judgemental, person-centred approach enables people to take positive steps toward healthy and fulfilling lives. Changing Lives now works with 6,000 people monthly, helping more people to change their lives for the better.

A large proportion of our clients experience multiple and complex needs, a combination of issues such as substance misuse, offending histories, homelessness and mental health problems. We therefore work with some of the most marginalised and vulnerable groups in both urban and rural settings, tailoring our work accordingly. We operate over 60 services, including providing accommodation, assertive outreach, supporting victims of sexual exploitation and violence, and those recovering from drug and alcohol abuse. We also offer a range of specialist support services for women, services for families and provide a variety of training and employment opportunities for our clients in partnership with local businesses. Around a quarter of our staff are people in recovery.

If this is a joint/consortium provider bid, please list all partners here. If it is a single bid, please check "Not Applicable"

Please list other bid partners

Not Applicable

2.2 If you have applied for, or plan to apply for, other funding sources to obtain support for this proposal, please give details below

Please give details of the funding source(s), the application dates, and the amount(s) applied for. Has a funding decision been made? If not, when do you expect to be notified? If you do not receive the funding what contingency plans do you have in place?

Homes and Communities Agency Affordable Home Round 4: £66,000 (successful Mar 15)
Homes and Communities Agency Affordable Home Round 4: £275,000 (applying Jan 16)

Several bids for capital and revenue funding are also currently in progress to the value of £817,280 to programmes such as the Big Lottery Power to Change fund and the Monument Trust. The current Homelife scheme has been underpinned by a contribution from Changing Lives' reserves and loan finance. Any shortfall in capital grants raised for the 14 properties will be supported in the same way.

Section 3 – Additional information

3. Additional information

Please use this space to provide any additional information you feel is appropriate:

Changing Lives has substantial experience managing capital build projects, having brought in over £8,500,000 of capital income over the last 10 years to build and renovate fit for purpose facilities, including state of the art Places of Change facilities for people who are homeless, one of which was built with service users actively involved as 'self-build'. We have a successful track record delivering capital projects on time and on budget.

We have recently completed a competitive tender exercise and appointed Mears Group as our refurbishment partner for Homelife properties. As part of the tender, Mears is required to provide a range of additional activities and services for Changing Lives' clients. Following appointment we have agreed that they will offer a minimum of 20 x 2 week work placements for clients, with the option to extend these to 6 weeks or more. There is no upper limit on the number of clients they will support. Mears already offer work experience opportunities to several organisations supporting vulnerable

people and they have the experience and understanding of our client group to ensure the programme is tailored to meet our needs.

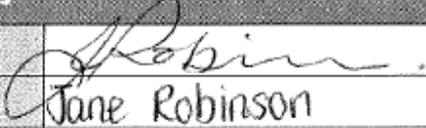
They will also provide:

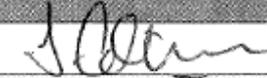
- Interview practice sessions and feedback sessions for clients who are long-term unemployed.
- Access for our clients to their training courses including customer care, DIY, trade days.
- Priority access for Changing Lives' clients who have been on work placement to their apprenticeship opportunities.

Please Note: Applications should be submitted to PHE in Word format only (Excel for budget workings)

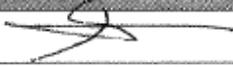
Section 4 – Signatures

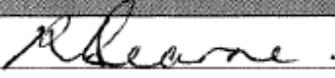
4.1 Local authority director of public health	
Signed	
Name	Carole Wood
Email	carolewood@gateshead.gov.uk
Telephone	0191 433 3066

4.2 Local authority chief executive	
Signed	
Name	Jane Robinson
Email	janerobinson@gateshead.gov.uk
Telephone	0191 433 2050

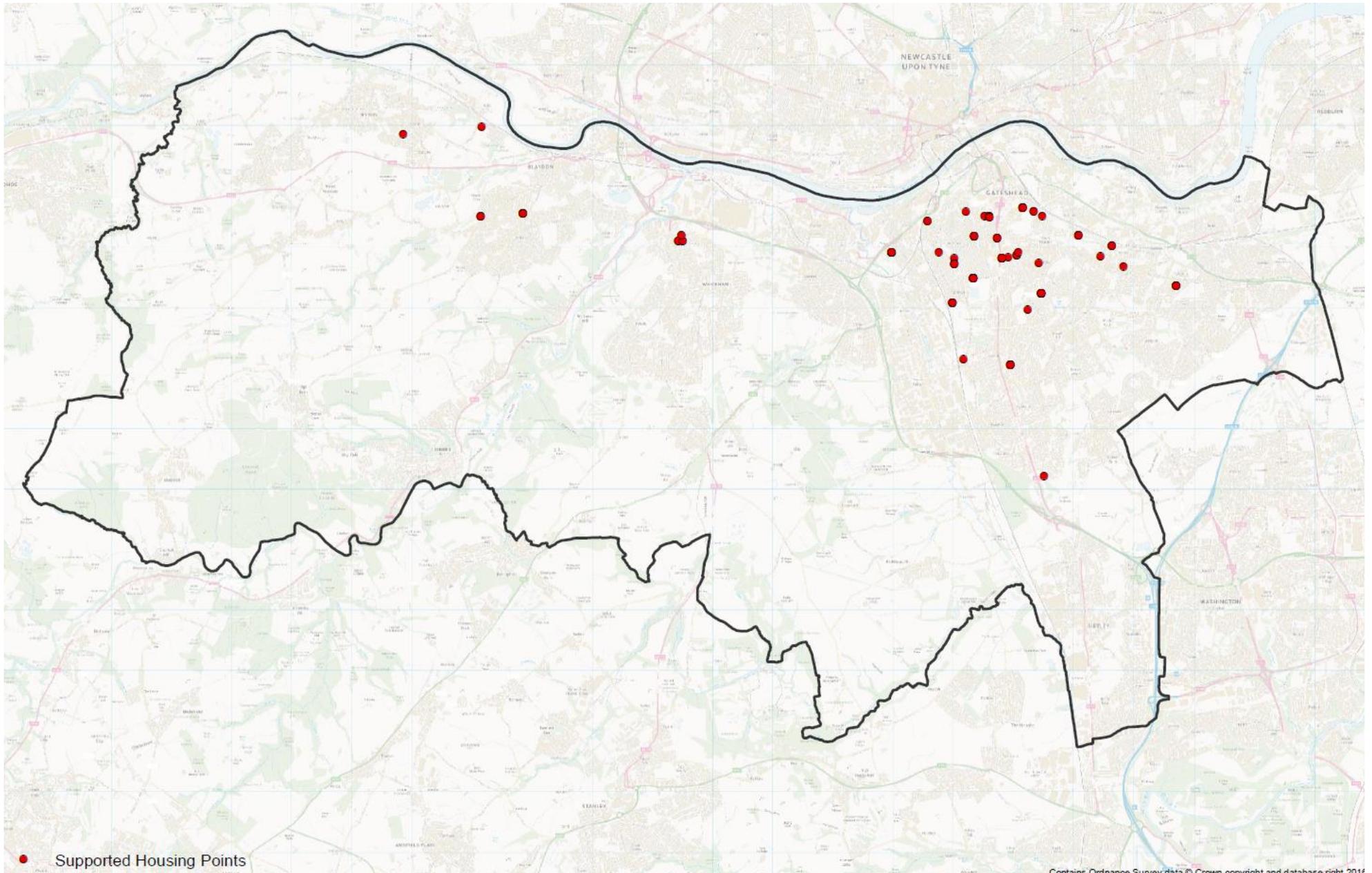
4.3 Local authority director of finance	
Signed	
Name	Darren Collins
Email	darrencollins@gateshead.gov.uk
Telephone	0191 433 3582

4.4 Local authority drug and alcohol commissioner	
Signed	
Name	Alice Wiseman
Email	alicewiseman@gateshead.gov.uk
Telephone	0191 433 2777

4.5 Recovery provider chief executive	
Signed	
Name	Stephen Bell
Email	Stephen.bell@changing-lives.org.uk
Telephone	0191 256 2901

4.6 Recovery provider project coordinator	
Signed	
Name	Rhiannon Bearne
Email	Rhiannon.Bearne@changing-lives.org.uk
Telephone	0191 481 3681

Map of supported housing in Gateshead



Contains Ordnance Survey data © Crown copyright and database right 2016

Qualitative feedback from supported housing providers

In terms of the Karis young mother's gaining employment given the issues many of them are still dealing with when they come to Karis; between the dates given none of the mums have been in employment. Karis has spent time supporting them in life skills to run a home, care for their young children, understanding utility bills, understand the benefits they are entitled to and accessing nursery placements and health appointments can often be more than enough information to take in. It's often one step forwards and two steps backwards, however we will try and try again, looking at different approaches of support to the specific service user's needs. If they need three or four chances then Karis will persevere with them. Once the service users begin to progress and make positive moves forward, then the support begins to look at education, part time work to give the residents a future to aspire to. We don't want to push them too early and set them up to fail, just to make our stats look better. Equally the loss of any housing benefit because of earnings would make living at Karis and working almost impossible.

As you rightly point out, the rent for supported housing is quite a barrier to people gaining paid employment – we have in the past had people move out because they have secured employment and they simply cannot afford the rent, despite them still needing the support. This makes an employment outcome quite difficult to achieve. We do however have better outcomes with volunteering/non-paid work, and education. If tenants have secured employment then there is no 'leeway' period with HB, to help them make the transition from getting full HB to them having to pay a significant amount of rent themselves. I personally feel that, as more of an incentive to gain employment and feel secure financially, there should be some sort of gradual HB reduction, or a freeze period to enable them time to adjust and to learn to budget their income. This would also help us support that person to not get into rent arrears. If they are in a planned programme of support and can evidence they are working with professionals then I think this would be much fairer to that person and also to landlords.

It is always extremely difficult to support SU's to cover their HB shortfall. Due to processing etc. HB often runs approx. 4 weeks behind, in 4 weeks SU's arrears are over £1,000. HB doesn't pay anything until they have proof of pay from payslips, then it is calculated and the SU's are informed of any shortfall by letter. Straightaway our SU's are in arrears with HB shortfall.

As an organisation we massively encourage our SU's to work, however there are some SU's who struggle to pay their weekly £10 service charge never mind a £30 per week HB top up. If a SU is working when they arrive at Naomi we request that they start an estimated HB shortfall payment straight away then any over/under payments can be sorted out when their HB becomes consistent. It's a tricky system to navigate.

Due to HB regulations anyone gaining employment has to move on quickly i.e within 2 weeks. Once we used to be able to claim a discretionary payment to cover any overlap whilst we source furniture, carpets etc. Though we can still apply for this it no longer is guaranteed making any move on coupled with employment very hurried and rather stressful for all involved.

My thoughts are that a guaranteed 3 months HB award to cover the initial move on would be of great benefit this could be set up with a descending award full the 1st month, 75% the second and 35% the 3rd. This would allow the client to get their foot on the ladder. Support would be in place for continuing budgeting, benefit advice.

It is important to remember that many of our clients may not have had their own property nor employment before so the transgression from supported housing to being on their own should be as comfortable as it can be. At this moment the rush to set up a new home can be very stressful particularly for those in recovery.

In relation to the HB/Supported Housing system. - It is clearly a big disincentive for people in services to gain paid employment and very anxiety provoking to those who may already feel quite vulnerable in relation to their housing; mental health and other needs.

We know that people describe meaningful activity and having a valued structure to their day (such as work), as being beneficial to both physical and mental wellbeing. Work is generally `Healthy` for us all. To support and enable people to take what is often a huge step is difficult for staff, as the system is unclear; complex and can seem punitive . Staff therefore find it very difficult to promote gaining paid employment or reassure service users about such a transition. Service user`s are often understandably reluctant to take a seemingly positive risk that potentially jeopardises there stability .

Having said that - the above does not really apply to the 7 people currently within our service in Gateshead who would struggle immensely with the prospect of employment - due to severity and complexity of mental health and other needs.

I`m really pleased to see you are looking at this important issue for service users which in it`s current form continues to promote dependency. I also feel that this problem is not exclusive to the Housing Benefit system and on occasions other individual benefits which have been maximised can also act as a disincentive to more able /skilled people looking for employment.

I would be happy to discuss further and give anonymised case examples / other information, if you feel this might be of help.

In terms of issues with housing benefit, we find the letters from HB are addressed to the service users, who often don`t understand the letters and don`t tell staff. Its not until we get notification from our finance department that there is an issue with the HB. It would be a great help to us and probably to HB if we could get copies of the letters that get sent out to the service users so we can deal with any problems quickly before they get messy.

Also we only get 4 weeks in which to get all the HB paperwork in which if we are working with a service user and child where there is DV can prove difficult also the service users are often in such chaos that it can take a couple of weeks to sort through things.

At present we find Gateshead council to be helpful to queries and processing our applications for new tenants. As I also have and do cover other areas in the north east and think staff feel HB system in Gateshead runs smoothly and we have had no issues to date. Other areas can take 12 weeks plus to process claims.

Haven had 17 residents in our Gateshead service between April – June this year. Only 1 was in employment and this caused him to accrue large arrears which he is currently addressing, housing benefit was a long and laborious process which involved many appeals and reconsiderations.

Themes and Key Messages from Homelessness Health Needs Assessment Consultation Event

Held on 5th July 2016 at the Dryden Centre Gateshead – 12:30 -4:30pm

83 Attendees

Organisations Represented at the event:

Changing Lives	Isos Housing
Crisis UK	Mental Health Concern
Fulfilling Lives	Metro Interchange surgery
FUSE	Millennium Practice
Gateshead Council	Newcastle Gateshead CCG
Gateshead Central Medical Group	Newcastle Homeless Service
Gateshead College	NHS England North
Gateshead Evolve	Northumbria Community Rehabilitation Company
Gateshead Housing Company	Oasis Aquila Housing
Gateshead Police Station	Richmond Fellowship
Gateshead Private Landlords Association	St Albans Medical Group
Gateshead Psychosis Pathway - QE	The Home Group
Healthwatch Gateshead	Tyne and Wear Fire & Rescue Service
Home Group	Voluntary Sector Advisory Group (VOLSAG)
Institute of Health and Society	Volunteer @ Jo's Place

Consultation Questions

During the course of the event participants were asked to consider four key questions linked to the service response to homelessness and multiple complex needs groups in Gateshead:

1. In relation to the current service response to this group, what is working well?
 - What **assets** do we have in Gateshead that can be used for the benefit of this Group? (e.g. skills, provision, ways of working, physical environment).
 - Examples of **good practice**?
2. What challenges do you face in responding to the needs of individuals with multiple and complex needs?
3. What do we need to do differently – what would an effective ('perfect') response look like?
 - What opportunities are there to do this?
 - How do we find solutions in current climate of austerity and reducing budgets?
 - What principles are important for this client group?
4. What outcomes would you expect to see?
 - How will we know if we are being effective? The so what question
 - How do we capture what really matters to the individual?

Method:

Presentations were given from local and national speakers to share some of the issues and experiences pertaining to receiving, commissioning, providing and researching services targeted at those experiencing homelessness and multiple and complex needs.

Participants were organised in to groups of 8-10 individuals sitting at round tables to facilitate reflection, debate and perspectives about the questions being posed. Each round table had a facilitator who documented responses as they emerged.

Results: Themes below were identified and verbatim responses have been organised under themes under the question headings.

Question 1. In relation to the current service response to this group, what is working well?

- What **assets** do we have in Gateshead that can be used for the benefit of this Group? (e.g. skills, provision, ways of working, physical environment).
- Examples of **good practice**?

Theme 1. Services and Provision in Gateshead

What was said

Community and Voluntary Sector Provision

- Voluntary sector (but this is not strong enough or recognised)
- NERS & Action Foundation
- BASIS@363 can be used to access the nurse/drop in register with a GP preventative, location, facilities, shower-room, sign posts
- Halios
- Citizen Advice
- Oasis Aquila – Single Parents
- Joe’s Place – non-judgemental – offers food, companionship
- Safe Families
- Fulfilling Lives
- MIND
- Broadacre House
- NE Advocacy - Aspirations
- Foodbank – ration packs for homeless clients
- Other services/strands of services that have developed out of learning from Oasis Aquila.

Local Authority

- Armed Forces Pilot
- Vulnerable housing panel
- Domestic Violence Pilot
- Very committed council/very proactive
- MASH and MARAC – good opportunity for professionals to network Signpost
 - Referral (Via vulnerable adults)
 - Advice & Assistance – Shelter
 - Debt/housing advice
 - Practical assistance
- Multi Agency Vulnerable Adult support (safeguarding)

- Work well with homeless families e.g DV, Safe houses, TAFI Families - but no statutory response for single homeless
- Care Leavers Panel
- Agreement in place for care leavers (this is example of good practice in some areas but not in others).
- Public Health moving into Council has helped to facilitate/galvanise local work on the topic area. Reliant upon key people showing leadership.
- Social Services more engaged looking at a lifecourse approach. Identifying transition points and planning for ongoing care. Preventative focus rather than fire fighting.

Health Services

- East Gateshead Social prescribing project (GP projects)
- Substance misuse
- Drug treatment providers really involved with crisis services
- Health Drop In @ Basis 363 (nurse provision half a day)
- Healthwatch – Feedback & Facilitate change
- Public Health – Live well Gateshead,
- Oaktrees - Quasi Residential
- Mental health and housing workers in Gateshead Housing Company
- Homeless Mental Health Team Currently working in Newcastle but starting to work in Gateshead

Housing

- Funding for hostels (but not in Gateshead some are just B&B's – housing benefits costs more)
- Lots of the wrong type of accommodation and barriers to access it (eg Criminality, substance misuse, mental health)
- Gateshead Housing Company -Specific Officers, Preventative approach – Private
- People are doing things but because of lack of direct access there is to & fro
- Supported Housing but not enough – exclusion criteria so not catering for all.
- Accommodation/homelessness services provide a basis from which other services can start to engage.

Community Safety

- Neighbourhood Policing

Workforce

- Individuals within services going above & beyond
- Individuals within services working well rather than services overall.
- How do we feed it back – tell service managers when someone is doing a good job – highlight when people are doing things well even if is seen as being a 'rebel' needs to go right to the top – people who have power to change.

Theme 2: Ways of working

Navigation/Outreach

- Someone is holding the person
- Help to navigate the system
- Service navigators @ OASIS, MIND, Fulling Lives, NE Advocacy, Broadacre House, NE Advocacy
- Guidance through system
- Signposting
- Outreach working which enables links and knowledge of local providers. Enables direct access. Take service to clients and be flexible in expectations/approach.

Integrated Approaches

- Barriers broken down providers working together.
- Multi-agency approaches to prevent homelessness
- Some services are working better together -Fulfilling lives, Evolve & Basis but not extending across the system
- Slowly improving partnership working
- Joint working between services and knowledge of what other services do
- Sharing information
- Marac/MASH – Good opportunity for professionals to network also staff knowledge very important
- Vulnerable housing panel, where people can be placed is identified
- Relationships between services - Better relationships, communication being open, not being protective, sharing
- Co-located teams info sharing (valuable info sharing) on quicker basis, early intervention/prevention
- Positive commitment across services
- Good partnership working, motivated staff passion & commitment.
- Example of good information sharing – pilot project Northumberland CC – Health & Social Care working together.

Environment

- PIE – psychologically Informed Environment

Access

- Quick response
- Can access with a label
- Single Gateway – personalised approach
- Move on protocol – having choice
- Allowed to look in more detail at referrals and look at current tenants

Engagement

- Lot of agency working with people & trying to engage them
- Staff/service user relationships – built upon trust, positive role modelling
- Empowering service users
 - Confidence
 - Self-esteem
- Strengths based approach, although still in early stages
- Personal response – through Fulfilling Lives
- Co produce

Peer mentorship /Experts by Experience

- Experts by experience
- Experts by experience /co-production/visible recovery
- 1 Peer mentors at Evolve
- More people with lived experience involved with service delivery - Could be better
- Develop e.g. peer monitoring course
 - Gives skills & training
- Trusting relationships with people with lived experience
- Linked service users reference groups embedded across the system

Listening & Learning

- Peer Research
- Peoples stories

- Qualitative Research
-

Theme 3: Types of Interventions

Activities

- Opportunities to access activities/venues
- Structured activities
- Edinburgh leisure card example £1 access all gyms – anyone marginalised can get
- Yearly award ceremony led by service users/EBE/Peer mentors

Housing

- Interventions with Gateshead Housing Company/12 weeks (2 way tenancy solutions)
- Good practice hostel: Tyne Group housing in Jesmond
-

- Carer support

Financial

- Financial capability sessions
- Young people – access to benefits
- additional support e.g. helping with bills, shopping

Theme 4. Wider determinants

Place

- Regeneration of Gateshead Centre
- Physical environment but not used to full potential e.g. noticeboard
- Safe Space
- Central Location of services in Gateshead

Building Social Networks

- Meeting new people/friendships
- Informal networks to meet – how to build on this?

System Change

- Genuine commitment made by the Local Authority in Gateshead
- Willingness for integrated commissioning
- Services that engage and influence across the sector
-
- Critical friend, gentle pressure on services to respond, services increasingly open to critical assessment
- Identify blockages
- Services have insight into the complexity of this issue & acknowledge current services are not always the answer.
- Identify GAP's (and fill them)
- Include unit cost calculator (Fulfilling Lives)
- Services more willing to change to change now - Use it as an opportunity
-

Economic

- Maximising income (2way tenancy solutions)

2. What challenges do you face in responding to the needs of individuals with multiple and complex needs?

Theme 1: Service gaps/types of provision

Mental Health

- Dual Diagnosis a big gap/ a major barrier
- Dual diagnosis/mental health
- Dual diagnosis – how do services adapt ‘the offer’
- Access to mental health/appropriate beds a real barrier
- Mental Health Services are under-resourced
- If mental health issues some places will not take them
- Access to psychological help
- Tramwell Unit closing
- Access to psychological help

Housing

- Lack of hostels in Gateshead
- Reliance on supported housing. Not everyone wants to access this. Current system does not allow for this. If you do not want to access this you end up on the streets.
- Certain service users are hard to place and therefore the options open to them are restricted. However, some of the housing options may be better than the alternative (rough sleeping).
- No direct access supported accommodation in Gateshead Council unknown services
- Lack of intensive support services
- Emergency accommodation (need a more pragmatic approach eg. empty houses)
- Housing stock – lack of one bedroom but abundance 2 bedroom stock
- Supported accommodation in Gateshead (not a problem in Newcastle – go into Newcastle to access appropriate support)
- Gender specific accommodation
- Drugs related death (vulnerability housed/sofa surfing)
- Empty housing stock/voids
- Where we place someone adds to their problems
- Multi-storey accommodation – service charges
- Concierges removed – Eslington/Redeugh/Warwick
- Housing support and vulnerability – floating support – home visits?
- Letting policy
- Duty discharged but may not be morally/socially right.
- Need to build new properties
- Lack of suitable housing including bedroom tax
- People pushed towards unsuitable private accommodation
- Hostel not good enough, not supportive, not healthy environments, no flexibility, policy and procedures needs to be shook up and changed.

Health

- How do we fit GPs into the picture. Registering with a GP
- Immediacy of GP appointments – delay in appointment + missed appointment and no help.
- Getting GPs talking to other services
- Access to primary care

Volunteers

- Volunteers – find numbers and people who want to be included. Also not enough resource and capacity within system to support volunteers properly.
- Volunteers are not free

Types of support

- Support packages are needed – not enough
- Increase in complexity of need
- Lack of asset based recovery pathways
- Need for someone to be lead practitioner
- Sticking with people even if they do not engage etc.
- Call services what they are

Theme 2: Ways of working

Intervening too late

- Social care assessment happening at wrong time, crisis intervention rather than prevention
- Often crisis point before people meet threshold
- Need to intervene before crisis point
- Timely responses/rapid access to crisis support (all services) – 3 month wait list for mental health service.
- Lack of preventative measures before eviction
- Crisis Intervention – Fire Fighting
- Provisions in place before they meet certain criteria eg. Tackle mental health before it turns into addiction
- Police last resort
- Lack of preventative measures before eviction
- Opportunities being missed and complexity increases
- Fire service do not have anything to do with the issue until it is too late eg a fire – role in looking at the state of the accommodation from a fire safety point of view.

Assessments

- Do we screen re needs/issues eg learning disabilities
- Understanding groups
- Concentration on ‘why’ rather than what do the services users need.
- Need to look at matching people to appropriate services.

Attitudes/behaviours of services/staff

- Stigma – arson, police vetting, stopping people getting a house – time delay
- Attitudes both personal and professional
- Negativity when someone fails
- Revolving door – front line staff desensitised (cynical)
- Too much stereo-typing – need to bust myths – both users and staff
- Stigma via media/politicians
- Belief system of service providers impacting upon decisions. Behaviours of service users can influence decision making
- Culture of organisations – need to change
- Stigmatisation (under 35’s over 55’s)
- Too risk adverse
- GP receptionists a big barrier

Attitudes/behaviours of those with multiple and complex needs

- Lack of aspirations/self-esteem, hope.
- People have to be ready, want to change – self sabotage
- Fear of accessing services

<ul style="list-style-type: none"> • Neglecting self – making vulnerable people more vulnerable • Engagement can be transient • Client group – doesn't recognise a crisis to be a crisis – find it difficult to predict a crisis.
<p>Not listening to users/choice</p> <ul style="list-style-type: none"> • Service user voice not being heard – involvement in contract reviews, development of specs, service reviews, procurement. • Not enough capacity/choice • Lack of service user involvement • Need to put person at centre and to look at their needs.
<p>Workforce development/system learning</p> <ul style="list-style-type: none"> • Staff training/attitudes • Training for commissioners – multiple needs • Learning from other areas • How do we strive for the best?
<p>Competing priorities</p> <ul style="list-style-type: none"> • Competing priorities eg Police.

Theme 4. Accessibility of the available services

<p>Access/Exclusion Criteria</p> <ul style="list-style-type: none"> • Too many 'hoops' to jump through • Always changing the rules • Tick box exercises stop services being person centred. • Restrictive services • People with no recourse to public funds/support, eg. Victims of domestic abuse have no recourse to public funds. No rights and supported housing providers struggle with caring for groups such as these. Issue for us professionals but also service users. • Problems with registration with GP can cause (problems in accessing appropriate accommodation) • Issues of having to have a home address. Gp practices who are willing to take on service users with a given address eg. Using BASIS@363 address to register with practice. • Doesn't meet front door where does this go? • System change – ASCD – front door – deflecting? • Understanding criteria to meet thresholds • Housing providers criteria • Specific barriers to meet needs (eg services may be in place but the access criteria prevents people accessing the services. • Lack of services for those who do not meet the criteria for support – eg those who do not meet Fulfilling Lives criteria • System barriers – referring to others, criminal records (add record).
<p>Location</p> <ul style="list-style-type: none"> • The back-up systems don't work – home visits or walk in centre but no transport to get there. • Out of locality of GP because of sofa surfing, embarrassment etc. • Local Connection still a big issue. Moving areas • Local area connection – barrier to accessing services (Newgates doesn't have primary care for the homeless) • Local Authorities should have reciprocal arrangements • Once someone leaves Gateshead cannot help them • Lack of services in rural areas • Location of services • Accessible services – provide transport

<ul style="list-style-type: none"> • Services situated all together in Gateshead. Pressure from elected members, residents and others for services to be dispersed over a wider geography.
<p>Unrealistic Expectations Upon Service User</p> <ul style="list-style-type: none"> • Assumptions of peoples capability – make a call, attend an appointment, access to phone/IT. • Navigating the system difficult – does not understand that people with complex needs miss appointments/may not read letter/ fear. Then they have to start again. • Reliance upon technology • Reliance on call centre
<p>Availability of the service</p> <ul style="list-style-type: none"> • Out of hours provision what happens at weekends • How do people know where to phone out of hours – do we publicise? • Fixed term tenancies • Access needed 24/7 • System and people change all the time • Slipping through the net, no-ones responsibility
<p>Communication</p> <ul style="list-style-type: none"> • People don't know what services are available • Always changing the rules • People unaware of options available to help
<p>Specific needs</p> <ul style="list-style-type: none"> • Sensory impairments/speech as a barrier • Getting people support if English not first language • Learning difficulties – need support in place to get same opportunities
<p>Transition</p> <ul style="list-style-type: none"> • Move on place • Discharge planning • Transitions services – children to adult • Follow on can be difficult eg. Once someone is sofa surfing/transient, can be difficult to follow up.

Theme 5. Services not working together

<p>Information Sharing</p> <ul style="list-style-type: none"> • Sharing Information/ Need to Know – fear of data protection • People repeatedly telling their story – distressing • Services should re-tell their story • How do you replicate informal networking • No central accessible database • Fear of information sharing • Access of data • No single data count of everyone who is homeless no matter what their reason eg failed asylum seekers
<p>Cohesion/pathways between services</p> <ul style="list-style-type: none"> • Link between statutory sector and third sector • Referral pathways are too rigid – forms –phone calls – interviews - locations • No cohesion between services • Services disjointed • No defined pathways • Different departments don't talk to each other

- Who and where are our stakeholders and partners
- Consider pooling/sharing resources
- Pathways – knowledge – understanding
- Fragmentation of services
- Fragmentation of commissioning
- Support alongside housing needs to go hand in hand.
- Commissioning services need to work as one (mental health, drugs and alcohol, homeless).
- Silo commissioning
- Health care assistants/navigators and GP feeding into the system.

Theme 6. Wider determinants

Welfare/Benefits/financial exclusion

- Bedroom tax
- Changes to legal aid
- Cost of transport
- Benefit sanctions
- Not having basic resources for house eg bed, utensils
- Practical help
- Universal credit
- DWP
- DWP a nightmare. Communication, accessing passwords, entitlements.

Political Landscape

- Political uncertainty
- Austerity
- Is homelessness a priority for those that can inflict/influence change? Eg strategic boards?
- Timescale and ability of delivering system change (partner agencies eg CAB)
- Challenges in getting the message across to commissioners about the needs of client group – discussions with commissioners.

Resource Issues

- Cuts in services - Demand is there and increasing
- Skills, experience being lost due to redundancies
- Reduction in funding
- Budgetary cuts
- Barrier accessing funding for ongoing costs – sustainability
- Funding. Having to find efficiencies in budgets over the coming years. More likely to stop services which do not have to be provided.

Root Causes

- Need to tackle and understand the root causes and make sure what is sustainable
- Lack of interventions in the early years
- Early intervention and prevention (but difficult to even respond to the crisis)

Place/social networks

- Lack of support mechanisms when we house someone in the community
- Community response
- Isolation factor – makes someone more vulnerable
- Isolation
- Relationships and communication

3. What do we need to do differently – what would an effective ('perfect') response look like?

- What opportunities are there to do this?
- How do we find solutions in current climate of austerity and reducing budgets?
- What principles are important for this client group?

Theme 1. Integration

Integrated services/support pathway

- We need drug and alcohol rehabilitation in Gateshead Supported Housing
- Pathway that would offer a range of opportunities of care
- Interlinking housing with rehab included (drug and alcohol rehab)
- Cross platform working i.e. prisons/mental health
- Integrated health and social care
- Integrated criminal justice system
- Integration of services and budgets
- Reduce duplication
- Joined up approach stop working in silos
- Partnership working across private/public/3rd sector
- Working together
- Amalgamated services
- Multi agency hubs exist in Wales – include social work, mental health and health.
- Single point of access
- Better links with Local Authority Services, neighbouring authorities, a regional response
- Reciprocal arrangements with other local authorities
- Physical health and mental health to be treated equally
- Non silo working
- Health – there need to be a lead coordinator, substance misuse, mental health, fulfilling lives coordinator role.
- Virtual contract/virtual organisation to address the needs of the service user.
- Need to ensure effective partnerships to support clients if provision isn't working.

Information sharing

- Services have shared information protocols – agreement across organisation
- Communicate more – everybody!
- Sharing of information
- Better information sharing
- Build networks and communicate for the benefit of the service user
- Communication between service providers and sharing of information between providers

Commissioning

- One overarching strategy
- Joint commissioning to prevent/reduce silo working
- Transparent commissioning process
- Joint commissioning work together not in silos
- Better, joint commissioning and a real understanding of what this looks like

Common processes

- Adult Common Assessment Framework
- Early Help Hub Model. A pick and choose the requirements of the client and ensure then appropriate access to the right service in line with client's needs.
- Single assessment for multiple needs
- Joined up thinking (like MASH)
- Joined up working
- Supply a support worker for every individual so there is always a lead practitioner – multi-agency team around the person
- Reduce complexity
- Reduce duplication
- Alliance model identifying gap in service provision and communicate it as an issue for everybody not just one provider. Opportunity to influence.

Theme 2. Components of good services/responses

Location

- Use hubs in Gateshead across the borough
- Support in places where service users want to see that support
- Services to be more local – not all centre of Gateshead Town Centre – need hub and spoke model
- Go to where people need services
- Co – located services
- Accessible services – transport provided
- Easy access centre – homeless should not need and address to access healthcare, primary care centres do outreach in London
- Start with a night shelter with advice and information
- Two empty nightclubs could be converted into crash pads/accommodation
- Build upon existing points of access
- Properties are there – providers need to talk to each other

Availability/Responsiveness

- 24/7 service needs – evenings, weekends, out of hours, shift patterns
- Not Monday to Friday 9-5
- Responsive services/people
- Immediate response
- More rapid responses to service needs – no one should be released from prison without benefits
- Principles – single point of access – accessibility 24/7
- Matching specialism with access – building upon existing points of access

Staff Skills

- Skilled people
- Services with specialist workers embedded in them to help facilitate/navigate access specialist services
- Kindness and concerns of professionals, dealing appropriately, effectively with people in the system.
- Retired people have lots of experience and people skills to offer
- Not passing the buck
- Immediate response
- Following up on the advice you give
- Admitting if you don't know something

- Not making promises you cannot keep
- Not having meeting about meetings
- Individual support worker – giving them the freedom to empower, inspire give hope, aspirations to service users

Staff Attitudes

- Non judgemental
- No labelling. Experience has formed outlook, need to make this positive. Build expectations and aspirations.
- Respect
- Less of power dynamic between professionals and service users, open dialogue
- No blame culture – embrace failure and stop blaming each other
- Need to show respect and dignity to client group
- Focus on assets and don't be judgemental
- Young people are allowed to be complex – they are not always badly behaved.
- Don't make assumptions
- Need to do more to tackle stigma
- Discuss language used by services eg. 'service user'.
- Attitudes of front line workers can be changed to support more effective interventions.

Individualised ways of working

- Time – including DWP – people need the time to find their feet.
- Support plan built around the individual and their needs
- Services wrapped around the person
- Not time limited – stick with the person
- Longevity of support eg. whole person, not closing cases when they are referred to another service
- Don't be afraid of failure
- Learn from past experiences
- A realistic response will improve the chances of helping
- Need to break down policies, criteria, rules – develop policies so have an element of flexibility.
- Flexible approach – treat people like individuals, listen to people and want they want
- More long term support networks
- More flexible criteria
- Knowledge of what clients can and cannot do and ability to work in a different way to support needs.
- People who are homeless get help
- Going the extra mile
- Determination and tenacity from the front line
- Keep people safe
- Taking responsibility for actions

User Involvement

- People involved in decisions that affect their lives
- Communication with service users to try and help them understand the reasons for decisions and to give them their identity and self-respect.
- Ensure that the client is at the centre and involved in decisions that are taken about them.
- Participation in decision making
- Client centred
- Holistic approach not just one issue at a time
- Learn from customers/clients – their experience
- Co-production
- Service user embedded and led delivery
- Listening to client group

- Listening to what service users are saying.
- Helping service users and others see the value in what they are saying
- Empowering people.
- Don't just pay lip service to engagement
- Listen to what experts by experience say and use this to build services
- Involve experts by experience in developing specs and in the service.
- Opportunities to influence

Theme 3. Workforce Development

Workforce Development

- Upskilling of practitioners ie. homelessness practitioners having basic mental health training
- Services have agreed basic skills/intervention
- Learn from other areas don't reinvent the wheel
- Read Hard Edges Report.
- Asset based workforce development
- Joint training/joint events/shared understanding
- Need to build and value and accept understanding of different organisations and their roles
- Educated and informed workforce – frontline to management
- Expert by experience designed and led training
- Joe's Place – all had food hygiene training to enable them to deliver
- Failure is an opportunity to learn
- Professionals need to get an understanding of how to navigate the system/services. As was shown from the slide of system the web is very difficult to navigate and will be for the client as well as the professional unless time to understand.....
- More events like this to open eyes to what others are doing

Supporting the workforce

- Recognise younger staff may not have experience/organisational memories (no job for life anymore)
- Work shadowing opportunities, pressure on staff/recruitment crisis/threats burn out.
- Forums are important
- Front line workers supported in doing their job.
- Training/education for society as a whole
- Support staff and volunteers, recognise benefits for volunteers also
- Support management and leadership
- Supervision from those who understand the challenges on the ground

Theme 4. Intervening Early

Early Intervention

-
- Stop firefighting and moving on rather than system change
- Root causes need to be looked into
- Deeper understanding of the determinants of health
- Early intervention
- Opportunities being missed at different life stages
- Earlier more effective diagnosis
- Stop fire-fighting and be proactive in undertaking preventative work.

Theme 5. Resources

- Invest to save
- Properly resourced early and timely intervention – how do we maximise funding – local solutions – working together.
- Think long term; NHS, Police and Probation are all facing massive challenges.
- Effective funding
- ‘communities can’ funding small pots to create opportunities
- Must acknowledge the impact of austerity and its constraints
- Personal health budgets – money follows person
- Acknowledge austerity cuts and the effect it will potentially have or has had

4. What outcomes would you expect to see?

- **How will we know if we are being effective? The so what question**
- **How do we capture what really matters to the individual?**

Theme 1. Methods of capturing outcomes

Ask the individual using the service

- Ask people if the service provision is effective. Need to ensure that their needs/aspirations are being met, not just a professional view
- People who use the service, identify their own outcomes to show progress
- Talk to the people – communicate
- Service user feedback
- Ask individuals what they want
- Opportunity to feedback
- Use suggestions made by service users
- Asset based approach
- Ask what they want – need to be realistic
- Service user forums
- More creative approaches to service user feedback
- Ask people we are working with and record their answers
- If patient client tells you
- Service users put their goals in an envelope and then revisit the envelope further along the support journey to see if change happened.

Service measures

- KPI's that are meaningful
- Unnecessary data collection abolished and removed – it is time consuming and takes us away from what we need to do.
- Targets and stats do not always show the true picture
- Effective recording – otherwise how will we know – eg. Single homelessness
- Case studies
- Peoples stories
- Narrative statements testimony
- Getting more impartial mediator/researcher to gather feedback
- Use social media/technology more effectively don't just use it for its own sake.

- Measure clients journey
- Listened
- Standards used to measure mental health and wellbeing before and after (WEMWBS?).
- Identify when things go wrong (not only beginning and end) identify moving on points.

Theme 2. Quantitative Outcomes

- Repeat homelessness
- Less people in crisis
- Reduced number of empty houses
- Repeat referrals
- Reduction in numbers – long term measures
- Reduced homelessness/repeat homelessness, less long term homelessness
- Reduced use of secondary services
- Less drug related deaths
- Less people homeless/less drug related deaths
- No second night out, monitored and reduced (by basis)
- Numbers seen out of hours
- Less repeats – no revolving door
- Potential savings – longer term
- Less people would be homeless (maybe forever)
- Support needs would be reduced
- Reduced waiting times for services as less crisis patients

Theme 3: User Involvement Outcomes

- Sharing expert voices and evidence of this throughout the process
- Involvement
- Expert/coproduced commissioning
- Mutual collaborative process
- You said we did
- People with lived experience are involved throughout – from shaping service to contract management.
- Involvement/mutual

Theme 4. Levels of service engagement outcomes

- Better attendance at appointments/better engagement with services
- Continue to access the services
- Comes back if needs extra help
- Improved prospects
- People have equal access to employment

Theme 5. Workforce outcomes

- Right people in the right job
- Senior management being more involved
- Create leaders not followers. Workforce development – all parts of the system (staff, experts by experience, voluntary sector, statutory sector) embrace those with lived experience
- Staff should take pride and responsibility in their role
- Higher proportion of experts in delivery roles
- Professionals feeling more satisfied! Less burn out – stress
- Investment in workforce development

Theme 6. Change in perception

- Empathy in society generally
- Raising awareness of homelessness to challenge stigma and attitudes
- Perceptions of homelessness
- Understanding reasons for drug use/effects of legal highs
- Less stigma and fear
- Stigma reduced
- Not sure how to measure but public perception changed
- Reduced stigma around services – less fear
- Changing attitudes towards those with multiple and complex needs
- Perceptions of homelessness – not always drugs and alcohol (PTSD/relationship breakdown/veterans).

Theme 7. Services working differently outcomes

What would we have

- Hub 'one stop shop'
- More multi agency hubs – less single services
- Everybody has a bed for the night
- Full service directory which is kept up to date and reviewed.
- Development of partnerships with shared outcomes around the user
- More joined up working /less services to navigate/less services involved with one individual.
- Route through the chaos
- Options for children in care moving on
- Local intelligence and working together
- Links with job centre – target homeless people – apprenticeships with support
- Everyone gets information that people can access one number
- Increased volume of supported accommodation
- Improved private tenancies and invest in social and supported housing
- Prevent eviction initiatives
- Support to maintain tenancies and prevent anti-social behaviour
- Blackpool (jobs, friends and houses scheme) learn from other areas
- Barnardo's night stop programme for young people under 25 – for emergencies.
- Less crisis type provision
- All services at gold standard
- Range of different housing options to address every need
- Tiered approach with flexibility to move backwards or forwards through the tiers based on need.

- Ability to move through levels of support both ways if needed

How are they working

- Permission to work on the less tangible elements
- Services are more free to innovate
- Barriers to information sharing are removed
- Services accountable to service users
- Policies being used properly
- Services sticking with clients
- Clients have choice
- Who cares enough
- Closing the revolving door so clients get supported effectively earlier.
- 'I' statements
- Clients have control over the future
- Demand led service based upon individuals requirements
- Demand led
- Flexibility
- Easily accessible services
- Take services to people who need them
- System accessible
- No back log/waiting lists/bottle neck
- Helped people to make changes
- Services should meet needs of clients
- Honesty/realistic
- Person centric approach
- More control over the future
- More choice
- Able to move through levels of support – both ways if required

Theme 8. Prevention

Prevention and cycles of homelessness causes – child-teen – adult
Transition between school and work/adulthood/apprenticeships/vocational opportunities

Gateshead Homelessness Health Needs Assessment

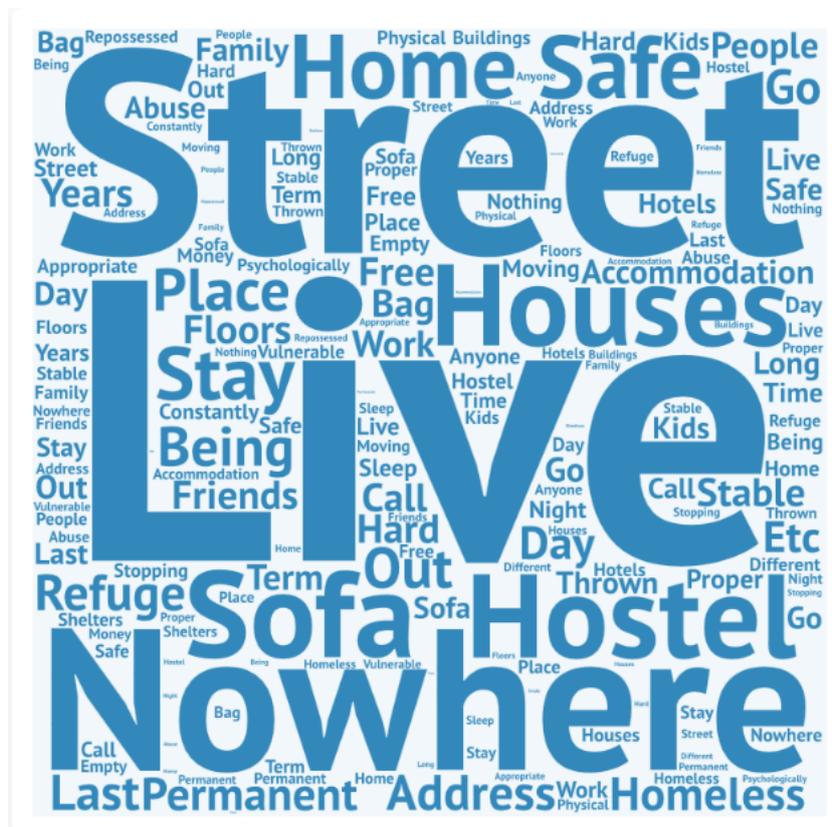
Stakeholder Consultation EventTuesday, 5th July 2016 - 12pm – 4:30pm

Dryden Centre, Evistones Road, Gateshead NE9 5UR.

Programme

12:00 – 12:30	Registration: Lunch and networking
12:30	Chairs Welcome: Jill Harland – Speciality Registrar Public Health (Gateshead Council)
12:40	Homelessness and Complex Needs – Ambitions for Gateshead Elizabeth Saunders – Interim Director Commissioning and Quality Assurance (Gateshead Council)
12:50	Gateshead Perspectives – learning from the ‘front line’ <ul style="list-style-type: none"> • System Mapping & Peer Research – Sophie Boobis (Fulfilling Lives) • Basis@363 - Resource Centre/Drop in and Health pilot – Phil Conn (Oasis Aquila Housing) • Vulnerable Persons Housing Panel - Mark McCaughey (The Gateshead Housing Company) • Homelessness and Social Isolation – Adele Irving (Northumbria University)
1:30 – 1:40pm	Learning from those with experience of homelessness Mark Tunny – Fulfilling Lives
1:40 – 2:20pm	Round Table Discussion
2:20 – 2:35pm	Refreshments
2:35pm	National Perspectives – Hard Edges Darren Murinas – Trustee (Lankelly Chase) & Chairman (Expert Citizens)
2:55pm	Q & A – Session with Presenters
3:15 -4:15pm	Round Table Discussion
4:15 – 4:30pm	Closing Remarks and Next Steps Councillor Liz Twist – Cabinet Member for Housing

Exploring the health needs of the homeless population in Gateshead: Peer Research Report



“Being homeless at any age is no one’s choice, I did not ask to be homeless or have mental health issues. I just needed someone to listen to me and be helped not labelled or bullied”

“Why should I have to defend myself to get help? Why ask when people don’t seem to want to help or understand?”

Authors: Narelle McKinley and Sophie Boobis (Fulfilling Lives Newcastle Gateshead)
with contributions from Sarah Macleod and Donna Douglas.

October 2016



Table of Contents



1. Introduction	3
- Background and context	3
- Peer Research	3
- Methodology	4
2. Findings	6
- Defining homelessness	6
- A journey to homelessness:	7
o Mental Health	8
o Substance Misuse	9
o Childhood	10
o Inappropriate housing	12
o Debt	13
- Accessing support	14
- Lack of support	15
- Improving support	16
- Conclusion	17
3. Recommendations	18

1. Introduction

Background and context

This research is part of a broader Health Needs Assessment (HNA) being undertaken on behalf of Gateshead's Health and Wellbeing Board. The HNA is focusing upon a subgroup of the homeless population who have overlapping health and psycho-social needs which cannot be met by a housing solution alone.

The HNA aims to systematically assess the scale, nature and impact of homelessness and complex needs in Gateshead in order to provide information which can be used to address wider determinants of health, improve service provision to prevent and alleviate homelessness and to reduce health inequalities.

The HNA Working Group recognised that the HNA should include the experiences and views of people with experience of homelessness. This approach is influenced by work emerging from the Fulfilling Lives Newcastle Gateshead Programme <http://www.fulfillinglives-ng.org.uk/> and the Lankelly Chase Foundation (Bramley and Fitzpatrick 2015), which has highlighted that data is only the first step in understanding what people's lives are like and where systems can go wrong. They argue that 'the case for change is best made through people telling their story in their own words' (www.hardedgesthestories.com).

The peer research is intended to build upon this emerging evidence:

- The importance of transition points across the life course where early service intervention could prevent individuals slipping into disadvantage (Fitzpatrick et al. 2012).
- The considerable overlap between groups experiencing homelessness and other health and psycho-social issues. These include drug and alcohol misuse, poor mental health, offending behaviours and institutional experiences (Fitzpatrick et al. 2012, Boobis 2015)

The aim of the research was to explore the following question:

What would effective support and intervention 'look like' at key points during the life course that may help to prevent or alleviate homelessness?

The research will seek to address the following objectives within the HNA:

- Identify where and how homelessness overlaps with other issues associated with deep social exclusion and poor health and wellbeing outcomes.
- Identify the triggers and pathways to vulnerability and protective factors across the life course and explore what successful support should look like by including the views of those with lived experience of homelessness.
- Understand the system and the multi-disciplinary service response (health, education, housing, social care, criminal justice, third sector) to homelessness in Gateshead.
- Inform what might be done to ensure more comprehensive ways of working that are better able to tackle homelessness and meet people's needs and aspirations for recovery and well-being.

Peer Research

The peer researchers who delivered this research were all trained through an accredited research skills course. This training explored all aspects of the research design process, research methods, analysis bias in questioning and analysing, and reporting. This training course is designed to give peer researchers the skills to take ownership over the research project and to be confident in leading and designing its' delivery. Whilst supported and advised by a professional researcher the peer researchers are the guiding partner in this piece of research.

Peer research allows the researcher to draw on their own lived experience which enables them to both compose surveys and conduct interviews in a way which aims to encourage the participants to share their own personal

experience as they both feel valued and identify with the researcher. Identifying certain phrases that immediately make those fearful or disengaged from services defensive and which would therefore discourage individuals from participating in the study is a vital part and benefit of peer research.

Researchers who have, or currently experience similar difficulties to the participants are privileged to access rich qualitative data due to authentic level of mutual trust. Sharing lived experience, showing genuine interest and empathy with the participants allows and facilitates a real conversation between two individuals not a person of authority and a research participant.

Furthermore, the peer researcher appropriately disclosing their experience can encourage participants to engage and give a more detailed account of their actual experience, not what the individual thinks they should say to appease services, detailing what they find helpful and unhelpful without fear of repercussions.

The benefits of peer research both as a method, and for the researchers themselves is highlighted by the quote below from the lead peer researcher on this project:

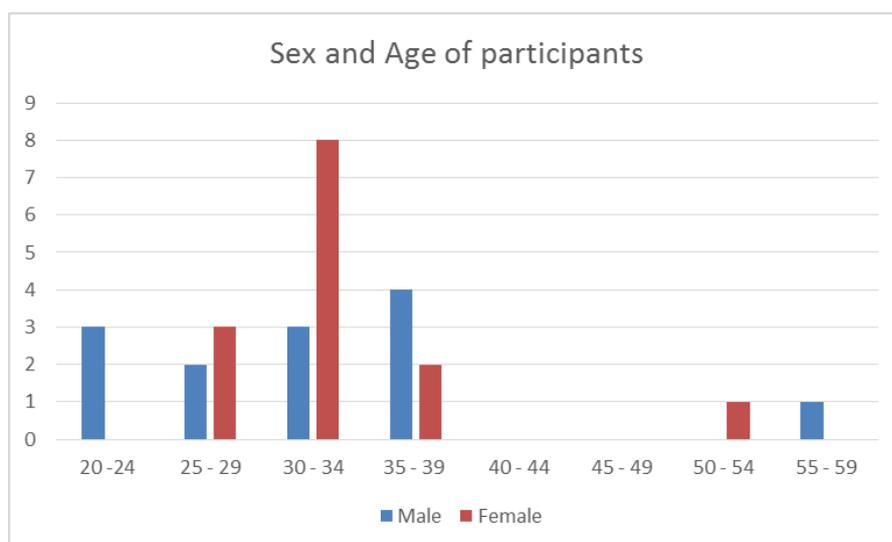
“The experience was very rewarding and emotive. It also motivated me to continue to try and work with services for system changes for those with multiple and complex needs. Although some participants seemed sceptical or reserved initially, once they realised peer researchers had similar life experience and were not paid workers in services, respondents appeared more willing and able to disclose more personal experiences and opinions. The fact that the participants were assured that their responses would not impact their future ability to access services or alternatively remain disengaged from services if that was their choice, they expressed a great interest in sharing their experiences in the hope that system change can benefit others experiencing homelessness and barriers to health care services.”

Methodology

The survey intended to explore the importance of pivotal times in the lives of individuals when early appropriate intervention and support from services could have prevented individuals from slipping into disadvantage and becoming disempower. The study also aimed to explore how those experiencing homelessness also experience other psycho social issues and multiple and complex needs such as mental health difficulties, addiction and offending.

Semi structured interviews were carried out by two peer researchers with individuals from the Gateshead area who were currently homeless, or had recently experienced homelessness.

Interviews were carried out with twenty seven individuals who responded to flyers advertising the research project in the Gateshead area. Researchers asked individuals from their own social networks and other charity organisations they were associated with to promote the research to access the desired participants. Researchers also asked individuals in the Gateshead area whom were on the streets to participate in the study. Fourteen females and thirteen males participated in the study with the average age of participants being thirty two, the youngest participant was twenty two and the eldest fifty five.



Two female peer researchers with lived experience of homelessness and multiple and complex needs designed and carried out the surveys. Having relevant lived experience and being peer researchers enabled the researchers to engage with respondents in order to attain rich qualitative data. The researchers highlighting the fact that they had

lived experience and were not paid service workers seemed to put participants at ease and enable them to disclose more personal experiences and opinions. It seemed particularly important to respondents to be assured that their participation and responses would not impact their future ability to access services or alternatively remain disengaged from services if that was their choice. Once reassured of this and the fact that their participation was entirely voluntary and confidential respondents expressed a great interest in sharing their experiences in the hope that system change can benefit others experiencing homelessness and barriers to health care services.

As both of the researchers were female this may have affected the number of female participants and also prevented them from accessing certain areas such as male hostels, bail hostels and certain areas of street research due to safety issues. Also as researchers used their own social networks and communities to advertise the research project this influences the number of respondents who were from the LGBT community, however, despite eight participants identifying as being gay, lesbian or bisexual only one mentioned this as a contributing factor for why they became homeless and therefore we do not consider it to have affected the findings.

The journey to homelessness

One of the key aims of this research was to explore what situations in people’s lives lead them to be homeless. This section of the report explores this and uses collective and individual stories to explore some of the causes of homelessness.

Chart 2.1 details the responses to the questions “what are the reasons that led to you being homeless?”, and “are there any contributing factors to you becoming homeless?” Health related causes top the main reasons given for homelessness, with mental health and substance misuse the most commonly given answers.

Mental Health

The most common response given when asked about factors resulting in homelessness related to mental health with other 50% of respondents giving this as a primary factor that led to their homelessness.

Mental health was often given in conjunction with other issues for example “*mental health problems, then lost job, then lost my home*”, “*rejected by my family and community due to my sexuality and mental health problems*”, or “*mental health, depression, hopeless, low self-esteem, gave up on myself*”. What these examples show is the real importance of the link between mental health services and homelessness and housing services. The stories that came from those that we interviewed suggest that this is currently not the case. The below case study details one individual’s story of how housing support had a significantly detrimental effect on her mental health, it is told from the perspective of the peer researcher.

It was clear from the research just how much stigma and discrimination those with mental health conditions had and continue to face. Highlighted by the following quotes given from those interviewed:

“Reducing stigma against mental health and providing more support would have prevented me from becoming homeless and losing my job in the first place but I was seen as “fine” as I was working. I had to lose my job and everything before anyone even tried to listen.”

“People need to stop being afraid of asking young people why they are struggling and not shame them for being mentally ill”

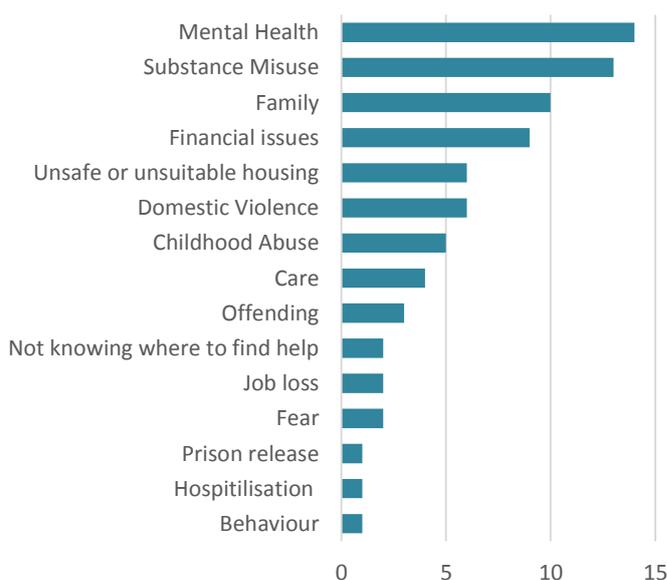
“I needed mental health support and was psychotic and scared not dangerous or bad but there is still massive stigma against those with schizophrenia”

Tackling the stigma associated with mental health needs, and making access to support more readily available could help to reduce the number of people falling into homelessness. Equally important is recognising mental health needs

Responses to the question:
“What reasons led to you being homeless?”



Causes of homelessness



as having a direct impact on an individual's housing situation. The case study above demonstrates how easily mental health issues can escalate when the surrounding support is not available.

One respondent was brave enough to share with me her very personal and powerful story of how the supportive housing in Gateshead had been very harmful and detrimental to her life and mental health. I met with this individual on multiple occasions to complete the interview and massively appreciated her giving up her free time to share such an emotive and in depth account of her experiences. Although hard to listen to at times I feel her story and her voice deserves and needs to be heard. When in her late teenage years this young woman who was experiencing severe mental health difficulties was in supportive housing. She was progressing well until she was told that due to her progress she was no longer eligible for the highly supportive accommodation, however, because she was diagnosed as having a personality disorder she could not access the less intensive supportive accommodation as this was only for individuals diagnosed with certain mental health conditions. Effectively she was doing too well to stay where she was recovering and accessing help but did not have "the right mental health" to be supported and housed anymore in a less intensive environment. She was denied access to accommodation where she thrived specifically because of her mental health diagnosis. When I went on to ask what happened next she explained that they said she had four weeks to find other housing and provided and helped her complete council housing application forms. She went on to explain how she was told she "had to bid on the first places that came up" and did this, however, this meant she had to bid on properties which were way out of the area and in quite rural locations. She unfortunately was given one such property twenty plus miles away from where she had been living. She stated "I was so isolated and alone, I didn't know where I was or anyone around me, it was two buses to get back home (Gateshead) and I shut myself away, I had never lived alone and didn't know what to do". At this point I was honestly astounded by how this vulnerable woman had been forced into isolation and excluded from services when she was just starting to show improvement in relation to her mental health condition. What I did not anticipate was the four years of suffering she then went to experience as a consequence of support being withdrawn. This young woman explained the rapid decline in her ability to manage her mental health and ability to access support from both services and those she knew, due to her inappropriate housing type and location. This contributed significantly to her spending numerous years in a psychiatric hospital, numerous suicide attempts and severe self-harm. The way she was treated took away her hope and dignity, and caused her not only years of immense emotional and psychological pain but caused her life long, irreversible physical damage and disability. How can one psychological label be a reason to cause years of suffering and long term hospitalisation by excluding a young woman from continuing to access a service that was helping her?

Substance Misuse

"I am not a bad person but people think I am straight away cause of my past and drugs and criminal record"

Alongside mental health, substance misuse was the second most common response to factors contributing to homelessness. This was highlighted as not only being an influence in them becoming homeless initially but also recurrently due to relapse.

Respondents discussed how their substance misuse left them excluded from accessing mental health support.

Many respondents expressed how once they disclosed that they were addicts or alcoholics either currently or in recovery this posed a huge barrier to the range of psychological support they were able to access. One female interviewed explained how after years of suffering with poor mental health, including both inpatient and outpatient care, she had been diagnosed with an eating disorder and Borderline Personality Disorder. She had finally secured her own private tenancy, after a year of being homeless and sofa surfing, and was prescribed new medication and DBT Therapy as the most effective treatment option. However, when she disclosed she was having up to four drinks per night in order to cope with how she felt living on her own for the first time and to manage her anxiety and depression she was informed she was no longer eligible for DBT therapy. She was told that as she was "only" drinking four small bottles of alcohol in the evening and managing to not drink during the day she did not qualify for support with her drinking, however, she was too reliant on it to access therapy options. With her alcohol consumption being a barrier to her accessing DBT, but not severe enough to allow her access to any help for her drinking, she feels stuck in a cycle that she is unable to get out of. She expressed also how *"If I had never mentioned*

the alcohol they would have seen me and I would be able to have someone to talk to about my past and how I am feeling, I should have just lied and said I never drank". This highlights why many with drug or alcohol addictions are unlikely to disclose such difficulties to medical professionals or services for fear of being denied the support and treatment they need due to a lack of education, understanding and provision for those with multiple and complex needs.

Another participant explained how although they had been heavily medicated for a psychological condition for over twenty years they were unable to access any psychological support apart from medication as for the last two years they had become reliant on cannabis and alcohol daily. They shared how each time they tried to talk about their mental health issues their issues and symptoms were solely based on their alcohol and drug usage and they were denied talking therapies or any other psychological support. The participant explained how exhausting it was to constantly be told that if they stopped drinking and smoking cannabis they would not suffer from mental health issues despite the fact that the mental health distress the individual experienced pre dated any substance abuse of any kind. The participant openly admitted that alcohol and drug use was not a long term solution for their mental health disorder, however, when no other treatment or talking therapy was available they had become reliant on substances to self-medicate. Self-medication as a way of dealing with mental health problems was a common thread through the responses.

Participants with experience of addiction expressed how they felt discriminated against because of their past or present drug or alcohol misuse and this prevented them from trusting or being willing to engage with services.

"I felt like they didn't care. They said I was complicated and couldn't help as I had mental health and addiction. So why would I trust them again?"

"Having mental health problems and addictions people often judge me by paper and not as a person and see my problems not potential."

Substance misuse as a barrier to accessing mental health services, is a known problem and needs to be addressed for this population. The stigma associated with substance misuse and the resulting impact on support accessed from other services, including housing services, should also be highlighted. Substance misuse should not be a barrier to help.

Childhood

"I wish someone had helped me understand when I was 16, [told me] that it wasn't my fault, and listened to me."

One of the most powerful findings within this research is how many of the causes related to, or started in childhood. Out of the 27 respondents over 50% talked about their childhood in relation to becoming homeless. Within this there were a number of different situations discussed, including childhood abuse, bereavement, a parent in prison, family breakup, being in care and lack of recognition or support as a child.

One respondent stated that 13 was the pivotal age that he wished services could have intervened: *"no one asked what was going on and why I was behaving the way I was, step dad abusing me and then sent into care. Branded a problem kid."* Children in difficulty not being recognised or noticed by those in positions of authority to them, such as teachers and educators, came up repeatedly.

"If people had listened to me at 15 about my step dad"

"I was a young carer and felt more trained than my teachers and had no help"

"I wanted someone to talk to and was angry and upset but no one listened"

The impact of not receiving support, or not being listened to, at this early age had a knock on effect on future experiences. The below interview extracts show the effects that not being helped as a child had on their lives:

“I needed help and support when in care and when I left care but I was left on my own to struggle with what had happened in my life and my mental health. I needed to be made more aware of addiction and recovery and not judged and discriminated against. I asked and asked for help but even when I tried to kill myself lots of times no one listened or tried to understand and help me. I had nowhere safe to live so sofa surfed and was street homeless as this was safer than foster care. Helping me when I was younger could have saved me a lot of suffering and further physical and mental health problems and trauma.

“If as a young child I had been listened to and received appropriate mental health care rather than being sent away to inappropriate psychiatric institutions I believe this could have helped me deal with issues and prevent my mental health from deteriorating and me from spiralling into addiction and self-destructive behaviours. I think teachers, doctors, mental health workers need to be more aware of the signs of childhood abuse and neglect and also of signs of mental health disorders in children and adolescents. Education and help at 14 when discharged from hospital could have given me choices and opportunities which could have alleviated my homelessness. This could have prevented me from living in environments where I was exploited and getting into toxic relationships in order to provide me with somewhere to live. Self-medicating with drugs and alcohol to cope with physical and mental health difficulties escalated due to homelessness and services failing to help me when I was vulnerable and suffering.”

The need for a focus around supporting younger people is echoed by the responses given when asked at what ages they would have benefited from both housing support and benefitted from physical, social or mental health support. The chart to the right details the responses to these questions. Please note totals are over 100% as respondents gave more than one response.

Incredibly stark for both types of support is the need for support to have occurred between the ages of 16 – 20. 96% of those interviewed stated they needed housing support between the ages of 16-20, and 81% physical, social or mental health support.

52% of participants stated they could have benefited from accessing physical, social and psychological support prior to reaching the age of sixteen, against 23% of those who needed access to housing support before 16. Coupled with the stories highlighted above this is a strong suggestion that early intervention in physical, social and mental health needs is vital to help support individuals and reduce homelessness.

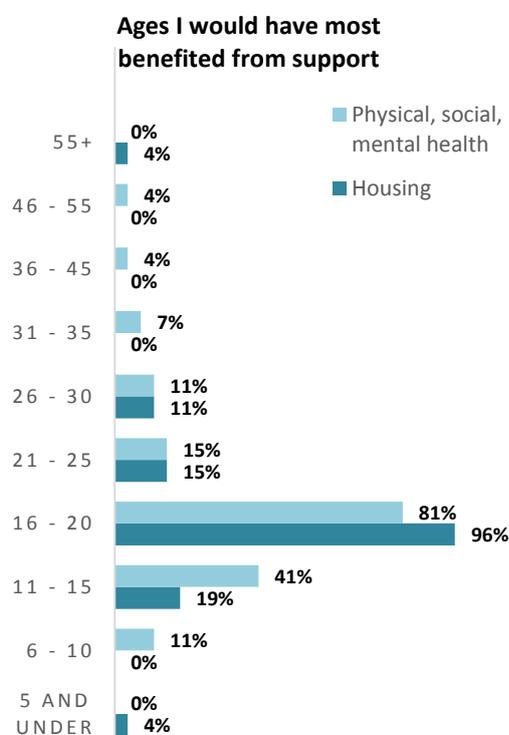
It is important to highlight that for both housing and physical, social and psychological support 16 was seen as the pivotal age for when support would have benefited the most. In particular for housing support, where there was almost as many respondents that stated 16 as any other age.

When delving further into the detail behind people’s responses to the factors that they consider led them to be homeless, the need for support to be accessed at an early age starts to fit into a coherent narrative.

Inappropriate Housing

When talking to individuals who stated leaving the care system as having a contributing factor to them becoming homeless one significant change became apparent, that of leaving care and transitioning, unsupported, from children’s to adult services. A particular issue related to this was finding themselves in inappropriate accommodation for their needs.

An interview with a young woman, who had been in the care system as a child, details this journey: from damaging childhood experiences to inappropriate accommodation. *“No one asked what was going on and why I was behaving*



the way I was, step dad was abusing me and they sent me into care. I was branded a problem kid." This woman then went on to discuss how at 16 she was placed in a women's refuge. When in this refuge she shared how she was very fearful of the other residents, who were all older women, who were using substances and very confrontational, bullying her and physically assaulting her. She was so terrified she shared that she left the refuge as she felt safer sofa surfing, engaging in one night stands for somewhere to stay, and sleeping on the streets rather than the supported accommodation. She shared that this affected her willingness to engage in services as she was *"scared to open up as felt no one wanted to help or listen. I thought it was pointless and I was better off alone"*. Although she had not previously, she admitted to taking drugs in the refuge and how this was because she was scared of not being accepted or being targeted by the other women. She also said this reliance on substances continued to escalate when street homeless to cope with how she felt, to self-medicate for her mental health difficulties, and to tolerate subsequent abusive relationships she engaged in.

A very similar example was offered by another young woman who shared her story of being placed in a women's refuge after being hospitalised for being physically assaulted by her partner. She shared that on being released from residential psychiatric services aged 15 she was thrown out of her parent's home and entered into an abusive relationship with a man many years her senior to have somewhere to live. Again a similar pattern emerged when she shared how frightening the refuge was and how she did not feel safe at all. She also claimed it was in the refuge she first abused substances. This female also left the refuge of her own accord feeling she too was safer out of the supportive housing she had been placed in. When asked what could have prevented her from becoming homeless again she clearly responded with appropriate and supportive accommodation: *"Appropriate safe, long term housing, more support surrounding addiction (relapse prevention) and mental health problems (PTSD/ PD) which impact upon their ability to access and keep appropriate housing"*.

This woman's story is an example of the importance of considering holistic needs not just focussing on a primary or presenting need. Housing an individual fleeing domestic violence in a women's refuge may appear to be an appropriate decision. However this focussed on the individual's primary presenting need and didn't assess her wider physical, psychological and social needs. This woman was already trying to cope with long term psychological illness, was additionally suffering from severe PTSD from her childhood and an abusive relationship. Shared housing caused an increase in anxiety, a decline in her overall mental health and led to self-medicating. This young woman also expressed that due to her past she did not have the life skills or emotional resilience to look after herself physically, emotionally and financially. Placing her with a group of older, influential women who were stronger and took the opportunity to manipulate more vulnerable residents left her open to harm. Had all this individual's needs been considered equally then that the refuge may be detrimental to her overall wellbeing would have been highlighted, and different options taken into account. In this type of environment, utilising a multifaceted and holistic approach the outlook for this young woman could have been very different.

A further example of the impact of inappropriate housing, and a lack of cohesion between children's and adult services was shared by a young man. Aged 16 he had lost his mother after she overdosed on intravenous heroin use. At the time his father was in prison for possession with intent to supply, and following his mother's death, he desperately wanted to remain close to his only remaining family, his six year old brother. During this period of time he states that he *"tried to find somewhere to live so me and my brother could stay together but I was turned away and he (younger brother) was put into care"*. Following two years in care the brother was adopted via closed adoption and no future contact between the brothers was allowed. During this time he was placed in an adult male hostel with no support offered to help him grieve for his mother, and brother. This man highlighted that not only was he very distressed he had also lost all hope, was very vulnerable, and was heavily influenced by the older men in the hostel and their criminal activity and drug usage. When asked how this experience effected his willingness to seek further help from services he responded *"When they would not help and my brother was taken into care, they wouldn't listen to me. By 19 I gave up, see point, no one cared or bothered. I don't trust them, they don't trust me cause I have a record and have used drugs"*. That a vulnerable young man was placed in a harmful hostel environment which led to a series of incidents resulting in his criminal record and addiction problems, highlights how important appropriate and supportive housing is.

These examples highlight the compounding negative impact that inappropriate housing can have on a person's ability to recover and be an engaged and active member of society. Accommodation needs to go beyond merely providing a bed, and generic support, but look holistically at an individual's needs.

Debt and job loss

After mental health needs, childhood trauma and substance misuse issues, debt and job loss constituted another key area that had led to homelessness. It's important to point out that debt was only discussed in conjunction with other issues such as mental health needs or substance misuse.

Discussions of financial issues could be divided into three primary groups: job loss leading to debt, inability to pay bills, or inability to manage money. The below quotes are all taken from questions related to causes of homelessness and demonstrate these three causes of debt or financial issue.

"Drugs and alcohol abuse, offending, debt, unable to pay bills"

"Drug abuse, unable to make rent payments etc."

"Didn't know how to handle money, got evicted."

"Unable to keep up Tenancy...unable to manage money"

"Mental health problems, lost job and home"

"Losing job due to mental health decline and addiction"

Whilst debt and financial issues, including money management, can't be ignored as a trigger for homelessness, that none of these issues were raised in isolation suggests that they aren't an overall cause for homelessness. As the below extract highlights, it was the job loss that resulted in homelessness but had mental health problems been dealt with earlier then this scenario might not have come to pass:

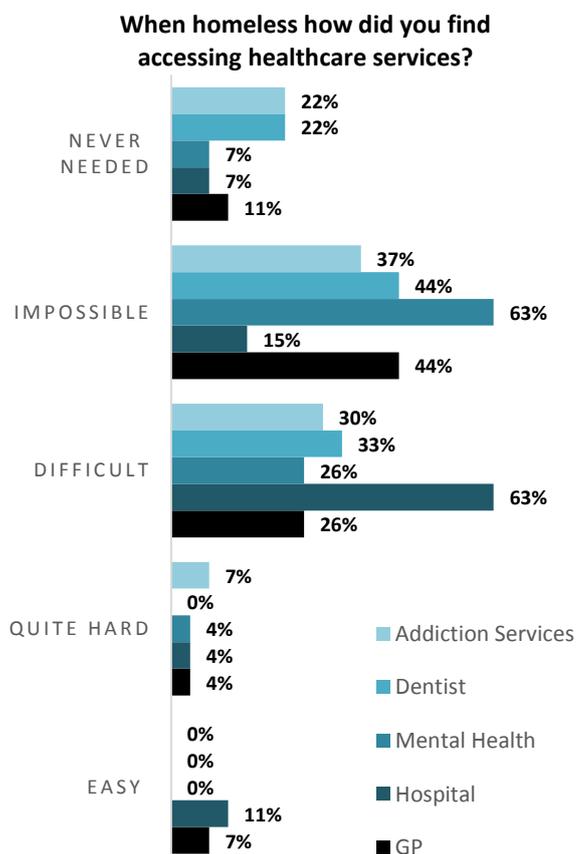
"Reducing stigma against mental health and providing more support would have prevented me from becoming homeless and losing my job in the first place but I was seen as "fine" as I was working. I had to lose my job and everything before anyone even tried to listen."

As with comments raised when exploring mental health, substance misuse and childhood issues an increased awareness, and reducing stigma could have a significant impact on accessing support.

Accessing support

When asked how easy they found it to access a range of different health services, respondents overwhelmingly answered that it was difficult or impossible to access support. The chart below demonstrates the breakdown of these responses.

Overwhelmingly respondents stated that they find it difficult or impossible to access health services. That mental health was raised as one of the primary causes of homelessness but 63% of those asked stated that they found it impossible to access these services, rising to 89% when including those who found it



difficult or impossible, highlights a primary area of concern in relation to homeless populations accessing needed health services. However 70% of the respondents stated it was difficult or impossible to access a GP, 78% that it was difficult or impossible to access other acute health services, and 77% that it was difficult or impossible to access dental care. In general access to health services was perceived as being incredibly challenging.

One of the key issues that was identified in terms of accessing health services was that of them being postcode determined. The homeless population is a particularly transient group, and often without a fixed postcode. This can limit ability to register for GP or dental services but can also cause challenges in accessing and maintaining the support of secondary services. When asked how access to health services could be improved this issue of postcode hindering access was raised repeatedly:

“More inclusive, not requiring permanent address/ proof of utility bills etc., not postcode determined”

“Stop barriers which prevent those who are homeless from accessing health care e.g. postcode requirements.”

“Easier access to health care without permanent address or being postcode defined.”

Improving access and support is explored further in improving support.

Another challenge highlighted when exploring accessing support is that of a lack of cohesion between different services. This is perhaps best demonstrated when looking at being discharged from either hospital or prison homeless. 56% reported being discharged from hospital homeless, 19% had experienced being released from prison with no housing. These transition periods can be crucial for maintaining engagement and providing a consistency of support. That individuals are being discharged between services without appropriate accommodation highlights this lack of joint working between health and housing.

Lack of support

It is not only accessing support that was raised as a problem but also the levels of support accessed once in a service. A number of respondents talked about lack of support and how this had contributed to their homelessness. This was presented both as not knowing how to, or being able to access support, and as poor support being received.

One of the most telling examples of the impact that poor support has had on their interactions with services is highlighted when exploring the responses to questions around their first interactions with services. 24 out of the 27 respondents stated that their first experiences were negative. This negative interaction has a big knock on effect and massively affected the individual's ability to trust and engage with the system in the future due to lack of trust building evidence. Ten respondents stated that when they initially went to seek out support services *“didn't listen”* or *“try to understand”* and then continued to say the support they were offered was inappropriate for both their physical and psychological needs, and their personal circumstances.

“They made me feel like I was wasting their time and they did not want to help or have time so I didn't ask anymore”

“I isolated and withdrew from asking for help for myself due to judgement and fear of losing my children and job and being judged and rejected from services again”

“Scared to open up as felt no one wanted to help or listen. Thought it was pointless and I was better alone”

“They did not take the time to understand or help me understand. They were judgemental and aloof and did not care so I stopped caring or trying to trust the system or services”

One particular story told by one of the respondents highlights a series of instances between services when support was not given, appropriate support was not available, or a lack of cohesion between services.

“If I had been able to have safe housing when younger I would not have had to marry to escape abuse. Also I wanted and tried to leave my ex-husband but couldn't as my eldest son was 14 so could not stay in refuge and could not leave him with abusive ex-husband so I stayed until the kids were grown.

No one asked why I was always ill and injured, felt like no one wanted to get involved. Even when hospitalised with fractured skull when pregnant no one offered me a way out or help. If they had me and the kids could have been saved from years of abuse, I begged for help but couldn't get any so blamed myself and still do.

Education is key to help people avoid homelessness and domestic abuse and make services more aware of those in desperate need of safe places to raise their kids.”

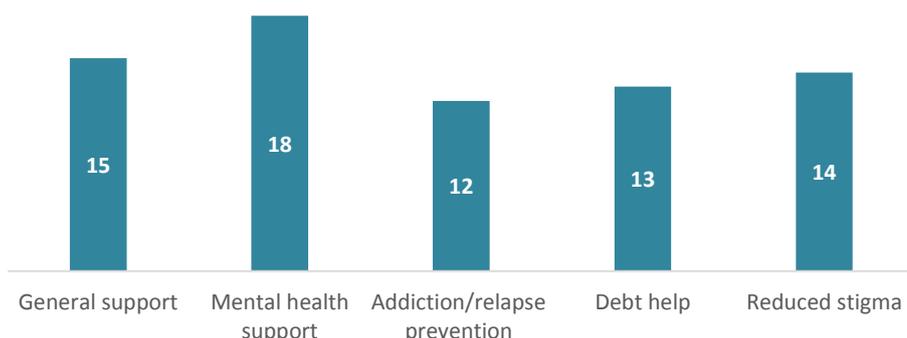
As this story highlights it is not one incident that results in homelessness, or problems accessing support, for this woman it was a series of missed opportunities that started in childhood, encompassed inappropriate accommodation (refuges that can't accommodate older children), and health services not reading the bigger picture.

Feeling like they were not being listened too, or seen as a person was highlighted many times by participants as they identified the need for a person centred holistic approach to housing and accessing psychological and social support.

Improving support

When respondents were asked “what could have prevented you from going from being in stable accommodation to becoming homeless again?” several key themes were identified:

What would have prevented you from becoming homeless?

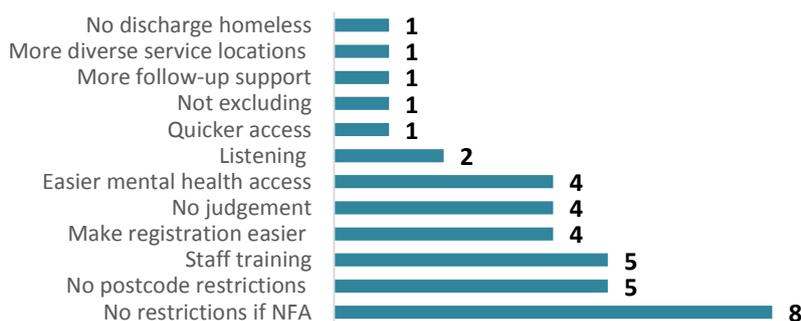


These categories very much relate to the themes identified when exploring the reasons leading up to homelessness, therefore when looking at how to better support this population these areas should be given priority.

improved. Chart 2.6 details the responses to this question. Lack of address and postcode restrictions were again highlighted as being one of the primary drivers that could improve access to services. Second to this are improvements relating to staff, focussing on both workforce development and looking to reduce real, or perceived, judgement and stigma towards this population.

When asked how housing services could be improved, there was an overwhelming weight towards more appropriate housing. This included better supported accommodation, more focus on creating safe environments, and as with health services, focussing on workforce development to help reduce stigma amongst staff.

How could access to health services be improved for homeless people?



Conclusion

Through an entirely peer led and developed research programme this report has looked to identify the causes leading up to homelessness, and the barriers that this population encounters in accessing support with a particular focus around health services.

A number of clear themes were highlighted as being particular

drivers leading to homelessness. Mental health, difficulty in accessing mental health support, and the continuing stigma that surrounds certain mental health diagnoses were identified as some of the primary causes of homelessness. When considered within the context of nearly 90% of those asked stating that mental health services were difficult or impossible to access, exploring how to improve access to mental health support for people both currently homeless, but also at risk of homelessness should be prioritised.

Childhood trauma was also identified as a common thread by those interviewed. When considering a preventative approach then more needs to be invested in supporting children's services and support agencies to understanding future impacts on those currently suffering from difficulties and trauma in their childhood. This should include a better awareness of the factors leading up to substance misuse, offending behaviour, and disengaging from support. In addition to this, a pivotal period identified was the transitioning between children's and adult services. With a majority of respondents highlighting that their late teens and early twenties were the critical periods in their life when support would be most needed, but that this would also be the time when they would be transitioning between children's and adults support and potentially facing disruption in their provision.

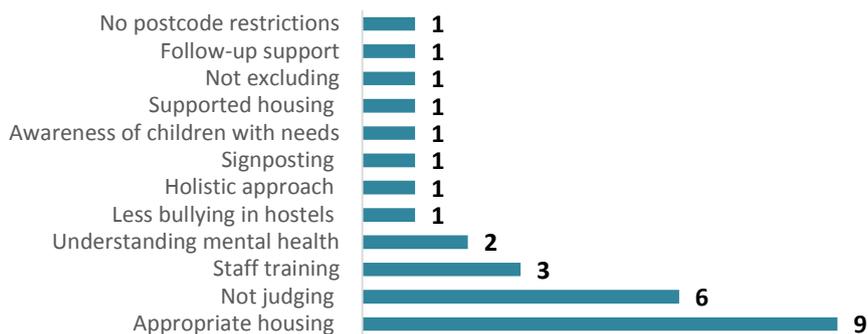
Substance misuse was also identified as a key reason behind homelessness, and was identified as one of the main elements that prevented access to support through both stigma, and the issue of dual diagnosis in mental health support.

Stigma overall, a feeling of not being listened to, or trusted were dominant themes raised in this research. Improved staff training and awareness of complex problems were highlighted as being needed to both increase a feeling of empathy between services and their users, and to increase knowledge and understanding of the issues these individuals are facing.

The solutions offered by those individuals interviewed directly relate to the themes identified through exploring the journey to homelessness. They identify certain practical recommendations such as easier access to health care services through reducing the need for permanent addresses and postcodes, or more diverse service locations but threading through the recommendations for both health care and housing services is the request for staff to listen and not to judge.

"They see a label and a complicated history and immediately see a problem not a person. People are scared by mental health and addiction but need educating not to judge"

How could homelessness services be improved?



3. Recommendations

Based on the findings of this research and the lived experience of the researchers, the following recommendations have been made to improve services and support for people struggling with homelessness.

1. Improved early intervention: Trauma, family breakdown, or support needed at an early age was a common theme amongst those interviewed. A lack of awareness amongst children's services, or systems they're interacting with, and appropriate support was highlighted as having an effect on their later life experiences. **Children's and youth services need to be better trained to deal with the impact of family breakdown, abuse, substance misuse and mental health needs on children.**
2. **Improved transition for those both leaving the care system and transitioning from children's to adult services.**
3. Increased education for front line workers to reduce stigma and discrimination: Service users report that they still face stigma and discrimination amongst services including dedicated support services for homeless individuals. **Workforce development is needed to ensure that individuals are seen as a person not a problem.**
4. **Changing policies around postcodes limiting access to health services:** either not being able to access services because of NFA or postcode, or because regularly change in addresses means support is no longer available.
5. Person centred, holistic approach in accommodation services: services aren't always appropriate for those in recovery, for those with mental health needs, for different age ranges etc. **Supported housing needs to be delivered by staff who are appropriately trained to support those with multiple and complex needs and by organisations focusing on outcomes that truly reflect and meet the needs of the individuals they support.**
6. **Substance misuse should not be a barrier in accessing mental health support.** Mental health services need to be better able to respond to individuals who have problems with both mental health needs and addiction.