Understanding the impacts of Homelessness in Wiltshire

A health needs assessment

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Wiltshire Council

Where everybody matters

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Executive Summary

Background

Homelessness is not just a housing problem; it can be caused by a multitude of social, individual and economic factors (Fitzpatrick, 2000). As a complex issue; it often occurs because of a combination of events, such as relationship breakdown, debt, adverse experiences in childhood, as well as ill health. The problem of homelessness is multi-facetted and therefore needs a multi-agency approach. There remains an intrinsic link between homelessness and ill health. Evidence reports the health of people experiencing homelessness is significantly worse than that of the general population. Understanding homelessness is essential in improving health outcomes and reducing health inequalities.

Purpose, Scope and Methodology

This needs assessment is an epidemiological, corporate and comparative needs assessment. It will be used to further the understanding of homelessness in Wiltshire.

Local Need

Demographics

Wiltshire is a predominantly rural county with a population of 486,000. In the next 25 years the population is expected to grow by 13% to 547,000. Military rebasing is a significant driver of this population growth. The population has a higher proportion of over 65s than the national average, and a BME population that is proportionally one third of that observed nationally. The county is relatively affluent although there has been an increase in relative deprivation since 2004. There are some localised pockets of significant deprivation.

Risk Factors and Triggers associated with Homelessness

This health needs assessment looks at those risk factors and triggers associated with homelessness. It helps to understand possible causes, and be better informed to predict when or to whom it may happen. Homelessness can result from the impact of structural, institutional, relationship and personal risk factors and triggers, which together can have a cumulative impact and are often underpinned by poverty and structural inequalities.

Prevalence of Homelessness in Wiltshire

Overall volume of homeless applications in Wiltshire are reducing, which contrasts with national trends. The greatest proportion of homeless presentations made were by lone female parents with dependent children (47 in 2017-18). Just under two-thirds (63%) of those statutory homeless in Wiltshire were aged 25-44yrs, with 16% being 16-24yrs. The majority of homeless applications were received from White/White British (97%) and 9% from Black/Black British. Comparison against local demographics, homelessness rates are disproportionately higher amongst black and minority ethnic groups.

Rough sleeping is the most visible form of homelessness and the most damaging. Rough Sleeper counts in Wiltshire have fluctuated since their inception; figures are relatively low, peaking at 42 recorded in 2018 (September). The Government's Rough Sleeper Initiative (RSI) was launched in 2018; Wiltshire's RSI project secured more than £600,000 over 2years. The last rough sleeper count in Wiltshire recorded 22 (November 2018).

Local Support

Local provision of homelessness support in Wiltshire has been mapped and recorded. Services available are a combination of support provided by both statutory and voluntary sector organisations.

Policy context

Homelessness as an issue has undergone radical political reform in recent years, which is because of better understanding of the wider social, economic, cultural and political context that underpins the agenda.

Impact of homelessness on health

Ill health can be both a 'cause' and 'consequence' of homelessness, with greater prevalence rates amongst homeless communities for some co-occurring conditions, such as mental ill health, substance misuse and alcohol dependency. The greatest health inequality experienced within homelessness communities and in particular those sleeping rough relates to life expectancy, with an inequality gap of 34yrs for men and 38yrs for women. Accessibility to primary care remains a concern, with a majority utilising emergency acute health services, at a far greater cost.

Impact of homelessness on children, families and communities

The impacts of homelessness on children, families and communities, are significant and long-lasting. The loss of a stable home environment increases the vulnerability of children and their risk of and exposure to violence and abuse, as well as trauma and adverse experiences.

Economic impact of homelessness

Homelessness in all its forms has significantly increased in recent years, and thought to cost the public sector more than £1billion a year. There is increasing recognition that failure to prevent and reduce homelessness is causing significant, but potentially avoidable increases in public spending

Evidence Review

Shelter remains one of our most basic needs. Safe and secure housing must therefore be a core outcome for meeting the health and social care needs of individuals and communities. There remains a vast evidence-base about 'why' people are homeless or experience homeless, which also expands into interventions to support those with complex needs, including substance misuse, mental health problems and other physical health conditions. Although much of this evidence relates to homelessness in general, rather than other subsets of vulnerability. Homeless communities are a key vulnerable group, who are at increased risk of experiencing health inequalities, with higher morbidity and mortality than the general population.

Conclusion

There is no single approach to addressing homelessness, it remains a serious and enduring issue. Wiltshire considers and addresses 'housing' as part of the wider determinants that can and will influence the health and wellbeing of our local communities. It is viewed as part of the wider vulnerability response and is considered in cases of domestic abuse, substance misuse, safeguarding, as well as across the wider Community Safety Partnership agenda.

Recommendations

Recommendations have been identified and include ways to strengthen an integrated approach to addressing homelessness and the wider subsets of vulnerability, and ensure data is captured to allow effective monitoring of the issues going forward.

Contents

"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)

Introduction

Homelessness has serious health implications for both individuals and populations. As a result, Wiltshire Council requested a health needs assessment (HNA) for homelessness. A HNA is a tool for change, used to identify the health needs of a population or a population in a geographical area. It is an important tool in tackling inequalities and encourages deeper inquiry into why health and well-being outcomes of a population of interest differ from the wider population and what can be done to close the gap.

This review focuses on homeless communities, who are often enduring multiple and complex needs. The work was prompted following the increased awareness that some homeless people in Wiltshire are experiencing more complex and numerous health and social harms than others, resulting in greater personal, social and economic cost.

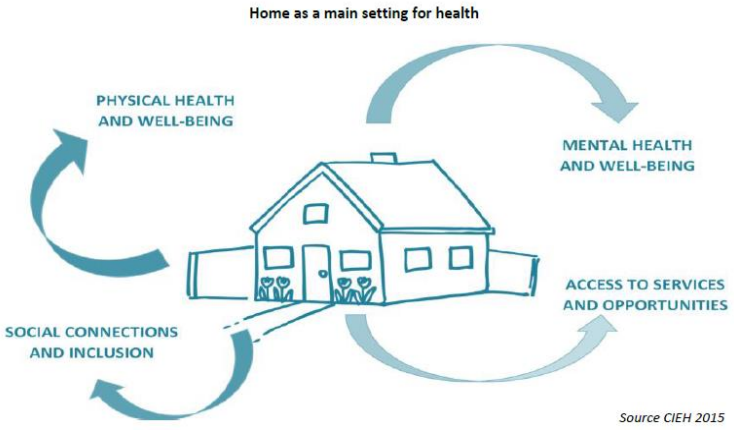
Background

Homelessness is not just a housing problem; it can be caused by a multitude of social, individual and economic factors (Fitzpatrick, 2000). Examining the number of people experiencing homelessness is difficult firstly because the definition and secondly, people who are homeless are typically mobile and therefore difficult to monitor.

The domains of homelessness are not mutually exclusive; and people may move in and out of these domains as their circumstances and needs change.

Public Health England (PHE) have recently developed a multi-stranded programme to reduce the impact of poor, unsuitable housing and homelessness has on physical and mental well-being. The approach focuses on the 'home' as the main setting for health throughout people's lives (Figure 1). This is driven by the recognition that the home plays a key role in enabling people to achieve good health and wellbeing (PHE, 2016).

Figure 1 Home as a main setting for health



Definition

The term **homelessness** is often considered to apply to those people 'sleeping rough'. A legal definition of homelessness centres on:

> **A lack of housing that someone could reasonably expect to occupy, ranging from a lack of housing, through to housing that is too insecure, overcrowded or otherwise unfit for occupation**

An alternative definition used by Crisis UK includes:

> **Homelessness is about more than rooflessness. A home is not just a physical space, it also has a legal and social dimension. A home provides roots, identity, a sense of belonging and a place of emotional wellbeing. Homelessness is about the loss of all these. It is an isolating and destructive experience and homeless people are some of the most vulnerable and social excluded in our society**

The legislation in England is contained within part 7 of the Housing Act 1996 (amended by the Homeless Act 2002). The responsibility is on local authorities to consider housing needs, including the needs of homeless households. The domains of homelessness are listed in Appendix A and include:

Statutory homelessness or threatened with Homelessness (priority need)
An individual or household is accepted by a local authority as meeting the criteria set out in the Housing Act 1996 we would have a duty to provide suitable accommodation. Being threatened with homelessness applies to those who are at risk of losing their home within 56 days.

Rough sleepers
Is the most visible form of homelessness; it involves those who sleep or live on the streets. Many people who sleep rough will suffer from multiple health conditions, such as mental health problems and drug misuse and they are also in greater danger of violence and poor ill health than the general population.

Hidden homeless
Individuals or households who do not have access to suitable housing, but may be staying with friends or family and are often not known to services. This can also include those who have no recourse to public funds.

Single homelessness or non-statutory homeless
Are those people who are not owed a duty by local authorities, therefore not entitled to an offer or settled accommodation. They either fall outside of the definition of priority need or found ineligible for support.

Priority Need is set out in legislation, which includes:

- Pregnancy
- A person with dependent children
- A young person 16-17yrs
- A person threatened with homelessness due to an emergency e.g. flood, fire etc
- Care leavers
- A vulnerable person including:
  - Old age
  - Physical/Learning Disabilities
  - Mental Health Problems
  - Fleeing Domestic Abuse

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.

People become homeless for lots of different reasons. There are social causes of homelessness, such as lack of affordable housing, poverty, unemployment and life events that cause individuals to become homeless. For many life events like a relationship breaking down, losing a job, metal or physical health problems, or substance misuse can be the trigger.

Purpose, Scope and Methodology

The Homelessness Health Needs Assessment (HNA) will assess the scale, nature and impact of homelessness in Wiltshire. It will provide information which can be used to address the wider determinants of health, as well as influence future strategies and actions to prevent and alleviate homelessness and to reduce health inequalities. This needs assessment is an epidemiological, corporate and comparative needs assessment.

It aims to:

- Understand and describe the population of Wiltshire.
- Understand and describe the prevalence of homelessness in Wiltshire.
- Identify where and how homelessness overlaps with other issues associated with deep social exclusion and poor health outcomes, including: *Drugs and Alcohol, Criminal Exploitation, Unemployment, Family Breakdown, Social Displacement etc*.
- Identify the triggers and pathways to vulnerability and protective factors across the lifecourse.
- Understand the system and service response to homelessness in Wiltshire.
- Understand and describe inequalities experienced by those experiencing homelessness and consider how these may be addressed.
- Collate the current policy context supporting the agenda and;
- Understand the enforcement options and civil remedies.

The traditional model of epidemiological, corporate and comparative healthcare needs assessment was developed by Stevens and Rafferty (1994). This review draws on all three approaches. The epidemiological need considers the severity and size of homelessness in Wiltshire. Corporate need looks at the perceptions of the service providers, commissioners and users while comparative need looks at the data in comparison to other localities/sub groups and national targets.

Wiltshire Housing have undertaken a Homelessness Data Review, should be read in conjunction with this Homelessness Health Needs Assessment.

Limitations of the data

The issue of homelessness remains a complex issue. This review attempts to bring together a variety of data sources to establish a more comprehensive understanding of the issues of homelessness and its impact it is having on the County. However, the data can be patchy and imperfect at times.

Governance arrangements for the Health Needs Assessment

The governance for the health needs assessment sits with the Wiltshire Community Safety Partnership and will be developed through the Homelessness Strategy and Health Needs Assessment Project Board.

National context

This chapter provides an overview of the national prevalence of homelessness.

Overview

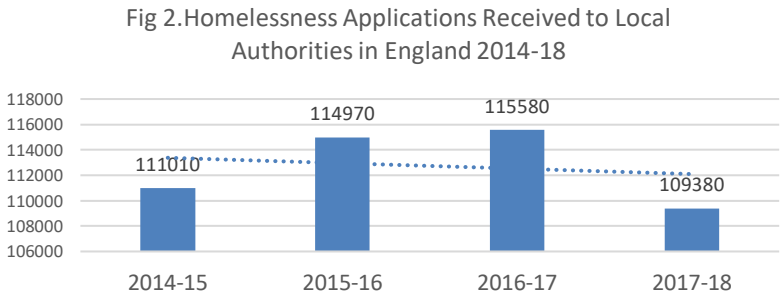
Homelessness is a complex agenda, with the scale and nature often being difficult to understand. Housing alone is often not the only solution, particularly when people are already in poor health and/or have other needs that require additional support (Leng, 2017). Over recent years, there has been increasing political interest in this agenda.

Prevalence

Over the last decade, homelessness has reported an upward trend nationally. To support a better understanding of the agenda, a government select committee launched an inquiry in 2015 (House of Commons, 2016); it's mandate included to understand prevalence, as well as begin to explore the pressures and impacts of homelessness on those it affects.

Since 2009/10 homeless applications have increased by 30% in England, peaking in 2016/17 (figure 2). Data in 2017/18, recorded 109,380 homeless applications, reflecting the first reduction (-5%, n=6,200) in recent years.

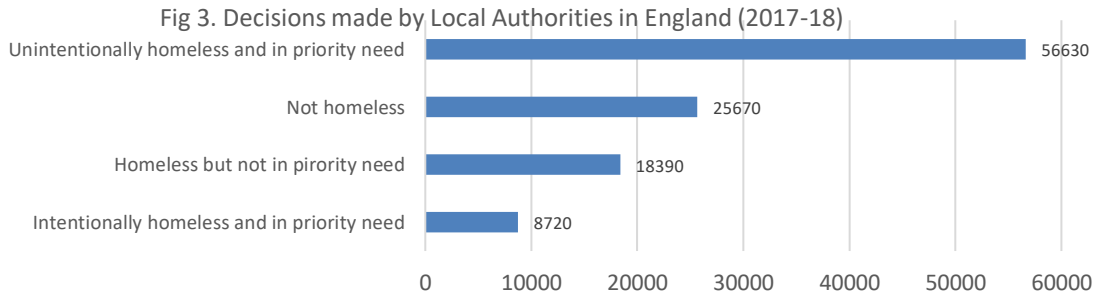
Figure 2 Homelessness Applications Received in England



source: Ministry of Housing, Communities and Local Government

In 2017/18, of the 109,380 homeless applications received, 52% (56,630 households) were accepted as statutorily homeless and in priority need. Figure 3 provides a breakdown of local authority decision in 2017/18. Just under a quarter (23%) of the housing applications received were assessed as 'not homeless'. However, 17% (n=18,390) of applications, whilst were assessed as 'homeless', were not in priority need, therefore no statutory requirement on local authorities to accommodate.

Figure 3 Decisions made by Local Authorities in England in 2017-18



source: Ministry of Housing, Communities and Local Government

The top three reasons for homelessness includes:

1. **Parents, other relatives or friends no longer willing or able to accommodate** (28% Q4 Jan-March 2018, DCLG 2018);
2. **Loss of rented or tied-accommodation due to termination of assured shorthold tenancy** (AST) (25%) and;
3. V**iolent breakdown of relationship involving a partner** (12%)

Termination of AST's has been an increasingly important cause of loss of last home over recent years. It can occur for a range of reasons including;

- Financial; lack of budgeting skills, rent increase, reduced employment income, changes to benefit entitlement, as well as;
- Changes in personal circumstances; relationship-breakdown, family fall-out, leaving an institution.

Households in temporary accommodation

To understand those households living in temporary accommodation (TA), national data uses a snapshot, rather than a cumulative total. As of the 31st March 2018, 79,880 households were living in TA (DCLG, 2018[1]). Of those recorded as living in TA, 86% (n=68,480) were housed in self-contained accommodation, with 14% (n=11,400) being housed using shared facilities e.g. bed and breakfasts, hostels or women's refuges.

Visible Homelessness (Rough Sleeping)

Outcomes associated with homelessness and rough sleeping remain poor. Many will experience poor mental ill health, substance misuse problems, as well as a range of physical health problems, further exuberated by their living conditions. Crisis (2016) reported that core homelessness had increased nationally by 33% between 2011-2016.

The annual count (and estimates) for rough sleeping in England, provides a snapshot of the number of people visibly sleeping rough on an identified night, within a local authority area. The total number of rough sleepers counted (and estimated) in 2017 was 4,751 (MHCLG, 2018). This represented a 15% increase (+617) on the previous count (4,134). Further information reported 14% of rough sleepers were women; 20% were non-UK nationals and 8% were under 25yrs old.

Conclusion

The volume of homelessness has continued to increase over recent years. This, coupled with a growing interest in the topic at a national and political level, has been contributory in an increasing recognition that homelessness is not a housing problem alone. Homelessness remains a complex agenda, one which requires a multi-agency approach.

However, whilst improvements have been made in data recording to better inform the understanding. The scale of the problem is still being masked, with those 'hidden' forms of homelessness such as staying with parents, family, friends, sofa-surfing etc, not always being considered. Whilst for some, homelessness will not be part of the equation, there will be others for whom this is a probable pathway.

[1] National figures are significantly skewed by London figures, with London accounting for 68% of the national total.

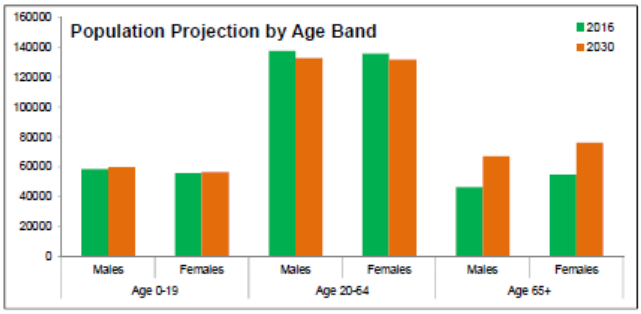
Local Demography

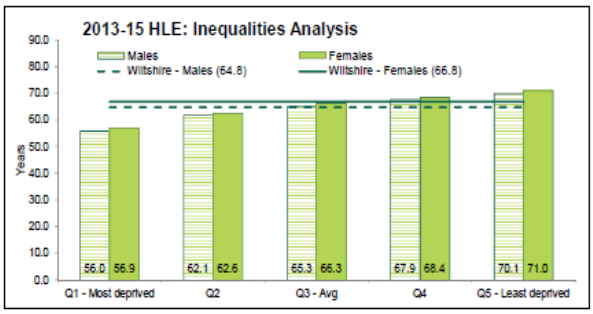
This chapter provides an overview of the Wiltshire population and considers the wider determinants influencing health and wellbeing.

Overview

Wiltshire is a predominantly rural county with a population of 486,000. In the next 25 years the population is expected to grow by 13% to 547,000, with most growth expected in the 65+ age group (figure 4). Military rebasing is a significant driver of this population growth. Wiltshire's population has a higher proportion of over 65s than the national average, and a BME population that is proportionally one third of that observed nationally.

Figure 4 Projected population by Age Band and Figure 5 Healthy Life Expectancy





source: Office of National Statistics

The number of people aged over 75 is projected to increase from 45,400 in 2015 to 76,400 in 2025 (an increase of 68%). By 2026, it is projected that the population will switch, resulting in the older population in the county for the first time exceeding the younger population.

The county is relatively affluent although there has been an increase in relative deprivation since 2004. There are some localised pockets of significant deprivation. 51% of the population is female.

Males in Wiltshire can expect to live till **80.8** years of age and **females 84.0** years of age (ONS life expectancy 2013 to 2015). However, healthy life expectancy will not be equal across our communities with an inequality gap in healthy life expectancy of about 14 years for men and women (figure 5).

Sex

51% of the population is female. The table below shows the population by sex and broad age bands. In line with national trends, due to different life expectancies there are significantly more women aged 65+ than men.

Figure 6 Population data by sex

People	Wiltshire		South West		England	
	Number	% of Pop	Number	% of Pop	Number	% of Pop
Age 0-17	104,046	21.4	1,082,081	19.8	11,677,856	21.3
Age 18-64	282,861	58.2	3,220,145	58.9	33,396,899	61.0
Age 65+	99,186	20.4	1,168,954	21.4	9,711,572	17.7
Total	486,093	100	5,471,180	100	54,786,327	100

Males	Wiltshire		South West		England	
	Number	% of Pop	Number	% of Pop	Number	% of Pop
Age 0-17	52,906	22.0	553,785	20.6	7,053,719	22.0
Age 18-64	141,992	59.1	1,602,476	59.6	19,768,448	61.6
Age 65+	453,95	18.9	531,835	19.8	5,252,278	16.4
Total	240,293	100	2,688,096	100	32,074,445	100

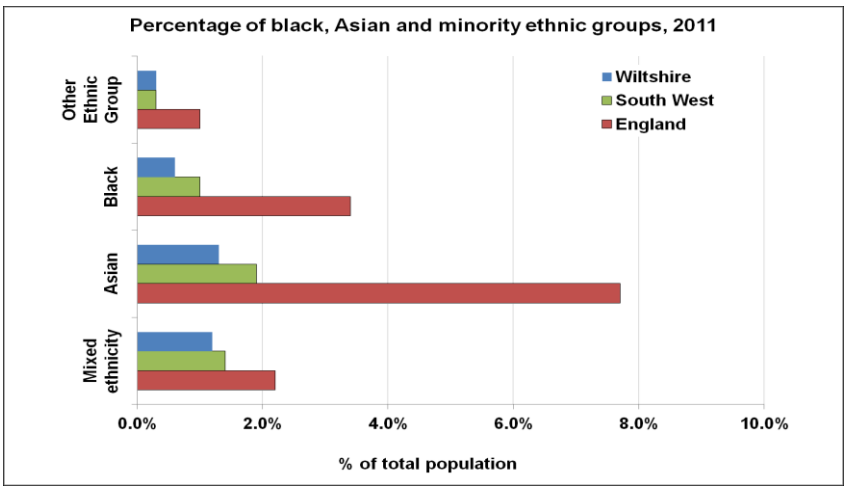
Females	Wiltshire		South West		England	
	Number	% of Pop	Number	% of Pop	Number	% of Pop
Age 0-17	51,140	20.8	528,296	19.0	6717,154	20.3
Age 18-64	140,869	57.3	1,617,669	58.1	19,959,546	60.4
Age 65+	53,791	21.9	637,119	22.9	6,358,889	19.3
Total	245,800	100	2,783,084	100	33,035,589	100

(source: Office of National Statistics)

Black, Asian and Minority Ethnic Groups

Wiltshire is predominantly White British (93%). People in minority groups are often not present in Wiltshire in sufficient numbers to form recognisable groups. According to 2011 Census figures, ethnic minorities make up 6.6% of the population (31,256 people). Wiltshire has a lower proportion of ethnic minorities than the South West region as a whole (6.6% vs 8.2%) and a considerably lower proportion than for England as a whole (6.6% vs 20.2%). The proportion of the population from ethnic minority groups in Wiltshire has increased by 129% between 2001 and 2011 compared to 114% in the South West and 74% in England. Obtaining accurate information on ethnicity between censuses is difficult.

Figure 7 Comparison data of Black, Asian and Minority Ethnic groups (2011)



source: Office of National Statistics

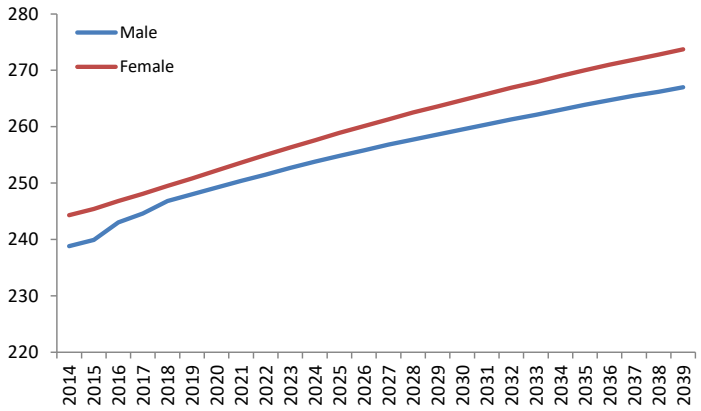
Projected Population Growth and the Military

Over the next 25 years the population of Wiltshire is expected to grow by around 12%, an addition 58,000 people (figure 8).

The steep rise in the male population between 2014 and 2019 reflects the impact of the military rebasing that is expected to occur. The ONS projections have not adjusted for accompanying spouses and children, and so are likely to be an underestimate of the true population. It is locally estimated there will be around 1,400 spouses and 1,800 children. Including additional military

spouses and families would take the projected increase in population from 12% to at least 13%, or an additional 61,000 people in total.

Figure 8 Projected population growth in Wiltshire



source: Office of National Statistics

Socio-economic

Wiltshire's overall deprivation level compares favourably against the national benchmark. However, the county has seen an increase in relative deprivation since the 2004. For the first time, Wiltshire now has one geographic region in the 10% most severely deprived in England (Salisbury St Martin – Central).

Wider determinants of health

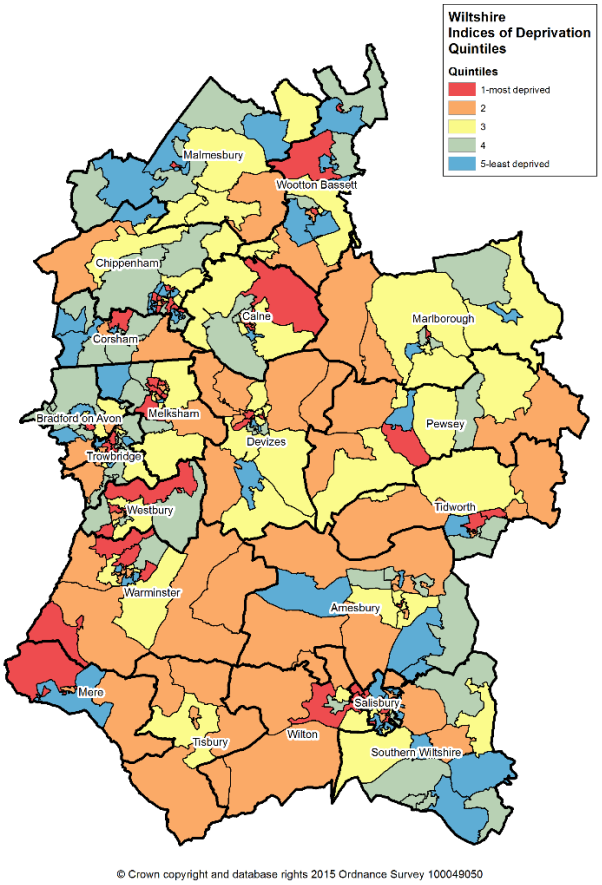
The wider determinants of health are also known as the social determinants and have been described as 'the causes of the causes'. They are the social, economic and environmental conditions that influence the health of individuals and populations. They include the conditions of daily life and the structural influences upon them. They determine the extent to which a person has the right physical, social and personal resources to achieve their goals, meet needs and deal with changes to their circumstances.

Deprivation

Poverty has a negative effect on health at all ages. Compared to England, Wiltshire has few areas of high deprivation. The English Indices of Deprivation 2015/16 Wiltshire report identified 39 (14%) of Wiltshire's 285 lower super output areas (smaller areas) were classified as in the most deprived 40% nationally. Of these one area (Trowbridge John of Gaunt-Studley Green) was in the 10% most deprived decile, 11 were in the second decile and 10 in the third decile.

Whilst Wiltshire can be considered least deprived than many other local authorities in England, 4% of Wiltshire's population live in the most deprived and second most deprived deciles in England. Figure 9 provides a map of all the locations within Wiltshire shaded to show the national deprivation decile into which they fall. Most of the deprived areas are in Trowbridge and Salisbury with Chippenham and Melksham also having a number of areas with high deprivation.

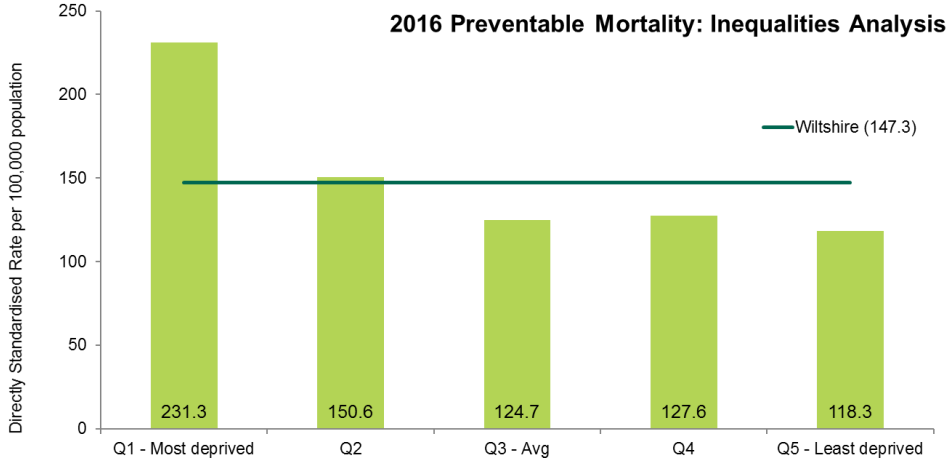
Figures 9 Map of Deprivation in Wiltshire with Community Areas (IMD 2015)



Source Ordanance Survey

To further demonstrate the impact of deprivation on our local populations, figure 10 illustrates those living in the most deprived areas have nearly double the rate of preventable mortality compared to those in the least deprived quintile.

Figures 10 Preventable Mortality – Inequality Analysis



Source Wiltshire Intelligence

Unemployment is associated with an increased risk of ill health and mortality. There are relationships between unemployment and poor mental ill health and suicide, as well as a higher prevalence of risky health behaviours including alcohol use and smoking.

In 2017 2,805 people in Wiltshire claimed Jobseekers allowance or Universal Credit and were required to seek employment. This represents 0.96% of the working age population, a rate lower than England and the South West. 4.1% of working age adults in Wiltshire (compared to 5.8% England) are unable to work due to illness or disability.

A further indicator includes the number of households living in fuel poverty. In 2015 it was thought 11.8% (23,965 households) were impacted.

Housing

To support the understanding of homelessness in Wiltshire, it is useful to consider the wider housing issues. Wiltshire's population is around 486,000 people, equating to around 205,000 households (ONS, 2016).

Wiltshire has a relatively small private rented sector and a larger than average owner-occupied sector. House prices remain high in Wiltshire. The average house price in June 2017 was £277,813 compared to £217,128 in Swindon, £253,374 in Mendip and £335,481 in BANES (Land Registry, 2018). The median house prices are now 8.99 times median annual earning (DCLG, 2016). Private sector rents are amongst the highest in the region (Valuation Office Agency, 2018), average £725 p/mth (South West range: High £1,000 Bristol to £540 Torridge, Devon).

Data for 2011 showed Wiltshire's private sector accommodated 17% of households (compared to 18.1% in England). The restrictions placed on certain welfare benefits (Nation Audits Office, 2017; Shelter, 2017), has further challenged the accessibility for benefit dependent families in affordable accommodation in the private sector. The stigma associated with welfare claimants, the well-publicised difficulties with universal credit, as well as reasons relating to landlord's insurance have all played contributory factors in making this more difficult in recent years.

Wiltshire Council have 5,289 rental properties. Aster, Selwood and GreenSquare (Registered Social Landlords) own 17,412 homes that are rented for general needs and sheltered units.

The increasing ageing population and the current military re-basing scheme in Wiltshire, means that a further 42,000 homes will be needed to address this projected population growth. With a further 1,136 additional units of extra care housing being required by 2026.

Conclusion

Wiltshire is expected to experience continued population growth over the next 25years. The military rebasing is a significant driver of this population growth. The population has a higher proportion of over 65s than the national average, and a BME population that is proportionally one third of that observed nationally. Whilst the county is relatively affluent, there has been an increase in relative deprivation since 2004, with some localised pockets of significant deprivation. Housing pressures in Wiltshire are likely to be impacted by high house prices, as well as the expensive and relatively small private rental market.

The prevalence of homelessness in Wiltshire

This chapter summarises the data to assess the scale, nature and impact of homelessness in Wiltshire.

Homelessness Review for Wiltshire

To support the development of Wiltshire's Homelessness strategy, the local authority's housing team produced a homelessness review. The homelessness review should be read in conjunction with the Homelessness Health Needs Assessment. The headlines are summerised in the section below.

Statutory homelessness

In 2017/18 Wiltshire received 356 homelessness applications, with 249 assessed as priority need, 53 were intentional and 16 non-priority cases (figure 11). The volume of applications has reduced since 2014/15. Nationally there has been a 4% increase in statutory homeless in the southwest during this time.

Figure 11 Statutory Homelessness applications

Year	Total Homeless Decisions	Those in Priority Need	Intentional	Non-priority	Acceptance Rate
2014-15	542	437	40	16	81%
2015-16	386	285	33	23	74%
2016-17	354	269	48	12	76%
2017-18	356	249	53	16	70%

Source Wiltshire Council, Housing

Just under three quarters (73%) of applications were assessed as priority due to dependent children in 2017/18.

The most common 'cause' for a homeless application in Wiltshire in 2017/18 was (figure 12):

- Termination of an assured shorthold tenancy, accounting for 31% of acceptances;
- Parents, friends or other relatives no longer willing or able to accommodate, accounting for 29% of cases in 2017/18, an increase of 17% from 2014/15

Figure 12 Primary reason for homeless application in Wiltshire

Primary reason	2014-15	2015-16	2016-17	2017-18
Parents no longer willing to accommodate	**41**	**47**	**32**	**27**
Other relatives / friends no longer willing to accommodate	**32**	**18**	**30**	**34**
Non-violent relationship breakdown	**44**	**32**	**34**	**37**
Violence in relationship	21	26	24	15
Harassment	0	0	0	0
Mortgage Arrears	0	0	6	0
Rent arrears	0	0	5	0
Termination of AST	**110**	**99**	**84**	**77**
Loss of rented accommodation other	10	11	17	11
Left institution	0	0	0	6
Left HM Forces	65	7	20	22
Other	0	0	**0**	7

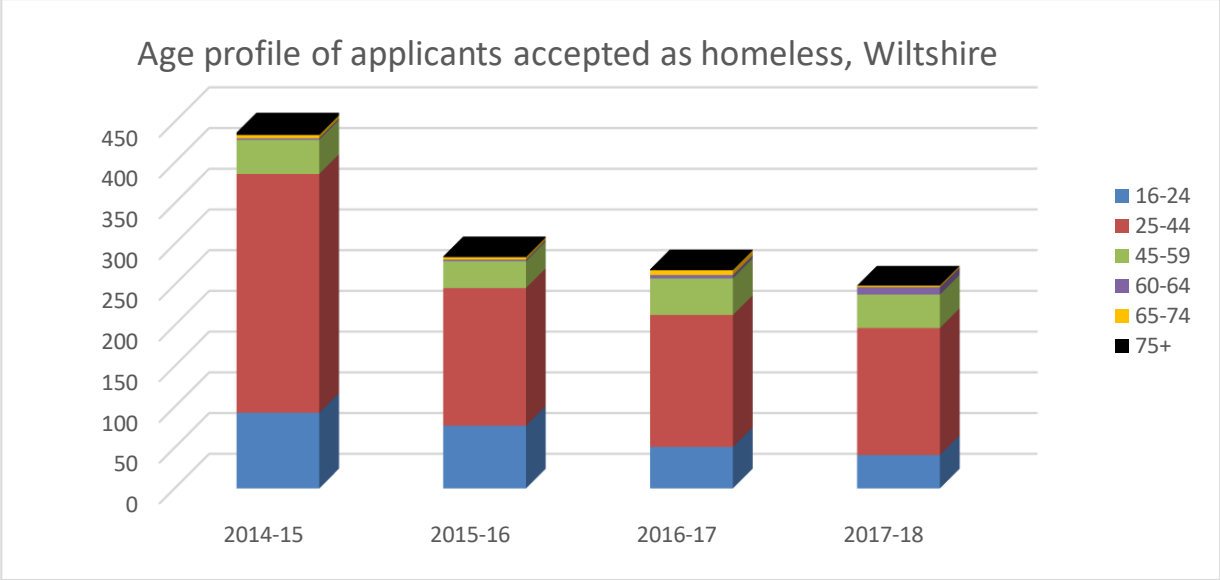
Source Wiltshire Council, Housing

Profile of Homeless Applicants

The most frequent household presentation in Wiltshire was a lone female parent with dependent children, accounting for 47% of statutory homelessness in 2017/18, (up from 41% in 2014/15). Single homeless households accounted for 17% of cases in 2017/18, double the applications received in 2014/15 (8%).

Figure 13 shows the age profile of applications, accepted as homeless from 2014/15 to 2017/18. The greatest proportion of applications are received from 25-44yr olds.

Figure 13 Age profile of homeless applicants



Source Wiltshire Council, Housing

The ethnicity of statutory homelessness has stayed roughly the same over the last 4 years, with 87% being white in 2017/18, 9% being of black or black British ethnicity. Comparing these figures against recent population data, homelessness rates are disproportionately higher amongst black and minority ethnic groups. This is not isolated to just Wiltshire and has been flagged through national government statistics as an emerging issue.

Temporary accommodation

The number of households in temporary accommodation has fallen from 106 in 2014/15 to 93 in 2017/18, although the number of children in these households has increased from 167 to 171. England has seen the use of temporary accommodation grow, with 3.4 per 1,000 households being in temporary accommodation during 2017/18. The rate of temporary accommodation in Wiltshire during 2017/18 is below this at 0.45 per 1,000 households, a decrease from 0.53 in 2014/15. Floating support is also provided to households living in temporary accommodation.

Figure 14 Total clients and children in temporary accommodation, Wiltshire

Year	Number of households	Number of children
2014-15	106	167
2015-16	127	200
2016-17	112	173
2017-18	93	171

Source MHCLG, 2018a

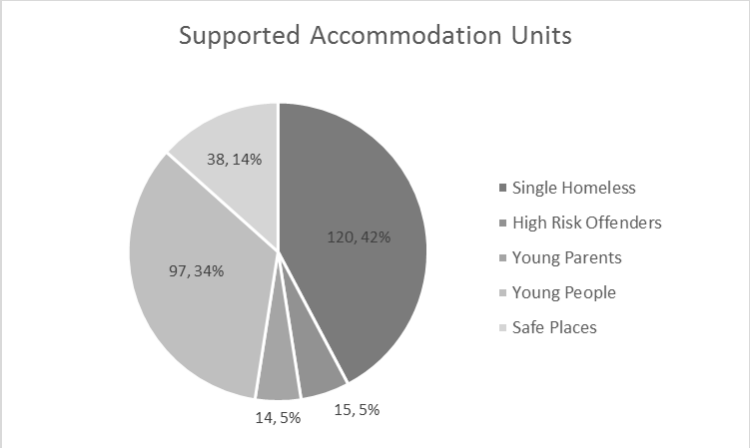
Supported Accommodation

The local authority funds services for homeless people with support needs falling into the following categories (figure 15):

- High risk offenders,
- Single homeless people,
- Fleeing domestic abuse (Places of Safety)
- Young parents and;
- Young people

Supported housing is generally provided in furnished hostels, shared houses and self-contained accommodation. Each service employs trained staff to support clients to develop their independence and tenancy management skills, to move on to longer-term accommodation. Support levels vary according to client need.

Figure 15 Supported Accommodation by units in Wiltshire



Source Wiltshire Council, Housing

Prevention and Relief

Homelessness prevention and relief refers to action taken to help resolve homelessness. In Wiltshire, homelessness prevention and relief cases have increased by 14% since 2014/15 to 5.62 cases per 1,000, well below the national rate of 9.16 cases per 1,000 where England saw a 5% decrease since 2014/15.

Wiltshire has a multi-faceted and innovative approach to homelessness prevention. For example, plans and processes relating to the extension of homelessness duties under the Homelessness Reduction Act 2017 were introduced in advance of the statutory implementation date. In 2017-18, Wiltshire was successful in preventing homelessness in 1171 cases. Wiltshire's extensive homelessness prevention work is particularly effective in reducing the number of homeless applications. Those that are made are more likely to be accepted; hence the higher rate than elsewhere.

Conclusion

Overall volume of homelessness applications has reduced in Wiltshire since 2014/15. The greatest volume of homeless applications in priority need are received from lone, females with dependent children. The average age profile accepted by the local authority as homeless is 25-44yrs. Homelessness rates are disproportionately higher amongst black and minority ethnic groups, although this is not isolated to just Wiltshire. Wiltshire continues to record reductions in its rate of temporary accommodation.

Vulnerable communities identified in Wiltshire

This chapter reviews those subsets of vulnerability, where the risk factors and triggers associated with homelessness are greater. This includes:

- Rough Sleepers (Visible Homelessness)
- Transitions and Care Leavers
- Learning Disability
- Severe Mental Health Illness
- Substance Misuse
- Domestic Abuse
- Ex-Service Personnel
- Offender Re-Settlement
- Modern Slavery and Human Trafficking
- Health protection for homeless populations – screening and immunisations

Rough Sleepers (Visible Homelessness)

Rough sleeping is the most visible form of homelessness and the most damaging. It can cause significant harm to an individual's physical health and mental health well-being, as well as reduced life expectancy. Rough sleeping and the street-based behaviour often associated with it, such as begging, street drinking and other forms of antisocial behaviour are also highly damaging to communities.

In Wiltshire, the number of recorded rough sleepers remains relatively low, however, the increase over more recent years has been significant, from 9 (2014) to 42 (2018). In comparison, the southwest recorded a 60% rise and a 73% in England. Figure 16 provides an overview of the rough sleeper data, which reports a fluctuating picture for Wiltshire.

Figure 16 Rough Sleeper Count - Comparison

Autumn of:	Wiltshire	South West	England
2014	9	362	2,744
2015	23	509	3,569
2016	18	536	4,134
2017	31	580	4,751
2018 (Sept)	42	Not Available	Not Available
2018 (Nov)	22	Not Available	Not Available

Source Wiltshire Council – Housing

Under the terms of the Government's Rough Sleeper Initiative, of which Wiltshire's project is one, local authority housing is required to submit regular rough sleeper counts. The most recent estimates of rough sleeping (September and November 2018), recorded 42 and 22 rough sleepers in the county. 80% of those sleeping rough were men and most being 25yrs or over. The latest figure reflects a significant reduction, which could reflect a positive correlation between the RSI project commencing. In Wiltshire, the local authority housing team have noticed an increase in the number of rough sleepers, who also have a range of overlapping and multiple disadvantages including substance misuse, poor physical and mental health and offending history.

Transitions and Care leavers

There is an increasing evidence-base acknowledging the complexity of the transitions journey from childhood to adulthood. A process further challenged if those young people transitioning have

additional needs (NICE, 2016). Those leaving care, may struggle to cope with the transition to adulthood and may experience social exclusion, unemployment, health problems or end up in custody. All of which reflect those wider subsets of vulnerability, which underpin the risk factors associated with homelessness.

Only half of the children in care have emotional health and behaviour that is considered normal and this poses additional challenges when adapting to life after care. In 2013, 50% of young people were still living with their parents at the age of 22. But young people in care have to leave by their 18th birthday and some will have to live independently as soon as they leave care. The cost of not moving into adulthood successfully is likely to be high to both care leavers and the public.

Approximate numbers of children and young people with a mental health disorder at any given time (based on national prevalence rates) have been calculated for Wiltshire:

- Nearly 4,000 children and young people (aged 5 to 16) with conduct disorders;
- Over 2,500 with emotional disorders (depression and anxiety);
- Over 1,000 being hyperactive (ADHD)
- Nearly 1,000 with less common disorders (ASD, eating disorders, tics)

The prevalence of these disorders is higher among looked after children, minority ethnic groups, young offenders and those from deprived areas. Whilst this data is taken from 2014, the proportions are unlikely to have significantly changed.

Learning Disability

Within Wiltshire, it remains extremely rare for a person known to the Local Authority with a learning disability diagnosis to become homeless; due to their care being overseen by a care manager (qualified social worker). The Local Authority has statutory duties towards this client group under the Care Act 2014. There are processes in place to notify housing, in the event a placement breakdown may occur and there is a risk of homelessness, as well as a in the event of a person presenting with an undiagnosed learning disability.

Severe Mental Health Illness

The provision available through the supported accommodation (figure 15), will look to house people with mental health issues. It is common for mental health conditions to co-exist alongside other conditions e.g. drugs and alcohol misuse, learning difficulties etc. In Wiltshire, persons with a severe mental health condition, who has become homeless may be able to access specific supported housing schemes.

Substance Misuse

The evidence-base supports a positive correlation between homelessness and co-existing conditions like mental health and substance misuse. The Wiltshire commissioned substance misuse service provided by Turning Point, have provided supporting information collected in relation to their clients and their housing status (figure 17). In 2017, the service supported 26 rough sleepers with substance misuse support (26, 2016 and 14, 2015). Whilst this figure is relatively small, other data captured indicates a higher proportion of clients being supported who could be flagged ‘at risk’ of homelessness i.e. temporarily staying with friends/family, sofa surfing etc.

A further challenge identified by the Drugs and Alcohol service in Wiltshire relates to engagement in support. Anecdotally, it is reported how the chaotic lifestyles of those individuals homeless with drug and/or alcohol issues often find it difficult to keep to appointments, sometimes further challenged to getting to where support is being offered. There is a joined-up approach between the Rough Sleep Initiative project in Wiltshire and substance misuse service, both offering outreach, the use of substances is recognised as push/pull factors into why someone may experience homelessness, as well as being used to self-medicate, further contributing to keeping them in the homelessness cycle.

Figure 17 Turning Point Clients by Housing Type

Row Labels	2013	2014	2015	2016	2017
Accomm with Care Support	21	31	28	21	28
Armed Forces Accommodation	1		9	26	11
Direct Access Hostel	10	32	26	10	4
Hostel	1	1	20	42	45
Mobile Accommodation		2	8	2	3
Other Homeless	17	17	25	20	3
Owner/Occupier	123	192	176	166	166
Parents Home	3		26	35	72
Rough Sleeper	7	18	14	26	26
Settled Caravan			5	1	2
Settled With Friends/Family	1		38	113	95
Sheltered Accomm	3	9	4	3	2
Sofa Surfing	26	19	30	39	27
Squatting			1	2	1
Temp Accom by LA	10	18	13	4	6
Temp Accomm Family/Friends	94	162	155	57	78
Temp B&B				1	2
Temp Short Stay Hostel			3	5	1
Tenant Housing Assoc	235	148	140	139	131
Tenant Housing Assoc (Greensquare)	9	6	3		3
Tenant LA/Reg Landlord	53	116	143	142	143
Tenant Private Landlord	132	148	191	151	173
(blank)	765	103	11	10	
Grand Total	**1511**	**1022**	**1069**	**1015**	**1022**

Source Turning Point

Domestic Abuse

A violent relationship breakdown is the 6th most common reason for homelessness in Wiltshire; there were 15 applications in 2017/18 (24, 2016/17). However, what we are unable to ascertain is the number of individuals whose experience of domestic abuse is the causation of using informal arrangements such as staying with family and friends. In Wiltshire, domestic abuse reports to the police in 2017/18 were 3,205 (Wiltshire Local Authority area), compared to 3,312 the previous year. The average number of women accommodated in a Wiltshire refuge was 127 (2015/16).

Wiltshire launched a new integrated domestic abuse and sexual violence support service in April 2018. The new contract incorporated places of safety. It provides emergency accommodation for those fleeing domestic abuse, which seeks to reduce health inequalities such as accessibility for male victims, large families, families with teenage boys, victims with multiple complex needs and families with pets etc.

Ex-Service Personnel

Wiltshire is part of the Government's Army Rebasing plan, which will see approximately 4,000 army personnel return and around 3,200 dependants. By 2020, it is projected that in Wiltshire there will be 17,700 armed personnel and an additional 14,300 family members. As the evidence

reports there are correlations between leaving an institution, such as the military and homelessness, data in Wiltshire is limited.

Offender Re-settlement

Currently in Wiltshire, HMP Erlestoke is a Category C establishment holding adult male sentenced offenders and from July 2018 a small cohort of Young Adults.

When someone is released from prison, they need stability and security to help get their lives back on track and reduce the risk of further re-offending. However, too often they are released with nowhere to go. Home Office findings suggested prisoners who have accommodation arranged on release are 4x more likely to have employment, education or training arranged, than those who do not. Evidence supports people leaving prison are at high risk of homelessness, which could be due to:

- Being homeless prior to prison sentence,
- Drugs and/or alcohol dependency
- Unable to access right support on their release

7 out of 10 homeless ex-offenders are re-convicted within a year (Homeless Link, 2018).

There are provisions for HMP Erlestoke in Wiltshire to become a 50% 'Resettlement' prison in 2019/20. The proposed changes will have an impact on the local housing infrastructure and support services. In Wiltshire, work has already been initiated to begin to better understand the relationship between offender and homelessness. Through this work it seeks to understand the demand and profile of accommodation needs for offenders, which will also consider the level of support needs also required. Using this information will ensure commissioners and housing providers are better informed to understand the risks of homelessness for offenders, to work together to reduce future reoffending.

Work is being planned to use information held by Probation and CRC on offender profiles and their needs, to map and plan demand of prison release cohorts for housing and support.

Modern Slavery and human trafficking

The Modern Slavery agenda continues to gather momentum and there are clear links between trafficking, modern slavery and homelessness (Homeless Line, 2018). Trafficking is a risk for people who are homeless, insecurely house or otherwise vulnerable. People may become homeless after escaping exploitation or be targeted by traffickers while using homeless services. Evidence suggests many British nationals who have become victims of trafficking have slept rough and/or have mental health issues or learning disabilities (Salvation Army, 2013). Traffickers are increasingly seeing those services supporting vulnerable individuals as prime locations to target people for exploitation. It is vital for homelessness services to work together with partner agencies to ensure vulnerable people are not put at any increased risk, when accessing their services.

Health protection for homeless populations - Immunisation and Screening

Evidence reports ill health to be both a cause and consequence of homelessness. Therefore, healthcare professionals have an important part to play, alongside a multi-agency response to (PHE, 2018):

- Identify the risk of homelessness among people who have poor health and prevent this;
- Minimise the impact on health from homelessness among people who are already experiencing it and;
- Enable improved health outcomes for people experiencing homelessness so that their poor health is not a barrier to moving on to a home of their own.

There is an anecdotal assumption that homeless communities are less likely to be invited or access routine screening and immunisation programmes. Immunisations such as flu, shingles and pneumococcal vaccinations are of significance in terms of their contribution towards keeping people healthy when homeless. However, homelessness communities are at greater risk of inequities with regards to accessibility to immunisation and/or screening programmes due to not being registered at a GP practice. Whilst there are some practices locally in Wiltshire supporting homeless populations, with some practices have enhanced service agreements with the Clinical Commissioning Group. However, there is a risk of accessibility and provision being post-code driven.

Conclusion

Availability of recorded data for some of Wiltshire's vulnerable and 'at risk' communities of homelessness remains limited. Going forward it would be useful to build a baseline picture to better inform a better understanding of the volumes impacted in Wiltshire.

Whilst there are specialist services operating in Wiltshire to support (visible) homeless communities, further work is required to join up the support with accessibility to health services including immunisations.

Local support offered

Overview

This chapter details the local support offer available in Wiltshire to support homelessness.

Rough Sleeper Initiate - Wiltshire

Wiltshire Local Authority were successful in a national bid for the Rough Sleepers Initiative, to deliver improvements to local provisions for rough sleepers over 2018-2020. Wiltshire were awarded:

£312,245 for 2018-19
£305,491 for 2019-20

Wiltshire's rough sleeping programme includes:

- Recruitment of a Rough Sleeper Team Leader managing a team of 5 rough sleeper outreach workers, (including one worker specialising in mental health and one rough sleeper prevention worker).
- An 8-bed winter provision in Trowbridge, including overnight support.
- 6 Intensive High level support bed spaces for entrenched rough sleepers with complex needs.
- 10 bed spaces at Alabare Place, Salisbury for a sit up service and Severe Weather provision, as well as 10 winter provision spaces at Unity House in Chippenham and 8 Severe Weather provision places.
- Funding to secure 15 private lets for rough sleepers and £10k to use for personal budget requests to help unlock barriers in securing accommodation.

Rough Sleeper provisions available in Wiltshire

Figure 18 tables the current rough sleeper provision available in Wiltshire.

Figure 18 Rough Sleeper Provision in Wiltshire

Project Name/Location	Opening **Times**	**Services provided**
Doorway, Chippenham	Monday morning & Thursday afternoon	Breakfast on Monday & a hot lunch on Thursdays, showers, laundry and benefit support.
Opendoors, Devizes	Monday 11:00 - 13:00 Midday meal, Wednesday 09:30 - 11:30 Breakfast, Thursday 14:00 - 16:00, Friday 17:00-18:30 Evening meal.	Access to showers, food and benefit support.
The Hub, Bradford on Avon	Monday - Friday 10:00 - 13:00	Benefits support, Internet access, Food bank and the

		Hub plan to provide hot food from the 1st November this will be for the winter months.
Breakthrough, Trowbridge	Monday & Tuesday 10:00am - 13:00	Providing Hot food, support with benefits.
Cornerstone, Warminster	Monday, Wednesday, Friday 10:00- 12:30	Access to the internet, support with benefits and a food bank.
Cross Point, Westbury	Monday, Wednesday 14:30 - 17:00 & Thursday, Friday 10:00- 12:30	Support with benefits. No food provided. Access to Warminster foodbank.
Alabare, Salisbury Street Project	Monday, Wednesday & Friday 11-15:00	Support with benefits, hot meals, clothing store, sleeping bags, laundry and washing facilities
SP2 Community Coffee shop, Salisbury	Monday - Friday 10:30 - 4:30	Reasonably priced drinks and snacks. Free drinks if RS.
Lifeline, Melksham	Monday and Thursday	Hot showers, Tea/Coffee, Debt/Housing advice.
Trowbridge Soup Kitchen, St Stephens Car Park, ground floor.	Every evening from 19:00	Hot food/drinks.
Unity House Drop in	Tuesday, Friday Sunday 14:00-16:00	Showers, Laundry, Link up with other services.

Policy context

This chapter considers the current policy backdrop surrounding the homelessness agenda.

Overview

To address the issues of homelessness consideration is needed in the design and delivery of services. Collective action is required on the wider determinants of health, including the wider policies that inadvertently or directly contribute to increased inequalities. Figure 19 lists key policies, outcome frameworks and guidance influencing overall health and wellbeing of those who are homeless and often have multiple, complex needs:

Figures 19 Key policies, frameworks and guidance

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 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)

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 Strategies
The Wiltshire Housing Strategy 2017-2022
Wiltshire Core Strategy (2015)
Army Rebasing Plan (and military covenant)
Swindon and Wiltshire Strategic Economic Plan (2016)
Wiltshire Local Transport Plan (2011-2026)
Wiltshire Joint Health and Wellbeing strategy (2015-2018)

Outcomes Frameworks
The Public Health Outcomes Framework, Healthy Lives, Healthy People: Improving Outcomes and Supporting Transparency
The NHS Outcomes Framework 2015-16

National Guidelines
NICE Guidelines

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 drugs misuse with mental health: guidance to support local commissioning and delivery care (2014)
NHS Alliance: Housing – Just What the Doctor Ordered (2016)

Further information on the key policies and frameworks are listed in appendix B.

There are two key areas of policy reform, including the Homelessness Reduction Act 2017 and Universal Credits, both significantly influencing the area.

Homelessness Reduction Act 2017

The Homelessness Reduction Act 2017 is one of the biggest changes to the rights of homeless people in England for 15 years. It effectively bolts two new duties to the original statutory rehousing duty:

- Duty to prevent homelessness
- Duty to relieve homelessness

It places new legal duties on local housing authorities and amends the existing homelessness legislation in the Housing Act 1996.

Universal Credit

Universal Credit is a single payment for people of working age that replaced six existing benefits; housing benefit, child tax credit, income support, working tax credit, income based job seekers allowance and employment and support allowance. It is paid monthly in arrears to people aged 16 and over who are in employment or who are out of work and looking for a job. Universal Credit may have contributory impacts onto the wider homelessness agenda, such as:

- Claimants must wait six weeks or longer before they receive their first monthly payment
- Due to the new process, the Department of Work and Pensions figures identify that some clients don't receive the money they are owed on time
- Social landlords have noticed a significant increase in rent arrears
- The transition from fortnightly to monthly payments is impacting on families who struggle to manage monthly budgets

Conclusion

Homelessness as an issue has undergone radical political reform in recent years, which is because of better understanding of the wider social, economic, cultural and political context that underpins the agenda.

Risk factors and triggers associated with homelessness

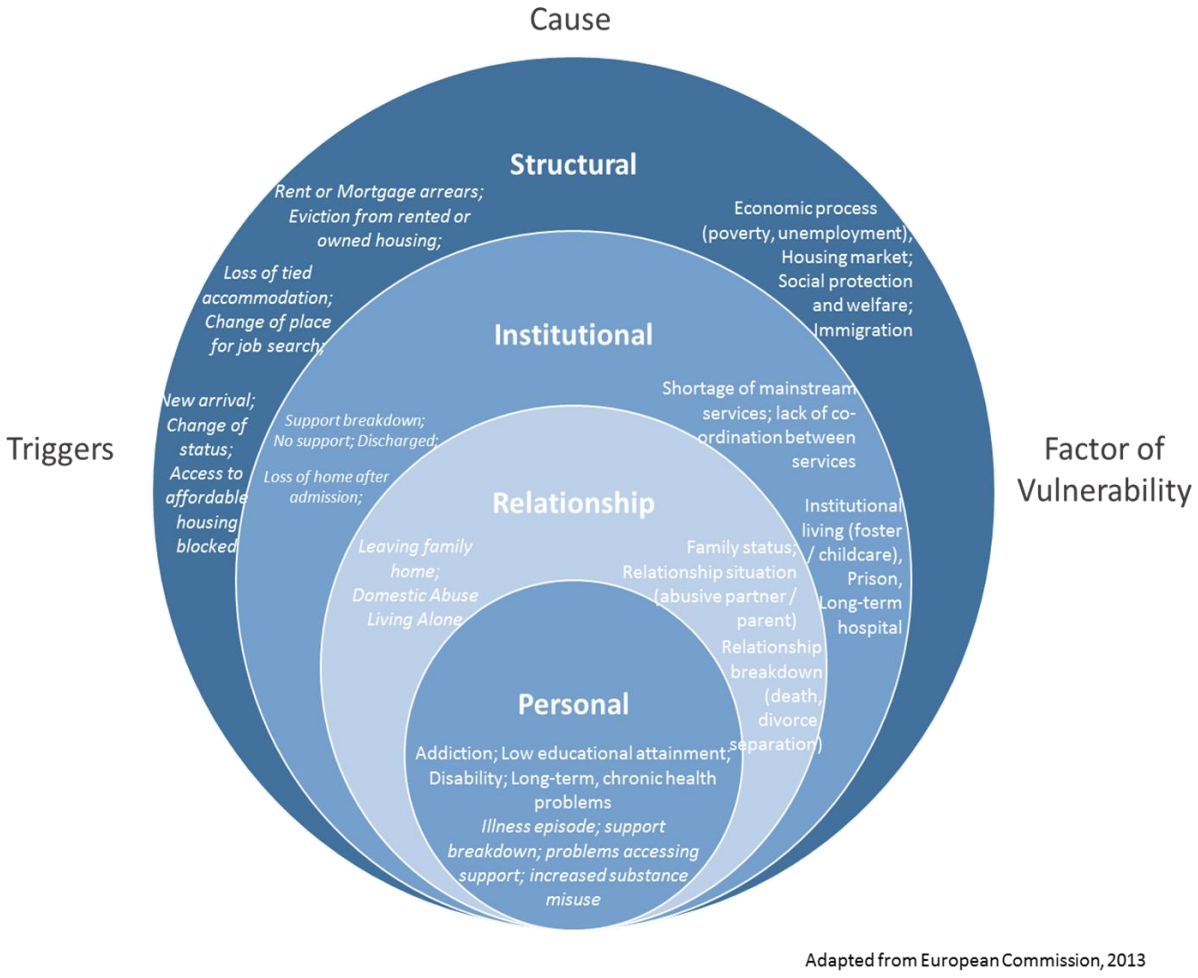
This chapter explores those risk factors and triggers associated with homelessness.

Overview

A knowledge of associated risk factors and triggers into homelessness is necessary to be able to understand what causes it and/or to have a greater opportunity to predict in advance when, or to whom it may happen. This goes someway to help inform service delivery and interventions that can mitigate social risk factors and target 'at risk' groups.

Evidence suggests homelessness results from the impact of structural, institutional, relationship and personal risk factors and triggers. Together, can have a cumulative impact, often further influenced by poverty and structural inequalities. These issues were considered in a comprehensive report by the European Commission (2013), represented in figure 20.

Figures 20 Factors and Triggers Associated with Homelessness



Adapted from European Commission, 2013

More recently, the Department for Communities and Local Government (DCLG) examined the root causes behind homelessness. In its third report, DCLG (2016) identifying how roots into homelessness are complex; often associated with numerous factors including the economy, the housing market, as well as personal factors linked to the individual or the family. The wider

determinants such as social displacement, exclusion, criminality and risk of exploitation offer further understanding of probable 'push-pull' factors linked to homelessness.

Supply of affordable housing

The overall supply of affordable housing was identified as a key 'structural' factor (Wilson and Barton, 2016). Affordable housing includes social rented and intermediate housing (provided to eligible households whose needs are not met by the market). This can be used to prevent and reduce homelessness, if it is rapidly accessible to those people at risk of experiencing homelessness (Please *et al*. 2015). There are now over one million fewer homes owned by local authorities and housing associations, then in 1977 (Wilson and Barton, 2016). Consequently, this limits local authorities' ability to house homeless families and those families in need.

Even if social housing is available, there are however obstacles preventing some individuals with often multiple complex needs from being able to access it. This population may be at higher risk of having lower levels of educational attainment, coupled with poor self-esteem, making accessing social housing systems harder to navigate (Please *et al*. 2015). The Inquiry into Homelessness (DCLG, 2016) highlighted obstacles, such as rejections from housing waiting lists for people with offending backgrounds, regardless of their housing need or the fact that the offences did not relate to management of a tenancy. A further obstacle cited by the inquiry included the requirement for rent in advance.

The private rented sector provides the main alternative to social housing, providing affordable housing to prevent and reduce homelessness. However, over recent years the appetite for private rental landlords to house vulnerable or high-risk tenants has reduced, citing the financial barriers and instability of tenancies as being too great (DCLG, 2016). Research indicates that the private rented sector is failing to provide quality, stable homes for those in need (Smith *et al*. 2014). Furthermore, a study commissioned by Crisis (Reeve *et al*. 2016) found government policy to be compounding, rather than mitigating the difficulties faced by homeless people.

Poverty

Common risk factors associated with homelessness are unemployment or working in very low-skilled and/or unstable employment. Those people who are not poor, are more able to avoid homelessness, because even if they experience a crisis, they are able to afford temporary accommodation. Research supports the relationship between poverty and homelessness is two-way. Poverty can be a 'precursor' to homelessness, as well as for those who experience homelessness, the majority will remain in poverty even after they have been re-housed.

A Joseph Rowntree Foundation review (2014) highlighted how the poverty people faced was further complicated by additional requirements for support e.g. mental and/or physical ill health. Homeless people were faced with further barriers in accessing and retaining employment which included: lack of stable housing, work disincentives associated with the welfare benefits system, vulnerabilities and support needs, low educational attainment, limited or no work experience, low self-esteem and employer discrimination. It went further to evidence 'primary' homeless prevention to combat structural factors that contribute to economic disadvantage in the first place, offer the most effective means to disrupt homelessness and poverty. As such, primary prevention measures seek to reduce the risk of homelessness, by improving housing supply, access and affordability, as well as reforming aspects of the welfare settlement.

Psychological Understanding

Understanding the psychological relationship with homelessness remains significant. Mental health issues are further exacerbated and linked with economic, social and health depreciation. Recent evidence collated by the University of Southampton for the DCLG Homelessness Inquiry, highlighted that psychological factors can influence the way in which individuals behave, given a set of environmental contingencies (Maguire, 2009). This research further showed high levels of childhood abuse and neglect in homeless communities, linked to attachment problems and difficulties in dealing with emotions. All are known contributory factors in drug and alcohol misuse and anti-social behaviours, which can lead to tenancy breakdown.

The Hard Edges study (Bramely, et al. 2015) identified a strong correlation between the extent of neglect and trauma experienced in childhood and the severity of disadvantage then experienced in adulthood. For example, people in contact with all three systems including homelessness, criminal justice and drug treatment were at least three times more likely (than those in contact with one) to have experienced growing up in a homeless family, had a parent who was violent, a parent with a drug/alcohol problem or a parent that was mentally ill *[ibid]*.

A 5-year research study undertaken by Cardiff University (Shelton, 2016) explored the risk factors for homelessness among young people. Shelton (2016) asked for further consideration to be given to how young people contending with intractable conflict, aggressions and abuse at home may be at increased risk of homelessness. As well as identifying a correlation between disengagement at school and risk of homelessness.

Lifecycle transitions

Research supports an increased risk of homelessness and lifecycle transitions. Key transition points include; adolescence, leaving education, the parental home or a care institution, including prisons, hospital, mental health institutions and foster care (European Commission, 2013). Data reported by Crisis (2016) identified across England of those in direct access with hostels, on average:

- 18% of clients were prison leavers
- 8% were care leavers
- 3% were ex-service users

Many people deinstitutionalised will not have a family home to return to, may have lost their home during their care/stay or unable to find suitable new housing. They are also vulnerable to social exclusion, which can further exacerbate the risk of homelessness (Wilson and Barton, 2016).

Understanding specific needs

Gender

Homelessness is an example of a gendered issue; the majority of those that are disadvantaged are middle aged, single men (European Commission, 2013). Women, in contrast are more visible in the statutory homeless system in the UK. This is in part enabled by the system being designed to support homeless lone women with dependent children and other women with support needs (Pleace et al, 2008). Single women account for approximately 17% of clients accessing homelessness services (Mackie, 2014). Triggers for men included relationship breakdown, substance misuse and leaving an institution. In contrast for women the most common reasons are physical or mental health problems and fleeing a violent or abusive relationship (Smith, 2008).

28% of homeless women have formed unwanted sexual partnerships to secure a roof over their heads, with 20% engaging in prostitution to raise funds for accommodation (DCLG, 2016). The same review, further identified women who had been victims of domestic abuse, were at increased risk of homelessness.

Ex-Service Personnel

This is a group of interest currently at a UK policy agenda level. The causal relationship between homelessness and military experience remains variable at an individual level. This can include; exposure to difficult and challenging experiences during military service, which continues to affect them after discharge; others carry vulnerabilities from childhood; whilst for others homelessness is triggered by an un-related crisis, e.g. bereavement or bankruptcy (Johnson et al, 2008).

Care leavers

Looked after children refers to all children under 18yrs being looked after by a local authority; this includes both those subject to a care order (s.31, the Children's Act 1989) and those looked after by a voluntary agreement with their parents (s.20, the Children's Act 1989). Whilst many young people in care will endure successful transitions into adulthood, there remains a significant proportion leaving care aged 16,17 or 18 who will encounter a range of difficulties. One of the most common features of a poor transition to adulthood is housing instability, risk of homelessness and actual homelessness. Around one third of young people with care backgrounds will experience homelessness at some stage between 6 and 24 months of leaving care. Homeless in this context included; sofa surfing, staying in hostels/refuges, sleeping rough and staying in B&B's. The National Audit Office (2015) reported in 2010 25% of those people who were homeless had been in care at some point during their lives.

Offending and Leaving Prison

There remains a close relationship between homelessness and offending, with 'prisons' being both a 'cause' and 'effect' of homelessness. 1 in 5 individuals leaving prison have no home to go to on release (DCLG, 2016). Furthermore, almost half of homeless people had been in prison or a young offenders institute at one point (Nacro, 2016). A survey of 437 single homeless people found 28% had committed a crime in the hope of being taken into custody (Reeve, 2011).

Prison populations experience greater health inequalities than those of the general population. The Prison Reform Trust (2016) highlighted 36% of prisoners were estimated to have physical or mental health disability, compared to 19% of the general population; 25% of women and 15% men in prison reported symptoms of psychosis; 46% of women report having attempted suicide at some point in their lifetime, more than twice male prisoners (21%) and significantly higher than the general population (6%).

Links to Adverse Childhood Experiences (ACEs)

Research is recognising the significant and long-lasting impact adverse childhood experiences (ACEs) have (figure 21). Bellis et al (2016), defined ACEs as stressful experiences occurring during childhood that directly harm a child (e.g. sexual or physical abuse) or affect the environment in which they live (e.g. growing up in a house with domestic violence, substance misuse or mental ill health). It is useful to start considering these impacts as part of the root causes of homelessness.

Figures 21 Adverse Childhood Experiences (ACEs)

Source: Centre for Public Health: Liverpool John Moore's University 2016

Conclusion

Roots into homelessness are complex; associated with multiple factors including the economy, housing market, as well as personal factors linked to the individual or their family. It continues to be a gendered issue affecting more males, typically due to greater protective measures available to support lone-women with dependents as part of the system-response.

Homeless people are often living with a multitude of issues, which are both 'causes' and an 'effect' of the position that they find themselves in. Increasing awareness and understanding of causal factors can help predict when or whom can be impacted in the future.

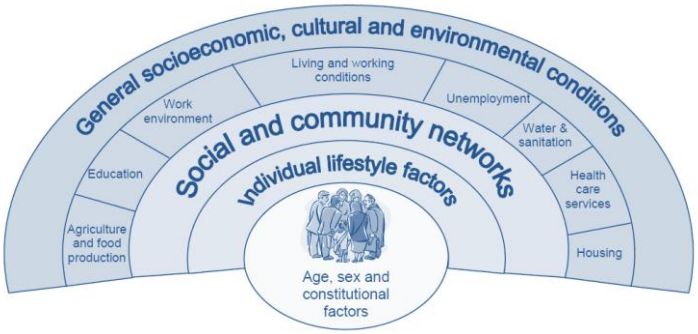
Impact of homelessness on health

This chapter reviews the impact of homelessness on health and how accessibility to a good quality and stable home plays a significant role in securing good health and wellbeing.

Overview

The link between housing and health is well established at both an individual and population level. Quality 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) as reflected in figure 22.

Figures 22 The Determinants of Health



Source: Dahlgren and Whitehead (1992)

Badly designed and poorly built housing, with inadequate heating, damp, lack of space, poor lighting and shared amenities are a major contributor to poor health. Examples of housing related health risks include: respiratory and cardiovascular diseases from indoor air pollution; illness and deaths from temperature extremes, communicable diseases spreading due to poor living conditions and risks of home injuries (WHO, 2010).

The greatest health inequality associated with homelessness relates to life expectancy. The average age of death of a homeless person is 47, reducing to 43 for females (Leng, 2017), compared to an average age of 81 for the general population.

Ill health can be both a cause and consequence of homelessness (DCLG, 2012). Health problems, particularly co-occurring conditions, such as mental ill health, substance misuse and alcohol dependency are more prevalent among the homeless population.

Homelessness has a significant impact on the individuals themselves. Those who are homeless are significantly more likely to be unemployed, have poor mental health, have long-term physical health issues and use drugs compared to the general population.

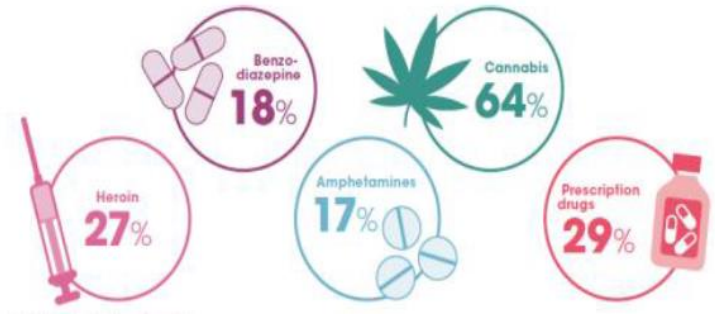
- Only 6% of those homeless are in work compared to 70% of the general population (Homeless.org)
- 26% of homeless use drugs recreationally, over triple the general population at 8% (homeless.org)

Drug and alcohol dependency

Substance misuse is *both* a mental and physical health issue; illicit drug use and alcohol dependency remains high within the homelessness population (Fazel et al, 2008). Substance misuse is the cause of 1/3 of homeless deaths *(iBid)*.

The Homeless Link audit (2014) collated 2,500 responses from homeless people (not just rough sleepers) who accessed services across 19 areas in England and found two in five (40%) service users were taking drugs or in recovery. Figure 23 depicts the audits findings by drug type.

Figures 23 Drug use amongst homeless people



Source: Homeless Link Audit 2014

Sexual behaviour and related poor health

Emerging data identifies that increased risk behaviour amongst homeless populations, increases the rate of sexual health problems e.g. sexually transmitted diseases (STIs) and blood borne viruses. There are also higher rates of sexual abuse and risk of sexual exploitation (John and Law, 2011; Noell et al, 2001). There is also evidence regarding an unmet need in terms of accessibility and the supply of information re: testing for STIs, condom and contraceptive advice etc.

Physical health

People who are homeless are more likely to have physical health problems than in the general population. The Homeless Audit (2014) identified 75% of people who are homeless will have a physical health problem including; joint/muscular pain, dental problems, respiratory disease, abscesses, physical trauma, stomach complaints, liver disease, infections, sepsis, MRSA.

Mental health

Homeless people have nearly twice the prevalence of diagnosed mental health problems, compared to the general population. 45% of homeless people reported a diagnosed mental health problem compared to the general population of 25% (Leng, 2017).

The 2014 audit identified (figure 24) high levels of depression, stress, anxiety and other signs of poor mental health[2].

Figures 24 Diagnosed Mental Health issues in the Homeless population

Source: Homeless Link Audit 2014

[2] N.b. general population figures in ().

Dual diagnosis

The prevalence of co-occurring mental illness and substance misuse (dual diagnosis) is high in homeless populations. Many homeless people will demonstrate a combination of physical illness, mental health problems and substance misuse. 40% of rough sleepers have multiple concurrent health needs (DCLG, 2012).

An evidence review (McDonagh, 2011), reported a positive correlation between homelessness and other support needs, identifying:

- A strong overlap between experiences of more extreme forms of homelessness and other support needs; over 50% of service users reporting experiences of institutional care, substance misuse, street begging and homelessness.
- Traumatic childhood experiences, such as abuse, neglect and homelessness are systemic in most homeless people's histories.
- Most complex needs were experienced by men aged between 20-49 years.
- People with complex needs are at serious risk of falling through the cracks in service provision.

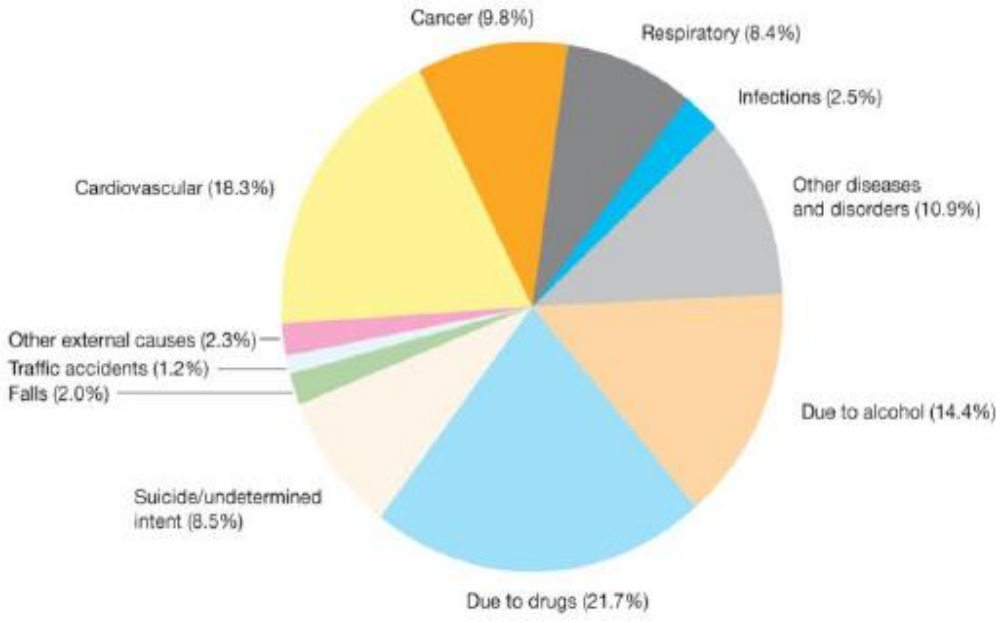
Hospital admissions

Homeless people are 3.2 times more likely to be admitted to hospital and at 1.5 times higher cost (DOH, 2010), due to being unable to access and speak to a GP. If not supported and treated effectively, homeless people are one of the costliest populations for the NHS.

Cause of death

Homeless mortality data (2001-2009) showed homeless populations are more likely than the general population to die from external factors e.g. drugs, alcohol, infections, falls, rather than cardiovascular disease and cancer (Crisis, UK 2011).

Figures 25 Distribution of causes of death for homeless people 2001-2009, UK



Source: Crisis UK (2011)

Deaths due to drugs and alcohol account for over a third of homeless deaths; these can both be the cause of the homelessness or as a result of the homelessness.

Accessing health services

Homeless populations in England have a much lower rate of GP registration than the general population (Elwell-Sutton et al. 2017). Research found 66.5% of rough sleepers were registered with a GP, with 83.1% single homeless in accommodation being registered and 89% of those identifying as hidden homeless. These figures are well below that of the general population, where 98% of adults are registered with a GP. This could in part be due to refused registration, where 25.8% of single homeless were refused registration at either a GP or a dentist in the last 6 months.

Homeless card

NHS guidelines say that GP services cannot refuse to register someone because they are homeless, do not have proof of address or identification, or because of their immigration status. GP surgeries can only refuse to register someone if they are already full or if the person is living outside the practice area, which must be explained in writing. However, not everyone is aware of their rights when it comes to registering with their local GP.

A charity called Groundswell has produced 'my right to healthcare cards' to help homeless people and the GPs themselves understand their rights.

Figures 26 Example of 'my right to healthcare cards' developed by Groundswell, London

Conclusion

The causal factors between poor housing and health remains complex, it is however, accepted that associations do exist. Ill health can be both a cause and consequence of homelessness, with greater prevalence rates amongst homeless communities for some co-occurring conditions, such as mental ill health, substance misuse and alcohol dependency.

The greatest health inequality experienced within homelessness communities relates to life expectancy, with an inequality gap of 34yrs for men and 38yrs for women. Accessibility to primary care remains a concern, with a majority utilising emergency acute health services, at a far greater cost.

Impact of homelessness on children, families and communities

This chapter discusses the impact of homelessness on children, their families and the communities in which they live.

Overview

The multiple drivers of homelessness has a strong potential to affect children's health and wellbeing adversely and can manifest itself through developmental delay and higher rates of acute and chronic health problems. Furthermore, homeless children and families tend to consume foods that have a lower nutritional quality and therefore children experience higher rates of malnutrition, stunted growth and obesity. Children who start life in an environment where housing is insecure, such as temporary accommodation, are more likely to have poor access to healthcare, including immunisations, and are also associated with an increased risk of accidents and rates of infection (Montgomery et al 2016).

Vulnerability

The loss of a stable, familiar, nurturing home and learning environment can mean that homeless children are an extremely vulnerable group (Hetherington and Hamlet, 2015). Homeless children are at an increased risk of, and exposure to, abuse, violence, psychological trauma and emotional distress. Frequent housing moves also interrupt education and impact on learning and academic performance. All cumulating in the potential that life circumstances will indeed lead them to homeless presentations themselves as young adults.

Rough sleeping is often associated with nuisance activities such as begging, street drinking and anti-social behaviour and can have a negative impact on communities. Whilst the literature does not go into this in much detail, it does talk about the legal framework underpinning this and the extent of the use of civil measures. Appendix C contains the available enforcement options by power.

The reasons why people street beg and/or street sleep are many and complex. Individuals engulfed by a life on the streets, do so as a result of early exposure to significant trauma/adverse experiences in early childhood (Fitzpatrick et al, 2013; 2012; Roos et al, 2013; Shelton et al, 2009). Such childhood trauma/adverse experiences include:

- Physical abuse
- Neglect
- Sometimes not being enough food to eat at home
- Homelessness
- Domestic violence/abuse in the household
- Parental substance misuse
- Parental mental health issues
- Poor family functioning
- Socio-economic disadvantage/poverty
- Separation from parents or carers

Evidence suggests early trauma in childhood experiences result in an increased likelihood of being homeless in the future. 98% of those experiencing such events, also experienced homelessness at some point in their adult life and/or where currently homeless (Fitzpatrick et al, 2013).

Conclusion

The impacts of homelessness on children, families and communities, are significant and long-lasting. The loss of a stable home environment increases the vulnerability of children and their risk of and exposure to violence and abuse, as well as trauma and adverse experiences.

Economic impact of Homelessness

This chapter explores the economic impact and costs associated with homelessness.

Overview

Homelessness in all its forms has significantly increased in recent years, and thought to cost the public sector more than £1billion a year (National Audit office, 2017). A decrease in affordable housing, coupled with welfare reforms have contributed to increases in homelessness. These costs do not include those associated with wider public services e.g. healthcare, criminal justice system, policing etc where there is additional burden on public services from homeless communities who experience poorer health outcomes or require more public-sector interventions than the general population.

Return on investment

Public Health England (2018) sought to understand the financial return on investing in street sleeping and begging. Whilst literature in this field is limited, one systematic review found investment in such interventions as positive (Master et al, 2017). It found the median return of investment for public health interventions was £14.3 for every £1 spent. There were 12 studies in this specialism, focussing primarily on the effectiveness of intervention in early years, particularly with young offenders or those at risk of offending.

It is estimated that:

- if 40,000 people were prevented from experiencing 1 year of homelessness, public spending would fall by £370 million. (crisis.org.uk)
- The cost of rough sleeping for 12 months is £20,128 compared to the cost of a successful intervention at £1,426 (Pleace, 2015)
- 30 people sleeping rough would cost an additional £600,000 in public expenditure, rising to £1.2m if the situation continued for 2 years (Pleace, 2015)
- The longer someone if homeless, or the more frequently they experience homelessness, the more they will cost the taxpayer (Pleace, 2015)
- The cost of an individual with multiple needs including homelessness costs around £19,000 per annum. 4-5 times the cost of an average person (£4600)

Conclusion

Increasing recognition that failure to prevent and reduce homelessness is causing significant, but potentially avoidable increases in public spending. Evidence also shows people who experience homelessness for 3months or longer cost on average (Please and Culhane, 2016):

- £4.298 per person to NHS services
- £2,099 per person for mental health services
- £11,991 per person in contact with the criminal justice system

Stakeholder Consultation

This chapter details the stakeholder consultation undertaken to support and inform the health needs assessment.

Overview

In December 2018, Public Health and Housing facilitated joint stakeholder consultations for both internal and external services on understanding the impacts of homelessness. Consultation sessions were held in Salisbury and Trowbridge.

The aim of the sessions included:

- Outlining the rationale for why this work is underway
- Share the initial findings of the health needs assessment for homelessness in Wiltshire;
  - National and local prevalence
  - Health inequalities
- Provide an insight into the system and service response to address homelessness in Wiltshire
- Contribute to the formulation of the health needs assessment

A total of 36 agencies attended the two sessions. Representation reflected wide range of statutory, community and voluntary sector services, including policy-makers, decision-makers, support providers, housing providers and commissioners. As part of the session, we sought to identify stakeholders' views on the following questions.

Consultation questions

1. **In relation to the current service response to support homeless communities, what is working well?**
   - What assets do we have in Wiltshire that can be used/accessed by this group which would benefit/support them?
   - Identify any examples of good practice
2. **What challenges do you face in responding to the needs of homeless communities?**
   - Does this differ (and why) if there are multiple and complex needs being experienced?
3. **What do we need to do differently – what would the perfect response look like?**
   - What opportunities are there to do things differently?
   - What principles are important to this community?
4. **What are the outcomes you would expect to see?**
   - What does good look like?
   - How do we know if we are being effective?
   - How do we capture what really matters to the individual?

Appendix D collates the consultation feedback in full and has been used to contribute to the Homelessness Reduction Strategy.

Evidence Review

This chapter provides an overview of the most recent health and homelessness literature and evidence-base practice, including:

- Prevention
- Housing Services
- Case Management
- Primary Care
- Secondary and Tertiary Care

Overview

It was Maslow's hierarchy of needs theory (1943) that states shelter is one of our most basic needs; and that only when basic physiological and safety needs are met, can needs relating to wellbeing, such as respect, self-esteem, a sense of belonging and personal growth be achieved. Safe and secure housing must therefore be seen as a core outcome for meeting the health and social care needs of individuals and communities.

Working to make homelessness a rare event

The aim of this section is to review the emerging evidence-base of models being developed to address homelessness.

The evidence-base for tackling homelessness continues to grow; it is recognised that finding effective solutions to end homelessness, rather than managing it and changing the ways of working will be challenging.

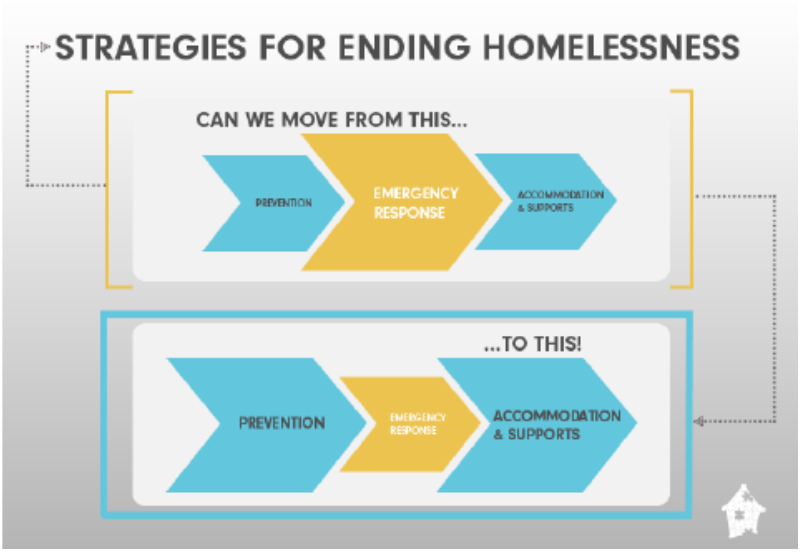
Preventing homelessness

Prevention and early intervention are arguably the most cost-effective and harm minimising approach to tackling homelessness. The benefits of prevention are clear; avert the issues before they happen, will not only increase the well-being of the individual, but will also reduce the demand being placed on services (DWP, 2011).

Under the Homelessness Act 2002, there is a duty for every local authority area to have a Homelessness Strategy, which should focus on 'everyone at risk' of homelessness, not just those who fall under priority need.

Whilst the recognition towards prevention is beginning to be realised, they are often still not early enough to support people before a 'crisis' and before homelessness becomes entrenched (Mackie, 2014). Most interventions are still not orientated at tackling the root causes of homelessness and the wider determinants of health.

Figure 27 Strategies for 'ending' homelessness



source: Homeless Hub, Canadian Research

Figure 27 demonstrates how the focus was once on managing homelessness, through investment in emergency services. However, implementing a greater strategic response, will still retain the emergency response (as people will still experience crisis), but the focus shifts to prevention and moving people out of homelessness. A key feature requires the investment in services today, to save money in the longer term.

Primary, Secondary and tertiary prevention

One way of understanding homeless prevention strategies is using a continuum with three levels;

- **Primary,**
- **Secondary and;**
- **Tertiary prevention.**

Gateshead Council in their health needs assessment produced the tables below (figure 28) across the proposed continuum. They suggest interventions across the three levels, which could be considered by areas when developing a local approach to addressing homelessness and determining the activity required.

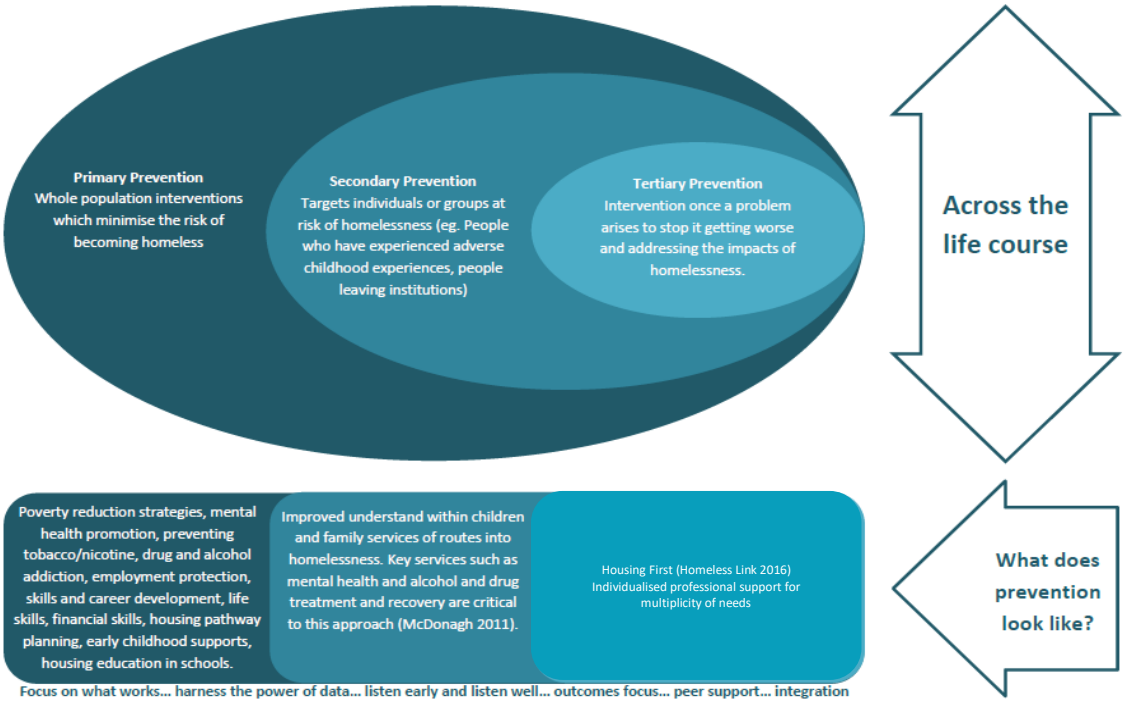
Figure 28 Primary, Secondary and Tertiary Approached to Prevention

Primary Prevention	What does this look like?
Whole population interventions which minimise the risk of becoming homeless.	• 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)	• 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 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). • 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)
	• 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.	• 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)

Source Harland, 2017

The infographic in figure 29, represents a vision presented by of what homeless prevention might look like.

Figure 29 Homeless Prevention



source adopted from Gateshead Health Needs Assessment, 2017

Housing services

Homelessness services have traditionally adopted a 'staircase' model, first providing emergency accommodation or temporary housing, before offering clients a permanent solution. This approach was often coupled with a requirement to meet certain criteria such as abstinence from illegal substances or alcohol (Padgett et al. 2015). In recent years however there has been a shift towards the 'Housing First' approach, with a focus on providing stable housing as the initial response, alongside support services to address wider health or social issues (de Vet et al. 2013).

The Housing First model has a number of core principles which are outlined in figure 30 below (Homeless Link, 2016).

Figure 30 Core Principles of a Housing First model

1. People have a right to a home	• Access to housing is prioritised • Eligibility for housing is not contingent on anything but willingness to maintain a tenancy • Individual will not lose their housing if they disengage or no longer require support • Individual is given their own tenancy agreement
2. Flexible support is provided as long as needed	• Providers commit to long-term offers of support depending on need • Services are designed for flexibility of support • Support is offered to transition away from Housing First if this is a positive choice • Relevant services across different sectors work together to meet an individual's needs

3. Housing and support are separated	• Housing is not conditional on engagement with support • Support stays with the person even if the tenancy fails
4. Individuals have choice and control	• Individuals have choice over type of housing and location • Support is person-centred and individuals are given the lead to shape their support, setting their own goals
5. An active engagement approach is used	• Support is proactive and attempts are made to make the service fit the individual rather than the other way round • Caseloads are small allowing staff to be persistent and proactive
6. The service is based on strengths, goals and aspirations of the individual	• Underpinned by philosophy that there is always a possibility of for positive change • Individuals are supported to identify their strengths and goals, and to develop the knowledge and skills to achieve them • Individuals are supported to develop self-esteem, self-worth and confidence and to integrate into their community
7. A harm reduction approach is used	• People are supported holistically • Individuals using substances are supported to reduce immediate and ongoing harm to their health • Individuals who self-harm are supported to undertake practices which minimise risk of greater harm

Source Homelessness Link, 2016

Multiple studies, conducted across a range of countries have demonstrated positive outcomes from the Housing First approach. Adherence to the core principles outlined above has been shown to be important to success, with those studies deviating furthest showing poorest outcomes (Homeless Link, 2016). It is acknowledged however that individual interventions must be designed with the needs of the local population in mind (Social Care Institute for Excellence, 2018).

Case management

For a proportion of those facing homelessness, support to secure housing coupled with low level interventions such as financial advice or mediation, may be sufficient to address their needs. However, many have multiple interrelated issues resulting in complex support requirements.

Despite this, services to address these issues are often delivered by multiple providers. In the recently published *Homeless and Inclusion Health Standards for commissioners and services providers*, endorsed by multiple major UK health organisations, integration was identified as being key to improving health outcomes for marginalised populations (The Faculty for Homeless and Inclusion Health, 2018).

Case management is one method which aims to coordinate care for those with complex needs. Several different models of support have been developed with differences displayed in figure 31.

Figure 31 Characteristics of Case Management

Traditional/Standard Case Management Models (SCM)	
Broker Case Management Model	Case manager coordinates services from a range of providers – the focus is on assessing needs, referring for support and coordinating and monitoring on-going treatment
Clinical Case Management Model	Case managers have clinical background and provide some/all services themselves. Focus is on engagement, assessment and planning, building community links and skill-building. Achieved through interventions such as psychotherapy, psychoeducation and crisis interventions
Intensive Case Management Models	
Assertive Community Treatment (ACT)	An intensive, comprehensive approach for those with high-level needs. Small caseloads, a multi-disciplinary approach with shared responsibility, outreach, unlimited time frame and 24-hour coverage. Addresses a range of needs including mental health, housing, life skills, socialisation, employment and substance misuse treatment.
Intensive Case Management (ICM)	Similar to ACT but responsibility is usually held by a single case manager rather than shared amongst a multi-disciplinary team.
Critical Time Intervention (CTI)	Time-limited intervention targeting people facing significant transitions in their life (e.g. discharge from institutional to community care).

Table adapted from: (Guarino, 2011)

Directly comparing the various models is challenging as outcome measures across studies are often varied. Furthermore, poorly defined control interventions and multiple confounding factors (e.g. complexity of cases, characteristics of case managers/teams, exact intervention offered) make it even harder to confidently identify one as superior to another (Guarino, 2011; de Vet et al. 2013).

Despite these challenges, evidence for models involving aspects of Clinical Case Management, rather than purely providing a brokering service, appears to be strongest. In particular, ACT has the largest volume of research reporting successful outcomes (Guarino, 2011). However, selecting the best model for each individual is clearly important and for those facing significant life-events, such as leaving care or prison, CTI can offer the rapid response required and help to promote independence (Social Care Institute for Excellence, 2018).

Regardless of the exact mode of delivery, crucial to all models of integrated care is good communication, the ability to easily share relevant information and a commitment to work towards shared goals (Social Care Institute for Excellence, 2018).

Involvement of peer support workers can benefit the individuals being supported by promoting engagement and providing advocacy services, but has also been shown to have a positive impact for the support workers themselves. Co-production of services, utilising the expertise of those with experience of homelessness, is also important to ensure services address needs in a way which is acceptable to those in receipt of them (Luchenski et al. 2018).

Primary Care

The poor health experienced by homeless people is related, in part, to their low levels of engagement with primary health care services. Access to care is determined by three key factors:

- Availability – the required services being provided in the right place and at the right time
- Affordability – direct costs of care, transport, loss of productivity
- Acceptability – the expectations and attitudes of provider and patients align (McIntyre et al. 2009).

Chronic disease management, A&E attendance rates and levels of patient satisfaction have been shown to be better when care is provided by dedicated homelessness primary care services. Integration of several services in one central location has also been cited as a facilitator to improving access (White et al. 2015). It is acknowledged however that the suitability of such a model will depend on local demand, and may not be feasible in areas with a small or widely distributed homeless population. In this scenario, an outreach model may be more effective (Department of Health, 2010).

For many homeless individuals, their health needs compete with, and often lose out to, more pressing needs such as finding food, clothing or shelter. Therefore, interventions which also assist with these needs will result in a greater ability to address health concerns. Help with transport is also important in areas where services are not co-located near to the individual, or cannot be provided via outreach (White et al. 2015).

Feedback from homeless patients suggests they often feel judged or stigmatised when accessing health care services (Hwang et al. 2014). On the other hand, healthcare staff may be reluctant to engage with homeless patients' wider needs if they lack the necessary knowledge and confidence to do so, or if they see them as overly complicated or outside their remit. Education for health care professionals to develop their cultural awareness and understanding of the issues facing homeless people is important to improve attitudes and facilitate positive patient-provider relationships (Luchenski et al. 2018).

Secondary/Tertiary Care

Studies have shown that the average length of stay for homeless patients is significantly higher than for the housed patient population (Department of Health, 2010). A 2012 report also showed that many homeless individuals were discharged back to the streets or unsuitable accommodation, often without their underlying medical problems being fully addressed. Aside from the obvious impact this has on the individual involved, it also increases the likelihood of readmission (Homeless Link and St Mungo's, 2012).

The “Pathway model”, developed after a pilot study at University College Hospital in 2009, seeks to address some of these issues. The programme, which has since been expanded to several hospitals across the country, involves a dedicated Homeless Health Nurse Practitioner, who works alongside a part-time GP and a Care Navigator (CN) with lived experience of homelessness. The team identify, support, and coordinate the care and discharge of homeless patients admitted to the hospital. Integral to the model are regular multi-agency meetings held between the HHP, GP, CN and other relevant organisations such as mental health services, drugs and alcohol teams, community housing and social care (Hewett, 2010).

Evaluations of this, and other similar programmes that integrate health care and housing services for homeless inpatients, have demonstrated an increase in those discharged to suitable accommodation and improved quality of life for those supported (Hewett et al. 2016; Homeless Link, 2015). Several areas implementing such models reported reductions in other markers such as bed-days, A&E attendances and readmission rates, and supported the cost effectiveness of such models of care (Mpath, 2013; Kings Health Partners Pathway Homeless Team, 2014; Wyatt, 2017). Provision of transitional care beds, for homeless individuals still recuperating from an acute hospital admission, has also been shown to help reduce the number of acute bed days and readmission rates (Hwang et al. 2014).

Conclusions

There is no single approach to addressing homelessness, it remains a serious and enduring issue. Wiltshire considers and addresses 'housing' as part of the wider determinants that can and will influence the health and wellbeing of our local communities. It is viewed as part of the wider vulnerability response and is considered in cases of domestic abuse, substance misuse, safeguarding, as well as across the wider Community Safety Partnership agenda.

There is a great deal of information and research available about 'why' people are homeless or experience homeless. Additionally, there is an increasing evidence base around interventions to support those with complex needs, including substance misuse, mental health problems and other physical health conditions. Although much of this evidence relates to homelessness in general, rather than other subsets of vulnerability. Homeless communities are a key vulnerable group, who are at increased risk of experiencing health inequalities, with higher morbidity and mortality than the general population. A focus on tackling and preventing homelessness will therefore contribute to reducing health inequalities.

The new Homelessness Reduction Act 2017 places further duties on local authorities to prevent homelessness and support all those requesting help irrespective of whether or not they meet the criteria in relation to priority need through assessing their needs and developing a plan with them to meet those needs. With the lack of housing/affordable housing currently in the market and changes to the welfare system, this will be extremely challenging.

Overall volume of homeless applications in Wiltshire are reducing, which contrasts with national trends. The greatest proportion of homeless applications accepted in Wiltshire were aged 25-44 (2017/18), with the majority being female, including those pregnant or have dependants. Homelessness rates are disproportionately higher amongst black and minority ethnic groups in Wiltshire, compared with recent population data, whilst not unique to Wiltshire, remains an area for further consideration.

The reasons for homelessness have remained consistent in Wiltshire and are in line with the national picture, with the most common reasons being loss of an assured short-hold tenancy, non-violent relationship breakdown and parents/family or friends no longer willing to accommodate.

Local data primarily focuses on 'statutory homeless households and the work undertaken by the local authority. These figures only really represent the tip of the iceberg, and do not go help to understand the relationship between health and wellbeing.

Research clearly demonstrates there is an association between people experiencing homelessness having higher levels of mortality and morbidity from a range of causes with substance misuse and mental ill health significant contributory factors.

Social determinants of those affected by homelessness contribute to their poor health status and needs with poverty, childhood trauma and neglect. Homelessness is both a cause and consequence of poor health and wellbeing.

Research recognises the vulnerability of children who are homeless, who have significantly greater health needs, resulting in developmental delays and acute and chronic physical and mental health problems. Young care leavers are also known to experience poorer health outcomes, with research recommending a multi-agency approach to break the cycle to disrupt and reduce the risk of them becoming homeless as adults.

People who are homeless or at risk of homelessness often experience barriers to accessing services, which can be inflexible to their needs and circumstances. As part of the consultation with stakeholders locally it was noted that issues such as a lack of a permanent address, chaotic lifestyles making keeping appointments difficult and inflexible services all contributory factors to barriers to accessibility.

Homelessness is often the end product of a long period of severe health and social inequality, therefore collective action is required across all social determinants, looking to maximise opportunities to embed homeless prevention into upstream interventions.

Increasing recognition that the 'home' should become the main setting for achieving good health and wellbeing.

Recommendations

Key recommendations arising from the findings of the HNA have been identified below:

Partnership response

To embed a multi-agency approach to addressing homelessness; developing a greater understanding that tackling homelessness holistically as part of a 'whole-systems response' which includes health has the potential to not only improve outcomes for individuals and families, but also positive outcomes for improved service efficiency and effectiveness.

Support and Service Delivery

The physical and mental health inequalities experienced by many who present as homeless is increasingly unacceptable. Working in partnership, priority should be given to upstream approaches, focusing on tackling the root causes and to better support those with co-occurring conditions e.g. mental health and substance misuse issues, and explore current links to addressing those other subsets of vulnerability.

Develop a joined-up approach with support services, to increase accessibility to health-based interventions e.g. immunisations programmes to protect and prevent the ill-health of homelessness communities.

Review the support pathways for those experiencing homelessness and/or living in temporary or supported accommodation, who are living with co-morbidity conditions such as mental health and substance misuse.

Young pregnant women presenting as homeless have been identified as an at-risk group, further work should be explored to better support this at-risk group during pregnancy, considering links to the role of the Family Nurse Partnership programme.

Data Gathering

Data captured as part of the homelessness data review and health needs assessment provides a baseline. Moving forwards, this can be used to measure future progress and be included as part of the future Joint Strategic Needs Assessment dataset.

Consideration to be given to developing the dataset used in the health needs assessment, to fill those gaps in understanding around the local impact of homelessness in particular on those areas of vulnerability and health.

Multi-agency workforce development

All services providing care and support should be more responsive and flexible to the needs of people experiencing homelessness. Workforce development focusing on attitudes and wider awareness of the issue and support pathways would help improve service response.

Recognising Wiltshire's vulnerable communities

Establish a commitment from all agencies to take responsibility to support this vulnerable group, with focus given to key transition points and those 'hidden' populations the HNA identified.

The proposed changes to HMP Erlestoke moving to a 50% 'resettlement' prison, further work is required to explore the impact on the local housing infrastructure and support services. The supporting evidence-base suggests offenders are a vulnerable group and have an increased risk of becoming homeless. Further understanding of the links and risk factors associated with the offender population and homelessness, can be used to inform future commissioning and ensure the accommodation needs for offenders including support is being considered.

Service User Consultation

The voice of the service user has not been represented in this health needs assessment, further work to consult wider with services users should be explored. to elicit their views and experiences, to ensure services meet their needs.

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Appendix A Domains of homelessness

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

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.

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)

Hidden homelessness

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.

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.

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.

Appendix B Key policies, frameworks and guidelines

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.

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.

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

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.

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.

Appendix C Enforcement Options by Power

Power & Overview	Requirements	Lead Authority	Enforcing Authority & Penalty for Breach	Benefits & Concerns
Sec 35 **Dispersal Power** (Anti-Social Behaviour, Crime & Policing Act 2014). Allows Police to disperse any person within the specific area for up to 48 hours.	Inspector or above can authorise area to be subject to a dispersal order where there is evidence that members of the public are likely to be harassed alarmed or distressed.	Wiltshire Police	Wiltshire Police, breach is a criminal offence and can be fined up to £2,500 and imprisoned up to 3 months.	Only last for up 48 hours and guidance advises against continued use. Can offer respite for other measures.
Sec 43 **Community Protection Notice** (Anti-Social Behaviour, Crime & Policing Act 2014). Power to require a person to stop doing something or to take action.	The conduct must have a detrimental effect and be persistent on the quality of life of those in the locality. A written warning must be served before the notice. Also allows council the ability to act on behalf of an individual.	Wiltshire Police or Wiltshire Council	Wiltshire Police or Wiltshire Council can issue a FPN for up to £100 or summons to court for fine up to £2,500	Could be used to require persons to remove property. The guidance advises caution on how this power can impact on vulnerable members of society.
Sec 1 **Civil Injunction** (Anti-Social Behaviour, Crime & Policing Act 2014). Court instruction to stop doing something such as accessing certain areas or carrying out certain behaviours.	Behaviour must cause alarm, harassment and distress. Court wishes to see an escalation is tools such as warning letters, ABCs or CPNs beforehand.	Wiltshire Police, Wiltshire Council or social landlords	All lead authorities can breach and Police can arrest if this power is applied for to the court. Breach is not a criminal offence but carries an unlimited fine or up to 2 years imprisonment.	Not a quick power to obtain but can be effective once in place.
Sec 59 **Public Spaces Protection Order** (Anti-Social Behaviour, Crime & Policing Act 2014). Creates a set of conditions that all persons of a specific area must obey.	Need evidenced behaviour that has a detrimental effect, is unreasonable and persistent. Current PSPO in place which allows Police to confiscate alcohol.	Wiltshire Council	The creating of the order is led by Wiltshire Council but enforced by Wiltshire Police. Breach can be dealt with by way of an FPN or a fine of up to £1,000 in court.	Continued breaching is good evidence for a CPN or Injunction. The enforcement of a PSPO can encourage groups to move to another site.
Offence of Sleeping Rough **Vagrancy Act 1824**	Need to evidence the behaviour. Power was last used in 2014 but was dropped by CPS for not being in the public interest, so this would also need to be satisfied.	Wiltshire Police	Wiltshire Police- Imprisonment of up to 1 year.	Enforcement of this act is controversial.
Article 31 Regulatory Reform (**Fire Safety**) Order 2005 empowers the Fire Authority to prohibit or restrict the use of premises. Notices issued under Article 31 are referred to as 'Prohibition Notices'. This is a general term given to a notice issued to either prohibit or restrict the use.	This is due to the standard of general fire precautions provided, falling so far below the expected standards, that relevant persons (any person who is, or maybe lawfully on, or in the vicinity of the premises) are placed at risk of death or serious injury in the event of fire.	Wiltshire Fire & Rescue Service	Wiltshire Police -The order requires persons to act such as leave the area. Failure to do is a criminal offence and can be imprisoned for up to 2 years or unlimited fine.	Act requires Fire Service to consult with Local Authority.
S18 Health & Safety at Work Act 1974 puts a duty on the Health and Safety Executive (HSE) and Local Authorities (LAs) to make adequate arrangements for enforcement.	Needs further research but any area which could be a place of work and pose a health and safety risk could have a notice served.	Wiltshire Council or Health & Safety Exec	Needs further research as to its appropriate application.	
Improvement notices, prohibition orders and hazard awareness notices (Housing Act 2004).	A prohibition notice can be served to stop residing in a premise where there is a hazard to health.	Wiltshire Council	Wiltshire Council, breach carries a fine of up to £5,000.	Further research is required into definition of a dwelling.

Appendix D Stakeholder Consultation Feedback

Response from Consultation	Council Response
Vision – "Wiltshire is a place where we all work together to prevent and resolve homelessness and rough sleeping"	
Suggestion to replace the word resolve with relieve in line with new language and 'to help' before prevent in both	Agreed – Current vision will be amended
Resolve – assumes there is an answer and it can be eradicated	The word resolve has been removed
Is it aspirational enough?	We believe under the current climate this vision is a challenge and will be reviewed at the end of the strategy
Include strengthen our communities – wider impact	Vision amended to include strengthen communities
Include prevent and tackle root causes of homelessness – a wider end goal	This will come out of one of the main priorities of prevention
Who has ownership – Who is 'We'	Everyone has ownership of this as the local authority is not able to respond in isolation 'we' includes all agencies / voluntary sector / partners who work to help address homelessness
Prevent – addresses the causes – focus should be here	This will come out of one of the main priorities of prevention
Wiltshire is a place where everyone has their own safe, secure home.	This links with the Homelessness Aim
Aims	
Homelessness: To prevent homelessness and where homelessness cannot be avoided help people secure and keep a suitable home	
No recommended changes	
To work to prevent or Help to prevent	Amended as suggested
Rough Sleeping: We will deliver an on-going reduction in rough sleeping an address he multiple harms it brings to individuals and communities through rapid intervention to offer a route off the street for all, improving health, wellbeing and resilience and tackling street activity associated with rough sleeping	
Aim 2. It was considered that the current wording was both an aim and an outcome – Suggested amendment was *"Working together to deliver on-going reduction in Rough Sleeping through prevention and relief"*	Amended as suggested
Consideration to the word 'on-going reduction' is this achievable	The flow of rough sleeping changes all the time and therefore an on-going reduction is realistic – it's not a firm figure that remains the same
Consider including support and maintenance (long term) not just rapid intervention	This will be an objective
Highlight the difference between those who choose to sleep rough as a lifestyle choice vs circumstances	This is certainly a consideration but not to define in the aim

Exercise A - In relation to the current service response to support homeless communities, what is working well?	
Prevention duties are working well and improved prevention work by housing staff	Noted
Link workers with the supported providers are extremely beneficial	Noted
B&B avoidance in Wiltshire and continued reduction of temporary accommodation	Noted
The range of supported accommodation across Wiltshire	Noted
Good working relationships and much better joined up working	Noted
Recent work with rough sleepers	Noted
Training of partner agencies on the introduction of the Homeless Reduction Act	Noted
Reducing homelessness and reduction in rough sleeping	Noted
No more shared supported schemes – units are now self-contained	Noted
Safe Places – new style accommodation for those fleeing Domestic Abuse including accommodation for men and older boys	Noted
Housing Options teams are more accessible	Noted
Increase use of DHPs – making better use of government resources	Noted
Multi agency working	Noted
Charities / support agencies	Noted
Additional grants – FHSG / RSI funding	Noted
Significantly improved information sharing	Noted
Improved awareness and work around safeguarding	Noted
Support from third sector organisations	Noted
Flu vaccination programme for homeless people	Noted
Training and robust information on the rough sleepers estimate and the verification process	Noted
The new contract with Turning Point	Noted
MARAC becoming more inclusive – much better information sharing	Noted
Exercise B - What challenges do you face in responding to the needs of homeless communities?	
Limited government funding – services dependent upon both grants FSHG / RSI	Priority 1 Action 10
Increased complex needs	Priority 3 Action 1
Better on the ground health engagement (drug / Alcohol / mental health) services to be outreach. Go to the client	Priority 1 Actions 2, 3, 4 and 5
Increasing thresholds mean more clients full through the net	Priority 3 Action 1
Primary care and drop in centres for Rough Sleepers	Priority 1 Action 3

Customers financial capability – tenancy ready / support	Priority 2 Action 2 and 3
Difficulty in accessing the Private Rented Sector	Priority 2 Action 1 Priority 4 Action 4
More robust enforcement of issues surrounding Rough sleeping hot spots – drugs / ASB – multi agency response required	Priority 1 Action 5
Obtaining clients trust in order to engage, challenge of lack of engagement through choice – Trust engage and build confidence	Priority 1 Action 1 & 2
Clients with no recourse to public funds – in particular those fleeing from domestic abuse	Priority 3 Action 1
Lack of knowledge for options for domestic abuse	
Lack of on-going support for high risk offenders once re housed (Transition period)	
Communication – all being aware of what is available	Priority 1 Action 6, 8 & 16 Priority 2 Action 5 Priority 3 Action 7
Wiltshire Council housing pages not easy to navigate	Priority 2 Action 5
Getting bank accounts for benefits – issues with ID and address	Priority 2 Actions 2 & 3
Access to health services – few GPs taking NHS clients	Priority 1 Action 3 & 5
Difficulties with moving on from supported accommodation due to rent arrears	Priority 1 Actions 11 & 12
Feeling isolated as property is away from social networks – lack of money for transport	
Trying to access on line services – lack of internet	
Difficulties of Universal Credit	
Public perception we aren't doing enough – therefore they over help, provide stuff that's not needed	Priority 1 Action 16
Limited life skills – 3rd generation, no role model	Priority 1 Actions 11 & 12
Complex cases falling between Housing Options and Adult Social Care	Priority 3 Action 1
Unsuitable accommodation for complex cases	Priority 4 Action 5
Direct Access Hostels all year round	
Exercise C - What do we need to do differently – what would the perfect response look like?	
Homelessness – consistent message re tenancy ready and financial management across all partners	
Wiltshire Council care worker – across all services to prevent passing between departments	

Work more with the voluntary sector to provide better engagement and support, potential boost fund	
Client background information needs to be more accessible for supported housing providers	
Adult Social Care gap in supporting at point of crisis	Priority 2 Action 4 Priority 3 Action 1
Supported housing provider accommodation needs to be better spread across Wiltshire	Recently re-commissioned all HRS services ready for April 18 and challenges were identified in securing suitable accommodation across the County. We will continue to consider this as part of re commissioning going forward
Referral form as part of duty to refer needs to have the facility to enable acknowledgment and also feedback	
Need to promote the positives more – improve communication / take advantage of social media / case studies	
Consideration of the Housing 1st model	Priority 1 Action 9
Increased affordable housing – social rent level	Priority 4 Action 1 & 3
Intensive support at the start of some tenancies	
Individual support plan based on clients needs	Priority 1 Action 4 Priority 2 Action 4
Open internet access rather than membership	
Automatic referral to Fire Service for a safe and well check when in TA / supported accommodation and perm accommodation	Priority 3 Action 9
Homeless medical drop in (mobile like BANES)	Priority 1 Action 3
All teams to have outreach workers to effectively engage with rough sleepers	Priority 1 Action 2
Better interactions with private landlords – improve incentives to encourage more lets	Priority 2 Action 1 Priority 4 Action 4