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JSNA FOR THE HOMELESS AND THOSE AT RISK OF HOMELESSNESS

EXECUTIVE SUMMARY

1. Key Findings Summary

1.1 Homelessness describes a wide range of circumstances where people have no secure accommodation. This JSNA categorises homeless people into three overlapping groups:

- **single homeless and rough sleepers (SHRS)** - group of homeless people for whom there may be no statutory duty or simple solution (around 500 are registered with CAS);
- **statutory homeless** - those defined in law[1] as being in priority need and entitled to housing support from local authorities (around 600 households across Cambridgeshire each year, largely families);
- **hidden homeless and those at risk of homelessness** – those not recognised by local authorities or services (thought to be much larger than the two other groups together)

1.2 There is a great deal of overlap between these groups with people frequently moving in, out and between them. This JSNA has particularly focused on the SHRS population as this group has the poorest outcomes in Cambridgeshire. However, the other two groups also have a constellation of needs and issues.

1.3 Homelessness is complex and there is rarely a simple explanation for someone becoming homeless. A number of interlinked personal and social factors can contribute towards people becoming homeless.[2] These may include individual factors, family background and/or an institutional background.

1.4 Housing is one of a number of factors that has an important influence on people's health. Homelessness is more than a housing issue and can occur as a result of poor health, unemployment, imprisonment or poverty. Health care, social services and criminal justice systems all impact on homelessness[3].

1.5 Compared to the general population, homeless people experience poorer health outcomes. Physical health, drugs, alcohol, mental health and well-being have been recognised as priority health issues among the homeless. However, homeless people generally experience difficulties with accessing health services; this poor access also impacts on their health status. Health outcomes are generally worst for SHRS but may also be poor in the statutory and hidden homeless. People who are accepted as statutory homeless are at risk of moving into non-statutory homeless groups for a variety of reasons.

1.6 Forty-four years old was the average age of death over the last 5 years among the patients registered at the Cambridge Access Surgery (CAS) (a dedicated GP practice largely for single homeless and rough sleepers). This is only just over half the life expectancy at birth in Cambridgeshire which is 80 for men and 82 for women.

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[1] Her Majesty's Stationary Office, 2002. Homelessness Act 2002.

[2] Department for Communities and Local Government, 2001. Homelessness Strategies; a good practice handbook.

[3] British Columbia. Ministry of Social Development and Economic Security, 2001. Homelessness: causes and effects. Volume 1. The relationship between homelessness and the health, social services and criminal justice systems: a review of the literature.

1.7 The housing pathway differs for statutory and non-statutory homeless with the statutory homelessness pathway being undertaken by local authorities and governed by homelessness legislation. For non-statutory homeless there are a range of entry points and the often chaotic lifestyle of this group means that their journey may not follow a clear pathway.

1.8 The purpose of the JSNA for Homelessness and those at risk of homelessness is to identify the current and future health and well being needs of people who are identified as homeless or at risk of homelessness in Cambridgeshire, and inequalities and stigma faced by the homeless population. It recommends ways to achieve real improvements in health and well-being outcomes for this group.

1.9 Partnership working has been an essential part of this JSNA and key to understanding the needs of the local homeless population. The JSNA has been developed through joint working between the NHS, the County Council, the City and District Councils in Cambridgeshire, and voluntary sector agencies.

1.10 Early intervention and proactive prevention of both homelessness and the poor outcomes associated with homelessness are key to improving the health and wellbeing of the homeless and those at risk of homelessness.

1.11 Having more integrated, person-centred services would enable more comprehensive joint care planning, information sharing and monitoring of outcomes with a common record of individual homeless pathways. This could avoid duplication, therefore saving money while improving outcomes.

1.12 Engagement of the homeless population in planning their own care is essential, and using the insight, information and interaction from the care planning process should inform commissioning and provision of services.

1.13 Joint commissioning provides an opportunity to ensure services are integrated, needs-led, evidence based and person-centred, focusing on prevention and early intervention and will make a real difference to outcomes for SHRS and for chronically excluded adults.

JSNA Community Views - the homeless

1.14 Generally there appears to be limited involvement of the homeless population in developing and evaluating local services. Homeless people often present with multiple and complex needs. Further work is needed to identify the individual outcomes that the homeless population want and it should be recognised that these outcomes may not be homogenous, just as the population described within this JSNA is not.

1.15 An example of service user involvement was in the development of the Cambridge City Homeless Strategy where current and former users of homelessness services and frontline staff were invited to a series of consultation events. The comments made at these events were incorporated into the strategy where appropriate which allowed the homeless population direct input into shaping the future of homeless provision in Cambridge City.

1.16 Other examples of obtaining views of the homeless population include:

- Public consultation on the alcohol service specification for Cambridgeshire, engaging with Winter Comfort to consult with the homeless regarding this service as well as frontline homeless service staff.

- A patient and stakeholder survey undertaken by CAS in 2007 which reported high levels of satisfaction with the service and that if the service was not available just under half of respondents would attend A&E or not access health care at all.

1.17 There needs to be more work done in engaging the views of this population to ensure services are responsive to their needs. 'Working together for change'[4] is an approach for engaging with people using services to review their experiences and determine priorities for change and places service users at the heart of the commissioning process and it is hoped that this model can be used with the homeless population.

Introduction

1.18 Homelessness and being at risk of homelessness are complex issues which can have wider implications for an individual's health, employment prospects and education. Making the transition out of homelessness can be an intensely difficult process, involving much more than the provision of housing.

1.19 These complexities are also reflected in the commissioning of services for the homeless which involves different funding streams and a variety of commissioning and provider organisations.

2. Key Facts: the population

2.1 In Cambridgeshire, data on homelessness are collected by numerous service providers. However, most of these operate stand-alone information systems and there is no robust way of uniquely identifying service users and so there are likely to be instances of double-counting. There are a number of factors concerning the current information base on the homeless population of Cambridgeshire which has made it difficult to clearly describe the homeless population, such as:

- The transient nature of the homeless population with high geographic mobility and turnover. Each individual is likely to go through rapid chronological changes with respect to street homelessness/ different temporary accommodations and also health indicators.
- There are seemingly insurmountable problems in correlating information from different agencies due to categories used, double counting and the impossibility of identifying individuals across services.
- There is large geographical variation of services, particularly for SHRS, between town and rural areas with an overwhelming concentration in Cambridge City and, generally speaking, where there are no services there are no data. Therefore we have limited information for much of Cambridgeshire.

2.2 Supporting People and other agencies tend to view the homeless population as different client groups such as single homeless, rough sleepers, older people, ex-offenders, homeless families, young people (at risk, leaving care or teenage parents), people with disabilities, travellers, migrants, refugees and asylum seekers and also people with drug, alcohol, mental health and domestic violence problems. These categories are not mutually exclusive and one person may fit into or move between different client groups at any one time. Their rather arbitrary nature makes it very hard to get a clear picture of individuals and the complexity of their needs.

[4] Department of Health, 2009. Working together for change: using person-centred information for commissioning

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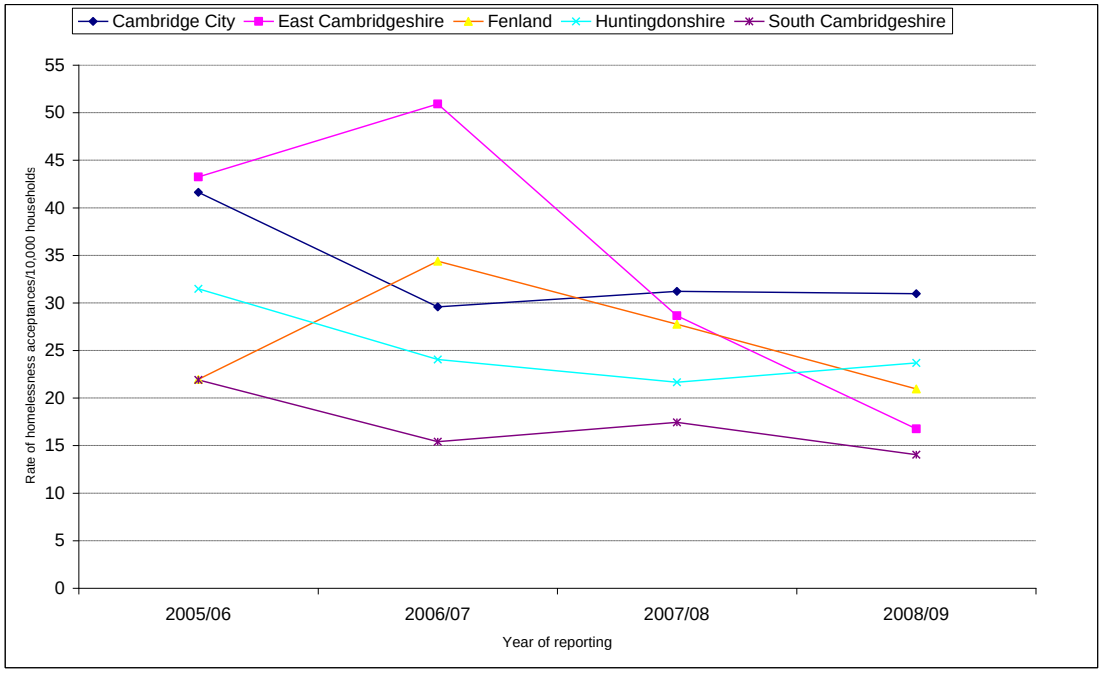
2.3 The overall trend in the number of households accepted as homeless both in Cambridgeshire (Figure 1) and nationally is downwards, largely due to local authority prevention strategies. However, there is some concern that the number of applications may increase due to the recession. In 2008/09, 40% of homelessness acceptances were as a result of parents/relatives/friends being no longer willing or able to provide housing and 74% of households accepted as homeless had a dependent child.

Figure 1: Rate of homelessness acceptances per 10,000 households by District, 2005/06 – 2008/09[5]



2.4 The largest client group accessing Supporting People funded services is single homeless and rough sleepers with 49% of clients being recorded as such in 2008/09 (Figure 2). Data from Supporting People and Cambridge City Council show that the majority of people presenting to services for the homeless are white British males aged between 26 and 49.

[5] Source: P1E. Household estimates: Research Group, Cambridgeshire County Council

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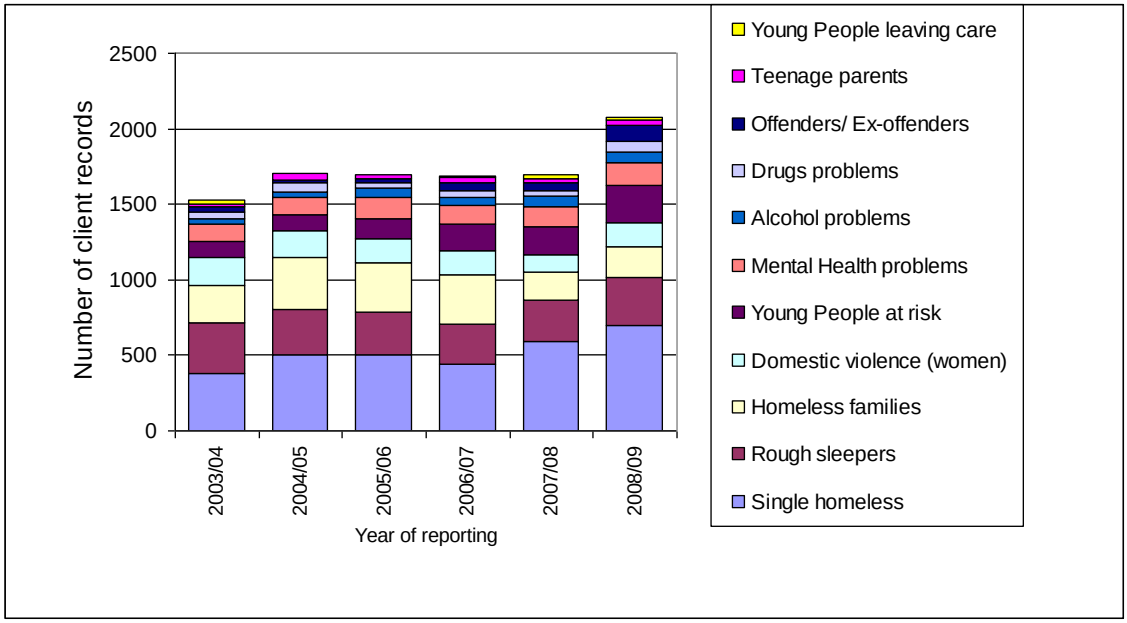
Figure 2: Number of clients accessing SP funded services by year of reporting and primary client group (presentations to services)[6]



2.5 The registered population of Cambridge Access Surgery is around 500 people. The majority of people accessing the service are single homeless/rough sleepers with a higher proportion of males. A substantial proportion have mental health, substance misuse (drugs and/or alcohol) and 'dual diagnosis' with a mean age of death being 44 years.

2.6 The voluntary and statutory agencies in Cambridge have identified 27 clients they believe to be chronically excluded[7]. These are individuals with very complex needs, who have usually experienced rough sleeping, and may currently be sleeping rough.

3. Existing Needs and Inequalities

Single Homeless and Rough Sleepers (SHRS)

3.1 The most common needs recorded for SHRS accessing Supporting People services are stated as support to maximise income, support to maintain accommodation and avoid eviction, support to access external groups and services and support to better manage substance misuse. The main reported reasons for these needs not being met are in relation to the client being unwilling or unable to engage or ceasing support before the outcome has been achieved.

3.2 The SHRS have very poor outcomes as illustrated by their reduced average lifespan (Figure 3). This partially reflects a small number of chronically excluded adults, with chaotic lifestyles, behavioural, substance misuse and control issues, and poor mental and physical health. They are often difficult to engage with services but represent significant costs to the tax payer as prolific offenders, having frequent hospital admissions and A&E visits, and intensive users of community and housing support services. Although this group represents relatively small numbers, it is essential that services are developed to help reduce the poor outcomes for this population.

[6] Source: Supporting People
[7] New Directions Team Assessment, August 2009

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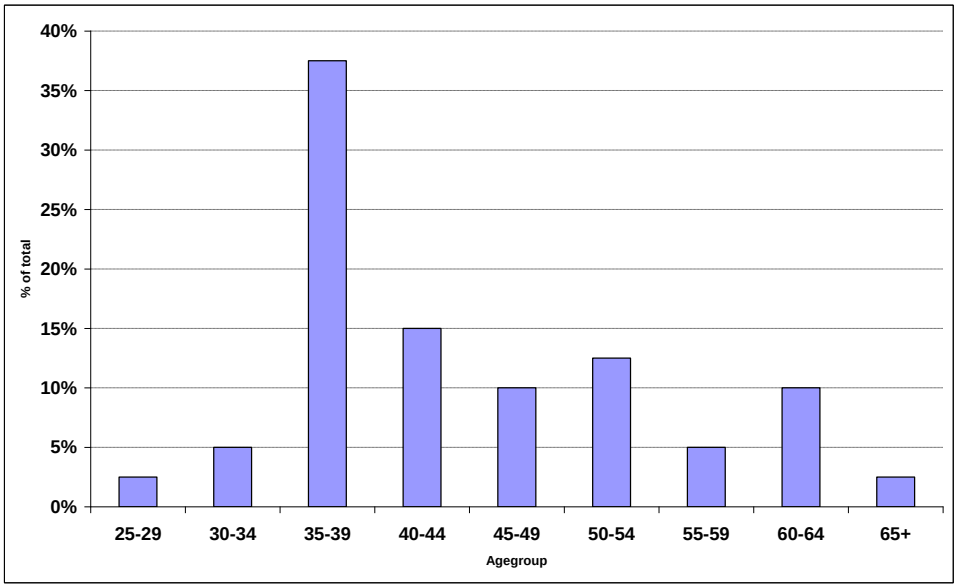
Figure 3: Age distribution of recorded deaths occurring among CAS registered population 2004-2006[8]



3.3 Single homeless and rough sleepers too often end up on a downward spiral of deteriorating mental and physical health with behavioural and control issues fuelled by alcohol and/or drugs on a background of socio-economic deprivation, dysfunctional relationships and inadequate access to support. Lack of past experience of a stable, emotionally secure existence reduces the chances of emerging from this downward spiral of homelessness. Homelessness further exacerbates the poor outcomes of the already disadvantaged because of the loss of daily living skills together with the pervasive culture of drug and alcohol use and associated crime and anti-social behaviour which are strong forces preventing successful re-housing. Many SHRS feel that they have been repeatedly failed by services and find engaging with services difficult. There are many dedicated staff trying to support the SRHS, who are constrained by a system that is not designed to meet the complex multi-factorial needs of their clients.

3.4 A substantial proportion of all homelessness services are based in Cambridge City however of newly homeless people in Cambridge City only 1 in 3 have a local connection with Cambridge City, while 2 in 5 have a local connection with other districts in Cambridgeshire. The size and character of Cambridge City make it an attractive place for homeless people and services have largely been developed there to meet their needs which in turn may attract individuals from both within and beyond Cambridgeshire.

3.5 At present, services for homelessness are commissioned independently and often covering different geographic and demographic domains with some services being commissioned by more than one agency within the same areas. There are concerns that the fragmented commissioning of services does not work well for the homeless and an integrated approach to providing services should be more robust.

3.6 This JSNA describes the wide range of current services for the homeless throughout the county. These include housing, health and drug and alcohol treatment, housing support and broader services directed towards rehabilitation such as training and employment. These services are delivered by statutory and non-statutory

[8] Source: ONS Public Health Mortality File

organisations, ranging from small local charities to national or county-wide organisations.

3.7 For many the main route out of SHRS is through being accepted as statutory homeless, but provision of accommodation alone is seldom adequate and many SHRS will require ongoing long term support to maintain tenancies and some will never find the personal resources to enable rehabilitation into society.

Statutory Homeless

3.8 Of clients referred to Supporting People, 22% were statutory homeless. This differs by client group with 72% of homeless families receiving SP services being statutorily homeless compared to only 2% of rough sleepers.

3.9 All Cambridgeshire local authority Homelessness Strategies have a focus on homelessness prevention and provision of appropriate accommodation, particularly reviewing the use of temporary accommodation. User involvement, partnership working and provision of support and services are also common themes. Some strategies also have a focus on specific client groups.

Hidden homeless and those at risk of homelessness

3.10 The characteristics of the hidden homeless population are largely unknown as those hidden homeless people who do not access services may never appear in the data collection systems and so the picture of the homeless population painted by existing data often misses this group as well as those at risk of homelessness. The hidden homeless are thought to be a transient population made up of some SHRS, 'sofa surfers', those living in hostels. There may be a large group who are in insecure accommodation, who may be at risk of either a crisis or relationship breakdown or loss of a temporary unskilled job

Effect of the Recession

3.11 Moving into the second decade of this century, there will be increasing pressure on public spending which will have an impact on health and social care budgets. Economic recession leads to increased unemployment, repossessions, homelessness and numbers of young people with difficulties in achieving a stable future. The effects of recession may include social problems and rising crime. The 'inverse care law' first described by Julian Tudor Hart in 1971[9] states that 'the availability of good medical care tends to vary inversely with the need for it in the population served.' The commissioning process needs to ensure that integrated solutions are provided for some of the most excluded and deprived sections of our society.

4. Recommendations

The following recommendations have emerged from this partnership working venture. The consistency in the needs identified by key stakeholders inspires confidence that these recommendations are founded in the experience of working with homelessness.

5.1 Development of a multi-agency steering group to strengthen joint commissioning to address the needs of chronically excluded adults, single homeless and rough

[9] Hart JT. The Inverse Care Law. *Lancet* 1971;i:405-12.

sleepers in Cambridgeshire with a focus on improving outcomes and the complex interrelations between health, housing and social care. Where possible more integrated multi-agency services should be commissioned including funded posts for liaison and co-ordination between services. This group could also consider development of a MARAC (multi-agency risk assessment conference) approach for chronically excluded adults.

5.2 Develop methods to encourage service user engagement in the commissioning process. Service users experience and perceived needs should be embedded in the care planning process. Information from individual care plans should be used to inform service development and commissioning to ensure direct input of homeless people and front-line service providers using the 'Working together for change' model.

5.3 Develop integrated information systems, data collection tools and ways of unifying individual client records so they can be used and accessed across services and care personalised across pathways to allow more holistic and person-centred identification of needs, commissioning of services and monitoring of outcomes. Develop a process for the sharing and disseminating of knowledge and experience on service provision for the homeless.

5.4 Develop services enabling prevention of homelessness and early intervention for the newly homeless to improve individual lives and to reduce overall homelessness. Support is particularly required at transition points such as leaving care, prison release and hospital discharge. In addition services should be co-ordinated, accessible and responsive to the needs of the homeless population.

5.5 Develop a strategy to address the health needs of the homeless population in Cambridgeshire as part of a joint commissioning strategy with action plans to support implementation and supporting the existing district homelessness strategies and action plans.

5.6 Recognise that the issues identified in this JSNA are ongoing and that there needs to be ownership and multi-agency partnership for action planning to implement the recommendations.