![Local Government Association logo]

THE IMPACT OF HOMELESSNESS ON HEALTH

A GUIDE FOR LOCAL AUTHORITIES

FOREWORD

It is a tragedy when a household becomes homeless. Homelessness often results from a combination of events such as relationship breakdown, debt, adverse experiences in childhood and through ill health. Homelessness and ill health are intrinsically linked and professionals in both sectors have a role to play in tackling the issues together.

Evidence tells us that the health of people experiencing homelessness is significantly worse than that of the general population, and the cost of homelessness experienced by single people to the NHS and social care is considerable. A recent audit found that 41 per cent of homeless people reported a long term physical health problem and 45 per cent had a diagnosed mental health problem, compared with 28 per cent and 25 per cent, respectively, in the general population. The last conservative estimate (2010) of the healthcare cost associated with this population was £86 million per year.

Homelessness is complex and often reflects other vulnerabilities or circumstances related to health, justice or social services. Successful homelessness strategies require all public services to contribute in a way that recognises the personal needs, strengths and assets of every household.

Councils are doing everything they can to prevent and solve homelessness, working closely with partners to place people into secure, appropriate accommodation and equip them with the skills to find work or ensure their health and wellbeing.

There are things we can do, together. Collaboration between local professionals – from environmental health and housing to allied health, public health and social care – is central to integrate services as a means to improve health outcomes and reduce health inequalities for those facing homelessness.

We are impressed and inspired by the energy and commitment of individuals working across local government – including health care, voluntary and community sectors – to improve the lives of people who are experiencing homelessness.

We hope that these materials and information will help local teams to reach out and join together to establish better health and wellbeing for homeless people in their communities. The challenge for us all is not just to develop good practice but to champion and share it.

Councillor Izzi Seccombe OBE
Chairman
Community Wellbeing Board

Councillor Martin Tett
Chairman
Environment, Economy, Housing and Transport Board

One in five adults reports a housing problem eg, affordability in the last five years, which had a negative impact on their mental health

Shelter, 2017

INTRODUCTION

Homelessness is bad for all our health, and wealth. Homelessness is a measure of our collective success, or otherwise, in reducing inequalities.

The information and ideas in this briefing aim to support local authorities in protecting and improving their population's health and wellbeing, and reducing health inequalities, by tackling homelessness and its causes.

- homelessness[1] is often the consequence of a combination and culmination of structural and individual factors: ill health can be a contributory factor

- homelessness, and the fear of becoming homeless, can also result in ill health or exacerbate existing health conditions

- people who are homeless report much poorer health than the general population

- homelessness in early life can impact on life chances and the longer a person experiences homelessness the more likely their health and wellbeing will be at risk

- homelessness is more likely amongst populations who also experience wider inequalities eg, care leavers and people with experience of the criminal justice system

- co-morbidity amongst the longer-term homeless population is not unusual; the average age of death of a homeless person is 47 (lower for women – 43), compared to 77 years amongst the general population

- people who experience homelessness can struggle to access quality health care and social care.
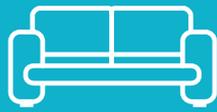
Homelessness has been rising since 2010. The scale and nature of homelessness is difficult to understand, and can be a complex problem to solve – housing alone is often not the only solution, particularly when people already have poor health or other needs that require additional support.

The Homelessness Reduction Act 2017 will widen access to assistance from local housing authorities[2] to all households at risk of homelessness and require earlier action to prevent homelessness. This presents a real opportunity to reduce homelessness, particularly amongst populations who have previously been unable to access services. However, success is highly dependent on the availability of sufficient resources and genuinely affordable homes to rent, and collective willingness amongst local systems leaders to play their part in prevention.

To improve health outcomes and reduce health inequalities, local leaders in health and social care systems clearly have a role to play in preventing, reducing and ending homelessness: in systems leadership and in enabling holistic responses that have the voice of people who have experience of homelessness at their heart.

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1   Homelessness is: rooflessness (without a shelter of any kind, sleeping rough); houselessness (with a place to sleep but temporary in institutions or shelter); living in insecure housing (threatened with severe exclusion due to insecure tenancies, eviction, domestic violence); living in inadequate housing (in caravans on illegal campsites, in unfit housing, in extreme overcrowding) (ETHOS, FEANTSA)

2   Local housing authorities are single tier or lower tier local authorities

Children living in overcrowded homes miss school more frequently due to medical reasons than other children

Shelter 2006

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THE IMPACT OF HOMELESSNESS ON HEALTH AND WELLBEING

Homelessness is complex but an understanding is essential to improve health outcomes and reduce health inequalities, and particularly considering an imminent change to homelessness legislation: commissioning for better outcomes across the systems that households at risk of becoming homeless or are homeless come into contact with will be necessary.

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51 per cent of young homeless people have been excluded from school, and 57 per cent are not in education, employment or training (NEET)

Public health teams in local authorities, working with colleagues, partners, people with lived experience and communities, are ideally placed and equipped to enable a shared local understanding of homelessness, health and wellbeing to inform commissioning, drawing on research and intelligence. Increasingly local authorities are completing a Joint Strategic Needs Assessment (JSNA) focused on homelessness, and/or have considered the topic in relation to specific populations or health conditions. Research suggests that some local authorities may wish to review their work in this area[1].

Official statistics present the 'tip of the iceberg' and do not help understand the relationship with health and wellbeing. Data relates primarily to 'statutory homeless households' and positive interventions provided by the local housing authority. This is important to remember in reviewing subsequent sections where 'official statistics' are referenced.

Homelessness is the subject of considerable research in the UK and abroad. This suggests that relationship between homelessness, health and wellbeing is different for different populations, across the life course.

The following sections broadly describe the scale and nature of homelessness and its relationship with health and wellbeing across the life course, and for populations who are at greatest risk of homelessness. Suggestions for local research are also provided, focusing particularly on households who are typically 'hidden' from services and/or in official statistics.

THE IMPACT OF HOMELESSNESS ON HEALTH AND WELLBEING

CHILDREN AND FAMILIES

Homelessness has particularly adverse consequences for children and can affect life chances. Starting life in temporary accommodation may impact on access to universal health care, for example immunisations, and temporary accommodation is associated with greater rates of infection and accidents. Homeless children are more likely to experience stress and anxiety, resulting in depression and behavioural issues. There is evidence that the impact of homelessness on a child's health and development extends beyond the period of homelessness. Homelessness can impact on educational attainment: accessing school places may be difficult; absenteeism from school is more likely; homelessness may 'single out' a child in a new school, increasing the likelihood of bullying and isolation.

Homelessness has a significant impact on the quality of the home environment provided by parents. Parents experience increased stress, depression and isolation. They may unintentionally overlook their child's needs.

There are additional costs associated with homelessness, for example, the cost of moving, storing or purchasing new belongings; increased travel costs; cost of new school uniforms. Managing these costs may require difficult decisions on household expenditure and parents may choose to go without food, or be unable to pay for their child to participate in activities.

Homelessness may 'single out' a child in a new school, increasing the likelihood of bullying and isolation

Official statistics indicate that homelessness experienced by families with dependent children increased by 56 per cent between 2009/10 and 2015/16 (41,970 households). Couples with dependent children increased by 73 per cent; these households are likely to have two working-age adults and in theory they should be better able to meet their own housing needs than a single adult household. In practice, the cost of housing is increasingly out of reach for working households, particularly but not exclusively in London and the South East. The main reason for homelessness amongst this population is likely to be loss of an assured shorthold tenancy: this can simply be the consequence of a landlord seeking higher rental income.

Homelessness experienced by families with dependent children increased by 56 per cent between 2009/10 and 2015/16

At the end of March 2017 there were 60,980 families with children in temporary accommodation, an increase of 68 per cent since the low point in December 2010. The length of time homeless households are spending in temporary accommodation is also increasing. Bed and breakfast (B&B) use is increasing: there were 3,010 households in B&B at end of March 2017, of which 1,290 households had lived there for more than six weeks.

In July 2017 the LGA published 'Housing our Homeless Households'[3] detailing how councils can sustainably provide temporary accommodation.

3   local.gov.uk/housing-our-homeless-households-full-report
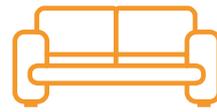
Children who have been in temporary accommodation for more than a year are over three times more likely to demonstrate mental health problems such as anxiety and depression than non-homeless children (Shelter 2006)

Living in temporary accommodation puts children at greater risk of infection, and accidents

(Shelter 2006)

Homeless children are **more likely to be in poor health** than non-homeless children
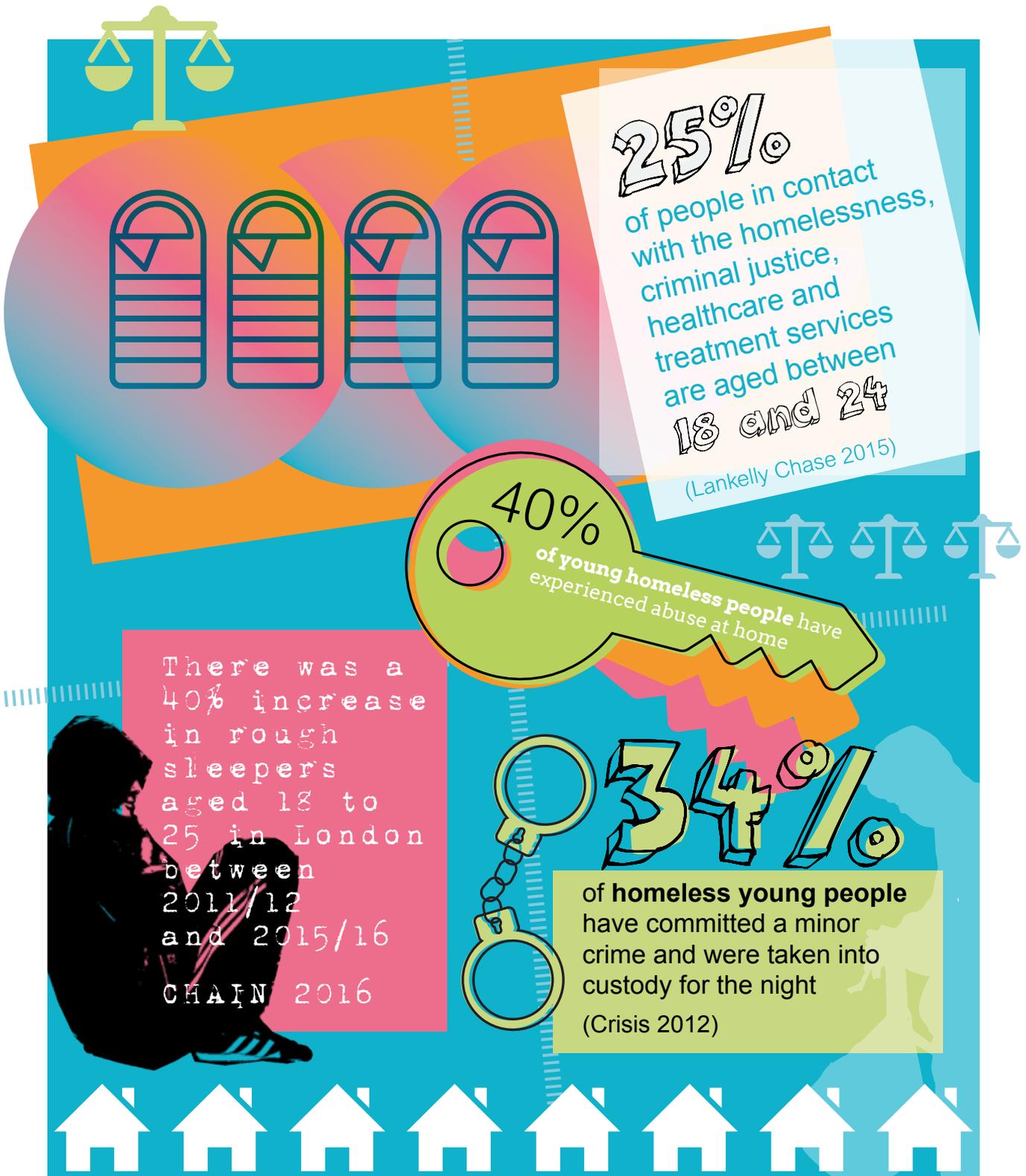
(Shelter 2006)[2]

Moving home many times in early life affects child behaviour and mental health (Urban Institute 2013)[3]

THE IMPACT OF HOMELESSNESS ON HEALTH AND WELLBEING

25% of people in contact with the homelessness, criminal justice, healthcare and treatment services are aged between **18 and 24**

(Lankelly Chase 2015)

40% of young homeless people have experienced abuse at home

There was a 40% increase in rough sleepers aged 18 to 25 in London between 2011/12 and 2015/16

CHAIN 2016

34% of **homeless young people** have committed a minor crime and were taken into custody for the night

(Crisis 2012)

YOUNG PEOPLE

Young people experiencing homelessness are extremely vulnerable, and face complex and compounding challenges:

- homelessness is often a consequence of relationship breakdown

- they lack relationship and independent living skills, formal support and struggle to access services

- they are more likely to have experienced trauma, abuse and other adverse experiences

- they are more likely to have been absent and/or excluded from school, and not be in education, employment or training (NEET)

- there are high levels of self-reported mental health problems, self-harm, drug and alcohol use

- there is an increased risk of exploitation, abuse and trafficking, and involvement in gang and/or criminal activity

- they are at more risk of sexually transmitted infections (STIs) and unwanted pregnancies and can come under pressure to exchange sex for food, shelter, drugs and money.

Young people leaving care, young people who have run away, BME young people, LGBT young people and young people with experience of the criminal justice system, young refugees and asylum seekers, and young people from rural areas are at greater risk of homelessness.

Young people who experience homelessness are at risk of embarking on a 'career' in the homelessness, criminal justice, health care and treatment systems, at significant cost to their own health and wellbeing, their families and communities, and to the public purse

Young people who experience homelessness are at risk of embarking on a 'career' in homelessness, criminal justice and health systems, at significant cost to their own health and wellbeing, their families and communities, and to the public purse. Their potential to contribute to and benefit from society and the economy is affected by homelessness.

Official statistics suggest that homelessness experienced by young people aged 16 to 24 years has decreased since 2009/10. This is primarily a consequence of a targeted preventative approach introduced by the Government in 2012 – the positive pathway[4] (this service is on offer to all local authorities).

In practice youth homelessness is felt by national bodies to have been broadly stable over the past decade, although this is difficult to verify: young people choose to remain 'hidden', staying temporarily with friends or family, and they do not access public services in the same way as adults. Going forward it is predicted that youth homelessness will

increase – accessing genuinely affordable housing is a challenge now for all households, but particularly for young people because:

- the level of unemployment amongst young people is much higher than for the working population as a whole

- there is strong competition for shared accommodation as a consequence of recent welfare reforms

- a recent decision has been taken by the Government to restrict entitlement to the housing cost element of Universal Credit for young people aged 18-21

- young adults account for the largest proportion of Jobseekers' Allowance (JSA) claimants sanctioned

- there are fewer service and accommodation interventions available in local areas to meet need, including emergency need.

Insight from those working with young homeless people suggests that their needs are more complex than in the past. Data for London suggests a 40 per cent increase in the number of 18 to 25 year olds sleeping rough between 2011/12 and 2015/16. Recent national research into the scale and nature of the population who are in contact with homelessness, criminal justice, healthcare and treatment services concluded that 25 per cent of this population (over 250,000 people) are aged between 18 and 24 years.

Up to 70 per cent of homeless young people have mental health problems and 33 per cent self-harm

LIVING AND WORKING WELL

Homelessness may arise as a consequence of loss of employment, insecure employment, and insufficient income from employment and/or social security to meet housing and related costs. Lower income places households at greater risk from private landlords seeking to increase and/or secure rental income and the end of an assured shorthold tenancy. Stress and anxiety associated with the threat of becoming homeless may affect existing employment.

Once homeless, it can be difficult to retain existing employment

Once homeless, it can be difficult to retain existing employment, for example: temporary accommodation may be some distance from the place of work; the cost of temporary accommodation may make work prohibitive financially; the household's health and wellbeing may deteriorate to the point where they cannot work. Homelessness affects self-esteem and confidence.

Young adults account for the largest proportion of Jobseekers' Allowance claimants sanctioned
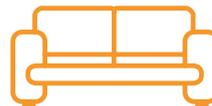
80% of single people experiencing homelessness want to work, but only **10%** are in paid employment

CV

Stress and anxiety associated with the threat of becoming homeless may affect existing employment

8 PER CENT OF THE MAIN APPLICANTS OF HOUSEHOLDS WHO ARE OWED THE MAIN HOMELESSNESS DUTY ARE WORKING AGE: **MOST ARE UNDER THE AGE OF 45**

THE IMPACT OF HOMELESSNESS ON HEALTH AND WELLBEING

For people who are homeless, out of work and have other support needs, perhaps related to their health and wellbeing, it is particularly difficult to access suitable employment, although the majority of people in this position want to work. Additional support may be needed to enable access to a job, and to sustain this.

Official statistics tell us almost nothing about homeless household's economic status or financial circumstances. It is known that 98 per cent of the main applicants of households who are owed the main homelessness duty are working age, and that the majority are under the age of 45 years (83.5 per cent in 2015/16). The effects of homelessness on this population's health, wellbeing and employment should be of interest to ambitions for economic growth and security. Data also suggests a 283 per cent increase between 2009/10 and 2015/16 in the number of foreign nationals with either worker status or self-employment as a reason for eligibility (3,490 households or 6 per cent of all statutory homeless households). Anecdotally there are many more workers from abroad who, whilst coming to the UK to work, will find themselves homeless but not be eligible for homelessness assistance.

No recourse to public funds is an increasing issue for local authorities and their partners for example health care professionals working to enable TB treatment completion, in trying to prevent and respond to homelessness for this population, and others who find themselves in the UK for other reasons eg victims of trafficking or failed asylum seekers.

AGEING WELL

This population includes those who have been homeless for years and those who become homeless for the first time in later life and, as with other populations, official statistics represent the 'tip' of the iceberg.

The relationship between homelessness, health and wellbeing in later life is not documented to the same extent as for younger populations. A three-nation study identified that physical and mental health problems, alcohol abuse and gambling problems were contributory factors in homelessness experienced by the first time by people in later life, following on from death of a close relative, relationship breakdown, accommodation being sold or needing repair, and rent arrears.

Physical and mental health problems, alcohol abuse and gambling problems were contributory factors in homelessness experienced for the first time by people in later life

Studies also indicate that existing health conditions are exacerbated by homelessness, and that older people experiencing homelessness are more likely to suffer from depression or dementia.

Risks to health are particularly high for people who have lived on the streets for some time, indeed it is estimated that the average age of death of a homeless person is 47 years – 'later life' is in fact much earlier than for the general population.
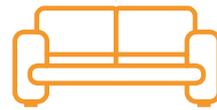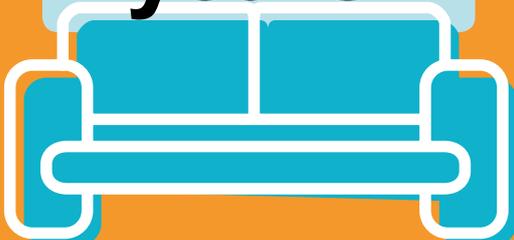

There has been a **111 per cent** increase in older (over 60) statutory homeless applicants **since 2009/10**

the average **age of death** of a homeless person is 47 years

47 years

Age UK estimates **1.6 million pensioners are in poverty**

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Limited research is a likely consequence of the small scale of homelessness amongst this population, which in turn can be related to the availability of accommodation, support and care for this population. However, it should not be assumed that low levels of homelessness in later life will continue (iin 2016/17 2,470 recorded homeless people aged over 60).

Older people experiencing homelessness are more likely to suffer from depression or dementia

• Official statistics indicate a 111 per cent increase in older (over 60) statutory homeless (successful) applicants since 2009/10, and 155 per cent increase in applicants aged 75 years and over. This compares to an overall increase of 48 per cent in all applicants.

• The increase in homelessness experienced by older people is being witnessed in many developed countries including Australia, Canada, Japan and the USA as a consequence of the general population ageing.

• Households are increasingly living in the growing private rented sector (loss of assured shorthold tenancy is the main cause of statutory homelessness).

• It remains the case that many older households live in poverty (Age UK estimates 1.6 million pensioners are in poverty).

• Low income in retirement is often linked to earlier low pay or time out of employment – homelessness earlier in life could be a contributory factor (see previous section).

• Access to specialist housing, support and social care to enable independent living is changing.[6]

There is evidence that the needs of older people who are experiencing homeless are increasingly complex: official statistics indicate a growth in 'older' statutory homeless households who are vulnerable because of needs other than their age; increased alcohol consumption and drug use may result in homelessness; the age of the prison population reflects that of the general population – older people are more likely than younger people to be homeless when released; in London there has been an increase of 163 per cent in rough sleepers over the age of 55 between 2015/06 and 2015/16 (11 per cent of all rough sleepers).

POPULATIONS AT GREATEST RISK

A number of people are at greater risk of homelessness as a consequence of individual factors, for example existing health conditions. They are also more likely to experience homelessness on more than one occasion and may be in contact with several 'systems' to meet their needs. The cost associated with improving health outcomes and reducing inequalities amongst these populations is likely to be higher if consideration is not given earlier enough, and in partnership, to an individual's living circumstances.

Official statistics provide almost no intelligence about these populations but research exists that can help to improve our understanding. The following information is a high-level summary: further reading is signposted in the resources section.

MENTAL HEALTH

Mental ill health can be a cause and a consequence of homelessness. There are correlations between:

- financial problems and mental health

- housing insecurity and anxiety, stress, loss of confidence and worry about the future

- overcrowding and mental health, particularly for children and young people

- stress, anxiety, depression and other mental health problems and poor housing conditions

- self-medication with alcohol and drugs.

For people who experience mental health problems the importance of safe, secure and affordable housing is well evidenced.

Common mental health problems are over twice as high among people who are homeless compared with the general population, and psychosis is up to 15 times as high.

PEOPLE EXPERIENCING THREATENING BEHAVIOUR, ABUSE OR VIOLENCE

People experiencing threatening behaviour, abuse or violence often leave their home to escape the situation.

Whilst both men and women can perpetrate and experience domestic violence and abuse, it is more often inflicted on women by men; particularly where it is severe and repeated violence, or sexual assault. Populations at increased risk of domestic violence are also more likely to become homeless for example, if someone:

- is aged 16–24 (women) or 16–19 (men)

- has a long-term illness or disability or mental health problem

- is a woman who is separated, and the risk is higher around the time of separation

- is pregnant or has recently given birth

- is a gay or bisexual man or is transgender.

The impact of abuse on victims is considerable: in addition to a negative effect on mental and physical health, the experience affects the victim's role in, and contribution to, society and the economy, for example it can isolate people from their family, friends and community, and have a negative effect on work leading to possible loss of independent income.

It is important to understand that domestic violence is significantly under-reported.

There are higher levels of reported domestic violence amongst people who have experienced homelessness over some time,

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and have additional needs: St. Mungo's Broadway reports that around a third of their female service users and 8 per cent of male service users have experienced domestic violence, compared to 8.2 per cent of females and 4 per cent of males in the general population[7].

PEOPLE WITH SUBSTANCE MISUSE PROBLEMS[8]

Homelessness can be caused or exacerbated by substance misuse, for example:

- early experiences of unstable housing circumstances are associated with drug use amongst young people

- family relationships are often put under great strain when people are addicted to either drugs or alcohol, leading to the loss of accommodation

- homelessness can be a route into addictions, either for people on the streets, or for people staying in supported accommodation, hostels or bed and breakfast (B&B) where others are using drugs or alcohol

- those who have addictions may not be able to keep accommodation because of money spent on drugs or alcohol, or because of their behaviour

- substance misusers may find it difficult to access or sustain employment, with a subsequent need to rely on welfare benefits.

Homelessness affects:

- decisions to use for the first time, or continue to use, drugs

- motivation for change and willingness to engage with treatment, and access to treatment

- the ease with which treatment providers can continue to engage with their client

- the level of support available from family

- the use of hospital

- withdrawal and relapse.

The likelihood of excess mortality is higher, particularly amongst substance misusers who are considered to experience 'persistent homelessness' and injecting drug users.

Dual needs (mental health and substance misuse) are common amongst homeless people, particularly those on the streets and on the edge of rough sleeping; for this population access to treatment is a challenge.

Substance misuse presents a challenge to responding to homelessness, and can perpetuate homelessness. For example, it may be the top priority in an individual's life, affecting the extent to which they are concerned with where they live and/or their access to housing.

The National Drug Treatment Monitoring System (NDTMS) suggests that of the 135,592 individuals (98 per cent) who provided their housing status, 7 per cent reported an urgent housing problem, usually no fixed abode (NFA), with a further 11 per cent reporting some form of current housing problem (such as staying with friends or family as a short term guest or residing at a short-term hostel).

Opiate clients had the highest rates of urgent housing problems (13 per cent).

Particularly high rates of housing need (50 per cent) were reported by clients citing both opiates and NPS at the start of treatment, compared to 29 per cent for opiate clients overall.

There is a strong correlation between homelessness, substance misuse and people with experience of the criminal justice system.

PEOPLE WITH EXPERIENCE OF THE CRIMINAL JUSTICE SYSTEM

Health amongst people who have offended is considerably worse than that of the general population, and there are health inequalities within the population. Homelessness can be a contributory factor in offending behaviour, or result from offending. Poor quality housing and neighbourhoods, precarious housing circumstances and homelessness are arguably more detrimental to offenders, yet it is common knowledge amongst those working in this field that it is exactly these circumstances that most offenders live in whilst in the community.

Research suggests that 15 per cent of the prison population reported being homeless before custody, including 9 per cent sleeping rough, compared to 3.5 per cent of the general population reporting ever having been homeless; 44 per cent of prisoners reported being in their accommodation prior to custody for less than a year; 28 per cent reported living in their accommodation for less than six months. This population is however almost invisible in official statistics.

For people receiving treatment in prison for drug and/or alcohol problems, tuberculosis or other communicable diseases, homelessness or unstable accommodation on release can mean that treatment is not completed. Not only does this have consequences for the individual's health and wellbeing, in the case of a communicable disease there are consequences for the public. The cost of treatment in prison may be wasted if homelessness follows release.

Offenders who have accommodation arranged on release from prison are four times more likely to have employment, education or training arranged than those who do not have accommodation. People in prison say that meeting their accommodation needs is a key factor in helping them to not reoffend, with recent research suggesting this is the case for 60 per cent of prisoners.

PEOPLE WITH MULTIPLE AND COMPLEX NEEDS

There are several different terms in use in the UK for this population, including multiple needs, chronic or multiple exclusion, and severe and multiple disadvantage (SMD).

Severe and multiple disadvantage is shorthand for the problems faced by adults in the homelessness, substance misuse and criminal justice systems in England, with 'poverty an almost universal, and mental ill health a common, complicating factor'. Research estimates the prevalence of the population in England with at least these three needs as 58,000, with around 250,000 people being affected by two of the three needs. The average local authority area might expect to

need to work with around 385 people with disadvantages in all three domains, or 1,470 people with disadvantages in two of the three areas. The largest group affected by SMD is white men aged between 25 and 44.

The evidence indicates that severe and multiple disadvantage appears to result from a combination of structural, systemic, family and personal factors, leading to great difficulty in achieving positive outcomes with this group.

With higher levels of rough sleeping in London, it could be expected that there is a greater number of people with multiple and complex needs, but this is not necessarily the case: areas identified as having the largest SMD populations are primarily in the North and Midlands.

PEOPLE WHO EXPERIENCE ROUGH SLEEPING

Official statistics report a 134 per cent increase in rough sleeping since 2009/10, with 4,134 people recorded by local authorities in autumn 2016 (a snapshot count or estimate).

More detailed data collected from outreach services in London throughout the year (CHAIN) indicates that the number of people who experience rough sleeping is much higher. In 2015/16 8,096 people were seen rough sleeping in London – the official snapshot figure was 964 people. London data also highlights that for many people, rough sleeping is a 'one off' or temporary living situation: during 2015/16 5,276 people had never been seen rough sleeping in London prior to April 2015. For many others however

rough sleeping has been experienced on a longer-term basis (after a year on the street this is more likely), some with intermittent periods of time in accommodation, and they may be described as 'entrenched': in London this population experienced the greatest increase. The latter population has similar needs to those described for people experiencing severe and multiple deprivation.

Research suggests that average age of death of someone who has experienced longer-term homelessness is 47 years (for women this is 43 years).

People who are rough sleeping (including those who move between hostels and sofa surfing and/or are otherwise chronically insecurely housed) face additional risks to their life chances:

- death by unnatural causes has been found to be four times more common than average amongst rough sleepers, and suicide 35 times more likely

- rough sleepers are more likely to be assaulted than the average person

- alcohol and drug problems are very high amongst rough sleepers, and people being resettled from the streets are more likely to face problems sustaining a tenancy if they have these problems

- the prevalence of infectious diseases, such as tuberculosis, HIV and hepatitis C, is significantly higher than in the general populations

- this population experiences poorer oral health than the general population.

Access to health care for this population is different to that of the general population: one third of rough sleepers are not registered with a GP; attendance at accident and emergency is at least eight times higher than the housed population.

OTHER INCLUSION HEALTH POPULATIONS

The following populations frequently experience homelessness, alongside significant health inequalities:

• Gypsies and travellers

• sex workers

• migrant workers, refugees and asylum seekers.

Further information about these populations can be accessed through resources signposted at the end of this briefing.

Older people experiencing homelessness are more likely to suffer from depression or dementia

HOW CAN COUNCILS END HOMELESSNESS?

Asking the following questions in your locality will help local leaders identify opportunities for the health and social care system to contribute to, facilitate and provide leadership to end homelessness, improve health outcomes and reduce health inequalities. References are provided for supporting resources, and further resources can be found later in this document.

1. IS THERE A VISIBLE COMMITMENT TO ENDING HOMELESSNESS, AND SYSTEMS LEADERSHIP TO ACHIEVE THIS?

Homelessness is complex and requires energy, ideas, talent and expertise from leaders in multiple systems. This might look like:

- Ending homelessness is a priority for the health and wellbeing board (HWB) and is communicated as such, for example in the Sustainability and Transformation Plan (STP), the local HWB strategy, relevant commissioning plans, and/or in a specific charter – see St Mungo's.[9]

- Governance for 'ending homelessness' is clearly connected to the HWB, for example there is representation on the HWB from a member of the local housing and homelessness partnership group.

- Governance includes partnerships/boards whose remit is to improve outcomes for people who are most at risk of homelessness and poor health outcomes, for example:

  ◦ the community safety board, whose interests will include victims of domestic abuse and violence, people in contact with the criminal justice system, antisocial behaviour

  ◦ the children's trust partnership board, whose interests will include care leavers, other vulnerable young people eg, those in contact with the criminal justice system, children living in temporary accommodation.

- The local housing authority's homelessness strategy (a statutory requirement)[10] recognises the relationship between homelessness, health and wellbeing and communicates plans to improve outcomes.

- Elected mayors and elected members are publicly prioritising homelessness in their localities and supporting action to tackle this (recent examples include statements by new Mayors in the West Midlands[11] and Greater Manchester[12]).

HOW CAN COUNCILS
END HOMELESSNESS?

2. IS LOCAL COMMISSIONING FOR IMPROVED HEALTH AND WELLBEING INFORMED BY A SHARED UNDERSTANDING OF THE PROBLEM?
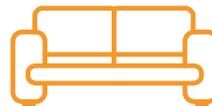
This might look like:

• A homelessness specific Joint Strategic Needs Assessment[13] (JSNA) and/ or homelessness is considered within at risk population or relevant health condition JSNAs eg, people in contact with the criminal justice system, mental health, tuberculosis and other communicable diseases.

• A homeless health needs audit has been completed and informs the JSNA, using Homeless Link's Health Needs Audit[14] (supported by DH and PHE).

• The local homelessness review[15], informing the homelessness strategy has considered health and wellbeing, and the role of health services.

• There are multi-disciplinary approaches to identifying homeless individuals and households who present to multiple services and may be at risk of not having their needs met holistically.

3. DOES COMMISSIONING TAKE A PLACE, OUTCOME AND ASSET BASED APPROACH, RECOGNISING THE STRENGTHS, RESOURCES, AND ASPIRATIONS OF THOSE AT RISK OF BECOMING OR EXPERIENCING HOMELESSNESS?

This might look like:

• All services in contact with people at risk of becoming homeless, or homeless, take a 'people first' not 'problem first' approach, recognising aspirations, abilities, interests and talents.

• Local leaders and the wider workforce have been supported to shift from the 'deficit' model to an asset-based model through training and development.

• Commissioning and procurement[16] for homeless prevention and response services support 'place and asset based' models and engages communities.[17]

• The social impact of tackling homelessness and its underlying causes is understood and informs commissioning eg, through social impact bonds.[18]

4. ARE SERVICES ACCESSIBLE, TIMELY, FLEXIBLE AND HIGH QUALITY, WITH CLEAR PATHWAYS IN PLACE?

This might look like:

- The adoption of standards for commissioning health services[19] for people experiencing homelessness.

- The adoption of guidance for clinical commissioning groups to improve health outcomes of homeless people.[20]

- Pathways, protocols and services are in place to prevent homelessness at 'high risk' points eg, on discharge from hospital (including mental health)[21][22] and on release from prison.[23]

- Access to assessments for health care and social care that are not predicated on thresholds.

- The adoption of the 'best practice' pathway models for young people, including those leaving care and in the criminal justice system.[24]

- Relevant involvement from organisations/professionals working with people experiencing homeless in local adult's safeguarding[25] and children's safeguarding[26] arrangements.

- Community centred approaches to improving health and wellbeing and tackling homelessness have been explored locally.[27]

- Peer-led approaches to delivering services eg, health peer advocacy.[28]

- People experiencing homelessness understand their rights to access health care.[29]

HOW CAN COUNCILS
END HOMELESSNESS?

5. IS THE FRONTLINE WORKFORCE EQUIPPED TO UNDERSTAND THE TRIGGERS, RECOGNISE THE THREAT OF HOMELESSNESS OR ACTUAL HOMELESSNESS, AND FEEL CONFIDENT TO RESPOND?

This might look like:

- Workforce development activity across relevant systems eg, health care, social care, criminal justice and welfare, supports professionals to recognise the threat of or actual homelessness amongst their service users/patients and to act.

- Communities of practice for frontline professionals in health, housing, criminal justice and social care agencies to improve service responses to people with multiple and complex needs.[30]

- Training and the adoption of standards for working with people experiencing homelessness in health care services eg, standards for GP receptionists in primary care [31]and practice managers.[32]

- Opportunities to meet the needs of people experiencing homelessness through the Care Act 2014[33] have been explored in local implementation.

- The homelessness workforce understands its role in enabling access to assessments for social care.[34]

- The use of available tools to assess the health care needs of people experiencing homelessness eg, the Queen's Nursing Institute health assessment tool.[35]

- Health care professionals understand their role, and the role of others, at population, community and individual levels, for example they know where they can find information about homelessness services and specialist health care for homeless people.[36,37]

6. ARE PEOPLE WITH EXPERIENCE OF HOMELESSNESS ABLE TO INFORM COMMISSIONING AND DELIVERY?

This might look like:

- Local services are committed to the involvement people with lived experience of homelessness (Pathway's 'Experts by Experience' involvement handbook provides useful tips).[38]

- Procured services are required to enable people to share their experiences "to improve the quality of services and inform commissioning.

- Engaging the National Youth Reference Group (young people from communities across England who are aged 16 to 25 and have experienced homelessness) to support, for example, local involvement with young people or to train staff in working with young people who have experienced homelessness.[39]

7. DO MEMBERS OF THE PUBLIC UNDERSTAND THE RISK OF BECOMING, AND IMPACTS OF, HOMELESSNESS ON THEIR HEALTH AND WELLBEING, AND CAN THEY MAKE INFORMED DECISIONS ABOUT THEIR LIVING CIRCUMSTANCES, HEALTH AND WELLBEING?

This might look like:

- All local sources of information, advice and guidance provide information about the health impacts of different living circumstances and how health impacts can be mitigated.

- Information about housing and homelessness is available in primary and secondary health care locations, and from health care professionals working in the community.

HOW CAN COUNCILS
END HOMELESSNESS?

8. DO COMMUNITIES UNDERSTAND THE RISK OF BECOMING, AND IMPACTS OF, HOMELESSNESS AND CAN THEY SUPPORT OTHERS EXPERIENCING THESE CIRCUMSTANCES?

This might look like:

• There is a culture of collaboration and co-operation with the voluntary, community and social enterprise (VCSE) sector working to improve health outcomes for people experiencing homelessness, and the sector is supported to be sustainable.[40]

• A single source of information for community groups/communities of interest, with support for those who would like to act eg, Street Support in Manchester and Leeds.[41]

• The faith sector works with systems leaders to play a positive role in identifying, preventing and responding to homelessness, and improving health and wellbeing.[42]

9. DO LOCAL BUSINESSES, ECONOMIC, EMPLOYMENT AND ENTERPRISE INTERESTS CONTRIBUTE TO THE AMBITION TO END HOMELESSNESS, IMPROVE HEALTH AND WELLBEING?

This might look like:

• Local plans for place-based economic growth are inclusive of people and communities who are at risk of becoming homeless and those who have experienced homelessness, and recognise that ill-health may be a barrier to work.[43]

• Local welfare and employment support services understand the relationship between employment, income and housing needs and health, and work with commissioners and housing providers to identify and prevent homelessness.[44]

• Leaders and commissioners support social enterprises to contribute to ending homelessness.[45]

• Local business and enterprise contributions are targeted to best effect eg, Street Support in Manchester and Leeds.[46]
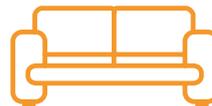
10. DOES TEMPORARY, SUPPORTED AND SETTLED HOUSING PROVIDE A HEALTHY, GENUINELY AFFORDABLE AND SUITABLE ENVIRONMENT FOR PEOPLE WHO ARE AT RISK OF BECOMING HOMELESS, OR WHO HAVE EXPERIENCED HOMELESSNESS?

This might look like:

• All services working with people at risk of becoming homeless or people experiencing homelessness consider the risks to health of their service users from poor quality, unsuitable, insecure and unaffordable accommodation, and act to mitigate this eg, working with the local authority environmental health team.[47]

• All temporary and supported housing (including that which is not directly procured by the local authority eg, unsupported temporary housing) is regularly inspected to ensure it provides a healthy environment.[48]

• There is a local temporary accommodation board in place, bringing together all local partners whose service users live here to ensure their health and wellbeing.

• Households placed in temporary or supported accommodation by any organisation working in the locality are supported to access health care provision.

• Schemes to enable access to homes in the private rented sector seek recognise the health needs of their customers, ensure homes meet relevant standards and enable people to connect with health care provision.[49]

There was a 40 per cent increase in rough sleepers aged 18 to 25 in London between 2011/12 and 2015/16

CHAIN 2016

CASE STUDIES

The case studies here represent just a small number of examples of joint working in localities to prevent and respond to homelessness, improve health and wellbeing and reduce health inequalities. Most have emerged from ideas and funding outside of local authorities, reflecting the opportunities that exist through partnership working.

Many other examples can be found on other homelessness, and homeless health, partner websites, for example the Queen's Nursing Institute Homeless Health programme.

Further links to resources are found in the next section.

Preventing homelessness on discharge from hospital – Cornwall's Homeless Hospital Patient Service

The service enables homeless patients to be discharged from hospital into secure and safe accommodation, which will in turn improve health outcomes, with support to reduce their length of stay in hospital and the likelihood of a readmission.

In place since January 2014 (the service was established with initial six-month funding from the Department of Health's hospital discharge fund) the service was developed through a partnership of Cornwall Council (led by the public health team), Shelter and other homelessness charities eg St Petroc's, Cornwall Housing, NHS (acute, primary care and mental health), Coastline Housing and Inclusion Cornwall.

It was developed to address high levels of rough sleeping (77 people in 2013)

and associated complex needs, poor physical and mental health, identified through local research[50], and the impact of unmet needs on likely age of death (Crisis suggests that the average age of death of a single homeless person (which includes those sleeping rough, in hostels and in other hidden homeless situations), is 47 years old and even lower for homeless women at just 43, compared to 77 for the general population.

The service is delivered by a patient liaison adviser, working in acute and mental health hospitals, who assesses patients who are homeless, or who may be homeless upon discharge, on admission to hospital, and provides housing advice to enable a planned discharge from hospital into suitable accommodation. The adviser position has also enabled:

- a county-wide protocol between agencies to enable access to accommodation

- a clear pathway to better outcomes, allowing for discharge to begin at the point of admission

- clarity around the process for those who are admitted that have no fixed abode

- information sharing across appropriate teams and professionals

- safer and more effective discharge plans

- more timely discharges, sometimes using a very small amount of funding to address a practical need eg, transport

- workforce development

- more appropriate use of health care professionals' time.

Crucially, the partnership has sought to provide the best possible environment for success, for example it has enabled access to dedicated suitable accommodation (this can be used flexibly, for example to enable someone experiencing homelessness to prepare for elective surgery), and it has been effective in securing ongoing resources from a variety of sources eg, NHS Winter Pressures and Shelter.

The service has identified that the most frequent reasons for hospital admissions from homeless patients are: psychosis; su icide threat or attempt; trauma; infection; alcohol or substance related collapse. Patients often have multiple and complex needs, mental ill health and co-morbidities. Between 2014 and 2016 the service has enabled:

- 450 homeless patients to be discharged with a support plan in place

- around 92 per cent of homeless patients to access suitable accommodation on discharge

- support for 90 rough sleepers

- 'savings' of 561 bed days (£280,500) in 2014 and 2015.

The national evaluation of the Department of Health hospital discharge fund is here.

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Working with social enterprises to prevent homelessness and improve health amongst young people: Your Own Place

Your Own Place CIC seeks to equip young people with the skills, confidence and knowledge to live safely and securely, to sustain tenancies and employment, to prevent homelessness[51].

Your Own Place currently operates in Norfolk and was established in response to a gap in the provision of support to young people to develop independent living skills (research by the Children's Society suggests this is a gap experienced across the country[52]). It seeks to prevent homelessness amongst young people, particularly, but not exclusively, those at greatest risk: young people leaving care; young people who have previously been homeless; young people who are unemployed and on a low income. Young people are able access Your Own Place through Children's Services, schools or college, amongst others.

Your Own Place delivers three interventions, primarily face-to-face, in groups and on a one-to-one basis:

- Tenancy and independent living skills (TILS) training courses are delivered in small groups of up to eight young people, or on a one to one basis, in a bespoke training flat (all facilities in which to practice, from reading the meter to cooking a meal), in a young person's home or in another location at the request of the young person or commissioner. The approach is

games-based, multi-media, fun and experiential learning, and covers all aspects of holding a tenancy including housing options, tenancy rights and responsibilities, money skills, debt and bills, setting up and managing utilities, meeting the neighbours, benefits, managing isolation etc. At the end the young people get a certificate, USB with useful information, budgeting tools and a tenancy pack. The training is delivered in partnership with peer trainers (young people who have also had the same experiences and already benefitted from the support of Your Own Place), credit unions, local housing authorities, utility companies and Job Centre Plus, amongst others.

- Volunteer tenancy mentors support young people in their first tenancy. From all backgrounds, mentors are trained, vetted, interviewed and matched to young people.

- Employment support is delivered on a one to one basis using the Journeys to Employment framework, and in partnership with employers who provide work tasters[53].

Outcomes in 2015/16 included:

- Twenty-two young people completed tenancy and independent living skills training: 86 per cent reported improved tenancy skills; 71 per cent have increased understanding of being a good tenant; 71 per cent have improved money skills.

- Volunteer tenancy mentors delivered 431 hours of support to 37 young people, of whom 70 per cent reported increased tenancy confidence and skills, 25 per cent improvement in managing bills and 50 per cent increased knowledge where to go for help.

- Employment support was delivered to 29 young people seeking work; 15 young people received certificates, awards and financial support, two were supported onto a level in youth work; 75 per cent reported feeling more confident about finding work.

Specific health and wellbeing outcomes are currently being measured, but it is reasonable to assume that these will be positive: support is provided in relation to shopping and cooking (diet and nutrition); support to enable access to work has included enabling a young person to use a bicycle (physical activity); anecdotal feedback suggests that group work has enabled young people who previously felt isolated from their peers to re-connect with others.

As a social enterprise, established in 2013, Your Own Place seeks a variety of revenue and income generation models and sits between a business and a charity in aiming to be business-like in its approach to bringing about sustained social change. In 2015/16 it leveraged support from over 60 partners, including a police and crime commissioner, a housing association, charitable bodies such as Children in Need, and private businesses. For more information about the value of social enterprises see Social Enterprise UK[54].

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CASE STUDIES

Harnessing local resources, community and business contributions to tackle homelessness: Street Support, Manchester and Leeds

Street Support[55] connects people experiencing homelessness who need help with those who provide services, and others in the community with resources to offer. It aims to make the best possible use of available resources in the cities it operates in, through an online service and app, and through support to a network of charities, voluntary groups, businesses and individuals who work together to end homelessness (Street Support hosts the Manchester Homelessness Charter and Big Change).

Street Support emerged from an initial conversation between one of co-founders (with digital expertise) and a young homeless man in Greater Manchester, where rough sleeping has increased considerably in recent years, and subsequent and considerable research with people and organisations working to end homelessness[56].

It is a not-for-profit organisation with a core team of three supported by a network of digital experts and volunteers. Funded by philanthropists, faith groups, a business group in Leeds, a loan and Leeds City Council, other local authorities are exploring the use of the site.

Street Support continues to evolve in response in local demands. New features are co-produced with people with lived experience of homelessness and professionals. As an example, it is working with Manchester's substandard accommodation action group and the council's housing options team to improve available accommodation advice: this is likely to improve access to healthy home environments for people.

To date Street Support has:

• Enabled easier access to support, including in an emergency, for outreach workers, volunteers and various professional agencies including police, ambulance and health professionals

• there are 121 providers and 255 services listed on the website

• the website has had 264,707 views (187,842 are unique) (May 2017).

• Enabled commissioners to understand the gaps in local provision to inform plans for the future.

• Directed individuals and organisations away from direct giving and providing street kitchens towards alternative, more effective, contributions, for example fundraising for night shelters, volunteering (donations to local charities have increased by at least £10,000 per year).

• Matched volunteers and organisations so that the skills on offer from the community and businesses are used to best effect (592 volunteers have registered at May 2017).

• Raised public awareness about action on homelessness through news updates and social media.

• Facilitated workshops and meetings to explore ideas, for example to look

at new ways of approaching morning outreach with rough sleepers.

- Encouraged employers to provide employment for people with lived experience of homelessness.

Going forward Street Support is seeking to explore how the website and networking can be developed to further improve and increase outcomes for people at risk of becoming homeless, or experiencing homelessness, in partnership with other local authorities and their partners.

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Enabling women with multiple needs to move on from homelessness – Threshold's Housing First

Threshold's service aims to provide suitable long-term housing alongside intensive support from specialist workers to assist reintegration into the community, for women who have recently left prison, or are currently subject to supervision in the community, and other women with complex needs.

Initially a two-year pilot, the service was established in 2015, funded by the New Charter Group (a housing association), working with Cheshire and Greater Manchester Community Rehabilitation Company. It operates in three local authority areas in Greater Manchester: Tameside, Stockport and Oldham.

Threshold is part of New Charter Group, and is a housing, advice and support charity with operations across the Greater Manchester area.

The service was developed in light of evidence that a number of women with complex needs were 'revolving' through the local women's prison and community-based services. The service has since developed to support other women with complex needs, not just those in contact with the criminal justice system.

The starting point for the housing first service is that housing is a human right, not something that has to be earned[57]. The model does not require someone to evidence that they can live independently before they are able to access housing ('housing last'). Instead, Housing First gives someone a home, if not immediately then very rapidly, then supports them to live in it.

Two workers provide intensive and assertive case management to 12 women, referred from several agencies including probation and third sector agencies. Support is not time-limited, and follows a 'recovery orientation', emphasising that positive change is possible, that help is available to achieve that change, and that the women have capacity to achieve things for themselves.

As a case management-only service, the service works via extensive collaboration with other services. These include Greater Manchester's women's centres, funded by the police and crime commissioner (now mayor), criminal justice partners and the Big Lottery, which are also providing

ways for the women to reconnect with social and economic life in a positive way, through training, volunteering and education.

An interim evaluation by University of York and a locally delivered social impact study have been undertaken. The evaluation profiled the women referred to the service: all had children but all were separated from them; all had experienced abuse and trauma; most had alcohol, drug and mental health problems; they all had experience of homelessness, most for more than one year and many had experienced homelessness at least three times.

Reported outcomes to date are:

- Women have been successfully supported. This is a significant outcome as this cohort of women have had multiple, hugely traumatic experiences over sustained periods of time, have been let down by mainstream services, with lives characterised by both violence and instability.

- Strengthened self-esteem, improvements in health and wellbeing and growing ambition amongst the women in the service.

- The known risk factors associated with desistance were being delivered.

The service has been very successful in engaging women with very high needs, and there is evidence from those women that they are moving away from homelessness, feel safe and better able to plan, and are moving towards greater social integration.

A conservative cost/benefit analysis (using GMCA's CBA tool[58]) suggests that for every £1 invested by Threshold in the project, benefits worth £2.51 have been realised for a number of beneficiary organisations/sectors.

The service has recently been funded for a further three years and Threshold is looking to roll out the model across a range of client groups. It was 'highly commended' at the Chartered Institute of Housing's 2017 awards.

Guidance on Housing First can be found here https://housingfirstguide.eu/

Information about support on offer to localities interested in developing a Housing First model is available from Homeless Link www.homeless.org.uk/our-work/national-projects/housing-first-england

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A single point of access for young people: The Point, Royal Borough of Greenwich

The Point enables young people, aged 16 – 19 (up to 25 years if the young person has a learning disability) to access a range of information, advice and guidance services including housing, health and wellbeing, education and skills, employment and volunteering, crime and justice, financial inclusion and community. It is a multi-agency 'one stop shop' for services which support young
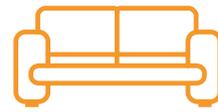
people to gain independence, reducing homelessness and health inequalities within Greenwich and London.

Established in 2009 the development of The Point was led by children's services as an 'early help' integrated approach to delivering the priorities of the Children and Young People's Plan and associated council priorities. Original drivers were high rates of teenage pregnancy, youth unemployment/young people not in education or training and youth homelessness. Its development and delivery is funded by the council.

The Point is open to young people Monday to Friday 9am to 5pm and at other times by arrangement. Access is either 'drop in' or by pre-booked appointment. Staff also work in other community based locations to widen their reach. The initial contact usually occurs with a youth support intensive practitioner from the Early Help Team who will make an initial assessment of needs, after which they will either directly support the young person and/or signpost them to a partner organisation for specialist support.

Key features of The Point and its effective operation are:

• The positive pathway: Greenwich was one of the first local authorities to implement the pathway in 2009, a best practice model to prevent homelessness through a more collaborative and integrated approach.

• Key services are co-located, including specialist health and wellbeing services. Young people can access advice and guidance on sexual health, maternity care, pregnancy and contraception; Family Nurse Partnership, emotional and mental health management; addiction; sexual/domestic violence; FGM and grooming.

• There is no wrong door; young people do not have to 'tell their story again and again'.

• The common core vulnerability is the need for Education, Employment and Training (EET) support of some kind. This is at the forefront of support.

• A high level of partnership engagement that harnesses specialist knowledge, skills and experience, through joint working, best practice development and knowledge sharing.

In 2016/17 the service saw over 13,000 young people.

Ofsted's 2016 inspection of services for children in need of help and protection, children looked after and care leavers cited The Point as 'good practice', providing 'an excellent range of multi-agency services to support young people in crisis', and playing a part in supporting young people who present as homeless well (no young person had been accommodated in unsuitable accommodation, including bed and breakfast provision, in the last 12 months). In relation to health inequalities, The Point was cited as part of Greenwich's 'high quality' services for care leavers.

Independent research commissioned by the council and completed in 2016 highlights a number of outcomes from the service. For the young person:

- They experience relevant and timely and non-judgement support which increases their trust and confidence and maximises positive engagement and behavioural change.

- The provision of housing related advice and support reduces stress, anxiety and confusion and acts as a solid foundation and a conduit for young people to seek support from others (and there are higher than average levels of engagement of young people accessing support).

- Complex needs are being identified sooner and additional time is being invested in understanding the "whole need" of young people.

- Improved safeguarding through increased understanding of broader issues, and positive development of trusted relationships and use of expertise.

- They are able to make informed choices about their health and affecting life decisions, are less likely to participate in risky behaviour eg, relating to sexual health, and experience better mental and physical health.

- Their housing needs are met and homelessness is prevented.

For the organisations involved outcomes include:

- Wider access to vulnerable young people than would otherwise be the

case: The Point is a trusted and well-known location for young people and onsite provision, eg, the Greenwich Sexual Health Clinic, benefits from this.

- A reduction in the duplication of resources and increased capacity of support organisations.

- A reduction in crisis or urgent intervention needs for young people, for example the need for treatment for substance misuse.

The research suggests that, using an analysis of Social Return On Investment, that for every £1 invested there is a return of £5.24. The forecasted additional value created as a result of The Point integrated model is 20 per cent to 30 per cent greater than if the services were delivered on their own.

The Point continues to evolve in response to the needs of young people and their feedback, for example access to services has been increased, including at evenings and weekends and in community locations, and social media is being adopted as a means of communication.

Further information about the positive pathway and access to support to implement this for young people locally is found here.

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FURTHER READING AND RESOURCES

The following reading and resources will support a greater understanding of the homelessness, health and wellbeing relationship, and the action that can be taken locally.

The Homes for Health Collection (PHE) lists many resources related to stable homes and homelessness including evidence and guidance.

https://www.gov.uk/government/collections/housing-for-health#stable-homes-and-ending-homelessness

Homelessness: Applying All Our Health (PHE) describes population, community, family and individual level interventions. It provides access to other sources of information from other organisations eg, Queen's Nursing Institute, the CQC, NICE.

https://www.gov.uk/government/publications/homelessness-applying-all-our-health/homelessness-applying-all-our-health

The London Homeless Health Programme has produced commissioning guidance relevant to all health commissioners, and other useful resources.

https://www.healthylondon.org/latest/publications/homeless-health-commissioning-guidance

The Faculty for Homeless and Inclusion Health, a free-to-join network of professionals and people with lived experience of homelessness, produces research and guidance to improve the effectiveness of homeless health care, including commissioning standards.

www.pathway.org.uk/publications/faculty/

The London Network for Nurses and Midwives is for specialist nurses, midwives and allied healthcare practitioners working in all areas of homelessness but is a useful source of information for anyone interested in homelessness and health.

http://homelesshealthnetwork.net

The Queen's Nursing Institute Homeless Health programme is a national network to improve the health of vulnerable or marginalised groups in the community, particularly people experiencing homelessness, Gypsy and Traveller communities, vulnerable migrants and sex workers. It is a source of practice guidance in relation to specific health matters eg, oral health, food and nutrition, amongst other resources.

https://www.qni.org.uk/explore-qni/homeless-health-programme/

Homeless Link provides research and resources to inform local commissioning and support improvements in practice, including a free-to-use homeless health needs audit, which can be used to inform JSNAs.

www.homeless.org.uk/facts/our-research/homelessness-and-health-research

Crisis and St. Mungo's are sources of research and guidance primarily in relation to homelessness as experienced by single people, including people who are sleeping rough.

www.crisis.org.uk/pages/health-and-dependancies.html

http://www.mungos.org/

Shelter has a particular interest in families, homelessness, and the availability and quality of housing and impact on health and wellbeing.
http://england.shelter.org.uk/search?query=health&Search

Groundswell exists to enable homeless people to take more control of their lives, have a greater influence on services and to play a full role in our community. It has supported homeless people to be involved in delivering solutions to homelessness. Research into oral health is one example of their work.
http://groundswell.org.uk

The No Recourse to Public Funds Network is a network of local authorities and partners focusing on the statutory duties to migrants with care needs who have no recourse to public funds, including those experiencing homelessness, and provides useful resources.
http://www.nrpfnetwork.org.uk/Pages/Home.aspx

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