



# Preventing homelessness to improve health and wellbeing

## Putting the Evidence into Practice

The right home environment is critical to our health and wellbeing; good housing helps people stay healthy, and provides a base from which to sustain a job, contribute to the community, and achieve a decent quality of life. Safe and suitable housing also aids recovery from periods of ill-health, and enables people to better manage their health and care needs.

Without good housing we know health and wellbeing are affected: poor conditions and precarious housing impact on people's physical and mental health. Ill health also puts some households at a greater risk of housing need and can be a trigger of homelessness— for example poor physical and mental health can make it harder to access and keep their home.

For people experiencing homelessness or prolonged periods of rough sleeping, the rate at which health problems occur increases rapidly. People experiencing 'single homelessness'<sup>i</sup> are particularly affected by poor physical and mental health:

- 73% of people report a physical health problem, and for 41% this is a long term problem compared to 28% of the general population.
- 45% have been diagnosed with a mental health issue compared to 25% of the general population.
- Factors which contribute to unhealthy lifestyles such as smoking, and drug and alcohol use, are also more prevalent than the general population (rates of 77%, 39% and 27% respectively)<sup>ii</sup>.
- Research also highlights higher rates of communicable health diseases such as TB; and higher rates of premature mortality among people experiencing single homelessness (St Mungo's Broadway 2014<sup>iii</sup>, Crisis 2011<sup>iv</sup>).

Homelessness also places substantial costs on the NHS. In 2010 the Department of Health estimated that people who are sleeping rough or living in a hostel, a squat or sleeping on friends' floors consume around four times more acute hospital services than the general population, costing at least £85m in total per year.

Preventing homelessness has obvious benefits for people's housing outcomes, but a recent review<sup>v</sup> conducted on behalf of Public Health England provides further evidence about how acting early also reduces health inequalities. The review identifies prevention activity developed in response to health and wellbeing needs, delivered by or in partnership with the wider health workforce. This document summarises some of the evidence from these approaches, highlighting how they can save money and bring about longer term health and wellbeing benefits for your local population.

## Let's end homelessness together

Homeless Link, Gateway House, Milverton Street, London SE11 4AP | 020 7840 4430  
[www.homeless.org.uk](http://www.homeless.org.uk) | Twitter: @Homelesslink | Facebook: [www.facebook.com/homelesslink](http://www.facebook.com/homelesslink)

## What does the evidence tell us?

Homelessness prevention activity has been well documented in recent years<sup>vi</sup>. However more recent evidence suggests there is considerable potential for those commissioning health and wellbeing services across the NHS and public health to incorporate these approaches within the services they already commission, and target those population groups known to be more at risk of homelessness. This can maximise the health and wellbeing gains which can be made as a result of tackling poor health and housing issues together.

Homeless Link's recent review describes prevention activity using four different models:

Typology	Description	Why is this needed?	Evidence of effectiveness	Translating into practice
<b>Welfare Rights and consumer advice</b> (includes housing advice) (primary prevention)	Advice within primary care settings such as GP surgeries; Targeted welfare advice for patients leaving secondary care; Holistic advice services (including debt, mental health) to young people in a non-health setting (eg youth advice services)	Housing and welfare problems can lead to and exacerbate mental health problems; links between financial exclusion, debt and homelessness are well documented	Existing evidence shows advice helps prevent homelessness and provides financial gains (to both the client and public services); can include improvements to mental health and wellbeing especially by decreasing stress and anxiety	To date evidence largely based on interventions for target groups (eg cancer patients) but there is potential to extend in health settings and via secondary prevention (to other 'at risk' groups)
<b>Holistic in-tenancy support</b> (secondary prevention)	Support and services available to people living in their own home/tenancy to help them live independently and successfully maintain accommodation. Usually targeted at those who are at risk of losing their homes	Known 'at risk' groups are vulnerable to repeat homelessness including those with mental health problems and in treatment programmes. Holistic support allows more than one issue to be dealt with at home and link in with other services to meet other needs	Existing evaluations largely positive about benefits including reduced A&E use; gaining employment and improved mental health. Evidence of cost savings from programmes such as Family Intervention programme (FIP) and Supporting People	Potential for in-tenancy support to include greater focus on health interventions, and act as co-ordinators of input from other services; potential to be located within health and community settings e.g. GPs, clinics and community centres
<b>Targeted support and advocacy to people leaving institutions</b> (secondary prevention)	Targeted support to plan and respond to known 'transition' points from institutions. Could include housing and income support for psychiatric patients pre discharge; residential programme for young people leaving care	Leaving institutions and the transition back into the community presents a trigger point where there is greater risk of homelessness and repeat admissions occurring, e.g hospital, psychiatric care, prisons and care system	Existing evidence shows that effective discharge planning from health settings can improve health outcomes and prevent repeat homelessness. Evidence for care leavers shows longer term improvements for health, employment outcomes and tenancy sustainment	Strong evidence base to build on. Potential to translate learning from recent hospital discharge programme <sup>vii</sup> to other secondary healthcare settings such as psychiatric hospitals, prison and care
<b>Critical time intervention (CTI) targeted at groups in the community</b> (tertiary prevention)	CTI is targeted at groups in the community who have already experienced homelessness and their characteristics and circumstances mean that once they are back living in their own accommodation are more likely to become homeless again.	The model recognises that there are 'critical times' where support is needed to prevent homelessness for those who also likely to experience multiple needs including substance misuse issues, fleeing violence, offending history and mental health needs.	Evidence points to positive impact on both reducing repeat homelessness and providing a cost effective solution.	Potential for CTI model to be used more widely with other high risk groups e.g. ex-offenders. However as a tertiary prevention measure CTI should exist alongside primary prevention interventions to reduce need for critical time interventions later on

### **Rabia's story<sup>viii</sup> – successful intervention by a health visitor to prevent homelessness**

Rabia is a lone parent with two young children and lives in a private rented property. She was struggling to manage her tenancy and during a regular check-up for her youngest child, her health visitor talked to her about the issues with her housing situation. She encouraged Rabia to go to a weekly housing advice drop-in at her local community centre.

Rabia talked to an advisor about her housing issues which included not having enough furniture, disrepair to the property, and problems with her landlord. She was assigned a support worker who helped her to access furniture, manage her bills, and who also liaised with the landlord about the repairs that needed doing.

Rabia is now much happier in the tenancy and wants to stay there. She is less anxious and feels much more confident about dealing with the landlord.

## **How can we put this into practice?**

As local authorities and the NHS look for more effective and efficient ways to reduce health inequalities, the case for combined early action around homelessness and health seems clear. A number of levers already exist to support this:

- The legal duties, introduced by the Health and Social Care Act 2012, for the NHS and public health to have regard to the need to reduce health inequalities; and to integrate health, social care and related services (including housing) where this will reduce inequalities in access to, and outcomes, from services.
- The requirement for joint health and wellbeing strategies, which underpin local commissioning plans, to reflect the wider determinants and not just the effects of poor health in our communities.
- The common outcomes related to the wider determinants of health in the NHS, social care and public health frameworks - the right home environment is critical to achieving these.
- The NHS Five Year Forward View, which calls for a 'radical upgrade' in prevention and public health and action to tackle health inequalities.
- The legal duties under the Homelessness Act 2002 for local housing authorities to have a strategy for preventing homelessness in their district. The strategy must apply to everyone at risk of homelessness, not just people who may fall within a priority need group - including people at risk of homelessness due to ill health is critical.

### **Current models of practice to build on**

#### **1. Targeted support for people with complex needs at risk of repeat homelessness**

The Equinox hostel link team in Brighton uses an assertive outreach model which targets the most complex clients – 88% are former rough sleepers and 76% have a history of eviction and/or abandonment from hostels - and challenges and supports them to address the obstacles they have to secure permanent accommodation. While initially set up to tackle alcohol and substance misuse it has evolved into a more holistic service to address other health and wellbeing needs, for example psychological assessments and rebuilding relationships. Of 34 clients supported between January and June 2014, 65% reduced their alcohol/substance intake, 78% reduced the unplanned departure from hostels and 83% reduced their attendance at A&E.

For more information see <http://www.equinoxcare.org.uk/services/equinox-brighton-hostel-link-team/>

#### **2. Targeted support for young people**

Centrepoin't's Health and Wellbeing team offers a range of in-house services to young people aged 16-25 living in Centrepoin't services. This support includes comprehensive health assessments, counselling and psychotherapy, advice and support on sexual health, nutrition and diet, healthy living, and drugs and alcohol. The team works in collaboration with external health services to deliver support in a holistic and person-centred way. Outcomes collected between April 2013 and March 2014 include; 90% of young people increased their physical activity; of the young people receiving a healthy living intervention 90% increased their intake of fruit and vegetables; and of the young people receiving a dual diagnosis<sup>ix</sup> intervention, 90% reduced usage, 100% of these were maintained three months after discharge.

These are just some of the opportunities for local areas to prioritise prevention activity. The following steps offer a guide to help put homelessness prevention at the heart of our efforts to reduce health inequalities:

### Stronger leadership and joint strategic working

- Joint Health and Wellbeing Strategies should include clearer priorities about homelessness prevention. Each local JSNA should clearly identify who is at risk of and experiencing homelessness in the local area; and the impacts on health and wellbeing for these groups.
- Basic health and housing literacy is essential for everybody working in a health and housing setting. Local leaders should provide clear and co-ordinated direction to all agencies and individuals to ensure that 'every contact counts', and equip the workforce to do this.
- Local leaders should help embed a 'prevention first' approach, identifying opportunities to prevent and intervene earlier for 'at risk' communities. This should consider the role of communities, the voluntary sector, and any workforce that comes into contact with 'at risk' groups, including, primary and secondary health care, allied health professionals, social care, housing and homelessness, criminal justice, employment and education.

### Access to advice and early intervention

- Extend availability of primary homelessness prevention in primary and secondary health care settings. The Care Act's requirements for information, advice and guidance provide renewed opportunity for Health and Wellbeing Boards to review and extend this provision, working with local and national voluntary sector advice agencies.
- There needs to be greater engagement with schools, educational establishments and early year's services by housing and health professionals to raise awareness and share effective practice in identifying children and young people at risk of homelessness. This should include training for school nurses, health visitors and staff that make home visits to households prior to starting school.
- Public Health and NHS managers should ensure frontline health professionals can identify appropriate services in their area to refer people at risk of homelessness to - e.g. through provision of online resources and stronger partnerships with local voluntary sector providers.

### Improve data collection and evaluation

- Improve the recording and sharing of data to enable services to target interventions at those at risk of homelessness, and evidence what works. The housing status of those accessing health services should be routinely measured, alongside the health and accommodation outcomes of interventions.
- Local public health teams should help develop and promote ways for services to evaluate cost effectiveness and show return on investment for interventions. The development of effective prevention 'metrics' would help demonstrate how prevention activity achieves improvements across shared outcomes in a locality.
- At a national level, the partners to the [housing and health memorandum of understanding](#) (MOU) have an opportunity to continue to support health, social care, housing and homelessness sectors to address gaps in evidence to inform new ways of working.

To read the full review please visit [www.homeless.org.uk/facts/our-research](http://www.homeless.org.uk/facts/our-research)

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<sup>i</sup> Single homeless people are generally those who are homeless but do not meet the priority need criteria to be housed by their local authority. Many, nevertheless, have significant support needs. They may live in supported accommodation, e.g. hostels and semi-independent housing projects, sleep rough, sofa surf or live in squats. Single homeless people may be in a relationship, or have children who are not currently living with them.

<sup>ii</sup> Homeless Link (2014) The Unhealthy State of Homelessness, London <http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf>

<sup>iii</sup> St Mungo's Broadway (2014) A Future. Now Homeless Health Matters: the case for change <http://www.mungosbroadway.org.uk/documents/5390/5390.pdf>

<sup>iv</sup> Crisis (2011) Homelessness: A silent killer, A research briefing on mortality amongst homeless people

<sup>v</sup> See the full evidence review at [www.homeless.org.uk](http://www.homeless.org.uk)

<sup>vi</sup> See Pawson, H., Netto, G., Wager, F., Fancy, C., Lomax, D (2007) Evaluating Homelessness Prevention, Department for Communities and Local Government; Busch-Geertsema, V. & Fitzpatrick, S (2008) Effective Homelessness Prevention? Explaining Reductions in Homelessness in Germany and England, European Journal of Homelessness

<sup>vii</sup> Evaluation of the Homeless Hospital Discharge Programme, Homeless Link 2015 <http://www.homeless.org.uk/sites/default/files/site-attachments/Evaluation%20of%20the%20Homeless%20Hospital%20Discharge%20Fund%20FINAL.pdf>

<sup>viii</sup> Case studies based on stories shared by clients as part of the evidence review. Names have been changed.

<sup>ix</sup> Dual diagnosis refers to people with both severe mental illness and problematic drug and/or alcohol use.