Health and Wellbeing Needs Assessment of Rough Sleepers in Barnet

Author: Louisa Songer

Role: Public Health Strategist – London Borough of Barnet

Date: June 2021

Contributors to report:
Sonia de la Orden – Barnet Homes
Ian Helcke – Barnet Homes
Nicole Harwood – Barnet Homes
Sarah Perrin – London Borough of Barnet/North Central London CCG
Sarah D'Souza – North Central London CCG
Joe Lee – Homeless Action in Barnet
Brian Johnstone – London Borough of Barnet Public Health
Jeremy Hooper – London Borough of Barnet Public Health
Julie George – London Borough of Barnet Public Health

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1. Executive Summary

In March 2020, in response to the COVID-19 pandemic, the government announced that all homeless people in the UK should be supported into accommodation. These arrangements ended in Barnet on 10th August 2020. At this time, London Borough of Barnet (LBB) continued to provide accommodation for those who had been placed in accommodation during the pandemic and also continued to offer accommodation to verified rough sleepers who were assessed as being vulnerable.

People who are homeless were considered particularly vulnerable to COVID-19 for several reasons:

- Up to 60% of homeless people are at increased risk of severe illness from COVID-19 – primarily due to high levels of chronic illness.
- People who are street homeless, living in hostels (with shared dining and bathroom facilities and sometimes with shared rooms) and emergency accommodation will not always be able to follow government advice on social distancing and self-isolation.
- There is strong evidence of premature aging in the homeless population with the average age of death being 46 for men and 43 for women.
- Homeless people over the age of 55 often have an underlying co-morbidity, although this may not be diagnosed due to lack of access to services.
- In communal settings there will be a very high likelihood of outbreaks with high attack rates.
- Many have other complexities such as substance misuse and mental health issues.

To appropriately address the needs of homeless people in Barnet through the pandemic, a multi-agency partnership task and finish group was established. This group developed this needs assessment to understand the support needs and complexities of this group. Whilst this needs assessment is a broad health needs assessment, COVID brings additional complexities that are to be considered. The partnership included representatives from:

- Barnet Homes Housing Options Service
- Homeless Action in Barnet
- LB Barnet Public Health
- LB Barnet Community Engagement & Participation
- LB Barnet Adults & NCL CCG Joint Commissioning Team
- NCL CCG

As a partnership, we are committed to delivering the effective and accessible services to our residents. Case studies and quotes in the needs assessment detail the experiences and feedback from people who use and work in services that support people who are homeless. We are committed to addressing the barriers and stigma described and continuing with the things that work well.

"The majority of people do not have any address/ proof of address. Although this are not required for homeless people to register with a GP, many GP practices do not accept this."
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"Some people who do have a GP get removed from the GP list as, due to their transient lifestyle, are out of the catchment area."

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"When homeless people try to engage or seek help, they often feel judged and marginalised because of their homelessness and often feel they are not being treated fairly or humanly."

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"The majority of homeless people already feel they don`t have any value or worth. When you add mental health issues, or the negative response they often get in a GP Surgery or A&E it often stops them asking for help ever again."

There are many different definitions of homelessness, but where the term 'homeless' is used in the need's assessment, it is intended to capture current rough sleepers and people with a history of rough sleeping who are now in temporary or communal accommodation.

It is not intended to capture the broader definition of homelessness that encompasses families living in temporary accommodation provided by the local authority.

The number of rough sleepers in Barnet is difficult to assess. It is estimated that in the spring of 2021, between 15-30 people were actively rough sleeping in Barnet but up to 200 could be at risk of street homelessness most of whom are currently accommodated in temporary accommodation. Barnet specialist service (HAB) have around 115 clients on their client list while regional estimates from CHAIN indicate that Barnet has 178 long term homeless residents.

Key findings:

1. Analyses of the wider determinants of health in two cohort's

There are many factors that cause homelessness and rough sleeping in Barnet, and it is likely that, as elsewhere in London, these cluster around two main factors: firstly people being asked to leave their accommodation for reasons including anti-social behaviour, rent arrears and relationship breakdowns and secondly relating to financial reasons linked to lack of employment. Approximately 90% of rough sleepers in Barnet are of working age; however, only 40% are in work or receiving job seekers allowance. This means that the other 60% of rough sleepers are either not eligible for benefits or eligible to work, or not able to work for health and other reasons. This finding demonstrates the need to focus on opportunities relating to employment, both in terms of prevention for people who are at economic risk and providing suitable employment and training options for people who are already homeless.

Secondly, the data indicates that a large proportion of Barnet rough sleepers are migrants, most commonly from Romania and Poland. Although there is work underway to support migrants to obtain settled status, these groups will need tailored support to access and engage with health and support services.

2. Health and Homelessness

The needs assessment has demonstrated that people who are homeless have different experiences of health services. Whilst some have good access to primary care, others appear to have no access or have been excluded. Case studies show homeless people experienced multiple, chronic health conditions which are often exacerbated by rough sleeping. They also identify that standard services are often not equipped to manage

these patients, as a more flexible approach is required that often involves longer appointments, in different settings, and include street-based outreach from clinical staff. The evidence indicates that homeless people experience a wide range of health issues, including mental health, musculoskeletal issues, skin conditions and respiratory conditions. There is therefore a need to consider how local health services can improve prevention, diagnosis and treatment of those conditions that disproportionately impact on homeless people. Additionally, people who are not originally from the UK face increased personal and structural barriers to utilising and navigating health services; and those people who were restricted from accessing secondary care felt their needs could not be adequately met and therefore risked developing serious illness that would result in emergency care.

3. Health-related behaviours:

The evidence in this report emphasises the need for all healthcare professionals to use their skills and relationships to maximise their impact on avoidable illness, health protection and promotion of wellbeing and resilience. The partnership has worked proactively and collaboratively to protect homeless people from the risks of COVID-19; however, further work must be done to ensure that other key public health interventions such as smoking cessation, cancer screening and immunisations are accessible.

4. Mental Health & Suicidal Ideation

Mental health concerns are a theme that present throughout this report. Case studies and feedback from staff and service users demonstrate how mental health pathways can be difficult to navigate, with staff working in homelessness services often feeling like they have no specialist support when working with people with multiple and complex needs. There is therefore certainly a need to clarify pathways and improve access to mental health support.

Furthermore, it is apparent that homeless people are at increased risk of suicide and there is certainly an opportunity to maximise suicide prevention work with this high-risk group.

5. Substance Misuse:

Comparable to London and national data, the rates of substance misuse reported in Barnet rough sleepers is low. As substance misuse can be both a driver for and an outcome of homelessness, it is probable that the Barnet data under-reports local prevalence. The reasons for the under-reporting are unclear and can be the result of poor identification, poor recording and reporting or the absence of suitable services. The PHE grant secured to develop specialist rough sleeping and substance misuse provision will address these issues and aims to improve the identification and access to support for homeless people.

6. Multiple Exclusion Homelessness

The reasons for homelessness are often a combination of structural and personal factors. What is clear from the literature is that many of those who find themselves as homeless, do so because of early exposure to significant trauma or adverse experiences in early childhood.

In order to address the issue of homelessness, it is essential to understand the circumstances, experiences and severe and multiple deprivation/social exclusion, which have impacted significantly on those individuals who have found themselves as homeless, and to recognise that there isn’t a single intervention that can tackle this on its

own, at population, or at an individual level. Better-integrated working across health and social care is needed to help people to access and navigate the range of physical and mental health and substance misuse services they require to sustain stable accommodation. Furthermore, it is essential to develop a life-course approach to preventing homeless across partnerships.

Recommendations:

1. Governance, Oversight and Prevention Opportunities
   - Establishing and improving governance and oversight
   - Updating LB Barnet Homeless and Rough Sleeper Strategy including opportunities for secondary prevention of homelessness
   - Developing clear links to LB Barnet Suicide Prevention Strategy

2. Improving insight and intelligence:
   This needs assessment highlighted some specific areas where improved consistency in record keeping would help the insight into this group of people, as well as some areas where information is lacking. Further work is needed for commissioners and providers to routinely collate and share information locally on the risk factors and health, housing and social care needs of those accessing services, as a starting point for estimating true population health need. This routine collation and sharing of information would also support the partnership to develop a joint client list to facilitate holistic care.

3. Addressing barriers to accessing suitable health care:
   - There are a range of resources developed by Healthy London Partnership that can be adapted and reviewed for local implementation. This could help improve access to primary care services.
   - Reviewing the NCL CCG locally commissioned homeless health service with consideration to how this service works proactively and flexibly, and facilitates pathways into other health services
   - Improved collaboration between LB Barnet and NCL CCG to develop local implementation of the proposed London workplan
   - Engage with the Barnet Integrated Care Partnership (ICP) health inequalities priority to consider opportunities for homelessness prevention through the life-course.
   - Improved access to routine screening and immunisations programmes

4. Housing and Support Pathways
   The recent COVID-19 pandemic has highlighted the need to review pathways for single homeless people, particularly for those with multiple or complex needs, with a focus on improving access when there are mental health concerns.

5. Addressing Substance Misuse Issues
   Specific resources should be directed to:
   - upskill the current workforce to improve identification
   - identify additional resources to work with people with multiple complexities such as dual diagnosis and substance misuse to provide appropriate treatment and support.

6. Improving Migrant Health

There are a range of services and initiatives to help people sleeping rough sleeping who are not from the UK to come off the streets and rebuild their lives. However, many non-UK rough sleepers do not engage with local services and as a result little is known about their health and support needs. Consideration must be given to suitable ways to engage with non-UK rough sleepers to understand their specific health and support needs.

2. Background & Introduction

In March 2020, in response to the COVID-19 pandemic, the government announced that all homeless people in the UK should be supported into accommodation. These arrangements ended in Barnet on 10th August 2020. At this time, London Borough of Barnet (LBB) continued to provide accommodation for those who had been placed in accommodation during the pandemic and also continued to offer accommodation to verified rough sleepers who were assessed as being vulnerable.

(Note: A "verified" rough sleeper is one that has been seen rough sleeping by an outreach worker and had their unique details recorded on the CHAIN[i] database)

The partnership included representatives from:

- Barnet Homes Housing Options Service
- Homeless Action in Barnet
- LB Barnet Public Health
- LB Barnet Community Engagement & Participation
- LB Barnet Adults & NCL CCG Joint Commissioning Team
- NCL CCG

To appropriately address the needs of homeless people in Barnet through the pandemic, a multi-agency partnership task and finish group was established. This group developed this needs assessment to understand the support needs and complexities of this group. Whilst this needs assessment is a broad health needs assessment, COVID brings additional complexities that are to be considered.

COVID-19 is a novel coronavirus that was first discovered as a human outbreak in Wuhan, China in December 2019. As this is a novel virus it is thought that everyone is susceptible to an initial infection with the COVID-19 virus and that there is no evidence of prior immunity other than from COVID-19 infection.

Whilst all people of all ages are susceptible to infection, older people and people with pre-existing medical conditions appear to be more vulnerable to being seriously ill with the virus. Whilst most people will have a mild illness and recover, some people will become seriously ill and there can be a rapid transition from mild symptoms to life-threatening illness and death. Death rates from COVID infection vary by age, ethnicity, and gender.

People who are homeless were considered particularly vulnerable to COVID-19 for several reasons:

- Up to 60% of homeless people are at increased risk of severe illness from COVID-19 – primarily due to high levels of chronic illness.
- People who are street homeless, living in hostels (with shared dining, bathroom, and sometimes with shared rooms) and emergency accommodation will not

always be able to follow government advice on social distancing and self-isolation.
- There is strong evidence of premature aging in the homeless population with the average age of death being 46 for men and 43 for women.
- Homeless people over the age of 55 often have an underlying co-morbidity, although this may not be diagnosed due to lack of access to services.
- In communal settings there will be a very high likelihood of outbreaks with high attack rates.
- Many have other complexities such as substance misuse and mental health issues.

Scope:
To appropriately address the needs of homeless people in Barnet through the pandemic and beyond, a multi-agency partnership task and finish group was established. This group developed this rapid needs assessment to understand the support needs and complexities of this group. Whilst this needs assessment is a broad health needs assessment, COVID-19 brings additional complexities that are to be considered.

The findings will be used to:
a) ensure suitable health and care support is available for homeless people in Barnet
b) support homeless people in Barnet to access and maintain appropriate housing
c) support new rough sleepers to access suitable support and housing.

There are many different definitions of homelessness, but where the term 'homeless' is used in this document, it is intended to capture rough sleepers and people with a history of rough sleeping who are now in temporary or communal accommodation. It is not intended to capture the broader definition of homelessness that encompasses families living in temporary accommodation provided by the local authority.

Governance:
The formal governance for the delivery mechanism of recommendations from this needs assessment is to be established. A recommendation is to establish a Strategic Homelessness Forum. Sub-groups of this forum may then be established to deliver particular themes, including an operational group focusing on substance misuse and homelessness. The Homelessness Forum will report progress to the Health and Wellbeing Board and Housing & Growth Committee.

3. Aims & Objectives

Aim:

The aim of this needs assessment is to understand the health and support needs of rough sleepers in Barnet, and to support them in to, and to maintain, appropriate housing.

Objectives:
- Identify the population that are rough sleeping or in hostels/hotels/temporary accommodation in Barnet and their demographics
- Identify the priority health needs for this group
- Identify any barriers to health services

- Identify the services already in place to improve access to health services
- Inform support and commissioning
- Inform step-down arrangements post COVID-19

4. Policy Context

The key legislation and other policy drivers and implications for local services are summarised below.

Housing Act 1996:
The primary homeless legislation - Part VII of the Housing Act 1996 provides the statutory foundations for action to prevent homelessness and provide assistance to people who are either threatened with homelessness or who are homeless. The Act includes:

- The principal criteria for determining which duties a local authority will owe to a homeless applicant
- Duties to inquire into an application
- How and when an applicant should be notified of a decision
- Main accommodation duties and the ways in which they can be discharged
- How a decision can be challenged

The Housing Act since having been introduced has been reviewed and amended multiple times. Notably, The Homelessness Act 2002 placed a requirement on local authorities to regularly review the levels and likely future levels of homelessness in their areas and ensure a more strategic approach to preventing and tackling homelessness by requiring a homelessness strategy[ii]. The Localism Act 2011 amended the 1996 Act further by giving local authorities powers to end the main housing duty by arranging an offer of suitable accommodation in the private rented sector.

The Homeless Reduction Act (HRA) 2017:

Implemented on 3 April 2018 was arguably the most significant change to homeless legislation to have taken place in recent times. The HRA placed new duties on local authorities to assess an applicant's need, intervene earlier to prevent homelessness and take reasonable steps to relieve homelessness for all eligible applications, regardless of whether they are considered as having a priority need under the Act. The HRA does not replace previous legislation but 'bolts on' new duties and only applies to those who applied as homeless after 3 April 2018. The purpose of the Act aims to reduce homelessness by:

- Improving quality of available advice
- A renewed focus on prevention work by local authorities
- Increase the support for single people
- A focus on partnership and joined up working from different services to provide better support for people especially those leaving institutions and other groups at increased risk of homelessness

Homelessness Code of Guidance:

The Homelessness Code of Guidance for Local Authorities is issued by the Ministry for Housing, Communities and Local Government (MHCLG) and provides statutory

guidance on how to interpret and apply homelessness legislation. Whilst not legally binding, local authorities are required to have regard to it where failure to do so could be used as a basis for judicial review challenge. The Code is periodically reviewed and was last updated at the end of June 2020, making changes to the chapter on Priority Need to reflect groups who are vulnerable from COVID-19 due to their health or history of rough sleeping. The main changes were that:

- Housing authorities should carefully consider the vulnerability of applicants from COVID-19. Applicants who have been identified by their GP or other specialist as clinically extremely vulnerable are likely to be assessed as having a priority need during the ongoing COVID-19 pandemic. The vulnerability of applicants with underlying health conditions that increase the risks from COVID-19 should also be considered in the same context.
- Housing authorities should also carefully consider whether people with a history of rough sleeping should be considered vulnerable in the context of COVID-19, taking in to account their age and any underlying health conditions.

"Everyone in":

On 26th March 2020, during the early stages of the COVID-19 pandemic, the government launched its "Everyone In" campaign. Everyone In required local authorities to take urgent action to house rough sleepers, and those at risk of rough sleeping, to protect people's health and reduce wider transmission of COVID-19. This included rough sleepers who would not normally meet eligibility criteria for housing and those people with no recourse to public funds (see below for definition). This required 'self-contained' rooms (with toilets and food service) or rooms with minimal sharing of facilities and increased cleaning (for example, if more than one person had to share a bathroom) to enable people to practise social distancing and self-isolate, as appropriate.

This marked a truly health-led response to rough sleeping in London. The NHS, local authorities and voluntary-sector organisations came together to triage people according to their risk level from COVID-19 and support them into the most appropriate type of accommodation available:

- COVID Care, providing a higher level of medical support for those presenting with symptoms
- COVID Protect, providing support and care for people who are most at risk
- COVID Prevent, providing support and care or those who are less vulnerable.

"No Recourse to Public Funds"

The term "no recourse to public funds" (NRPF) is used through this report and applies to people who are 'subject to immigration control' and, as a result of this, have no entitlement to certain welfare benefits, homelessness assistance and an allocation of social housing through Barnet Homes. This includes non-EEA (European Economic Area) nationals who require leave to enter or to stay in the UK, but do not have such leave; non-EEA nationals who do have leave which is subject to a condition that they have no recourse to public funds or have leave which is subject to a maintenance undertaking. Examples of people with NRPF include those with refused asylum claims, illegal entrants, and visa overstayers.

EEA nationals are not 'subject to immigration control' under section 115 of the Immigration and Asylum Act 1999, and therefore are not automatically excluded from

claiming benefits or housing assistance. They will however be ineligible for these if they fail the right to reside and/or habitual residence tests. They are often referred to as having NRPF. An EEA national who is not exercising treaty rights e.g. working or in training or education is not usually eligible for homelessness services.

NHS Long Term Plan[iii]

Following announcements from the Government of additional funding for the NHS, the NHS developed their plan and vision to make sure the NHS has a bright future ahead of it. The plan, developed collaboratively with national leaders and partners, sets a vision for how people working in the NHS will be supported to deliver that care and identifies the actions to be taken.

Regarding homelessness specifically, the plan identifies that the NHS England will invest up to £30 million extra on meeting the needs of rough sleepers, to ensure that the parts of England most affected by rough sleeping will have better access to specialist homelessness NHS mental health support, integrated with existing outreach services.

Beyond this, the plan commits to more NHS action on prevention and health inequalities which is certainly relevant to homeless populations.

Public Health England guidance "Homelessness: Applying all our health

Finally, the Public Health England guidance[iv] outlines that for most people who are at risk of, or experiencing, homelessness and rough sleeping there isn't a single intervention that can tackle this on its own, at population, or at an individual level. The guidance goes on to describe the action required to support better-integrated health and social care, and to help people to access and navigate the range of physical and mental health and substance misuse services they require in order to sustain stable accommodation.

Health and care professionals play an important role, working alongside other professionals to:

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

The guidance recommends that there needs to be clear local action, strategic partnership working (across the local authority, clinical commissioning group and other local organisations) and understanding and alignment of commissioning decisions to prevent and respond to homelessness across the life course.

This could include:

- Strategic partners recognising homelessness as evidence of health (and wider) inequalities in their policies, and taking appropriate action to contribute to homeless prevention and reduction
- Health and Wellbeing Boards recognising homelessness in their Joint Strategic Needs Assessment, and if appropriate, in their Health and Wellbeing Strategies

- Developing local data systems to ensure recording of information about patients and service users housing circumstances, including homelessness, and that this is used to inform integrated, person-centred, commissioning and delivery across sectors and services
- Monitoring feedback on access to services and outcomes to local commissioners, as experienced by homeless patients or other homeless service users

5. Methods

The findings in this need's assessment are informed by three main methods.

i. Service user and staff feedback and experience

Service user feedback and the experiences of staff were collated by Homeless Action Barnet both for the purpose of this needs assessment and to inform continued service improvement.

ii. Analysis of local and national data

An information sharing agreement was signed by local partners which allowed the partnership data to be analysed by the Public Health team.

Much of the data provided by local partners is self-reported. Obtaining accurate and representative data on this population is challenging, due to poor uptake of health services, formal diagnosis data may underestimate condition and self-reported data may also under-represent due to lack of disclosure. However, triangulation of multiple local data sources which can be supplemented and compared with national data sets allow us to form reasonable conclusions for this need's assessment.

The main local data reviewed was:

Barnet Homes:
Barnet Homes manages and maintains Barnet Council's housing stock and provides various housing functions including Barnet's Housing Options Service.
Analyses of Housing Options (HO) cohort
Barnet Home's Housing Options (HO) Service provided a list of rough sleepers (n=190) which had been accommodated through the COVID-19 pandemic. The data included some basic demographic information and limited information relating to housing need.
Analyses of demand data

Barnet Home's Housing Options Service also provided some service usage data for their departments.

Homeless Action Barnet:
Homeless Action in Barnet (HAB) offers practical services including food parcels, access to Wi-Fi and shower facilities but focus on working with people to achieve and sustain the change they want in their lives. They work with people who are at risk of losing their place to stay, and people who are currently homeless.

Homeless Action in Barnet (HAB) gained the consent of 83 homeless people to share the data collected as part of their assessment and engagement with the service.
Analyses based on combined HAB consented people and Housing Options (HO) data:

The data for the 83 homeless people consented by HAB was combined with Housing Options data to form a new combined list of 48 individuals, which was composed of 44 males and 4 females.

North Central London (NCL) CCG Homeless Report:
Data on homeless people within Barnet at GP practice level was received from North Central London (NCL) CCG. The report identifies 663 homeless people across 52 GP practices in Barnet. It is unclear on what criteria GPs use to classify and record an individual as a rough sleeper and therefore it is expected that this cohort includes people who fall into broader homeless categories beyond rough sleeping, and that many of this cohort may not be currently homeless or rough sleeping.

Stay Club report:
On 10th June 2020, there a was a site visit to the Stay Club hotel by Brent GPs. At the time of the visit, there were 59 residents within the hotel, of which 43 were seen. The report includes basic summary information of the doctors' appraisals.

There are a range of regional and national data sources available that have been used as part of the analysis throughout this report, both to supplement what is known about the local population and to allow national comparison.

CHAIN:
CHAIN is a multi-agency database recording information about people sleeping rough and the wider street population in London. The system, which is commissioned and funded by the Mayor of London and managed by St Mungo's, represents the UK's most detailed and comprehensive source of information about rough sleeping.
CHAIN allows users to share information about work done with rough sleepers and about their needs, ensuring that they receive the most appropriate support and that efforts are not duplicated. Reports from the system are used at an operational level by commissioning bodies to monitor the effectiveness of their services, and at a more strategic level by policy makers to gather intelligence about trends within the rough sleeping population and to identify emerging needs.

Homeless Link Data:
Homeless Link are the national membership charity for organisations working directly with people who become homeless in England. They publish up-to-date information, including good practice resources and research. They also use data to identify trends and gaps in provision and provide relevant sector intelligence.

iii. Applying principles from national evidence

Rapid literature review was undertaken exploring the impact of homelessness on health. National evidence is applied to help interpret local data and draw conclusions where data is incomplete.

Limitations:
Data quality: The local data used in this report was captured for assessment and housing purposes and therefore not necessarily collected in a systematic way across providers.

Combined data sets to assess multiple needs: Data was not collected specifically for the purposes of this needs assessment and therefore retrospective consent had to be

obtained for some analysis. Additionally, it was not possible to analyse personal data from multiple sources to provide a richer picture of individual's needs.

6. Service User Experience

As a partnership, we are committed to delivering the effective and accessible services to our residents. The following case studies and quotes detail the experiences and feedback from people who use and work in services that support people who are homeless. We are committed to addressing the barriers and stigma described and continuing with the things that work well.

Client 1

Client has progressively deteriorating vision. He presents with mental health problems and distress which he consistently does not acknowledge. He becomes agitated at the mention of any psychological difficulties.

His vision causes problems with orientation. A degree of peripheral vision has been retained but his ability to orientate himself is becoming more difficult. Reading his post is impossible, he can't send a text message.

Some months ago, his optician suggested an urgent referral to Moorfields. Client will not allow us to support him to access outpatient ophthalmology. We have only been able to snatch a glance at the clinical report from the optician.

Client 2

Client has Korsakoff Syndrome, historic head injury and a history of substance misuse. He presents with amnesiac syndrome mimicking dementia.

He has had 4 hospital admissions plus police involvement over the last 4 months due to wandering and getting lost.

Social services (older adults) assess client as having capacity and reject client on the basis of continued substance misuse.

The symptoms he experiences are evident to staff that support him but a comprehensive neuro/psych assessment is hard to access due to his complexities and resulting behaviour.

HAB staff and service users were asked for feedback regarding general barriers to services. The following was provided:

The majority of people do not have any address/ proof of address. Although this are not required for homeless people to register with a GP, many GP practices do not accept this.
***

Some people who do have a GP get removed from the GP list as, due to their transient lifestyle, are out of the catchment area.

***

Some homeless people do not trust “the system” or simply do not understand it.

***

Many of those who die homeless have mental health issues and even though the issue of mental health is being talked about more, rough sleepers find it incredibly difficult to engage.

***

When homeless people try to engage or seek help, they often feel judged and marginalised because of their homelessness and often feel they are not being treated fairly or humanly.

***

The majority of homeless people already feel they don`t have any value or worth. When you add mental health issues, or the negative response they often get in a GP Surgery or A&E it often stops them asking for help ever again.

***

Language barriers.

***

Major difficulty in both arranging and keeping appointments. Other things can take over and seem more important.

***

Travel issues – many can’t afford to get to their appointments.

***

If they don’t understand the system most will only look to seeing a doctor once they are unwell.

***

No routine check-ups or health screening takes place as they cannot be reminded.

***

People can often be discharged back to the streets from hospital. On several occasions recently ambulances have brought discharged patients to our Centre.

***

Hospitals are reluctant to admit people for surgery if they know they won’t have an address to be discharged to.

***

Nowhere to send Hospital appointments to that will guarantee they know about them before the appointment date. I’ve often seen a client open a letter which says the appointment was a week ago.

***

Access to dental care is almost impossible as you cannot get an appointment for the day its needed, so you end up with all the problems relating to appointments.

***

Early intervention isn’t possible unless there is adequate and appropriate outreach. This often means things don’t get picked up until they are more serious – this is not cost effective.

***

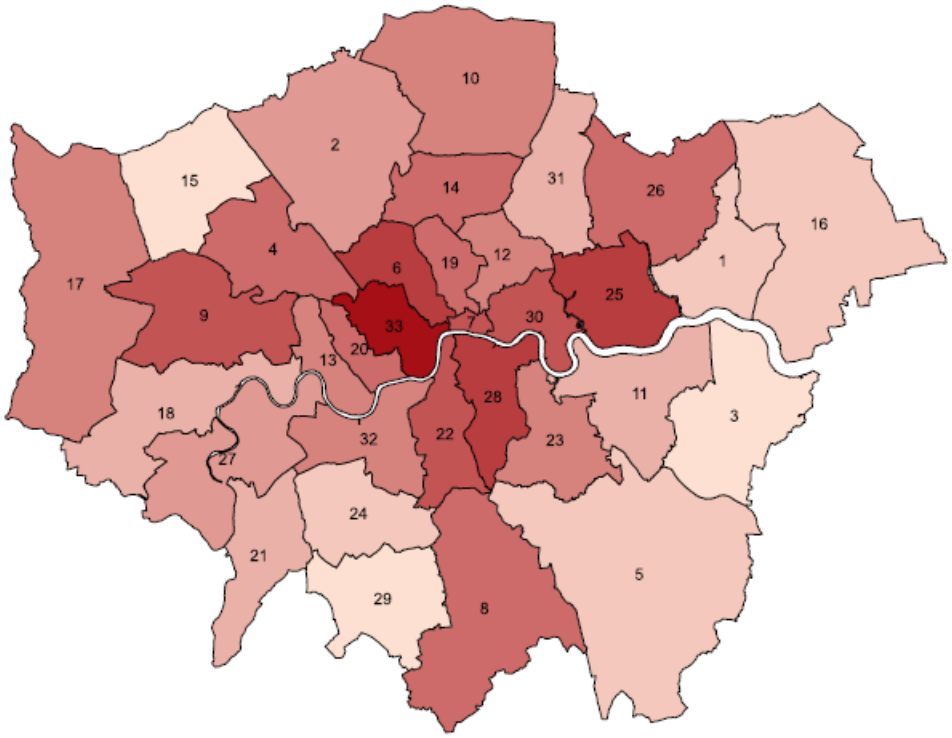
Providing services via the Centre is a much better solution – this can be seen from the high uptake of flu and pneumonia vaccinations and the TB screening by the mobile unit that comes every 6 months. This has already picked up one case of TB which meant treatment could be given and contacts traced etc.

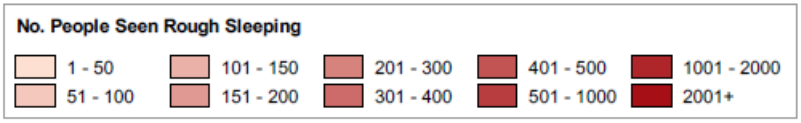
7. The Local Picture

Figure 1 below shows the number of rough sleepers registered on the CHAIN database in 19-20 across London. Although the numbers of rough sleepers in Barnet are slightly lower than inner London boroughs, they continue to grow at a similar rate. It is also expected that boroughs in inner London would see higher numbers than outer boroughs. Barnet is similar to neighbouring borough Enfield but higher than many other outer London boroughs.

Total rough sleepers by borough: Map

The map below shows a colour coded representation of the total number of people seen rough sleeping during the year in each borough.





Key	Borough	Total
1	Barking & Dagenham	85
2	Barnet	178
3	Bexley	42
4	Brent	320
5	Bromley	67
6	Camden	639
7	City of London	434
8	Croydon	306
9	Ealing	493
10	Enfield	206
11	Greenwich	133

Key	Borough	Total
12	Hackney	275
13	Hammersmith & Fulham	266
14	Haringey	327
15	Harrow	45
16	Havering	71
17	Hillingdon	270
18	Hounslow	147
19	Islington	367
20	Kensington & Chelsea	316
21	Kingston upon Thames	124
22	Lambeth	431

Key	Borough	Total
23	Lewisham	229
24	Merton	92
25	Newham	724
26	Redbridge	330
27	Richmond	152
28	Southwark	548
29	Sutton	34
30	Tower Hamlets	459
31	Waltham Forest	133
32	Wandsworth	203
33	Westminster	2757
34	Heathrow	241

Figure 1: The number of rough sleepers registered on the CHAIN database in 19-20 across London

A rough sleeper “snap shot” called a street count is conducted every year. This snap shot provides a picture of how many people are rough sleeping on a single autumn night. It’s a useful way to assess the change in numbers of people sleeping rough over time and for providing information on basic characteristics of a boroughs rough sleeping population. In 2019, the number observed in Barnet on a November evening was 24. In 2020, the number was 6. It is likely that this observed decrease is as a direct result of the governments drive for “everyone in” during the pandemic. It is impossible to determine the exact number of rough sleepers in a borough as many do not come in to contact with any services and remain hidden.

Through the pandemic, Barnet accommodated almost 200 single people who were currently or at imminent risk of rough sleeping. Homeless Action in Barnet were at the time supporting 113 rough sleepers. This indicates that the actual number of rough sleepers in Barnet in the spring of 2020 was at least 113 people but could be as many as 200.

Many of those individuals remain in temporary accommodation whilst their support needs are assessed and longer-term housing options are explored. However, some have returned to the street and although slow, there remains a continued new flow of people rough sleeping. It is estimated that in the spring of 2021, between 15-30 people were actively rough sleeping in Barnet.

Local Service Provision
There are various specialist services in Barnet that address the needs of people who are rough sleeping directly. These are:

- Homeless Action Barnet (HAB) – HAB are a local charity that offer practical support like food, clothing, washing machines, wi-fi and showers, but also personalised support to help people who are at risk of losing their accommodation, and for people who are already homeless. Through the pandemic, HAB kept in regular communication with people who were or had been recently rough sleeping, ensuring they had access to food and other essentials and supporting the co-ordination and delivery of their support packages.

- Barnet Homes’ Rough Sleeper Team - The Rough Sleeper Team engages with people who are sleeping rough around Barnet through a persistent and assertive outreach approach. They were a vital link to ensuring that people who were sleeping rough during the pandemic were supported into accommodation.

- GP in-reach – Homeless people can register with any GP, but two local GP’s deliver a satellite session in the HAB day centre to ensure that the physical and mental health needs of people who are homeless are not overlooked. They support their patients to access suitable healthcare and treat any presenting health problems. Through the pandemic, they continued to offer phone support to a number of their patients who had recently been homeless.

- Together in Barnet – winter night shelter delivered by the faith community across various locations in Barnet and resourced by volunteers. Due to the COVID-19 pandemic and restrictions around using shared spaces, the winter shelter was unable to deliver the usual model through the winter of 2020-21. Together in

Barnet successfully bid for a grant from the MHCLG Winter Transformation Fund to provide 16 hotel bed spaces for winter of 2020-21.

Services Commissioned by GLA/Mayor's office
The Mayor and GLA commission and fund a range of services to help rough sleepers come off the streets and rebuild their lives. These complement those provided by London's councils.

- Streetlink
  StreetLink enables members of the public to tell specialist outreach teams about rough sleepers, ensuring that people are linked in with the most appropriate local support as quickly as possible.

- Rapid Response Outreach
  This is an outreach service which focusses on rapidly responding to StreetLink referrals for rough sleepers. This supports our own outreach team by freeing up capacity to work with more people and allows us to focus on longer term rough sleepers within the borough.

In addition, people who are rough sleeping are supported to access other local services when required such as substance misuse treatment, mental health services and other social care services. Feedback from professionals supporting people who are rough sleeping, and from the residents themselves indicates that these services are often difficult to access and engage with for various reasons. This view is supported by the fact that a high number of people disclose additional support needs; however, many of these people are not receiving support for these needs. This will be explored in more detail later.

8. Analyses of the wider determinants of health in two cohort's

Wider determinants, also known as social determinants, are a diverse range of social, economic, and environmental factors which impact on people's health. Such factors determine the extent to which different individuals have the physical, social, and personal resources to identify and achieve goals, meet their needs and deal with changes to their circumstances.

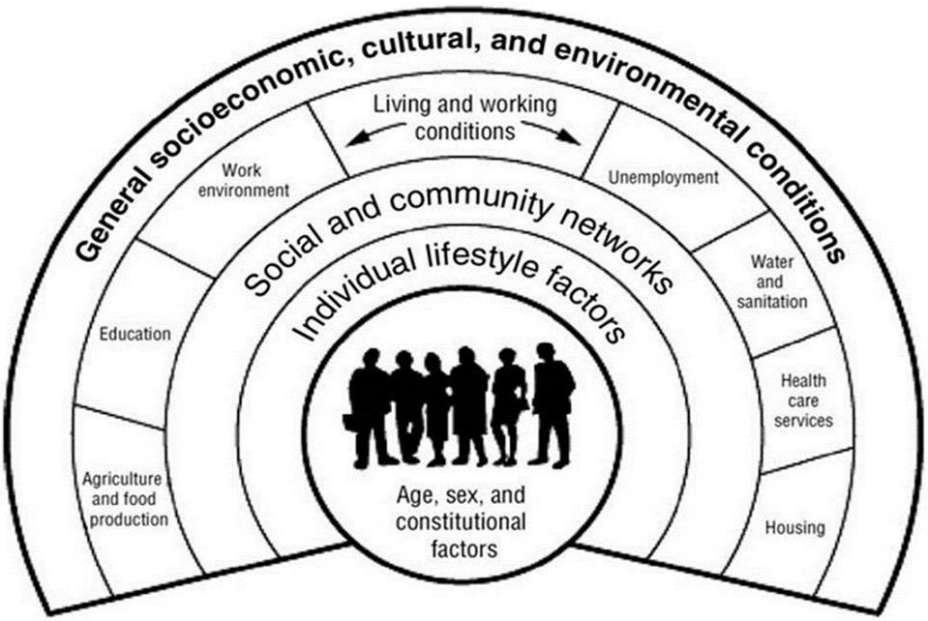


Figure 2: The Dahlgren and Whitehead model of health determinants[v]

Analyses of Housing Options (HO) cohort
Barnet Home's Housing Options (HO) Service provided a list of rough sleepers (n=190) which had been accommodated through the COVID-19 pandemic on which the following analyses were based.[vi]

Age & Gender:
This HO cohort of rough sleepers is composed of 32 females (17%) and 158 males (83%) and has an age range of 18-75 years (mean age = 40.5 years). As with the HAB consented cohort, the most common age group for this HO homeless cohort is aged 30-39 years and once again this accounted for around a third of the overall group under consideration (35%, n=66) (refer to Figure 3).This is similar to the London picture (annual Chain report), where 17% of the sample were female and 83% male. Also, 32% of the sample in 2019-20 were aged 36-45 and 27% were aged 26-35.

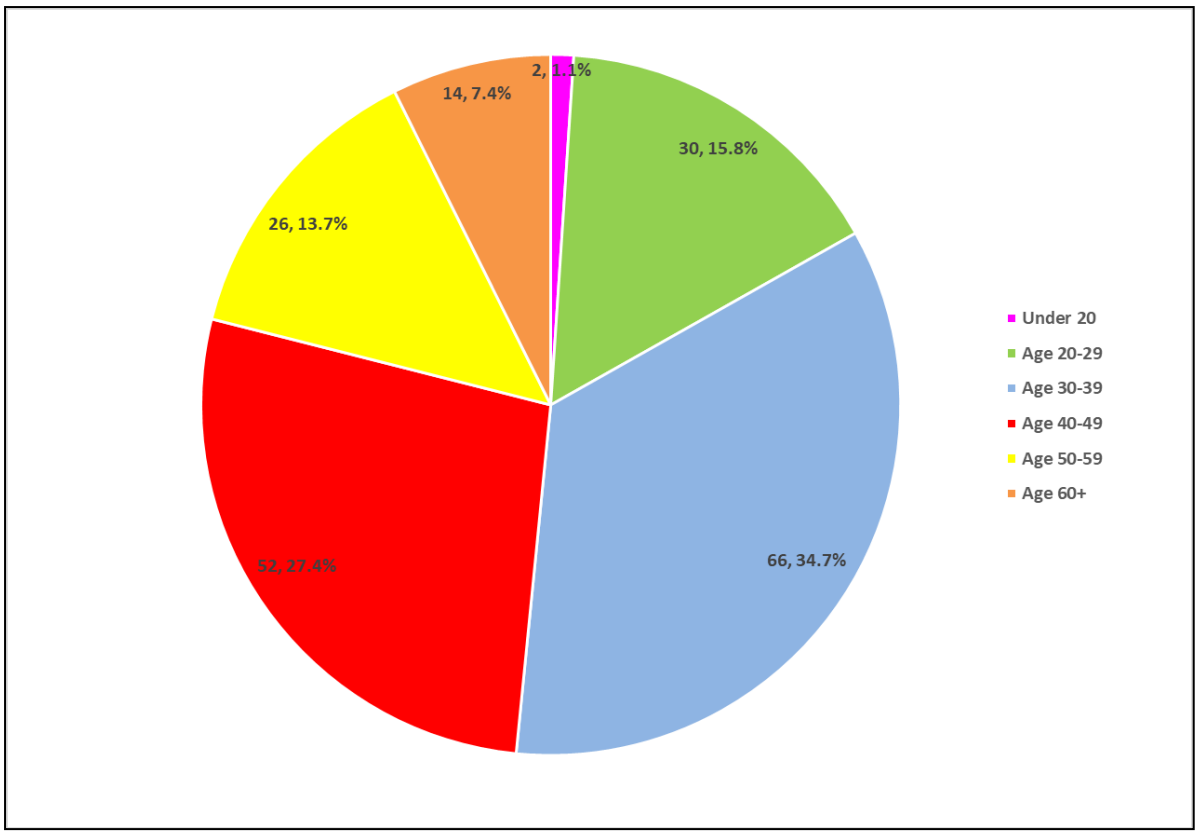


Figure 3: Age groups in rough sleeper cohort, July 2020 (n=190)
Source: Housing Options (HO)

Nationality:
Table 1 shows the nationality of the HO cohort, based on counts and percentages. The most common nationality was UK national, 37%, followed by Romanian nationality for 15% (n=29) of the HO rough sleeper cohort. Similarly, across London, 48% of people who were rough sleeping were UK nationals and 30% were from countries in central eastern Europe. Like Barnet, people from Romania account for 15% of the London sample. This group has also grown the most over the last three years. In 2017/18 there were 664 people from Romania rough sleeping in London. Last year, this increased to 1,491.

Nationality	Count	Percentage
UK national habitually resident in UK	70	36.8%
Not available	31	16.3%
Romania	29	15.3%
Non-EEA country national	26	13.7%
Other EEA country national	14	7.4%
Poland	10	5.3%
Czech Republic	3	1.6%
Lithuania	3	1.6%
Bulgaria	1	0.5%
Hungary	1	0.5%
Latvia	1	0.5%
Slovakia	1	0.5%
Total	**190**	**100.0%**

Table 1: Nationality of Rough Sleepers (n=190)
Source: Housing Options (HO)

Reason for homelessness:

In 2019, The Ministry of Housing, Communities and Local Government and the Department for Work and Pensions commissioned Alma Economics to undertake a feasibility study[vii] on the causes of homelessness and rough sleeping.

The review found that most research divides causes of homelessness and rough sleeping into structural factors (wider societal and economic issues that affect the social environment for individuals) and individual factors (personal circumstances of individuals).

Structural factors leading to homelessness include:

- Lack of affordable housing
- Decline of social sector housing as a proportion of all housing
- Tighter mortgage regulation and higher costs for first time buyers
- Unfavourable labour market conditions / rising poverty levels
- Growing fragmentation of families
- Reduced welfare provision

Individual factors include:

- Traumatic events
- Relationship breakdown (including domestic abuse and violence)
- Mental illness
- Addiction
- Discharge from prison
- Leaving the care system
- Financial problems

Beyond this, the factors can be categorised as social determinants of health. These are non-medical factors that influence health outcome

There is certainly an interaction of structural factors alongside individual factors. Structural factors create conditions within which homelessness is likely to occur, and people with personal problems that leave them at risk of homelessness are more vulnerable to being affected by these adverse conditions. In this way, the high concentration of people with complex personal problems in the homeless population can be explained by their susceptibility to adverse structural forces and not solely by their personal circumstances. Furthermore, the economic impact of coronavirus is exerting further pressure on people already pushed to the brink by low wages and high rents. This means we can expect a continued new flow of people experiencing homelessness.

Unfortunately, we are unable to report on the reason for homelessness for the Barnet cohort as this data was not captured in a meaningful way. For nearly two-thirds of the Barnet cohort (63%, n=119), the reason for homelessness was given as "Rough Sleepers Project," which is not a specific reason for homelessness. Going forward, recording an alternative response to "Rough Sleepers Project" as the main reason for homelessness, would shed more light on the circumstances surrounding the entry into homelessness for the individual (see Table 2).

When "Rough Sleepers Project" is set aside as a reason for homelessness, the most popular response was "no fixed abode" (n=25, 13%). This still does not provide us with any meaningful information relating to the reason for homelessness.

Reason for homelessness	Count	Percentage
Rough Sleepers Project	119	62.6%
No fixed abode	25	13.2%
Relative or friends NTQ	9	4.7%
Parental NTQ	5	2.6%
Domestic violence and abuse from partner/husband	4	2.1%
Leaving prison	4	2.1%
Not provided (blank)	4	2.1%
AST term not rent arrears	3	1.6%
SWEP	3	1.6%
Affordable	2	1.1%
Leaving hospital	2	1.1%
NASS accommodation terminated	2	1.1%
Other loss tied accommodation	2	1.1%
Domestic violence and abuse from family member/associated person	1	0.5%
Emergency Fire or Floor	1	0.5%
Leaving institution	1	0.5%
Medical reason	1	0.5%
Private Sector arrears	1	0.5%
Sexual harassment and bullying	1	0.5%
Total	**190**	**100.0%**

Table 2: Reasons for homelessness for rough sleeper cohort, July 2020 (n=190)
Source: Housing Options (HO)
Key: NTQ = Notice to quit. SWEP: Severe Weather Emergency Protocol

Figure 4 below shows Information is available on reason for homelessness at a London level from the Chain annual report 2019/20. The data available is for approximately 50% of the London sample. It shows the leading driver of homelessness relates to people being asked to leave their accommodation. This could be for a range of reasons including anti-social behaviour and rent arrears. The second largest reason relates to financial reasons relating to lack of employment, and the third relating to relationship breakdown.

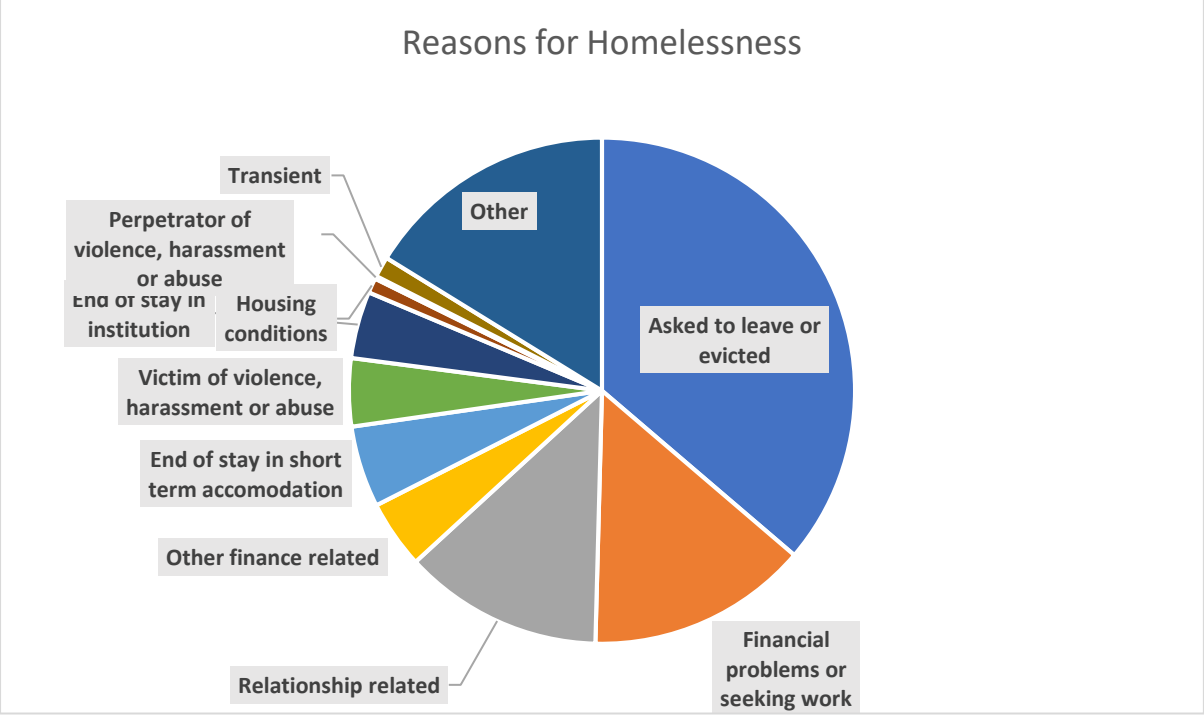


Figure 4 Reason for homelessness at a London level
Chain Annual Report 2019/20.

Location of placements:

The most common borough for placing homeless people within this cohort was Brent, which accounted for over a third of placements (38%, n=73). Almost two-thirds of this cohort were placed in either Brent or Barnet (65%, n=124) and over three-quarters (76%, n=144) were living in either Brent, Barnet, or Haringey (refer to Table 3).

London Borough	Count	Percentage
Brent	73	38.4%
Barnet	51	26.8%
Haringey	20	10.5%
Enfield	14	7.4%
Not available (blank)	13	6.8%
Camden	6	3.2%
Harrow	6	3.2%
Hackney	5	2.6%
Ealing	1	0.5%
Islington	1	0.5%
Total	**190**	**100.0%**

Table 3: Where homeless people have been placed, by borough, July 2020 (n=190)
Source: Housing Options (HO)

Type of placements:

An analysis of the type of accommodation provided to this group of homeless people (based on "Construction type"), revealed that "studio" was the most common option, followed by "house of multiple occupation" and then "hotel room."

During the COVID-19 lockdown and following government guidance, the HO Service has managed to provide temporary accommodation to significant numbers of rough sleepers (Table 3). The increased demand from this cohort posed a significant challenge on the HO service due to the increased number of applicants and reduced availability of accommodation. Several agents that Barnet Homes frequently use were closed or providing a limited service with not many new properties being available to them. Further, the UK wide ban on evictions which came into effect on 18 March 2020 meant that there was little to no movement from emergency accommodation for those already accommodated and thus resulted in reduced turnover. At the beginning of the lockdown in mid-March 2020, the majority of hotels we use for emergency accommodation were also closed.

Nevertheless, Barnet Homes put enormous efforts into securing accommodation for rough sleepers as part of the 'Everyone In' scheme in April 2020 within the borough or as close to the borough as possible. They were able to procure a few larger units where rough sleepers could receive ongoing support, as well as units where a custodian/security reception were open around the clock for support. When hotel or Houses in Multiple Occupation (HMO) placements were procured, cooking facilities or microwaves were placed in the rooms to allow clients to self-isolate in line with government guidance.

Throughout allocating properties, multiple factors were considered including:

- What accommodation was available at the time
- What accommodation was suitable to meet the applicant's needs
- Whether or not the client was required to shield

- Any potential risks to the health and/or safety of the client or others
- Whether the client could access relevant support
- Whether bills needed to be included in certain cases (for example, for clients with No Recourse to Public Funds, etc.)

Table 4 shows the numbers and proportions of this cohort based on the type of accommodation allocated to them, as of mid-July 2020. Over half of the cohort were accommodated in a studio (55%, n=105), whilst 17% were in a house of multiple occupation (17%, n=33) and only 7% were in a hotel room (7%, n=14). 80% of this cohort of homeless people were accommodated in either a studio, house of multiple occupation or hotel room in mid-July 2020 (n=152).

Type of accommodation	Count	Percentage
Studio	105	55.3%
House of Multiple Occupation	33	17.4%
Not specified	21	11.1%
Hotel Room	14	7.4%
Flat	12	6.3%
Room or bedsit	5	2.6%
Total	**190**	**100.0%**

Table 4: Type of accommodation for homeless cohort, July 2020 (n=190)
Source: Housing Options (HO)

Analyses of Homeless Action Barnet (HAB) cohort

HAB gained the consent of 83 homeless people to share data that had been collected as part of their assessment processes. Much of the HAB data presented later in this report is based on self-reported information and therefore allows for a richer picture of personal circumstances.

Age & Gender:
The cohort ranged in age from 20 – 65 years (mean age = 41 years). The most common age group was 30-39 years, which accounted for around a third of the cohort (n=27; 33%). Less than one in ten of the cohort of consented homeless people were aged 60 and over (n=7, 8%). (refer to Figure 5). This is similar to the age range of the housing options cohort.

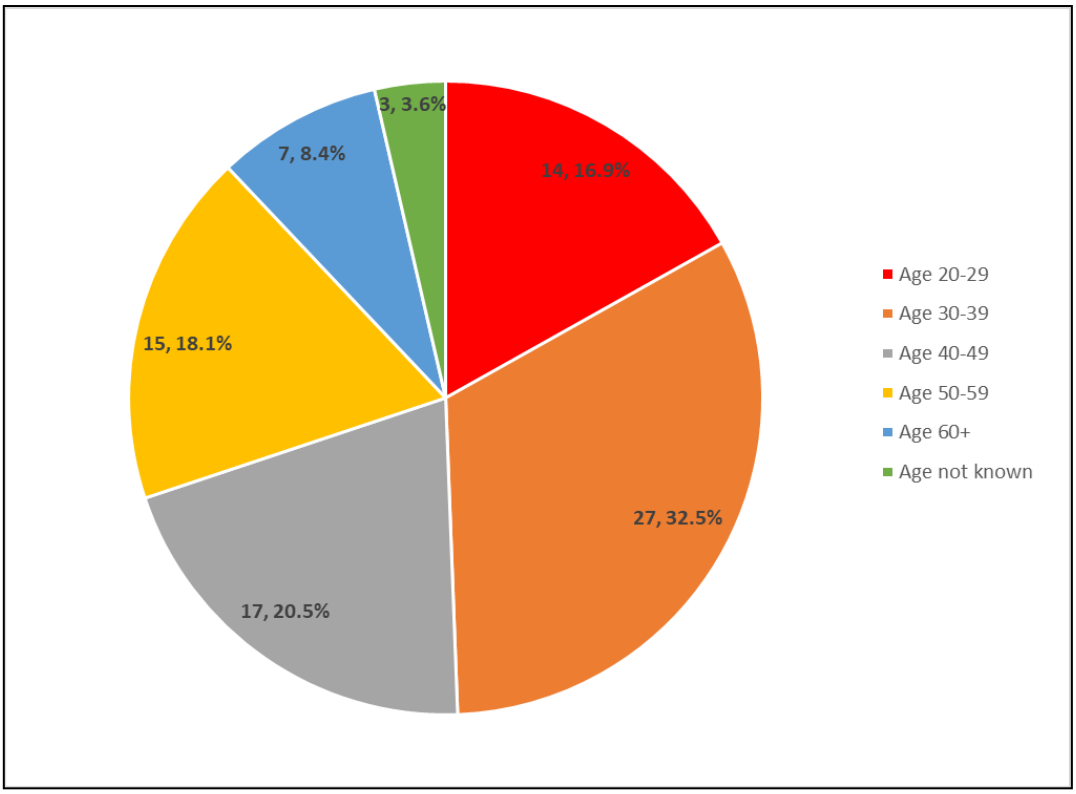


Figure 5: Age groups within the cohort of homeless people (n=83)
Source: Homeless Action in Barnet (HAB)

This is comparable to the Housing Options cohort.

Age range	HO Cohort %	HAB Cohort %
Under 20	1	0
20 – 29	16	17
30 – 39	35	33
40 – 49	27	21
50 – 59	14	18
60+	7	8
Unknown	0	4

Table 5: Age comparison between HO Cohort and HAB Cohort

Age is relevant when considering homeless health needs; as mentioned earlier in this report, there is strong evidence of premature aging in the homeless population, with recent ONS[viii] data showing an average age of death of 46 for males and 43 for females; in the general population of England and Wales, the mean age at death was 76 years for men and 81 years for women.

As in the general population, homeless people die from a broad range of causes such as accidents, diseases of the liver, ischaemic heart diseases, cancers, and influenza and pneumonia.

However, the ONS data also shows that in 2019 37% of deaths in the homeless population in England and Wales were related to drug poisoning. Suicide and alcohol-specific causes accounted for 14% (112 deaths) and 10% (76 deaths) of estimated deaths of homeless people in 2019 respectively.

Whilst deaths from drugs and alcohol have remained relatively stable, deaths from suicide have increased by 30% from 2018 2to 2019. Suicide prevention work is explored later in this report.

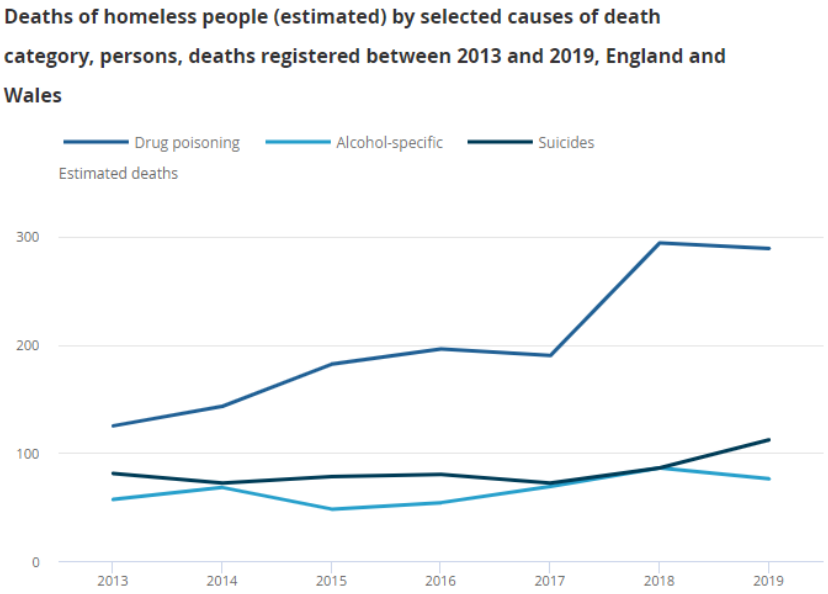


Figure 6: Death of homeless people (estimated) by selected cause of death between 2013-2019

In terms of gender, the group was 84% male (n=70), 10% female (n=8), 1% transsexual (n=1) and 5% unknown (n=4). A larger percentage of female people (17% n=32) were accommodated by the housing options team through the pandemic.

On sexuality, 78% of this group were heterosexual (n=65) and one was bisexual (1%), whilst 10 preferred not to say (12%) and 7 did not provide data (8%). We do not have comparable data for the housing options cohort.

Nationality:
Data on country of origin was used as a proxy for nationality. Based on this data, the most frequent nationalities were Romanian, UK and Polish. Romania was reported as the nationality for a quarter of the homeless people (n=21, 25%) and the same proportion came from the UK (n=21, 25%). Ten homeless people (12%) were from Poland and a further 9 from Asian nations (11%).

Over half of the homeless people consented were from either Romania or the UK (n=42: 51%). Nearly two-thirds of the cohort were from Romania, Poland, or the UK (n=52, 63%).

Country of Origin	Total	Percentage
Romania	21	25.3%
UK	21	25.3%
Poland	10	12.0%
Asian Nation	9	10.8%
African Nation	7	8.4%
Lithuania	4	4.8%
Czech Republic	2	2.4%
Bulgaria	1	1.2%
European Nation (Non EU)	1	1.2%
Greece	1	1.2%
Ireland	1	1.2%
Portugal	1	1.2%
Slovakia	1	1.2%
South American Nation	1	1.2%
Not provided (blank)	2	2.4%
Total	**83**	**100.0%**

Table 6: Nationality of HAB consented cohort (n=83)
Source: HAB data on country of origin

Looking at the HO cohort in comparison to the HAB cohort, UK nationals form a larger percentage and accessed accommodation more than other nationalities.

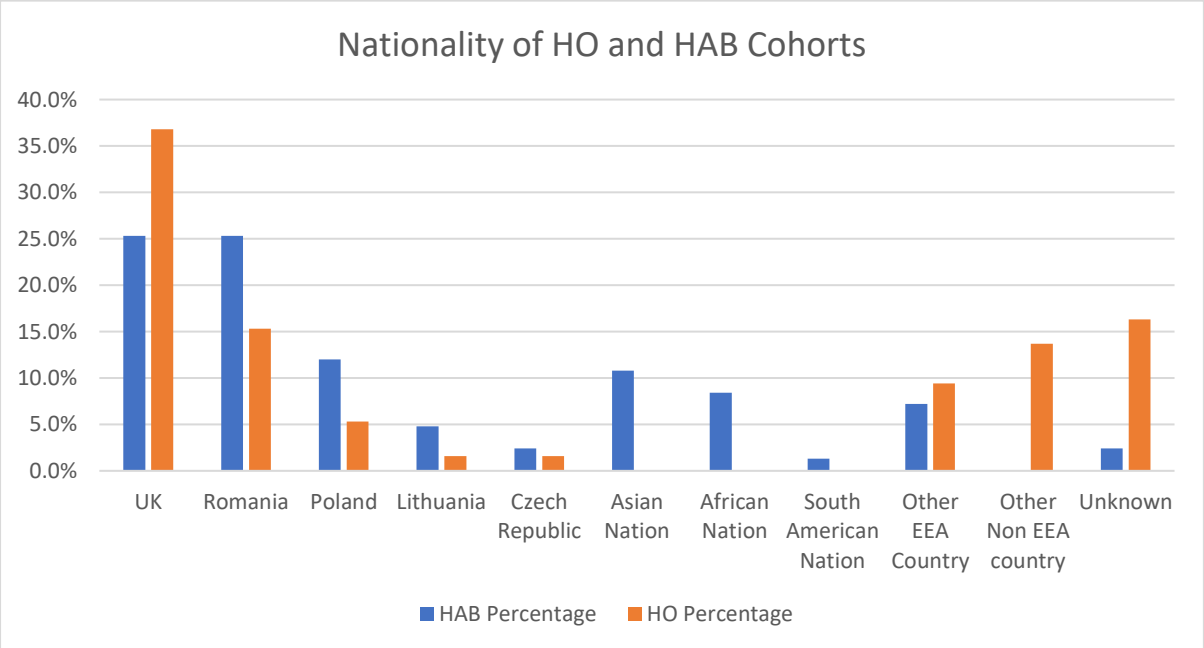


Figure 7: Comparison of nationality between HAB and HO cohorts

Economic Status:

Figure 8 depicts the composition of the cohort in terms of economic status. Jobseekers accounted for the largest proportion (39%; n=32), followed by those with no recourse to public funds (21%; n =17) and then people who were long term sick / disabled (16%; n=13).

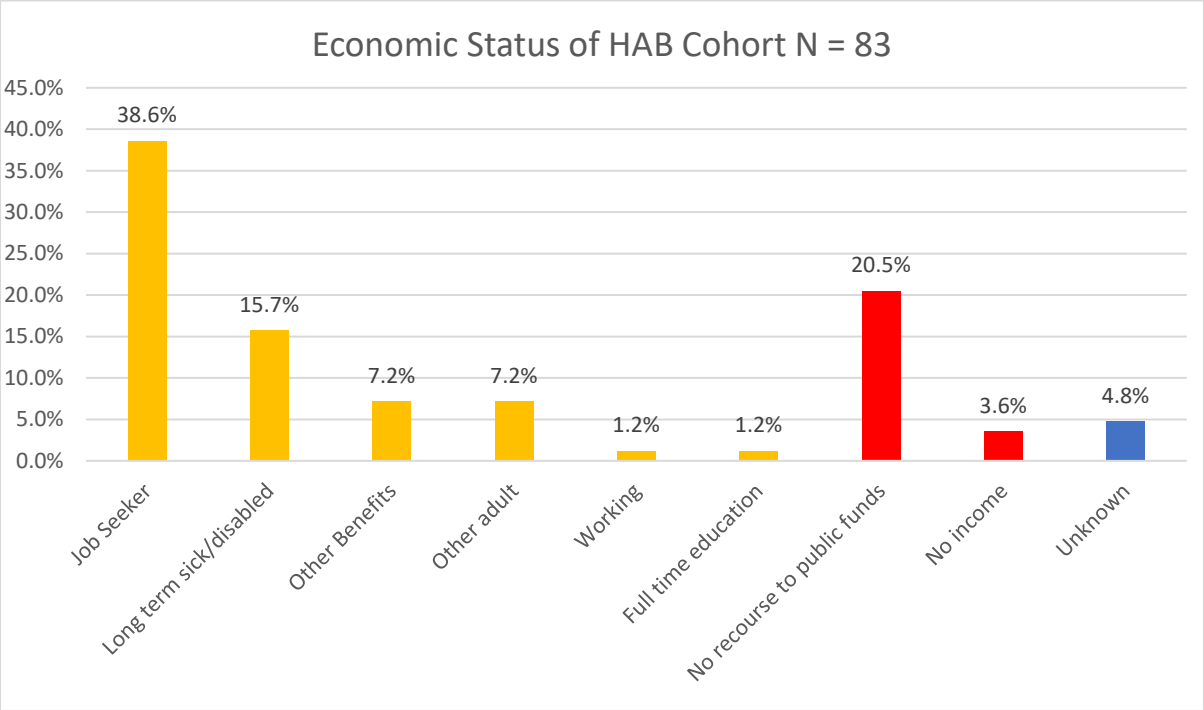


Figure 8: Economic Status of HAB cohort
Source: HAB data

Whilst unemployment, low income and a lack of recourse are already significant drivers of homelessness, the COVID-19 pandemic will have surely worsened this with its reported impact on the economy. It is expected that unemployment rates will increase and the long-term impact of the furlough scheme unknown.

Those people with no recourse to public funds are not usually entitled to any housing or welfare support; however, local authorities were directed to temporarily suspend usual eligibility rules in order to respond to the COVID-19 public health emergency and protect all rough sleepers by providing accommodation, regardless of their immigration status.

Migrants with no recourse often work in informal, undocumented ways in industries like hospitality, cleaning, and construction. Therefore, migrants who have lost their job during this pandemic are at risk of destitution if they cannot access public funds or are forced to take up less stable, more exploitative employment out of desperation.

The health inequalities of migrant groups are well documented, groups of vulnerable migrants living in the UK include[ix]:

- asylum seekers and refugees
- unaccompanied children
- people who have been trafficked
- undocumented migrants (those who are living in the UK with no legal status)
- low paid migrant workers

Conclusions:
There are many factors that cause homelessness and rough sleeping in Barnet, and it is likely that similarly to elsewhere in London these cluster around two main factors: firstly people being asked to leave their accommodation for reasons including anti-social behaviour, rent arrears and relationship breakdowns and secondly relating to financial reasons relating to lack of employment. Approximately 90% of rough sleepers in Barnet are of working age; however, only 40% are in work or receiving job seekers allowance. Meaning the other 50% of rough sleepers are either not eligible for benefits/eligible to work, or not able to work for health and other reasons. This includes a large group of people from Romania and Poland.

This demonstrates the need to focus on opportunities relating to employment, both in terms of prevention for people who are at economic risk and providing suitable employment and training options for people who are already homeless.

Secondly, the data indicates that a large proportion of Barnet rough sleepers are migrants, most commonly from Romania and Poland. Although there is work underway to support migrants to obtain settled status, these groups will need tailored support to access and engage with health and support services.

9. Health and Homelessness:

It is well documented that the health and wellbeing of people who experience homelessness is poorer than that of the general population. We know that homeless people have poorer health outcomes than the general population and an average age of death 30 years below the national average at 46 years, and even lower for homeless women, at just 43 years.[x]

Homelessness can make people vulnerable to illness, poor mental health and drug and alcohol problems,[xi] therefore co-morbidity (two or more diseases or disorders occurring in the same person) among the longer-term homeless population is common.

Homeless people often seek medical treatment at a later stage during illness, leading to costly secondary health care and worsened health outcomes. Exacerbated by this is the reduced potential for recovery due to many homeless people returning to insecure accommodation or even rough sleeping after medical treatment.

It is not uncommon for homeless people to not be registered with a GP. Groundswell's *More than a Statistic research*[xii] revealed that one of the key barriers that people who are homeless face to getting healthcare is registering and making use of a GP practice.

59 rough sleepers accommodated by LB Barnet in the Stay Club hotel in Brent were assessed by a GP during a visit. A quarter (n=15, 25%) were not registered with a GP. This is similar to the HAB consented cohort, in which 29 out of the 83 consented sample (35%) were not registered with a GP. In comparison to national data, this is an unusual picture and is indicative of positive partnership work delivered locally. HAB and Barnet Homes have been supporting people to register with a GP as part of their packages of care. However, service user and staff feedback demonstrate that there remains work to be done here as many report problems registering and accessing local GP services.

Data on homeless people within Barnet at GP practice level was received from NCL CCG.[xiii] The CCG Homeless Report identifies 663 homeless people across 52 GP practices in Barnet, for July 2020. Within this cohort, roughly two-thirds are male (66%, n=434) and a third female (35%, n=229). The majority, 95% had been seen in Barnet General Practice within the last 12 months. There is no definition of what "homeless" means in this context, and it is likely that the majority of this sample are not rough sleeping. Many people who become homeless do not show up in official figures. This is known as hidden homelessness. This GP sample could include hidden homeless people, this includes people who become homeless but find a temporary solution by staying with family members or friends, living in squats or other insecure accommodation.

For Barnet GP practices in Barnet, the overall rate for July 2020 is 152.76 per 100,000. Seven out of 52 GP practices in the borough were found to have a statistically significantly higher rate than Barnet overall. In contrast, 10 GP practices in Barnet have rates of homeless (per 100,000) within their practice lists which are significantly lower than Barnet GP practices overall. These practices are displayed on a map below. Those practices with higher than average numbers mostly cluster in the west of the borough, whilst those with lower numbers are distributed across the north, east and south. Interestingly, this clustering aligns with the fact that the west of the borough exhibits higher levels of deprivation than the East.[xiv] In addition, the one practice in the west with higher rates of homelessness is also the closest practice to the HAB day centre.

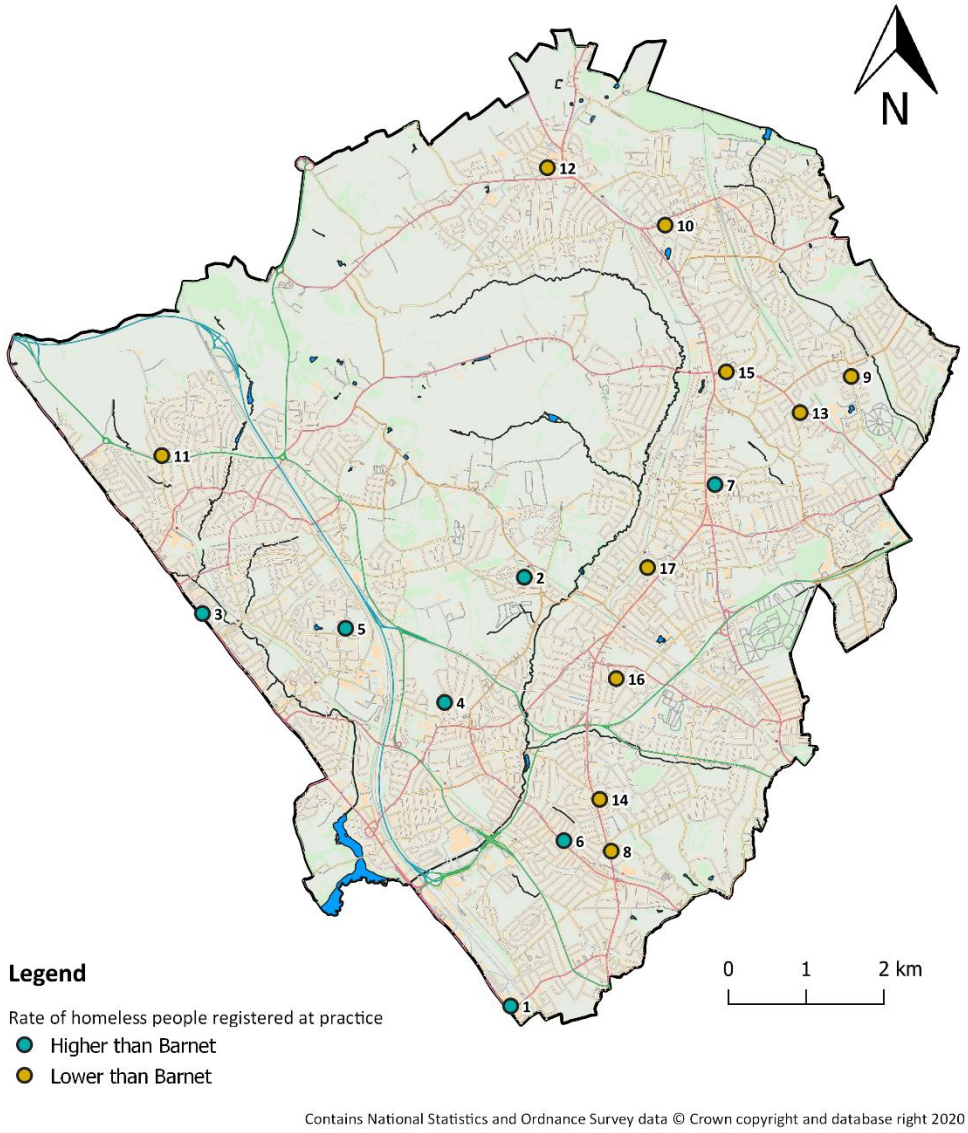


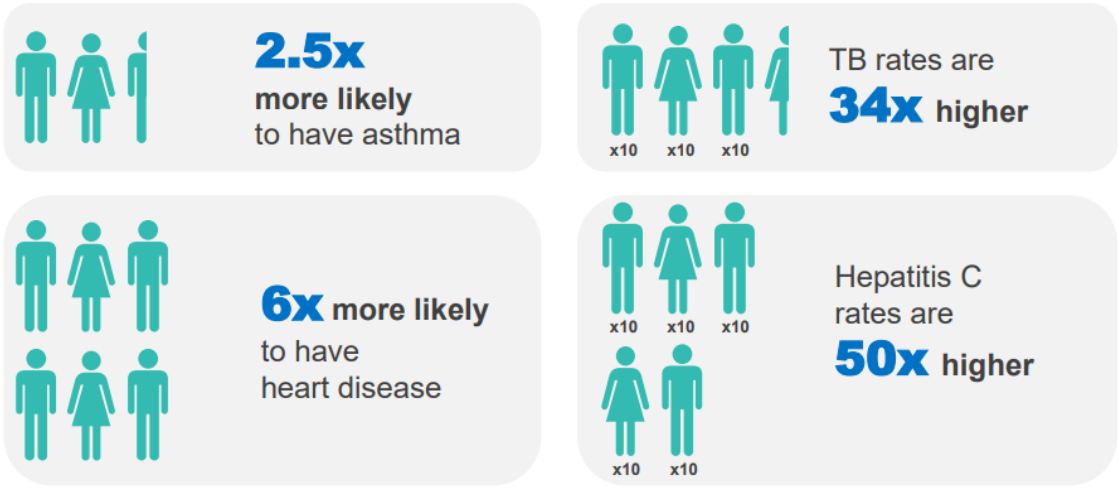
Figure 9: Map of Barnet GP's with higher and lower than average registered numbers of patients who are homeless
Source: Barnet Homeless Report, NCLCCG.

Summary of Health Conditions:
Prevalence data on a number of conditions was available and the most prevalent conditions are summarised in Table 7. Based on this data, the most prevalent type of condition was "mental health," which affected over half of the sample (54%, n=356). Over one in five of this homeless cohort within Barnet GP practices had musculoskeletal and physical trauma (23%, n=154) or skin and subcutaneous tissue disease (23%, n=151).

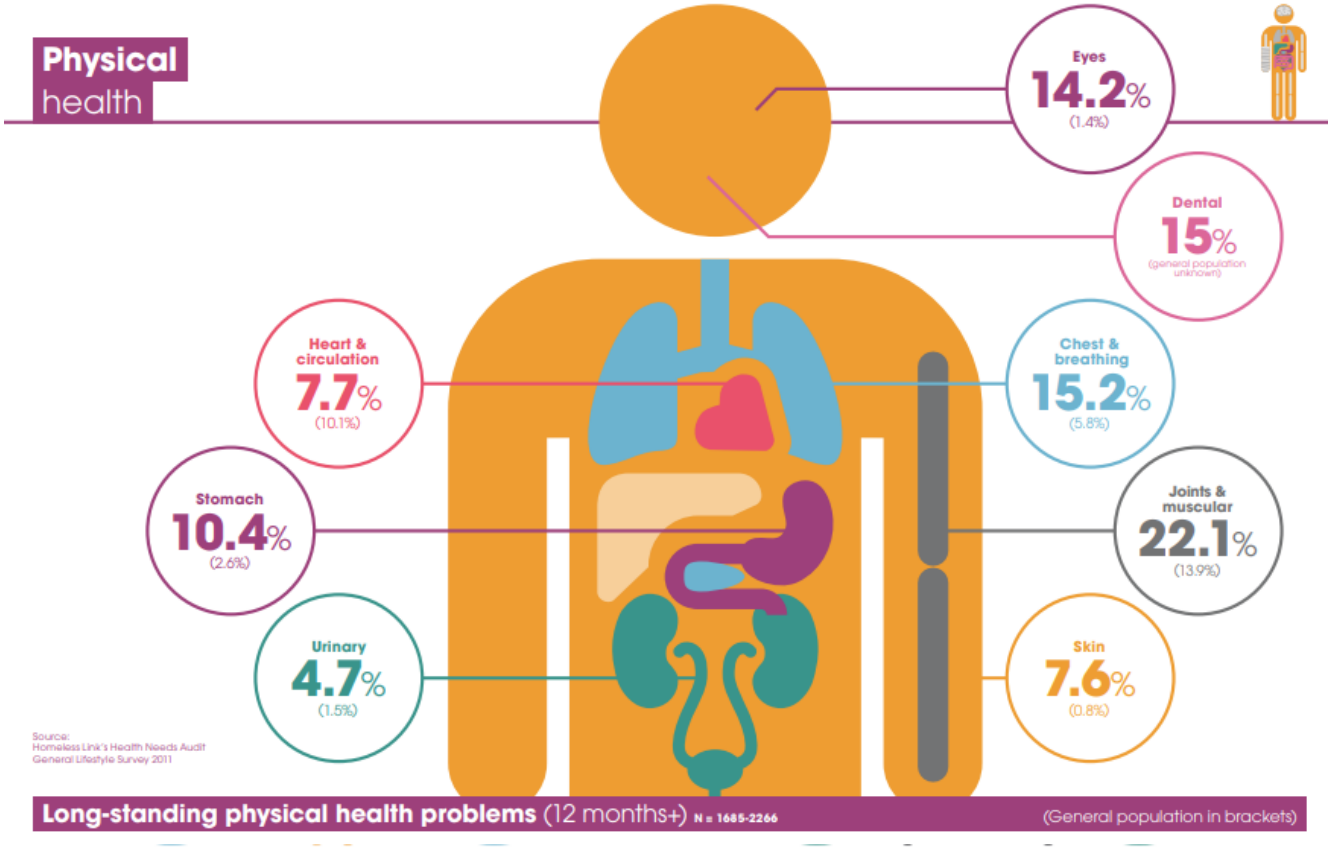
Condition	Count	%
Mental Health	356	54%
Musculoskeletal and physical trauma	154	23%
Skin and subcutaneous tissue disease	151	23%
Respiratory condition	108	16%
Circulatory system/Endocrine diseases	104	16%
Neurological/Head injury	38	6%
Pregnancy	24	4%
Liver Disease	14	2.1%

Table 7: Most prevalent conditions of homeless people within GP practices in Barnet, July 2020
Source: Barnet Homeless Report, NCLCCG.

The NCLCCG report did not allow us to compare the incidence of these illnesses in the homeless population to the entire Barnet population; however, it is likely that the homeless population will see a higher rate of these conditions. The Healthy London Partnership conclude that people who are homeless suffer more health problems than housed people. [xv]



A health audit[xvi] by Homeless Link found the following:



Worse than the general public	Health issue	Homeless population	General population
Physical, mental and substance misuse issues remain prevalent among the homeless population and at levels that are much higher than those experienced by the general population.	Long term physical health problems	41%	28%
	Diagnosed mental health problem	45%	25%
	Taken drugs in the past month	36%	5%

Interestingly although it is unclear who is included in the Barnet GP cohort, there are certainly some similarity in the types of illnesses and rates observed.

NCL CGG have been reviewing opportunities for improving the health of homeless people and have been taking the following areas forward:

- Working with local public health and homelessness teams to develop proactive approaches to vaccinating homeless people against COVID-19. This includes mobile vaccination services and designated clinics.
- Securing funding to develop models including specialist homeless intermediate care, specialist step-down accommodation, and move on co-ordinators. These models will be piloted and evaluated to decide future investment.
- Working on a local programme taking into account the London vision and workstreams

NCL CCG share the London vision shown in the Figure below.

Conclusions:

The needs assessment has demonstrated that people who are homeless have different experiences of health services. Whilst some have good access to primary care, others appear to have no access or have been excluded. Case studies show homeless people experienced multiple, chronic health conditions which are often exacerbated by rough sleeping. They also identify that standard services are often not equipped to manage these patients as a more flexible approach is required that often involves longer appointments, in different settings, and include street-based outreach from clinical staff.

The evidence indicates the homeless people experience a wide range of health issues, including mental health, musculoskeletal issues, skin conditions and respiratory conditions. There is therefore a need to consider how local health services can work collaboratively and in partnership to improve prevention, diagnosis and treatment of those conditions that disproportionately impact on homeless people. Consideration should be given to taking forward this work through the Health Inequalities priority of the Barnet Integrated Care Partnership.

Additionally, people who are not originally from the UK face increased personal and structural barriers to utilising and navigating health services; and those people who were restricted from accessing secondary care felt their needs could not be adequately met and therefore risked developing serious illness that would result in emergency care.

Health-related behaviours:
In terms of public health outcomes, 29 people had undertaken cervical smears in the last 15 months, which is 13% of the female sub-sample of homeless people within Barnet practices (n=229). Roughly one in ten of female homeless people within this population (11%, n=24), had declined a smear test.

Almost two-thirds of this homeless sample (62%, n=414) had their smoking status recorded, and almost a third (30%, n=201) received smoking advice during the last 15 months.

Within the entire sample (n=663), a Hepatitis B vaccination had been given to 45 individuals (7%), whilst 2% had declined a Hepatitis B test (n=11). For HIV, 4% of this

homeless sample declined an HIV test (n=24) and only one individual had undertaken an HIV test in the last 15 months (0.2%). Around one fifth of this homeless population had received a vaccination for influenza in the last 15 months (22%, n=143), and 18% had received a pneumococcal vaccination (n=119). It is possible that uptake of immunisations is higher than recorded as there is a particular focus on vaccinations in the satellite health clinic that operates in HAB. This emphasises the need for improved data recording.

Conclusions:
The evidence in this report emphasises the need for all healthcare professionals to use their skills and relationships to maximise their impact on avoidable illness, health protection and promotion of wellbeing and resilience. The partnership has worked proactively and collaboratively to protect homeless people from the risks of COVID-19; however, further work must be done to ensure that other key public health interventions such as smoking cessation, cancer screening and immunisations are accessible.

Mental Health & Suicidal Ideation:
As mentioned earlier in this report, people who are homeless are more likely to experience poor mental health than the general population and suicide is a leading cause of death in homeless people.

Three Stay Club residents (5%) were "supported for immediate GP referral in view of mental health concerns,"[xvii] which is similar to the 15% of the HAB consented sample with reporting diagnosed an undiagnosed mental health issues (n=12).

The picture in the CCG GP cohort is different. Mental health was recorded in over half of the sample (54%, n=356). Within this group, 4% (n = 29 people) had a history of suicide or and 2% (n= 16) had psychotic illness recorded.

When HAB service users were asked about possible risk of suicide, the response was concerning. Over half of the cohort cite some suicidal ideation, with 38% reporting they feel at high risk of suicide.

In addition, feedback from service users and staff working within homelessness services consistently state that they have experienced barriers to accessing mental health services. The Homeless Link health audit[xviii] identified that 86% of respondents disclosed a mental health problem, and 44% had a diagnosed mental health condition. Mental health issues are high in homeless people as they are both a cause and an outcome of homelessness. People with poor mental health are more likely to become homeless, and people who are homeless are more likely to develop mental health as a result of their circumstances.

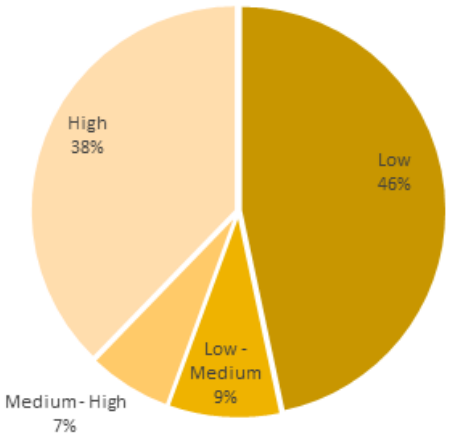


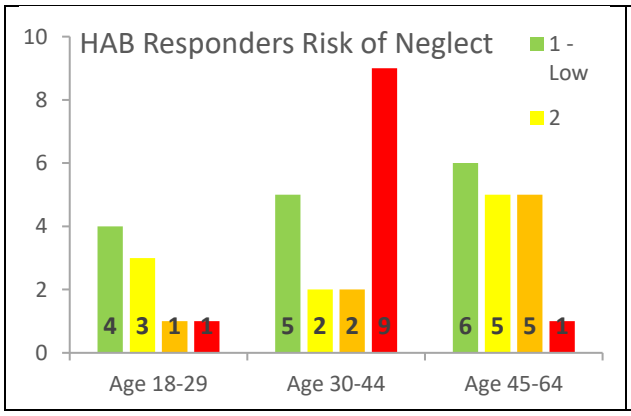
Fig 11 Risk of Suicide
Source: HAB data

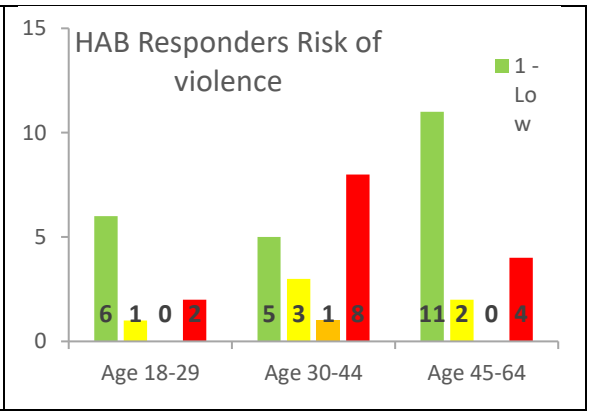
Samaritans research[xix] links deprivation with an increased risk of suicide and shows that homeless people are particularly at risk as deprivation, debt, and inequality, all of which can increase suicide risk.

The ONS data also shows that drug-related deaths of homeless people increased by 52 per cent over five years, and that homeless people accounted for 5% of all drug poisoning deaths, 1% of alcohol specific deaths and 2% of suicides in England and Wales in 2017.

The graphs below show how HAB service users categorise their risk of neglect, violence, and suicide, grouped by age. Interestingly, when looking at this assessment data from HAB service users, it appears that those aged 30-44 are most likely to categorise themselves as high risk in all three of those areas. The data also shows us that this group are also more likely to be job seekers rather than long term sick/disabled and generally have no physical health problems.

The most recent ONS report[xx]on suicides in England and wales states that Males aged 45 to 49 years had the highest age-specific suicide rate (25.5 deaths per 100,000 males). Although the highest risk group in the Barnet homeless cohort is slightly younger than this, the age range is similar, and it is possible that many of the risk factors are similar and compounded by factors relating to homelessness.





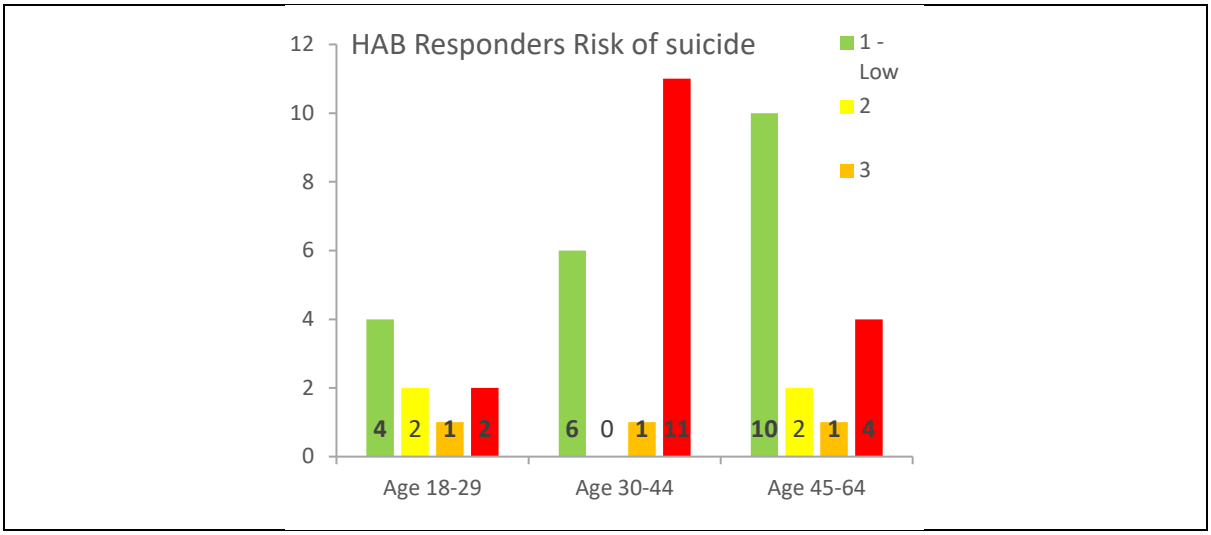


Figure 10: Graphs to show self-reported scores of risk of neglect, violence, and suicide, in HAB cohort, grouped by age.

Conclusions:
Mental health concerns are a theme that present throughout this report. Case studies and feedback from staff and service users demonstrate how mental health pathways can be difficult to navigate, with staff working in homelessness services often feeling like they have no specialist support when working with people with multiple and complex needs. There is therefore certainly a need to clarify pathways and improve access to mental health support.

Furthermore, it is apparent that homeless people are at increased risk of suicide and there is certainly an opportunity to maximise suicide prevention opportunities.

Substance Misuse:
For the HAB consented sample, seven homeless people (8%) were identified as alcohol dependent, which was not statistically significantly different for from the proportion of alcohol dependent Stay Club residents (5%, n=3). However, around 15% of the CCG GP homeless cohort were recorded as showing alcoholism or harmful alcohol use, whilst less than one in ten (7%, n=43) having received alcohol advice in the last 15 months.

The comparison between the two groups in terms of drug use is tenuous. Within the HAB consented homeless cohort, 17% reported drug dependency (n=14), compared to 4 heroin users and 6 regular cannabis users in the Stay Club setting. Assuming these are completely separate people, this would equate to 17% drug dependency within the residents of the Stay Club, which coincidently is the same as that reported within the HAB consented cohort. Within the CCG GP cohort, 2% (n=14) of this homeless sample were recorded as having a current or past history of substance misuse, whilst only 4 people had no history of substance misuse, clearly underlining the challenges of collecting complete and reliable data in this area.

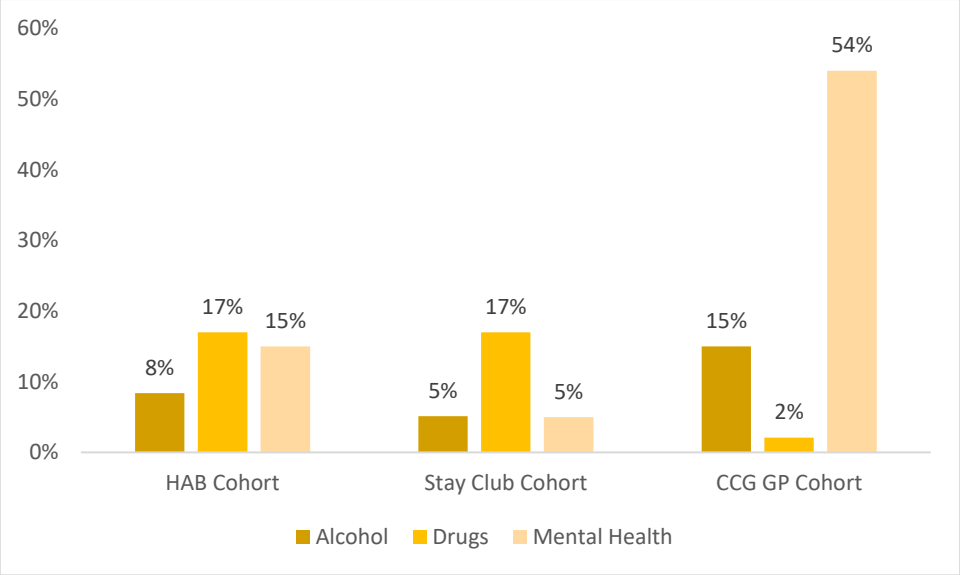


Figure 11: Substance misuse and Mental health in three cohorts: HAB, Stay Club and GPs
Source: HO data, HAB data, NLCCG homeless report

It is important to note the validity and accuracy of this data. There are relatively small sample sizes, small counts for each of the conditions (alcohol dependency, mental health and drug dependency), as well as disparities in the way people were grouped, which all contribute to limiting comparability between the HAB consented and Stay Club samples. Additionally, this data is captured by self-report to professionals and therefore is likely that mental health and substance misuse are largely underreported.

Last year the Advisory Council on the Misuse of Drugs published a report[xxi] into homelessness and drug misuse. The report reviewed evidence relating to prevalence rates and concluded that due to different methodologies, it is difficult to assess accurately the extent of drug use among homeless populations. There is however evidence of an association between being homelessness and an increased risk of problematic drug use. The report highlighted that there is likely to be differences in substance misuse between rough sleepers and those in temporary accommodation, with more than one study finding that half of rough sleepers were alcohol dependent and 29% misused drugs. The type of drug use does however vary from area to area. Homeless Link reported[xxii] that 27% of people that participated in their Health Audit had alcohol problems and 41% had previous or current drug dependency issues.

In December 2020, LB Barnet Public Health were successful in their bid to PHE for grant monies to address substance misuse in homeless people. The grant funding will support the development of a specialist outreach team to support current rough sleepers and those in temporary accommodation to address their substance misuse issues. The service will also include a specialist homelessness nurse post, a complex needs post and a Romanian speaking post.

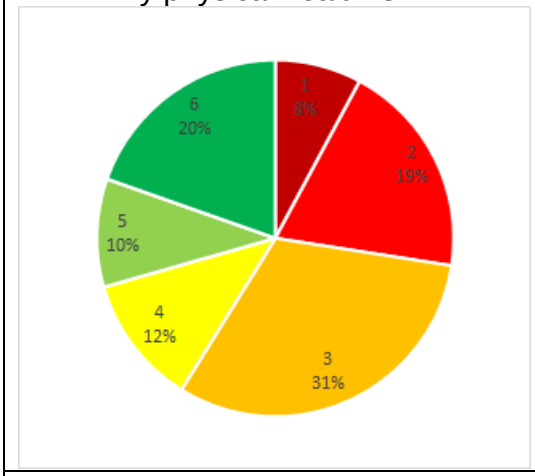
Conclusions:
Comparable to London and national data, the rates of substance misuse reported in Barnet rough sleepers is low. As substance misuse can be both a driver for and an outcome of homelessness, it is probable that the Barnet data under-reports local prevalence. The reasons for the under-reporting are unclear and can be the result of poor identification, poor recording and reporting or the absence of suitable services.

The PHE grant secured to develop specialist rough sleeping and substance misuse provision will address these issues and aims to improve the identification and access to support for homeless people.

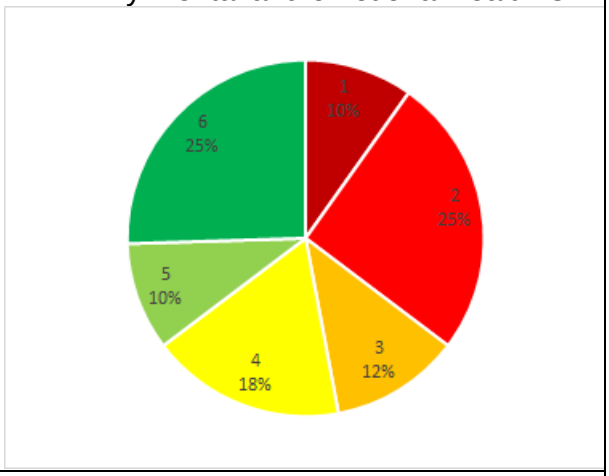
Wellbeing and Social Functioning:
Staff at HAB have conducted holistic assessments with people accessing the service. The graphs on the following pages will provide a summary of these assessments.

The following data has been extracted from the assessments completed by staff at HAB. A score of 1 demonstrates the person feels very inadequate in this area. A score of 3 or 4 indicates the person feels fair to middling in this area. A score of 6 shows the person feels they are excellent in this area.
Key: 1 = Very Poor, 2 = Poor, 3 & 4 = Fair to middling, 5 = Good, 6 = Excellent

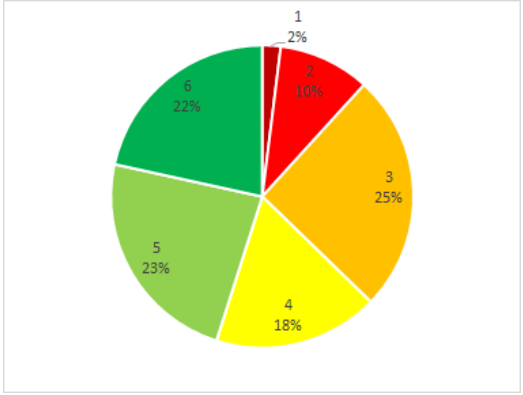
1. My physical health is:



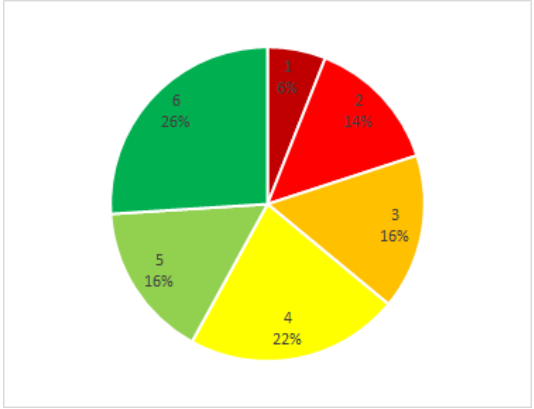
2. My mental and emotional health is:



3. I can enjoy things without losing control (Addictions Alcohol/Drugs/Gambling)



4. have a level of education and training that I am happy with



5. I feel good about myself:

6. I can take care of my day to day needs

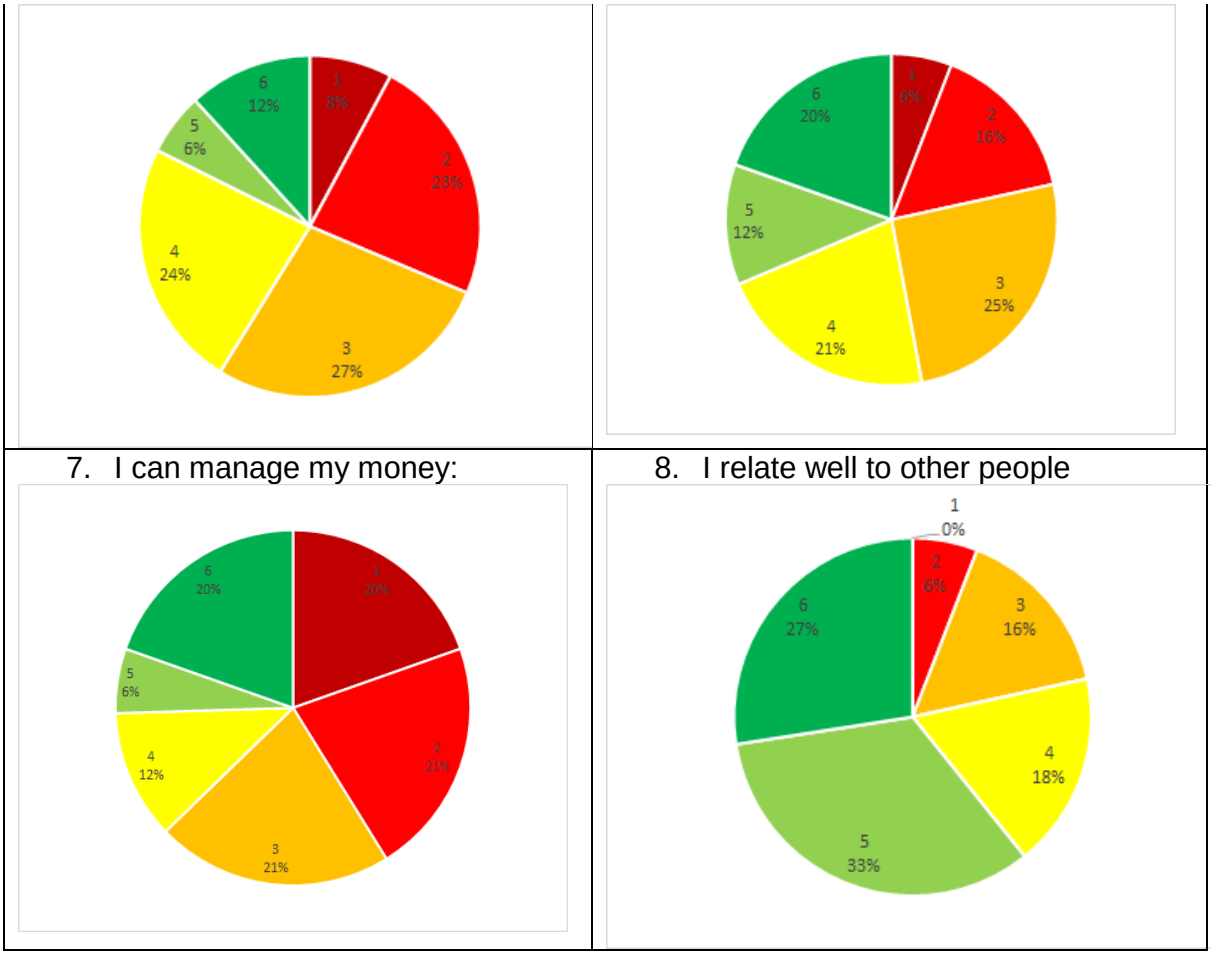


Figure 12: Summary of wellbeing questions asked in HAB assessment
Source: HAB data

It is apparent that responses are varied with people displaying a range of support needs. Whilst around 20% - 30% seem to rate themselves positively, the majority of the cohort identify at least one area of weakness.

Most notably, areas where people are rated most poorly include money management, meeting their day to day needs, assessment of physical health and assessment of emotional and mental health.

Furthermore, it is likely that where an individual has more than one support need, their vulnerability and complexity increase substantially. It is also well known that these issues tend to cluster together.

10. Multiple Exclusion Homelessness

As mentioned earlier, the reasons for homelessness are often a combination of structural and personal factors. What is clear from the literature[xxiii] is that many of those who find themselves as homeless, do so as a result of early exposure to significant trauma or adverse experiences in early childhood.

Such childhood trauma/adverse experiences include:

- physical abuse

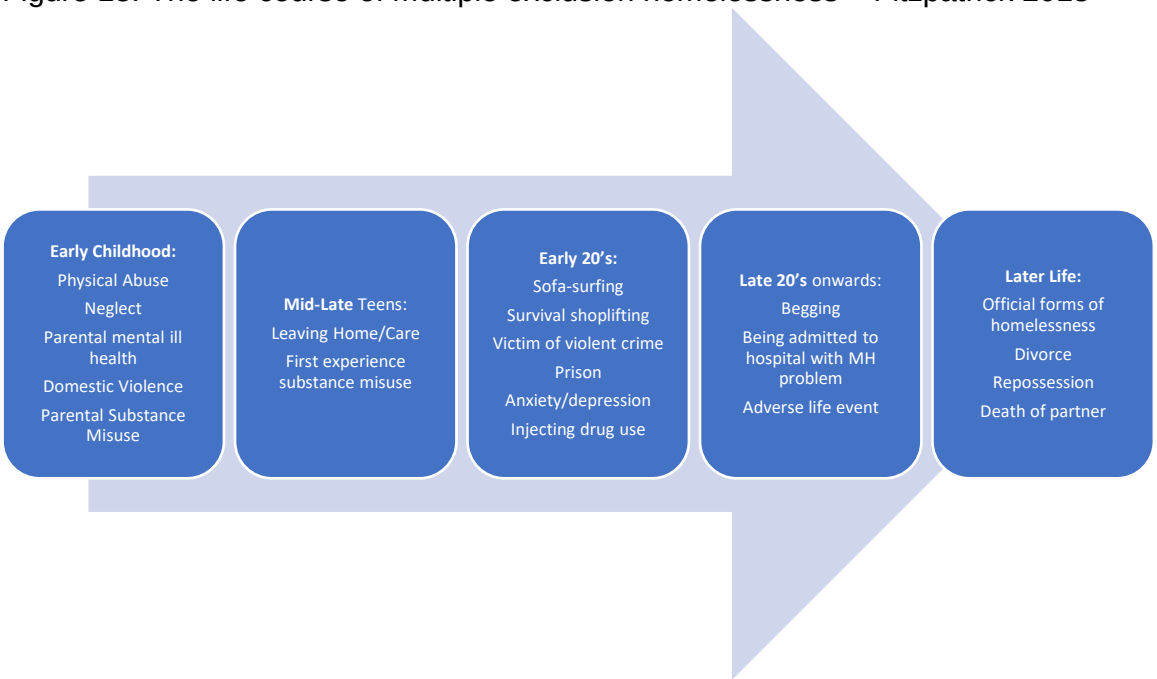
- neglect
- there sometimes not being enough food to eat at home
- homelessness
- domestic abuse in the household
- parental substance misuse
- parental mental health issues
- poor family functioning
- socio-economic disadvantage/poverty
- separation from parents of care givers

In order to address the issue of homelessness, it helps to understand the circumstances, experiences, and severe and multiple deprivation/social exclusion, which have impacted significantly on those individuals who have found themselves as homeless.

Multiple Exclusion Homelessness (MEH) can be described[xxiv] as; 'People have experienced MEH if they have been 'homeless' (including experience of temporary/unsuitable accommodation as well as sleeping rough) and have also experienced one or more of the following other domains of 'deep social exclusion': 'institutional care' (prison, local authority care, mental health hospitals or wards); 'substance misuse' (drug, alcohol, solvent or gas misuse); or participation in 'street culture activities' (begging, street drinking, 'survival' shoplifting or sex work)'

Fitzpatrick et al describe pathways into MEH almost as a life course, with particular MEH experiences happening through our lives, which then increase the likelihood of us experiencing homelessness and other complex issues such as mental ill health and substance misuse. Through their work, they were also able to 'cluster' MEH experiences and identify subgroups within the MEH population with similar sets of experiences.

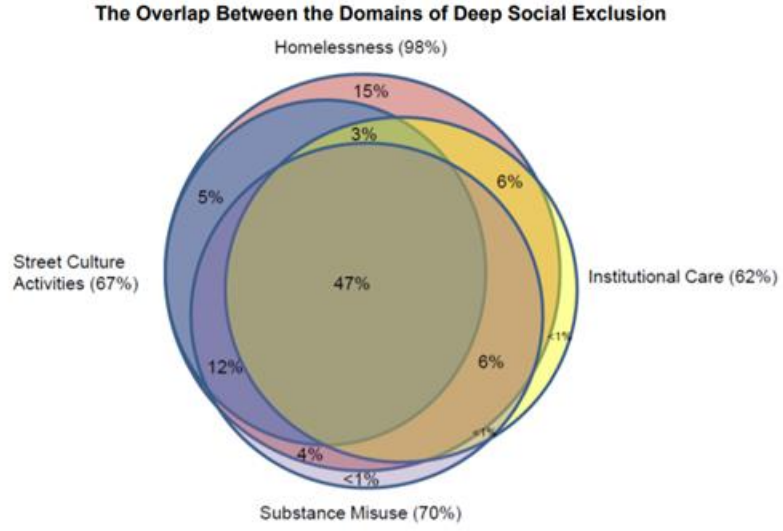
Figure 13: The life course of multiple exclusion homelessness – Fitzpatrick 2013



Fitzpatrick et al advise that preventative interventions should focus on earlier signs of distress wherever possible, including preventing childhood adversity and/or finding ways of mitigating against the negative outcomes. For example, with schools, drug and

alcohol services, and the criminal justice service who are likely to come into contact with those vulnerable to homelessness well before housing and homelessness agencies do. For this to happen, an inclusive and integrated approach to homelessness and the commissioning of services is required to improve the health and wellbeing of vulnerable people.

The study also demonstrated that the experience of specific domains of deep social exclusion (homelessness, institutional care, substance misuse and street culture activities) was extremely widespread amongst this population. The graphic below shows the complex nature of the interactions between the domains and indicates that almost all had experienced homelessness (98%); 70% had experienced substance misuse; 67% had experienced street culture activities and 62% had experienced institutional care. The degree of overlap is huge and some 47% of people have experienced all 4 domains.



Source: Fitzpatrick, 2012.

The annual CHAIN report 2019/20 reported the support needs identified in assessments by those people working with rough sleepers. Whilst 41% had no support needs, the majority of these people were people who had only been seen rough sleeping once or twice. Of those longer term rough sleepers, a variety of issues were noted, as shown in figure 14 below. 47% of people assessed disclosed mental health issues, and 40% disclosed a multiplicity of issues. These rates are much higher than seen in the general population.

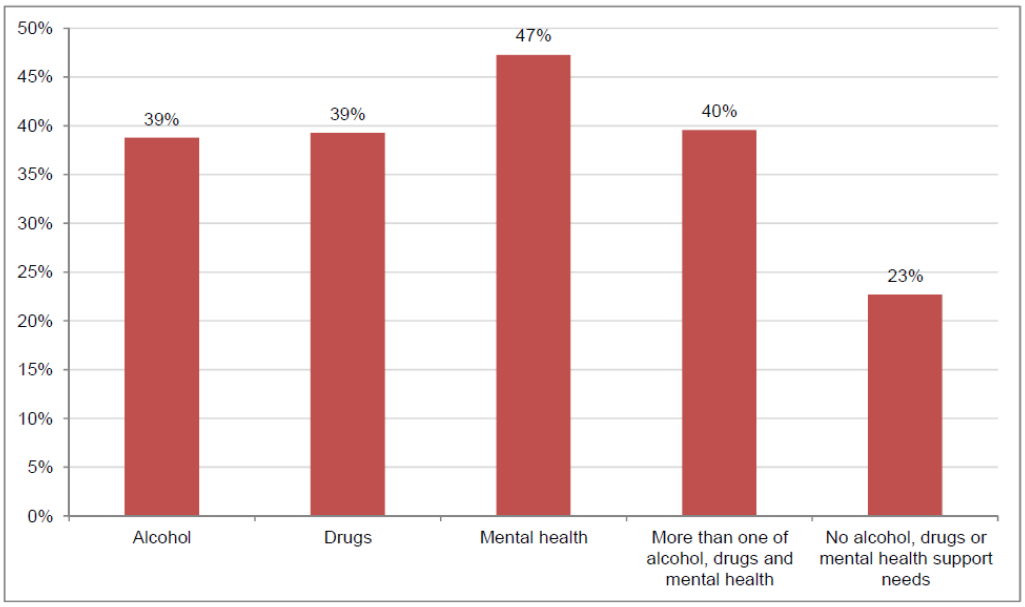


Figure 14: Support needs identified in London rough sleepers, CHAIN 2019/20

11. Recommendations

I. Governance, Oversight and Improving Prevention Opportunities

To support strategic delivery, formal partnership delivered through good governance is essential. There is a need to establish formal governance arrangements to provide leadership and accountability for improving health and homelessness outcomes, including delivery of needs assessment recommendations. These governments arrangements should include a forum where commissioning arrangements can be discussed.

LB Barnet Homeless and Rough Sleeper Strategy
Under the Homelessness Act 2002, all housing authorities must have in place a homelessness strategy based on a review of all forms of homelessness in their district. The strategy must be renewed at least every 5 years. The social services authority must provide reasonable assistance; and the strategy must set out the authority's plans for the prevention of homelessness and for securing that sufficient accommodation and support are or will be available for people who become homeless or who are at risk of becoming so. The Barnet strategy is due for review in 2024; however, given recent unprecedented events including the impacts of Brexit and the recent COVID-19 pandemic, it is proposed that work begins on reviewing the strategy imminently. The partnership can take this opportunity to consider what action is needed to ensure i) people do not return to rough sleeping and homelessness ii) there is a suitable health-led response to homelessness locally and iii) what wider systemic change is needed to prevent future homelessness and respond effectively to COVID-19 impacts.

The role of upstream primary prevention initiatives is not yet fully understood or embedded within strategic approaches, either nationally or locally. Primary prevention, relates to those measures that can be taken to prevent homelessness early, thus reducing the risk of someone being at risk of homelessness in the future; and secondary prevention, relates to prompt measures that can be put in place once a person is at risk of homelessness to stop the problem escalating in severity.

It is clear that there are opportunities within existing primary prevention interventions to address risk factors for future homelessness, and that secondary prevention opportunities such as using the “duty to refer” provides an opportunity to engage a wider frontline workforce on the impact of housing on health and identify needs earlier.

As mentioned earlier, studies highlight the way in which the risk of becoming homeless in the future is increases significantly if there are particular experiences in early childhood thus key primary prevention opportunities to prevent or reduce such outcomes would be to identify and intervene at the earliest opportunity. Preventing childhood adversity and/or finding ways of mitigating against the negative outcomes associated with such experiences is crucial.

However, for the purpose of this needs assessment, we will focus more on secondary prevention opportunities. Ways that we can do this is:

- Identification of people with financial vulnerability and debt: The recent COVID-19 pandemic has had a lasting economic impact, resulting in increasing levels of unemployment and financial insecurity. This is suspected to result in a new demand from people who would not ordinarily come in to contact with council housing and support services. A proactive approach must be taken to ensure people at risk of financial vulnerability are supported.
- Furthermore, suitable employment, training and education services must be extended to all people currently or recently homeless. This includes suitable support for non-UK nationals.
- Increasing access to tenancy sustainment and floating support for people with addictions, mental health, and other vulnerabilities such as people who have spent time in prison and ex armed forces. Models such as Housing First[xxv] have shown to be effective. Housing First is designed to provide open-ended support to long-term and recurrently homeless people who have high support needs.
- Upskilling front-line professionals to work in a trauma-informed way in order to support people with multiple complexities

LB Barnet Suicide Prevention Strategy
In response to the findings of this need’s assessment, the Barnet Suicide Prevention Strategy (2021-2025) and plan recognise the risk of suicide in people that are homeless and identify opportunities for action.

II. Improving insight and intelligence:

This needs assessment highlighted some specific areas where improved consistency in record keeping would help the insight into this group of people, as well as some areas where information is lacking. Further work is needed for commissioners and providers to routinely collate and share information locally on the risk factors and health, housing and social care needs of those accessing services, as a starting point for estimating true population health need. This routine collation and sharing of information would also support the partnership to develop a joint client list to facilitate holistic care.

This includes a focus on recording in primary care, particularly on the type of homelessness (for example, differentiating between who is rough sleeping and who is in temporary accommodation). Additionally, more information is required on what data is available from secondary care.

III. Addressing barriers to accessing suitable health care:

Healthy London Partnership (HLP) has reviewed how to improve the health of homeless people[xxvi]. HLP have developed a number of resources for health professionals that can be used locally. These include:

- An e-learning training package for GP receptionists and practice managers to equip them with the skills and knowledge to better identify and support homeless people[xxvii]
- Credit card sized plastic cards designed to be carried by adults who are homeless across London, including people who sleep rough, live in hostels, sleep on family and friend's sofas, or who are chronically insecurely housed. They can be used to remind GP receptionists and other practice staff of the national patient registration guidance from NHS England[xxviii]
- Developed a resource pack including useful websites and additional sources of information relating to homelessness[xxix]

In addition to implementing these resources locally, it is recommended that:

- a thorough review of the locally commissioned homeless health service is conducted, with consideration to how this service works proactively and flexibly and facilitates pathways into other health services.
- LB Barnet and NCL CCG collaborate to develop the proposed local programme considering the London vision and workstreams.
- LB Barnet and NCL CCG to collaborate to develop models including specialist homeless intermediate care, specialist step-down accommodation, and move on co-ordinators.
- LB Barnet and NCL CCG to collaborate to ensure improved access to routine health screening and vaccinations is reflected in the work programme.
- Engage Barnet Integrated Care Partnership (ICP) to consider opportunities for homelessness prevention through the life-course approach.

IV. Housing and Support Pathways

The recent COVID-19 pandemic has highlighted the need to review pathways for single homeless people, particularly for those with multiple or complex needs. The needs assessment has identified gaps in the current pathway including:

- Improving access to social care support – During the COVID-19 pandemic, Barnet Homes and LB Barnet trialled an alternative pathway for homeless service users to access care-act assessments. This was reported to be affective and therefore consideration should be given to this when agreeing the pathway.
- Clarifying and improving access to mental health support by working with Barnet, Enfield & Haringey Mental Health Trust to establish clearer pathways and consider opportunities for a more targeted and proactive offer.
- Throughout the pandemic Barnet rough sleepers have been placed in temporary accommodation in neighbouring boroughs due to the lack of affordable supply in the borough. This has been challenging when accessing services in times of crisis. A clear pathway is required for support workers working operationally to access crisis intervention.
- As mentioned above, there is currently no provision or pathway for accessing more supported accommodation for those with complex needs but do not meet care act eligibility criteria. Accommodation options are needed for those limited number of cases in Barnet that have high and complex needs. Linked to this is the discharge of

vulnerable single homeless people from hospitals or recovery houses who are deemed capable of independent living and are placed into temporary accommodation without the necessary care planning and support being put in place. This will hopefully be addressed by the funding obtained by NCL CCG.

- Access to physical activity – although the borough is well served by outdoor gyms, the partnership identified that improved access to physical activity services, particularly for people in begin their housing journey, could improve the overall health and wellbeing of rough sleepers.

V. Addressing Substance Misuse Issues

Lastly, the needs assessment has shown that the number of people who are homeless in Barnet, and misuse substances, is lower than expected. Whilst this might be in fact the case, it is more likely that there is poor identification of substance misuse and subsequently poor engagement with substance misuse treatment. It is therefore recommended that specific resources be directed to a) upskill the current workforce to improve identification, b) identify additional resources to work with people with multiple complexities such as dual diagnosis and substance misuse to provide appropriate treatment and support.

As mentioned earlier in the report, a specialist team is currently being developed to support homeless people with substance misuse needs. This team will be key in developing our local understanding of the problem locally and ensuring we develop sustainable ways to support this cohort.

VI. Improving migrant health

There are a range of services and initiatives to help people sleeping rough sleeping who are not from the UK to come off the streets and rebuild their lives, and whilst there are some restrictions to what people with no recourse can access, in Barnet, a public health and support-led approach has been in place throughout the pandemic to ensure equitable access to housing and support.

Having said this, many non-UK rough sleepers do not engage with local services and as a result little is known about their health and support needs. Consideration must be given to suitable ways to engage with non-UK rough sleepers to understand their specific health and support needs.

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