healthwatch Reading advice • advocacy • action

NHS Berkshire West Clinical Commissioning Group

Reading Borough Council Working better with you

READING HEALTH AND WELLBEING BOARD

DATE OF MEETING:	13 JULY 2018	AGENDA ITEM:	16
REPORT TITLE:	COVER REPORT FOR READING HOMELESS HEALTH NEEDS AUDIT		
REPORT AUTHOR:	VERENA HUTCHESON	TEL:	0118 937 4136
JOB TITLE:	HOMELESSNESS AND HOUSING PATHWAYS MANAGER	E-MAIL:	Verena.hutcheson@reading.gov.uk
ORGANISATION:	READING BOROUGH COUNCIL		

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 Throughout January and February 2017, over a five week period, partners from Reading's Homelessness Forum commissioned and undertook a Homeless Health Needs Audit in Reading. The Audit included completion of questionnaires with 150 individuals who were single or part of a couple without dependent children and who were homeless - for example those who were rough sleeping, sofa surfing, living within supported accommodation, refuges or in Bed and Breakfast. The aims of the Audit were to listen to and take account of single homeless people's views on their health; provide an evidence base and fill in any information/evidence gaps; contribute to Reading's Joint Strategic Needs Assessment (JSNA); consider what is currently working well within services, with a view that this could inform improvements; and develop a case for change for homeless people in Reading.

The findings of the Homeless Health Needs Audit are intended to be a research piece that can inform improvement and service development across sectors where key issues from respondents have been highlighted and management within sector services are invited to set out their responses to these findings and develop subsequent action plans.

1.2 Appendix 1 - *Reading Homeless Health Needs Audit: A report based on findings of a Homelessness Forum partnership project into the physical, mental and sexual health needs of Reading's single homeless population.*

2. RECOMMENDED ACTION

2.1 That partners that represented at the Health and Wellbeing Board note the Reading Homeless Health Needs Audit report research to inform improvement and service development within their area and across housing, health and social care sectors.

2.2 That management and commissioners within and across housing, health and social care sector services develop responses to the Audit's findings and report back to the Board plans to address highlighted issues and barriers for those who are single, or part of a couple without dependent children experiencing homelessness.

3. POLICY CONTEXT

3.1 The Homeless Health Needs Audit and associated toolkit was first developed by Homeless Link, in partnership with the Department of Health and nine pilot areas across England, in 2010. In 2015, with funding from Public Health England, it was updated to take into account changes to local commissioning environments and other relevant reforms impacting on homelessness and health.

Homeless Link established that people who become homeless have some of the highest and costliest health needs in a local community, but those needs are often overlooked when healthcare and social care services are planned and commissioned. Homeless Link advise that addressing health inequalities is a statutory requirement for the NHS, including local bodies such as Health and Wellbeing Boards, public health teams and Clinical Commissioning Groups. They advise that improving the evidence base around homeless people's health and the services they use is of vital importance in achieving this aim.

The Homeless Health Needs Audit itself provides a framework for gathering and using information to access local need and improve healthcare services using the direct experiences of people who single, or part of a couple without dependent children and that are homeless. In gathering local data, Audits across 27 local authority areas have aimed to do the following:

- Increase the evidence available about the health needs of people who are homeless and the wider determinants of their health
- Bring statutory and voluntary services together to develop responses to local priorities and address gaps in services
- Give people experiencing homelessness a stronger voice in local commissioning processes
- Help commissioners understand the effectiveness of their services

4. THE PROPOSAL

4.1 Current Position

Audit data has been collated and a report has been prepared that analyses and presents this research for housing, health and social care services.

4.2 Options Proposed

That Audit data is considered and utilised by housing, health and social care management and commissioning services to develop action plans that address highlighted issues and barriers.

5. CONTRIBUTION TO READING'S HEALTH AND WELLBEING STRATEGIC AIMS

5.1 The proposals within this cover report contribute to the following of Reading Health and Wellbeing's Strategy priorities:

- Supporting people to make healthy lifestyle choices (with a focus on tooth decay, obesity, physical activity and smoking)
- Reducing loneliness and social isolation
- Promoting positive mental health and wellbeing in children and young people
- Reducing deaths by suicide
- Reducing the amount of alcohol people drink to safe levels
- Increasing breast and bowel screening and prevention services
- Reducing the number of people with tuberculosis

6. COMMUNITY & STAKEHOLDER ENGAGEMENT

6.1 To ensure that the Audit had the widest possible input and impact it was conducted in partnership with agencies across statutory and voluntary sectors. The partnership was formed as a sub-group of Reading's Homelessness Forum. Details of all partners involved are included within the body of the report. 23 volunteers and staff across sectors were involved in completing Audits with individuals. All staff and volunteers were fully trained and had the full support of staff within the Homelessness Support (Pathways) Services team.

7. EQUALITY IMPACT ASSESSMENT

7.1 Not applicable

8. LEGAL IMPLICATIONS

8.1 Not applicable

9. FINANCIAL IMPLICATIONS

9.1 Not applicable

10. BACKGROUND PAPERS

10.1 None

Reading Homeless Health Needs Audit

A report based on findings of a Homelessness Forum partnership project into the physical, mental and sexual health needs of Reading's single homeless population

September 2017

Icons have been resourced from www.flaticon.com and www.piktochart.com

Contents

	Page(s)
Executive Summary	3
Partner Organisations	5
Acknowledgements	6
Objectives of the Audit	7
Background Information	8
Methodology and response sources	12
Who took part in Reading's Homeless Health Needs Audit?	18
Analysis of who took part in Reading's Homeless Health Needs Audit	19
Initial anecdotal themes from the Audit project sub-group staff and volunteers	21
Data findings and analysis	22
Statements about health	23
Physical health: Summary and analysis of findings	25
Mental health: Summary, analysis of findings and key messages from respondents	28
Smoking, alcohol and drug use: Summary, analysis of findings and key messages from respondents	32
Access to health services: Summary, analysis of findings and key messages from respondents	36
Focus on rough sleepers' health needs: Accessing primary and secondary healthcare services	45
Prevention opportunities - Immunisations, sexual health screening and those leaving custody: Summary, analysis of findings and key messages from respondents	52
Case study comparison: Health needs of long-term/entrenched rough sleepers and those who are new to the streets	56
Conclusions	62
Appendix 1 Homeless Health Needs Audit Project Group Terms of Reference	68
Appendix 2 Homeless Health Needs Audit Questionnaire for Reading	69

Executive Summary

Throughout January and February 2017, over a five week period, partners from Reading's Homelessness Forum commissioned and undertook a Homeless Health Needs Audit in Reading.

The Audit completed questionnaires with 150 individuals who were single or part of a couple without dependent children, who were homeless - for example, those who were rough sleeping, sofa surfing, living within supported accommodation, refuges or in Bed and Breakfast.

The aims of the Audit were to listen to and take account of single homeless people's views on their health; provide an evidence base and fill in any information/evidence gaps; contribute to Reading's Joint Strategic Needs Assessment (JSNA); consider what is currently working well within services, with a view that this could inform improvements and develop a case for change for homeless people in Reading.

The findings of the Audit and this report are intended to be a research piece that can inform improvement and service development across sectors. Key issues from respondents have been highlighted and management within sector services are invited to set out their responses to these findings and develop subsequent action plans.

The report is set out under the following headings:

- Statements of health
- Physical and mental health
- Smoking, drug and alcohol use
- Access to health services
- Focus on rough sleepers' health needs
- Prevention opportunities

Key findings from the report show that respondents have particular concerns about their mental health and the support they receive to manage their mental health needs. 80% of respondents reported having a mental health problem with many stating that their homelessness was a contributing factor to their mental health problems; that they had difficulty accessing mental health services (waiting times, inconsistency; concurrent substance misuse issues); that they would rather have face-to-face support and that specialist trauma services would be beneficial.

Regarding the physical health needs of respondents, the top three longer-term needs concurred with the national picture as (1) joint aches or problems with bones/muscles; (2) heart problems or chronic breathing problems and (3) dental/teeth problems. A third of respondents reported problems with their teeth/mouth. Several respondents stated that they had not received treatment for dental health problems in the last 12 months primarily due to fear of examination; not being able to get an appointment and not feeling motivated to get treatment.

A significantly high proportion of respondents were smokers. Alcohol and drug misuse amongst Reading's respondents was in line with other health need audits across the country with drug use at 43% and alcohol misuse at 30% and the use of NPSs being minimal. Over half of respondents stated that they were using drugs and/or alcohol as a means to cope with mental health or past trauma.

Compared to other health need audits, Reading's respondents had a slightly lower GP registration rate and significantly lower registration refusals. This can be attributed to Reading having a well-used Walk-In Centre facility. Those within supported

accommodation were more likely to be accessing primary health care and less likely to be refused access to services.

Over a third of respondents stated they had accessed A&E at least once in the last year; with just under a third admitted to hospital from A&E. Those most prolifically using A&E and ambulance services were primarily living in supported accommodation and had multiple and longstanding health issues. Only one was sleeping rough. All but one respondent accessing A&E identified as having depression and anxiety as well as at least one other mental health diagnosis - primarily Personality Disorder and a dual diagnosis (alcohol/drug misuse and a mental health diagnosis). Respondents stated that they valued having appointments with a regular and familiar GP; were frustrated with not being able to get an appointment with a GP in a timely way; sometimes felt disbelieved and judged when presenting with symptoms at A&E and felt that discharge staff could do more in establishing a patient's housing situation.

Sexual health checks and confidence about accessing sexual health advice were higher than in other Audit areas. Reports of HIV, TB and Hepatitis B and C were very low. Uptake of the Hepatitis B vaccination was significantly higher than other local authority areas. Respondents who had recently been in custody stated that they considered their health and wellbeing needs had not been addressed whilst in custody in preparedness for their release.

There were several examples of responses from those who partook to highlight the following positive experiences of health care and support in Reading: availability and accessibility of Reading's Walk-In Centre; accessibility of in-reach services provided by the Health Outreach Liaison Team (HOLT); peer support services for those with substance misuse issues and high levels of respondents knowing how to access contraception and advice about sexual health.

Respondents showed that they would like to see improvements in the following areas:

- Obtaining GP appointments and wanting consistency of support from the same GP.
- Access to accommodation and a feeling of home to improve overall mental health and well-being.
- How mental health support is obtained, delivered and it's availability.
- Access to more support, including peer support and specialist trauma support, for mental health and/or substance misuse.
- Attitudes of health care staff towards those who have physical and/or mental health issues alongside substance misuse issues; wanting to feel believed, not judged, and given time by professionals.
- Feeling able and comfortable in accessing dental health services.

The Council's Housing Needs team currently commission several homelessness support services in Reading to meet the needs of those who are single and homeless. From September 2018, these services will be recommissioned, in line with local best practice and national recommendations, to create immediate and emergency responses to those who are homeless or sleeping rough; housing and support offers to address the differing needs of single homeless people and services that pre-empt and prevent homelessness. Since June 2017, the Council and St. Mungo's have set-up a two year Housing First pilot as an innovative approach to housing and supporting those who have complex and entrenched behaviours where traditional models of supported accommodation have proved to be ineffective. Housing First works with the principle that individuals do not need to engage with treatment services as a precursor to accessing accommodation, where such conditions can be a barrier. This model will house 8 - 10 Reading individuals who will be supported by a full-time Housing First Worker.

Partner Organisations

To ensure that the Audit had the widest possible input and impact it was conducted in partnership with agencies across statutory and voluntary sectors. The partnership was formed as a sub-group of Reading's Homelessness Forum.

The Homeless Health Needs Audit Project Group was formed with the following partners to provide steer, direction and operational support to the process:

- Ability Housing Association
- Berkshire Healthcare Foundation Trust - including Adult Mental Health Services, Thames Valley Diversion and Liaison Team, Health Outreach Liaison Team (HOLT) and Royal Berkshire Hospital (RBH)
- Berkshire Women's Aid (BWA)
- Bournemouth Churches Housing Association (BCHA)
- Churches in Reading Drop In Centre (CIRDIC)
- Christian Community Action (CCA)
- Community Rehabilitation Companies and National Probation Service
- Elizabeth Fry Charity
- FAITH Christian Group
- Healthwatch Reading
- IRIS Drug and Alcohol Service, Reading
- Launchpad Reading
- NHS South Reading Clinical Commissioning Group (CCG)
- PACT Charity
- Patient Voice Reading
- Public Health England
- Providence Chapel
- Reading Borough Council - including the Homelessness Support (Pathways) Services Team, Adult Social Care Commissioning and Public Health Reading
- Reading Voluntary Action (RVA)
- Riverside
- St. Giles Trust
- St. Mungo's
- The Mustard Tree
- The Passage
- The Salvation Army
- YMCA Reading

The partnership was led by Reading Borough Council's Homelessness Support (Pathways) Services Team. Terms of Reference for the Project Group are attached as an appendix.

Acknowledgements

Thank you to all Audit respondents for their honesty and time in providing a voice to those with lived experience of homelessness and health needs in Reading.

Special thanks to local voluntary sector partners for their input from a non-statutory perspective - this has been very valuable in shaping the Audit and challenging perceptions, as well as supporting with completions of questionnaires.

We are immensely grateful to all volunteers, across sectors, who undertook essential training to assist with the Audit and who dedicated their time during the day and in the evenings to complete questionnaires with participants.

Thank you to Healthwatch Reading for supporting the Audit with their expertise and supplementing the Audit with additional qualitative focus group data, provided in a separate report.

Nationwide provided five pound denominations of vouchers to incentivise the project. This financial support enabled the Audit to reach further groups and those who we may not otherwise have been able to engage with. Thank you to Sascha Chennell for organising the provision of vouchers for the project.

Homeless Link enabled Reading to access the Homeless Health Needs Audit template and toolkit. Thank you to Debra Hertzberg for her advice on designing the questionnaire and to Sarah Gorton for attending the Homelessness Forum initially to explain and promote the Audit project to Reading partners.

Thank you to commissioned homeless and housing support services in Reading who invested a significant amount of staff time and effort into completing the Audit with their clients.

Finally, thank you to Homelessness Forum members for supporting the Audit and making it happen and to the Homelessness Support (Pathways) Services Team for designing and providing volunteer training and for inputting, analysing and presenting the data contained within this report.

Objectives of the Audit

The Homeless Health Needs Audit is a framework designed by Homeless Link for gathering and using information about health inequalities that single homeless individuals may be experiencing, by asking partners to complete a questionnaire with those affected. The information gathered is then analysed to inform lead partners – housing, health, commissioners - about changes that can be made to services, service delivery and partnerships to improve the health of homeless individuals and their access to services within the local area.

Reading's Homeless Health Needs Audit 2017 was commissioned by Reading's Homelessness Forum and the findings aim to develop an understanding of the health and wellbeing of those who are homeless in Reading. The aim is to offer commissioners and service providers, across all sectors, a better understanding of the health conditions that homeless individuals face and to make recommendations on how to improve partnerships and services.

The objectives of the Audit are:

- To listen to, take account of and record the views of single homeless regarding their health needs using relevant evidence gathering procedures by giving people experiencing homelessness a stronger voice in local commissioning processes
- To provide an evidence base on the health needs of single homeless people by building a comprehensive dataset on Reading's local homeless population to fill in any information or evidence gaps.
- To contribute to Reading's Joint Strategic Needs Assessment (JSNA).
- To demonstrate the value of homelessness services in contributing to the health agenda and vice versa – identifying what we are doing well and where improvements could be made by helping commissioners to understand the effectiveness of their services
- To improve service access and delivery for single homeless individuals in Reading and ultimately improve their overall health.
- To develop a case for change by considering the development of new services; service remodelling; new or better partnerships and systems, or additional training for targeting and engaging single homeless individuals.
- To bring statutory and voluntary sector services together to develop responses to local priorities and look to address gaps in services.

The Audit does not aim to and cannot provide answers to all questions sectors, services and commissioners might have about single homeless individuals and their health needs. It provides an evidence base; however, there will still inevitably be some gaps in information and evidence that arise from the data explored. The main areas of focus for the Audit are:

- Access to health services
- Physical health
- Mental health
- Drug and alcohol use
- Prevention: Vaccinations and screening

Background Information

Single homelessness and rough sleeping in Reading

In January 2017 the Department for Communities and Local Government (DCLG) published autumn figures for rough sleeping across England. The figures provided a snapshot of the number of people every local authority estimates or counts to be sleeping rough on any one given night.

A total of 4,134 people were counted or estimated to be sleeping rough on a 'typical night' in 2016. This was a 16% increase since 2015. People sleeping rough has more than doubled over the last two years. This is an increase of 134% since 2010 when this centralised and mandatory methodology for local authorities estimating and counting those rough sleeping began[1].

In 2016 Reading saw an increase in rough sleeper numbers on a 'typical' night of 22 individuals, up from 16 in 2015. The number of people known to rough sleep on occasions, for example those who have some sofa surfing options with friends and family and then spend some time rough sleeping, has increased in Reading over the last five years too.[2]

There are many reasons why there have been increases in single homelessness numbers across England in the last few years including:

- The impact of welfare reform, such as the application of under-occupation charges; benefit sanctions and those aged under 35 only being entitled to a rate of Local Housing Allowance (LHA) that meets the cost of a room in a shared house.
- From April 2017 those aged 18 - 21 who are claiming Universal Credit are no longer entitled to financial help with housing costs unless deemed vulnerable or unable to live with parents.
- Increases in European nationals and unsuccessful asylum seeker applications where people have no recourse to public funds.
- A reduction in local authority funding from central government which has impacted upon the commissioning and delivery of non-statutory single homeless accommodation and related support services.
- Difficulties with move-on from supported accommodation into longer term accommodation. This is primarily due to availability and affordability where market rents, significantly in the South East, exceed Local Housing Allowance rate entitlements.
- Thriving day and night time economies in towns and cities like Reading in the South East which can attract those wanting to access on-street donations through begging to fund day-to-day cycles of Class A drug and alcohol misuse. In less lucrative areas, this cohort may otherwise choose to access supported accommodation or reconnect to their area of origin rather than sleep rough to maximise their begging opportunities.

Reading does not have access to data that accounts for numbers of homeless individuals who are staying with various friends and/or relatives on an ad-hoc basis - this is often referred to as 'sofa-surfing'. CRISIS refers to 'hidden homelessness'[3] where people have no fixed address and tend to 'sofa surf' amongst friends and relatives, but rarely enter into

---

[1] Homeless Link (2016) *2016 Rough Sleeping Count*. Accessed at http://www.homeless.org.uk/sites/default/files/site-attachments/Homeless%20Link%20-%20analysis%20of%20rough%20sleeping%20statistics%20for%20England%202016.pdf on 22/08/17.

[2] Please note that since this report was authored, further data has been released regarding rough sleeping numbers. In January 2018, figures for 2017 for Reading were released where Reading saw an increase in numbers from 22 to 31 rough sleepers found during an official annual count.

[3] Fitzpatrick, S. et al. (2017) *The Homelessness Monitor: England 2017*, CRISIS, London.

rough sleeping. These individuals are rarely seen by street outreach teams or housing advice officers within local authorities. Where such services are commissioned, like in Reading, some are supported by floating support teams into the private rented sector where it is appropriate and affordable to do so. For the purposes of the Audit, the partnership group recognised the importance of representing these groups and housing circumstances within responses gathered. This is outlined further within the *Methodology and Response Sources* section.

It is worth noting in this section that Reading Borough Council commissions several homelessness support services for those with a local connection to Reading, including 217 supported accommodation bed spaces; a rough sleeper outreach team and a floating support service to prevent homelessness.

Reading's voluntary and faith sector community provide several services for those who are homeless or vulnerably housed including a night shelter throughout January and February and several groups and outreach functions for meeting the basic needs of these individuals.

Homelessness and health

It is widely recognised and has been demonstrated by Homeless Link Homeless Health Needs Audit responses from across several local authority areas since 2010 that homeless people experience specific and multiple health problems, that not only contribute towards the cause of homelessness, but that can also exacerbate their homeless situation.

Those who experience homelessness can also experience the detrimental effect that is has upon their physical and mental health wellbeing. A report by CRISIS in 2011 determined that the average age of death of a male who is sleeping rough is 47 and for women this is 43. The report concludes that those sleeping rough are nine times more likely to commit suicide[4].

Homelessness and in particular rough sleeping is an independent factor for premature mortality and chronic homelessness is an associated marker for tri-morbidity. Tri-morbidity is the combination of physical ill health with mental health and substance misuse, complex health needs and premature death. Tri-morbidity often has roots in histories of complex trauma, including high levels of child neglect and abuse, that impact upon developmental trajectories and subsequently an individual's adult mental health and well-being.

There are several factors that can mean that homelessness and in particular, but not exclusively, rough sleeping itself makes it difficult to access health care services because homeless people:

- Can be prevented from registering with a GP because they are unable to provide proof of their address or identity.
- Can find it difficult to make and keep appointments due to inflexible booking procedures and a lack of phone number or safe address for arranged appointments to be sent to or take place in.
- Can perceive or experience stigmatisation and discrimination because they are homeless which can deter them from accessing healthcare or can cause them to disengage with healthcare services before their health needs can be met.
- Can be chaotic in their nature and therefore are more likely to access acute healthcare services disproportionately to the general population. Data from the London Pathway in 2016 detailed that homeless people attend A&E up to six times

[4] CRISIS (2011) *Homelessness: A Silent Killer - a research briefing on mortality amongst homeless people*, CRISIS, London.

as often as the general population; are admitted four times as often and, once admitted, tend to stay three times as long in hospital[5].

Rough sleepers have a lower life expectancy and greater health and support needs compared to the general population and this puts pressure on and increases costs for other public services.

Homelessness and healthcare provision in Reading

Reading Walk-in Health Centre[6]
The Walk-in Centre is open seven days a week, 365 days a year from 8:00 am until 8:00 pm where people can see a nurse practitioner as a walk-in patient. Patients do not have to be registered at the Centre to see a GP or nurse and being seen at the Centre does not automatically mean a patient has been registered. Individuals can choose to register with the Centre if preferred. Referral to a GP will be at the discretion of a nurse practitioner rather than at the request of the patient and referrals to a GP are only made if medically necessary.

Waiting times can be anything from five minutes up to four hours - a number system is used, but urgent cases are seen out of turn. This decision is made by a nurse practitioner having assessed waiting patient's presenting needs.

For unregistered walk-in patients staff at the Centre do not have access to a patient's medical records and therefore there are limitations on prescriptions that can be provided. Where patients are registered with other GP surgeries, a record of contact and treatment is sent back to this surgery for their records, unless otherwise requested. For unregistered walk-in patients specialist referrals will not be made.

The Centre does have an upper capacity limit and therefore patients may be directed towards their GP, a pharmacist, 111 services or A&E where appropriate.

Homeless Outreach Liaison Team (HOLT)[7]
The HOLT is a unique service commissioned in Reading that specifically targets working with those who are homeless, living in a hostel or where people are having difficulties accessing mainstream health services. The team comprises two specialist workers in physical and mental health needs.

HOLT conducts outreach clinics for initial assessments and treatment at the following locations:

- **Every Monday**, 11am to 1.30pm, at the Churches in Reading Drop In Centre (CIRDIC), 1 Berkeley Avenue, Reading, RG1 6JT.
- **Every Tuesday**, 7am to 9am, in partnership with St Mungo's, Reading, to offer help to anyone found sleeping rough.
- **Between Tuesday and Friday**, a number of clinics on a referral basis at different locations including approved premises, Launchpad and 1st Stage supported accommodation.

Generally the service is open Monday to Friday, 9am - 5pm.

[5] Urban Village Medical Practice (2016) *Manchester Homeless Health Needs Audit 2016*, Urban Village Medical Practice, Manchester.
[6] NHS (2017) *Reading Walk-In Centre*. Accessed at http://readingwalkinhealthcentre.nhs.uk/ on 20/09/17.
[7] Berkshire Healthcare Foundation Trust (2017) *Health Outreach Liaison Team.* Accessed at https://www.berkshirehealthcare.nhs.uk/our-services/adult-healthcare/health-outreach-liaison-team-holt/ on 20/09/17.

Referrals and appointments are not needed, but can be made by health care and other support services where appropriate and requested. If health needs cannot be met by the team at these clinics then clients are supported to access the right service such as registering with a local GP, dentist or optician.

Methodology and response sources

The Audit Tool

The Homeless Health Needs Audit aims to offer a practical way to improve the health of people who are homeless at a local level and across sectors. The Audit was first developed in partnership with the Department of Health and nine pilot areas in 2010. In 2015, with funding from Public Health England, the tool was updated to take into account changes in local commissioning environments and other relevant reforms impacting on homelessness and health[8]. The Audit is designed, with accompanying guidance, to be used by anyone with an interest in the health of homeless individuals, including those with responsibility for improving health and wellbeing and reducing health inequalities.

Project Sub-Group

A sub-group of the Homelessness Forum, comprising partners outlined in the *Partner Organisations* section, was formed and met prior to the Audit taking place in July, October and December 2016 and then after the Audit in June 2017 to discuss and analyse the data and findings.

The sub-group ensured that the questionnaire was adapted to meet the purposes of members and sectors; that adequate training and preparation was undertaken for questionnaires to be completed comprehensively and sensitively and that guidance was provided on how to sufficiently signpost any safeguarding concerns or other needs raised with interviewers throughout the Audit process. Terms of Reference were devised in line with aims outlined in the *Objectives of the Audit* section.

Definition of homelessness for the purposes of the Audit

The definition of homelessness for the purposes of the Audit was as recommended by Homeless Link. The Audit was designed to only include single people, or individuals that formed part of a couple without dependents, who were:

- Aged 18 or over
- Living on the street - Consistently, regularly or occasionally
- 'Sofa surfing' with friends or family
- Squatting
- In bed and breakfast, hostel or other temporary accommodation including refuges, supported accommodation currently referred to in Reading as the Homelessness Pathway or any temporary night shelter

The Audit in Reading

Reading's Homeless Health Needs Audit was undertaken between 23 January and 24 February 2017. The project sub-group agreed to undertake the Audit during the second month that Reading's night shelter, established and co-ordinated by FAITH Christian Group, was open. This is because FAITH was a key partner in assisting with the completion of questionnaires and capturing views from those who were rough sleeping.

[8] Homeless Link (2014) *Homeless Health Needs Audit: Better planning to improve the health of people who are homeless in your area*, London, Homeless Link.

Sample size and representation

A sample size minimum of 50 - 75 participants is set by Homeless Link to ensure a valid comparable and substantial dataset. The project sub-group were aiming for at least 100 participants ensuring that respondents were representative in terms of age, gender, ethnicity, sexuality and type of accommodation currently occupied. It was recognised that different groups amongst those experiencing homelessness would likely have different needs and varying access to health services and how important it would be to capture these in the Audit. Reading's Audit exceeded expectations with 150 responses in total and respondents were representative across the groups detailed above.

The Audit Questionnaire

The Audit uses a standard set of questions developed by Homeless Link. Some questions were omitted where the sub-group considered them not to be as relevant to Reading as to the national picture and some additional questions/changes were made in conjunction with partners, including Public Health England, Reading West Berkshire CCG and homelessness and health sector partners. Questions asked covered basic demographic information, access to primary care, acute and support services along with wider questions on physical and mental health wellbeing.

It was a decision by the project sub-group to go through the full version of the questionnaire as a collective; discuss and agree which questions were necessary, which questions should be removed and what additional questions would be beneficial. The aim was to keep the questionnaire as short as possible.

A copy of the full version of the questionnaire was taken to NHS South Reading CCG's GP Management Executive meeting for advice on phrasing, questions being asked, suitability for complex respondents and to identify any possible gaps. The draft questionnaire was also considered by residents at Willow House and peer mentors at IRIS drug and alcohol support to gain feedback on preferred incentives; preferred approach for asking questions and any questions that needed clarifying to inform the staff and volunteer training.

Alterations suggested were to:

- Categorise respondent living circumstances by determining whether an individual is rough sleeping, in B&B, in supported (Pathway) accommodation etc.
- Establish the length of time a respondent had spent in their current living circumstances
- Include more in-depth questions regarding access to dental services
- Consider attitudes of health services staff towards respondents
- Reduce the length of the questionnaire to ensure there was a relative balance between a reasonable amount of time taken to complete it and maintain the respondent interest and capturing as much useful data as possible

From a Homeless Link standardisation position and striking a balance between excessive length and data capture, not all suggested amendments were made; however, as many as feasibly possible were incorporated.

All questionnaires were completed by trained staff and volunteers with respondents in a one-to-one setting on paper copies. Responses were to be inputted into an on-line survey tool provided by Homeless Link at a later date by RBC staff. It was agreed by the partnership group that the questionnaire should not be completed by participants independently, but with the assistance of staff or volunteers. Appendices from Homeless Link's Homeless Health Needs Audit Toolkit were used to ensure that the completion process was ethical and that respondents understood why the Audit was taking place; that the questionnaire data would be anonymous and how the local authority planned to use the anonymised data.

Homeless Link advised that it would take approximately 30 – 40 minutes to complete the full questionnaire, with core questions taking around 15 – 20 minutes. Completion of core questions was key to be able to compare data at local and national levels. The shortened, core question version of the questionnaire provided an option to capture the views of individuals who might find it difficult to engage, without them having to commit to the full questionnaire; thus giving us a broader and more representative sample when it comes to those with more complex needs. In reality, the full questionnaire took around 30 minutes to complete, although some were much shorter and other participants were particularly keen to express their feelings about their needs at length.

Questionnaires were completed in the following locations over a timetable of five weeks to ensure representation, equality of access and equal opportunities to respond:

- Alana House
- B&B placements
- BWA refuge premises
- CIRDIC Day Centre
- Elizabeth Fry Approved Premises
- FAITH Soup Run (St. Mary's Church)
- Homelessness Support (Pathways) supported accommodation across all stages
- Reading Churches Bed for the Night (various church locations)
- Reading YMCA
- St. Leonard's Approved Premises

A copy of the questionnaire can be found in Appendix 2.

Volunteer and staff training

Three two-hour training sessions were held by the RBC Homelessness Support (Pathways) Services Team for volunteers and supported accommodation services staff in the afternoons and evenings of 11th and 12th January 2017.

A total of 23 volunteers and Homelessness Support (Pathways) Services staff attended these sessions and were given a copy of the completion timetable and locations to sign up to. The plan was for each session to have a representative from RBC; coupled with a volunteer from Patient Voice, Healthwatch, Launchpad or IRIS. Completions by Bed for the Night volunteers, Launchpad and Ability staff were carried out without RBC present. It was compulsory for anyone completing questionnaires with participants to undertake the training session.

The project sub-group agreed that the training should include the following:

- Safeguarding - including how to identify and report any immediate concerns
- Boundaries
- Familiarisation with the Homeless Link Audit Toolkit and available resources
- Skills practice - including a sense of how it feels to be asked the Audit questions
- Signposting to other services
- An opportunity to discuss any concerns and any other useful resources

Support was provided for volunteers via:

- The Audit Toolkit with extensive explanatory notes and advice for questionnaire completers
- Training sessions for volunteers
- A resource sheet devised by the Homelessness Support (Pathways) Services team that detailed drop in times and contact details for all relevant support services in Reading. Participants were able to take this away.

- A tick sheet/script to prompt volunteers/staff to introduce the Audit and thank the participant for their time; cover confidentiality; check that the participant had not completed the Audit previously; explain, provide and document the incentive and signpost to support where required.
- Hard copies of the Reading Streetlife Guide aimed at single homeless individuals http://www.reading.gov.uk/media/5417/Street-guide/pdf/RBC_Street_Guide_2016_v5.pdf
- The Homelessness Support (Pathways) Services Team as a point of contact for advice at any time including the opportunity to reflect with and report back any concerns or worries having completed questionnaires with complex individuals.

Anonymity and incentivising the Audit

Nationwide Building Society donated funds to purchase five pound vouchers from a supermarket chain to incentivise participation. The project sub-group decided to keep track of vouchers issued and avoid duplication as much as possible, by asking volunteers and staff conducting the questionnaires to document the names, location and last four digits of the voucher barcode. These lists were returned to RBC to collate a list of completions and identify any duplication. Questionnaires were still anonymous as names could not be connected to the completed questionnaires. Duplication was minimised and was not significant enough to skew any findings.

Data Analysis

Homeless Link was initially able to provide access to Lime Survey for inputting data and the use of on-line analysis tools. However, Homeless Link undertook a server change midway through Reading inputting the questionnaire data. This meant that the Lime Survey tool and analysis was unavailable for a substantial amount of time. Whilst a workaround was found using Microsoft Excel, the issue with Lime Survey at Homeless Link was never resolved and therefore, the analysis was undertaken without the aid of Homeless Link's on-line analysis tools. This delayed and extended feedback and report writing timeframes.

Data comparison

In most instances, the data captured in Reading has been compared with a summary of 27 Homeless Health Needs Audits completed across England, which has an overall sample size of 3,355. Some information has had to be compressed due to small numbers and some data was not available for comparison.

Findings and data dissemination

The project sub-group agreed not to attempt coinciding with sector and service commissioning cycles, for example, for data to feed into the NHS's commissioning cycles the Audit would need to have been completed by January 2017. It was decided that January - February, whilst the night shelter was operational, would be the best time to carry out the Audit where data quality and opportunity for collation would take precedence.

Data will be fed into Reading's Joint Strategic Needs Assessment (JSNA) and a report and the Health and Well-being Partnership Board for the Board to determine whether to develop and monitor an Action Plan within this strategic group.

The project sub-group suggested that the report should also be disseminated to and discussed at the following groups and forums:

- Reading Carers Steering Group
- Older People's Partnership
- Access and Disabilities Steering Group
- Physical Disability and Sensory Needs Partnership

- Learning Disabilities Partnership Board
- Reading Voluntary Sector Wellbeing Forum
- Mental Health Well-being Strategy Group

Barriers to and limitations of the Audit data

As this was the first time the Homeless Health Needs Audit was undertaken in Reading, the tool and concept was new to partners and the following barriers and limitations were identified during the process of its use and analysis. These will be used to inform any future or similar projects. They will also be fed back to Homeless Link to contribute to the overall development of the Audit tool:

- The server change issue at Homeless Link, which has not been resolved to date, resulted in additional work to input, analyse and present the Audit data.
- There were notably more responses from those living in supported accommodation where (a) there was more opportunity to complete them as respondents had accommodation available to them; (b) there was more resource available from supported housing providers to complete questionnaires and (c) the Homelessness Support (Pathways) Services team who commission supported accommodation services were leading on the Audit and therefore partner interest was weighted towards the support sector.
- There was some duplication of results as returns were anonymous. However, this was minimised by asking respondents to sign to say they had not completed the survey previously and ensuring that interviewers were kept informed about those who had already responded. Whilst mitigated as far as possible, this method was not infallible so duplication was inevitable where an incentive was offered. Offering an incentive did result in some individuals providing false names or disingenuous answers so that the voucher could be obtained. This was not significant enough to discount the sample data.
- Responses could vary depending on the skill and experience of those completing questionnaires with respondents. Although this was mitigated as far as possible through training sessions with all staff and volunteers, not all volunteers and staff were used to working within the homelessness sector and/or undertaking primary research with members of the public.
- By using Homeless Link's Audit tool the breadth of research was limited to single people only. Several partners expressed how beneficial it would be to undertake a similar piece of work with homeless families and households with dependents.
- Within Stage 1 supported accommodation environments, where individuals were more complex and likely to have recently come from rough sleeping or custodial environments, the Audit was undertaken by RBC staff and partner volunteers. Within Stage 2 supported accommodation environments where individuals were likely to have been further along their journey of independence the Audit was completed by key working staff and support workers known to respondents. There was some debate within the project sub-group about whether people would be more honest in their responses with unknown staff and volunteers, or with known support workers. The sub-group's conclusion was that it would be entirely respondent dependent and that this could not be mitigated. Anecdotal feedback from staff and volunteers is that most people appeared to be genuine about their needs.
- Some concerns were raised by the project sub-group about people spending their incentive vouchers on alcohol if they were donated by a supermarket. With the amount being five pounds the project sub-group felt that if residents and service users are to take part, there should be no restriction on how or what they spend their incentive upon.
- There was some duplication of resources by completing the questionnaire on paper and then inputting this online. It would have been more efficient use of time to

input the questionnaires directly online. However, mobile internet connections can be unreliable and using a laptop or screen can be impersonal and create an unnecessary physical barrier between interviewer and respondent.

- There was some suggestion from the sub-group that respondents, where possible, might like to complete the questionnaire themselves and that answers given might be more honest. However, the Audit questionnaire has not been developed by Homeless Link in a Plain English way and it might not be very 'readable' or as 'user friendly' without training and toolkit guidance. It was also important to have all core questions answered to ensure that responses were valid and comparable. Having a trained volunteer or staff member ensured this.
- The *Information for Respondents* sheet from the Audit toolkit was translated into written Polish by Reading Borough Council. However, if the respondent's understanding of English was too limited to understand the Audit questions, they would not be able to partake in the Audit. However, anecdotal feedback from interviewers was that no-one was prevented from completing a questionnaire on the basis of language being a barrier. Homeless Link was not able to provide the questionnaire in other languages.
- Gathering quantitative data through the Audit has unearthed more questions and scope for further research. Partners have requested further clarification on some of the data that unfortunately this 2017 Audit cannot provide.

Who took part in Reading's Homeless Health Needs Audit?

Gender

	Reading	England
Male:	69%	71%
Female:	30%	29%
Not known:	1%	-

Sexuality

	Reading	England
Heterosexual:	88%	93%
Gay/lesbian:	<3%	4%
Bisexual:	6%	3%
Not known:	3-5%	1%

Age

	Reading	England
Under 18:	0%	4%
18 to 25:	18%	28%
26 to 35:	31%	22%
36 to 45:	27%	23%
46 to 55:	19%	16%
56 to 65:	3-5%	6%
66 and over:	3%	2%

Migration and Ethnicity

	Reading	England
UK resident:	95%	93%
White ethnic group:	81%	89%

Physical Health problems

78% of participants in both Reading and England reported physical health problems

53% of participants in Reading had long-term physical health problems, compared to 44%in England

Current sleeping situation

	Reading	England
Hostel or supported accommodation:	69%	69%
Emergency or temporary accommodation:	12%	6%
Sofa surfing or squatting:	7%	9%
Rough sleeping:	11%	9%
Other:	<3%	1%

Mental Health problems

81% of participants in Reading reported mental health problems, compared to 86% in England

Analysis of who took part in Reading's Homeless Health Needs Audit

The demography of the Audit has been compared to the Homeless Health Needs Audit data collated from 27 other English local authority Audit partnerships with an overall sample size of 3,355; census data and information known about single homeless populations.

Gender

Reading's Audit data is consistent with others across England. In Reading between a third and a quarter of individuals accessing supported accommodation and known to be sleeping rough are female. This data is consistent with and representative of what is known about single homeless individuals in Reading.

Sexuality

A report by Homeless Link[9] identified that those who identify as LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Queer and +)[10] are disproportionately more likely to be homeless or insecurely housed than their non-LGBTQ+ peers and are at higher risk of substance use and mental health issues due to discrimination, lack of acceptance and abuse. Additionally they may face multiple discrimination and they may present with specific needs if they are at risk of being homeless. Statistics show that 1.7% of the UK population identifies as lesbian, gay or bisexual. For younger adults aged 16 - 24 this rises to 3.3%. Young people identifying as LGBTQ+ are more likely to find themselves homeless than their non LGBTQ+ peers, comprising 24% of the youth homelessness population with approximately 4% of individuals using services for people experiencing homelessness identifying as being lesbian, gay, bisexual or transgender.

Reading's Audit data seems to be over-representative of those who were lesbian, gay or bisexual respondents at just under 9% of the sample, when compared to Audit data across England and the UK population. However, as identified from the data published by Homeless Link those accessing homelessness services and members of the youth homeless population are more likely to identify as LGBTQ+ so Reading's data is congruent with this.

The 'not known' figure of 3 - 5% for Reading could be attributed to interviewers unfamiliar with primary research and working with this particular cohort not feeling comfortable asking this question.

Age

Data from Reading's Audit is consistent with the overall English picture in that approximately 50% of respondents are under the age of 35; approximately 45% being aged 36 - 65 and a marginal percentage over the age of 66.

The Local Housing Authority and Children's Social Care departments have duties under the Housing Act 1996 and the Children's Act 1989 to ensure that no-one aged 16 or 17 are sleeping rough. In Reading this is enabled by a joint working protocol between the two agencies. Although the Audit in Reading specified those aged 18 or over, this was with a

---

[9] Homeless Link (2017) *Supporting LGBTQ+ people in homelessness services: An introduction for frontline staff*, London, Homeless Link.

[10] Queer has historically been used as a slur, however the word has now been reclaimed by the community to take away its power as an insult. However, this term should only be used by those who identify as queer. "Q" can also refer to questioning however, and is indicative of the fact that definitions and terminology are fluid and can change. + is anyone who may not feel they quite fit into any of the aforementioned definitions e.g. asexual or intersex people (Taken from Homeless Link (2017)).

view that no 16 or 17 year old should be included in the Audit where duties should be met by statutory authorities.

Migration and ethnicity

Information taken from Reading's Joint Strategic Needs Assessment (JSNA)[11] states that census data from 2011 shows 75% of Reading's population is from a White ethnic group, compared to 86% in England overall. Therefore the difference in data of 81% for Reading's Audit and 89% across English Audits is still proportionate to census data from 2011. Recent data returns from local authorities have shown an increase in black and ethnic groups presenting as homeless and this has been reflected in the Audit data.

Current sleeping situation

As stated under *Barriers to and limitations of the Audit data* section of this report, for Reading's Audit there were notably more responses from those living in supported accommodation where (a) there was more opportunity to complete them as respondents had accommodation available to them; (b) there was more resource available from supported housing providers to complete questionnaires and (c) the Homelessness Pathway team who commission supported accommodation services were leading on the Audit and therefore partner interest was weighted towards the support sector. This is consistent with how other boroughs and areas have conducted their Audit - however, by conducting the Audit at the same time as the night shelter was operational Reading was able to get more representation from those rough sleeping who were within this temporary provision.

Primary reasons for homelessness

The following primary reasons for homelessness were given by respondents, attributing to 45% overall:

1. Parents or care givers no longer able or willing to accommodate (23)
2. Homeless upon leaving custody (20)
3. Non-violent relationship breakdown with partner (13)
4. Unemployment (12)

Homelessness upon leaving custody and health needs is explored further under the section *Prevention Opportunities - Immunisations, sexual health screening and those leaving custody*.

[11] Reading Borough Council (2017) *Joint Strategic Needs Assessment - Migration*. Accessed at: http://www.reading.gov.uk/jsna/migration on 5 September 2017.

Initial anecdotal themes from the Audit project sub-group staff and volunteers

The months immediately after completion of the Audit in Reading, prior to any initial analysis of data, project sub-group members involved in completing questionnaires with respondents collated some intuitive and anecdotal thoughts on the responses received. Interestingly, these have since been supported by the data collated. The project sub-group felt it was important to share these initial thoughts within this report and these are detailed as follows:

Homelessness

- People surveyed felt strongly that their homelessness played a big part in their poor physical and mental well-being where they felt that a settled and permanent home would improve both.

Access to healthcare services

- Interviewers felt that, having explored this with respondents, there were fewer issues for respondents in accessing primary care services than anticipated.
- Many respondents stated they have dental problems, but were not accessing dental services.
- Most respondents were having regular sexual health checks and there was a general confidence and knowledge amongst respondents about where to access free contraception and advice about sexual health concerns.
- Several respondents highlighted waiting times to access mental health services and their GP as a problem for them.
- There were several positive statements about IRIS drug and alcohol support services and key workers within supported housing services.

Smoking, drug and alcohol use

- Most respondents were smokers, tending to use rolling tobacco as this is cheaper and often smoking without the use of filters.
- Hardly any respondents stated that they were using New Psychoactive Substances (formerly known as legal highs) where Class A drug use and/or alcohol misuse were most prevalent.
- The Homelessness Support (Pathways) Services team particularly felt that not as many people respondents stated that they were IV drug users as expected, although several heroin and crack users were identified. This may be because the question about IV use was not well placed within the design of the questionnaire.
- There were several respondents using drugs who have a mental health need (dual diagnosis) who were not accessing mental health services.
- That the main method of support for mental health and substance misuse (dual diagnosis) was medication with there being fewer uptakes of counselling, alternative therapies or peer support programmes.
- Younger respondents were tending to use cannabis and not identifying this as a 'drug problem'.

Mental health

- It seemed, as interviewers, that more respondents expressed concerns about their mental health, than concerns about their physical health - even where it appeared that respondents had several physical and mental health issues. Interviewers observed that people seemed to feel less in control of and that they had fewer options or solutions around their mental health.

Data findings and analysis

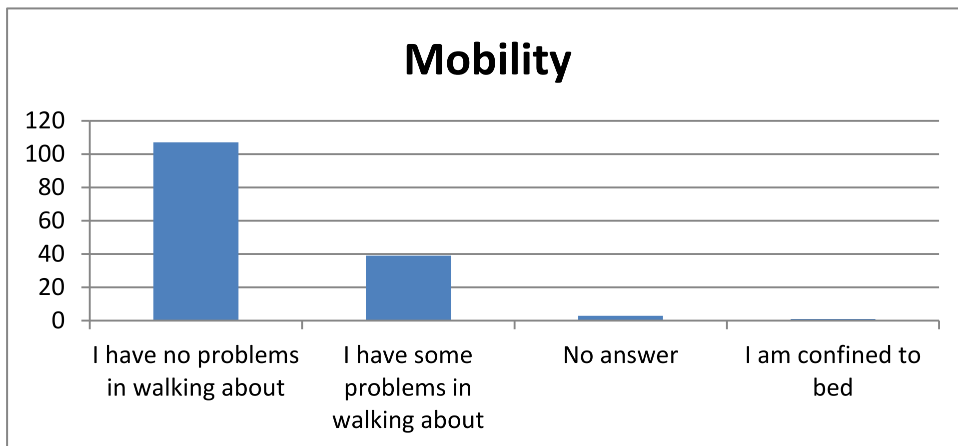
The following section provides a pictorial summary, an analysis of the Audit's main findings and some key messages from respondents, as follows:

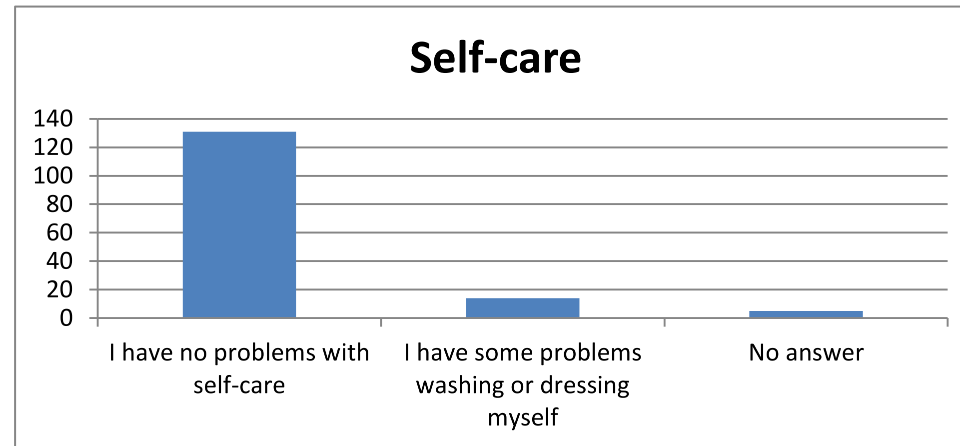
- **Statements about health**
- **Physical health**
- **Mental health**
- **Smoking, drug and alcohol use**
- **Access to health services** - including primary and secondary care service use and accessing support and treatment
- **Focus on rough sleepers' health needs -** including access to primary and secondary healthcare services
- **Prevention opportunities** - Immunisations, sexual health screening and those leaving custody

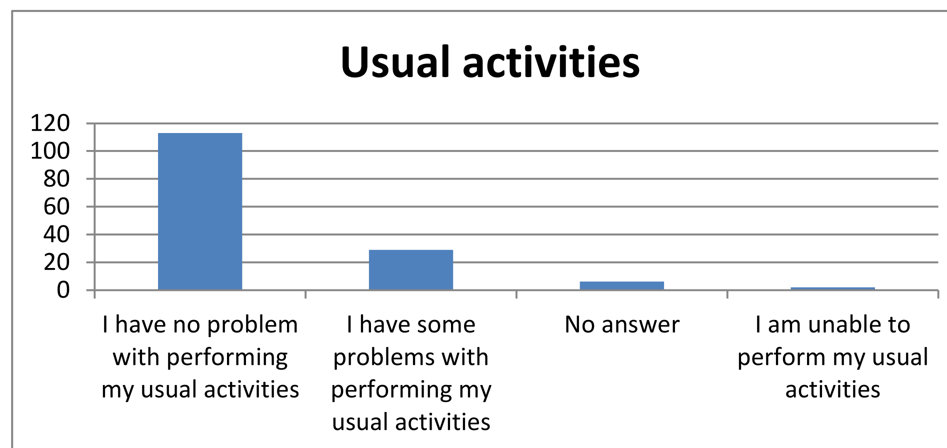
Statements about health

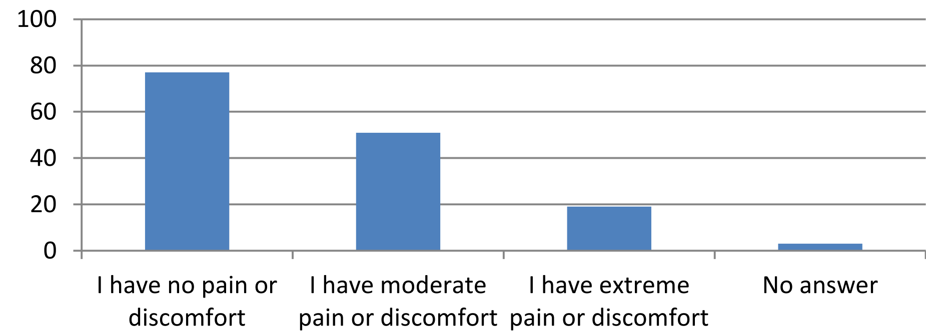
As part of the Audit, respondents were asked to rate how they felt, day-to-day about their mobility, self-care, undertaking 'usual' activities, pain/discomfort and anxiety/depression on a scale of 'not a problem' up to being an 'extreme problem'.

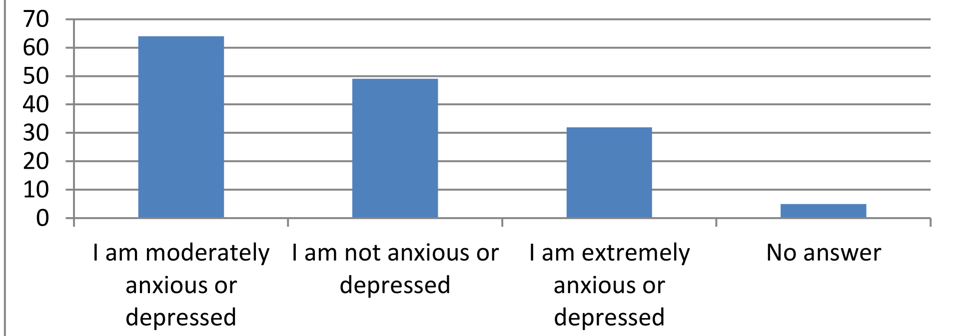
These broad findings are detailed below and support the initial thoughts of the project sub-group that respondents had particular concerns about managing their mental health needs where a majority felt moderately or extremely anxious and/or depressed on a day-to-day basis.








Pain/Discomfort
100
80
60
40
20
0
I have no pain or discomfort
I have moderate pain or discomfort
I have extreme pain or discomfort
No answer

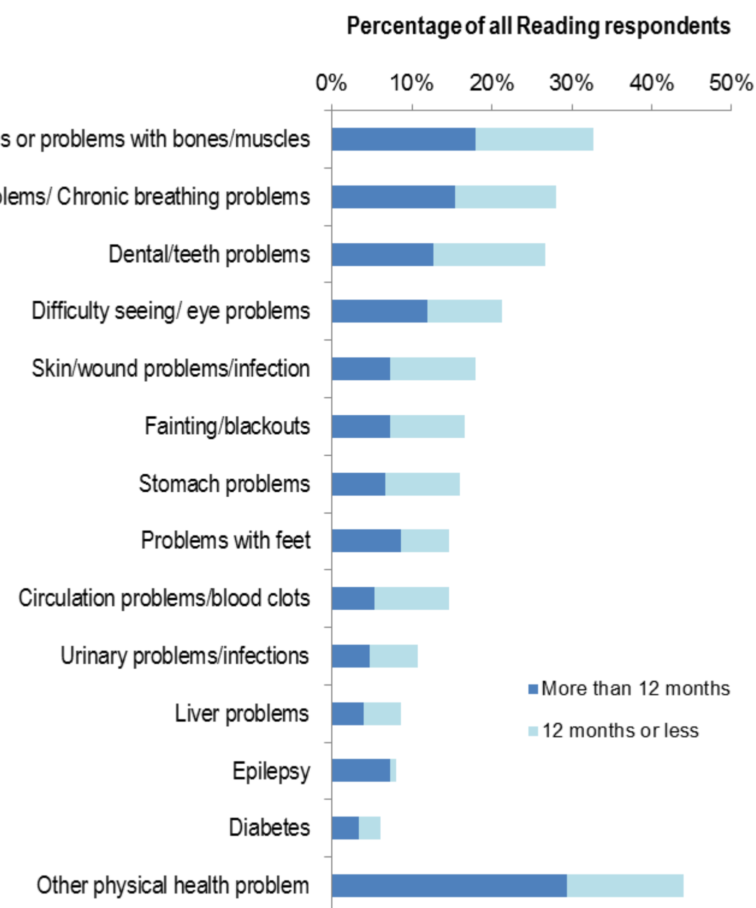

Anxiety/Depression
70
60
50
40
30
20
10
0
I am moderately anxious or depressed
I am not anxious or depressed
I am extremely anxious or depressed
No answer

Physical health: Summary

78% of respondents in Reading reported a physical health problem, which was congruent with other Homeless Health Needs Audits in England.

53% of respondents in Reading reported a long term physical health problem (on-going for 12+ months), compared to 44% in the other England Health Needs Audits.

Summary for Reading respondents	Physical Health Problems	Long-term Physical Health Problems
Gender		
Male:	79%	57%
Female:	76%	44%
Age		
18 to 25	70%	56%
26 to 35:	72%	43%
36 to 45:	83%	50%
46 to 55:	83%	59%
56 to 65:	100%	100%
66 and over:	100%	100%
Currently sleeping		
Hostel or supported acc:	70%	60%
Emergency or temporary acc:	72%	47%
Sofa surfing/squatting:	83%	55%
Rough sleeping:	83%	28%
Own home:	100%	60%
Other:	100%	-



Physical health: Analysis of findings

Long-term physical health problems

Nearly 10% more respondents in Reading reported long term physical health problems (on-going for 12+ months) than other Audit respondents across England.

This could be attributed to a number of factors, including that Reading's homeless population:

- Have poorer physical health generally due to their living situations
- Have better access to primary healthcare services to enable diagnosis
- Reported symptoms rather than diagnosis when answering this Audit question

Top three identified physical health diagnoses

An analysis of the top three recent and longer-term physical health diagnoses identified by homeless people in Reading corresponded exactly with the national picture for single homeless people Audited in England. These were:

(1) Joint aches or problems with bones/muscles
(2) Heart problems or chronic breathing problems
(3) Dental/teeth problems

Gender and physical health

Male respondents reported higher levels of physical health problems and longer term physical health problems than females with female respondents in Reading reporting long-term physical health problems in line with the national Audit representation.

In Reading and nationally, single homelessness tends to be divided into between a quarter to one third being female and three quarters to two thirds being male[12]. Single homelessness and rough sleeping is dominated by men. In Reading and in line with good practice responses to rough sleeping, female rough sleepers are viewed as acutely vulnerable when rough sleeping and therefore, are often prioritised for vacancies within supported accommodation. This may account for why females contributed to fewer of the 'top three' long term conditions associated with homelessness.

Age and physical health

There is clear correlation between a respondent's age and an increase in reports of recent and longer term physical health problems reported by respondents.

Current sleeping situation and physical health

Those accommodated in supported accommodation or sofa surfing reported higher levels of long term physical health needs than those rough sleeping or in emergency or temporary accommodation (night shelters, approved premises, refuges or B&B); however the opposite was true of physical health problems overall.

It would be anticipated that those rough sleeping or in very temporary/less secure accommodation would report having more physical health needs, but perhaps with less diagnoses. Those accessing supported accommodation or sofa surfing may be more likely to engage with primary healthcare services and support services generally in addressing physical health needs, where continued and regular engagement with primary healthcare services could mean a more forthcoming diagnosis.

[12] Homeless Link (2017) *Supporting women who are homeless: Briefing for homelessness services*, London, Homeless Link.

Dental problems

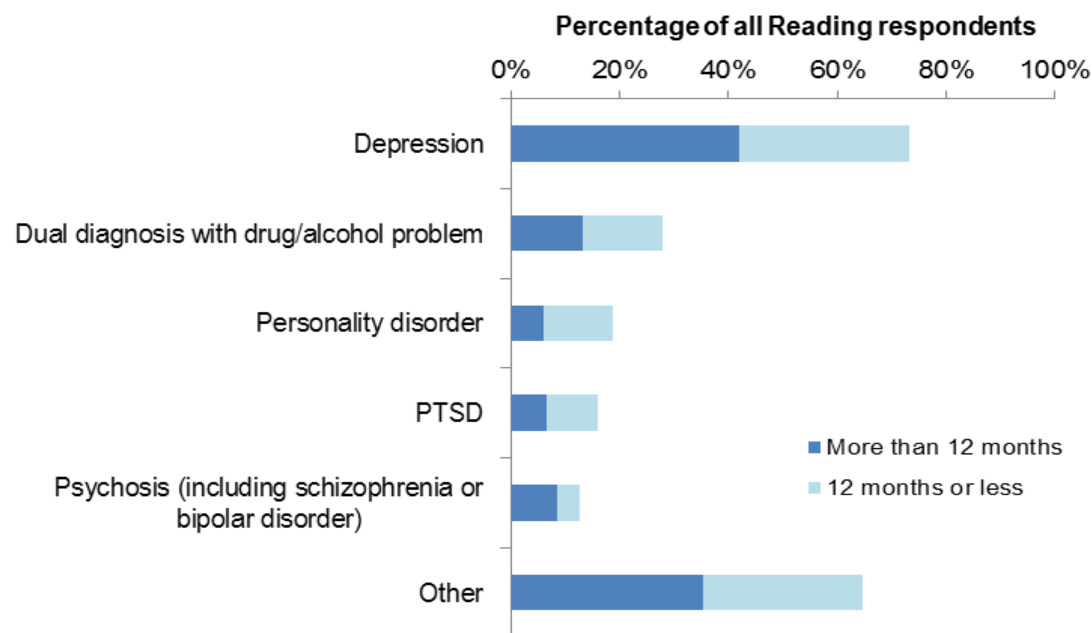
A third of respondents, 49 out of 150, stated that they had problems with their teeth or mouth. Only 14 of those reporting problems stated that they were receiving treatment for these problems. Those accessing treatment were primarily receiving it from dental surgeries.

Mental health: Summary

81% of respondents in Reading reported a mental health problem, compared to 86% across Homeless Health Needs Audits in England.

55% of Reading respondents felt that they had or were using alcohol or drugs to cope with mental health problems.

Summary for Reading respondents	Mental Health Problems
Gender	
Male:	79%
Female:	87%
Age	
18 to 25	89%
26 to 35:	78%
36 to 45:	83%
46 to 55:	76%
56 to 65:	100%
66 and over:	67%
Currently sleeping	
Hostel or supported acc:	85%
Emergency or temporary acc:	72%
Sofa surfing/squatting:	82%
Rough sleeping:	71%
Own home:	80%
Other:	67%



Mental Health: Analysis of findings

In line with feedback from other Homeless Health Needs Audits in England, single homeless respondents in Reading reporting a mental health problem exceeded 80%, with females and those aged 18 - 25 identifying themselves as having the highest levels of mental health problems.

Overwhelmingly Reading respondents reported a diagnosis of anxiety (88 out of 150) and/or depression (110 out of 150) as their main mental health problem. 44 respondents advised that they had a dual diagnosis with a drug and/or alcohol problem.

28 out of 150 advised that they had been diagnosed with Personality Disorder; 24 with Post Traumatic Stress Disorder (PTSD) and 19 with psychosis. Other identified mental health problems, with no significant trends were Obsessive Compulsive Disorder (OCD), agoraphobia and Sensory Integration Disorder (SID).

There seemed to be no significance in the levels of mental health problems within different housing situations, with those accommodated within supported housing having the highest diagnosis rate.

Women and mental health
Female respondents identified with a much higher level of mental health problems than male respondents. This is congruent with research from St. Mungo's[13] and Homeless Link around the exceptional and gender specific trauma and feelings of stigmatisation that homeless women can associate with.

[13] St. Mungo's (2014) *Rebuilding Shattered Lives: The Final Report*, London, St. Mungo's.

Mental health refused to see me as they said an assessment would have to take place within my accommodation, but I was homeless!

Assessments on the phone do not work as they are not face to face.

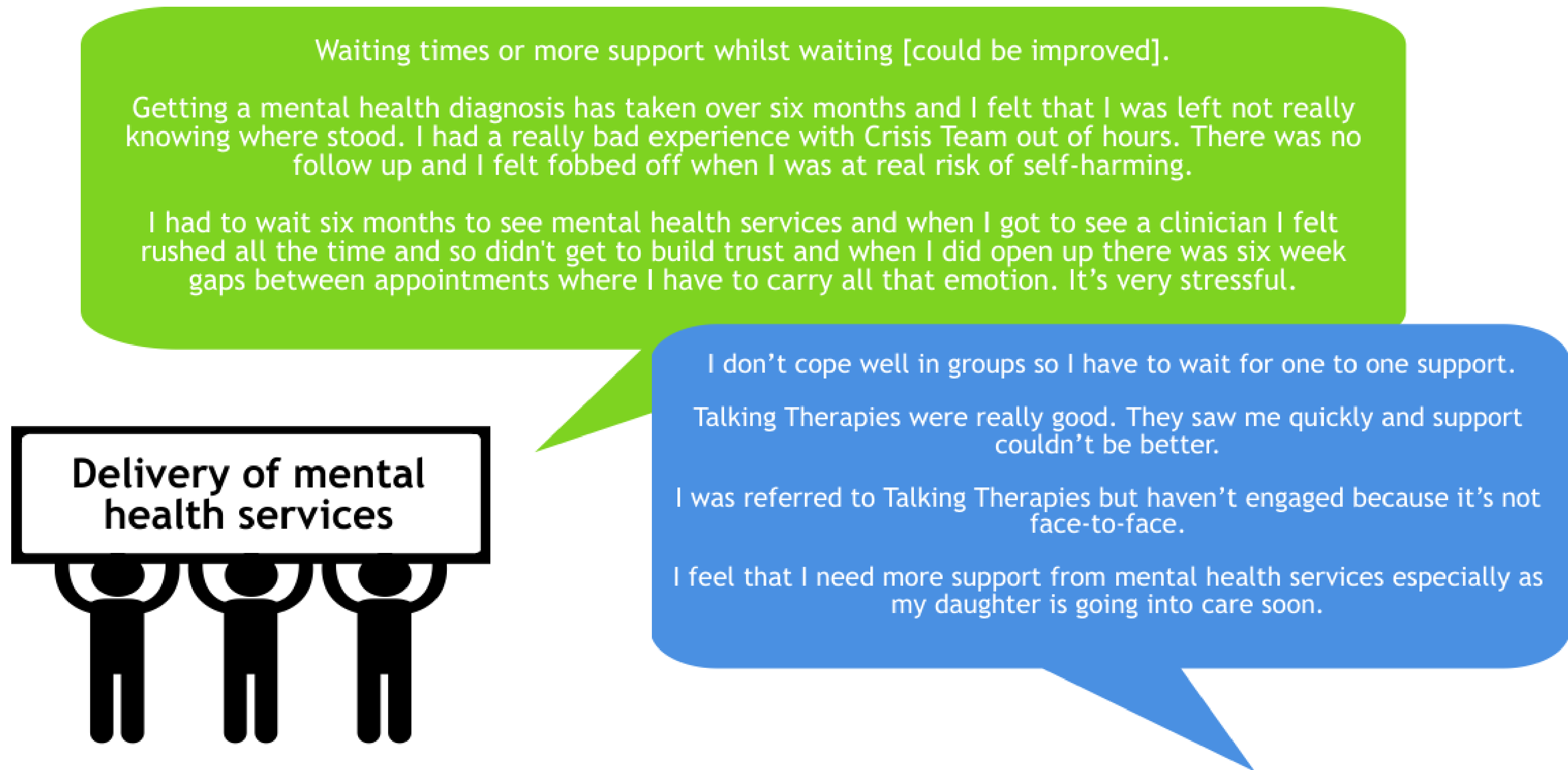
It's hard to access mental health services. You have to understand how to apply; where to go and how to get it.
You have to be "un-mad to be mad" if that makes sense?!

Mental health services are too quick to block services when they discover the patient uses drugs.

Staff can be dismissive or be too quick to say it's your drug/alcohol problem.

Key messages from respondents: Delivery of mental health services

- Within the section that asked *"What could be improved within health care services in Reading?"* over a third of 80 individuals who responded to this question contributed that they had experienced difficulties in accessing mental health services and this had made them doubt the effectiveness of how mental health services are delivered.
- Some respondents advised that their experience of accessing services had been difficult in terms of navigating the system and having to explain their feelings on the telephone rather than face-to-face.
- Some respondents outlined their personal barriers in accessing services were that as a homeless person they had no accommodation to be assessed in at point of referral and a feeling that their substance misuse was preventing them from receiving support with their mental health.



Key messages from respondents: Delivery of mental health services

- Nearly a quarter of those that responded to the question *"What could be improved within health care services in Reading?"* advised that they felt waiting times to access services are long; that times between appointments feel uncertain and appointments and contact with the Crisis Team can feel rushed.
- There was some positive feedback about experiences of Talking Therapies. A third of respondents who answered the same question about what could be improved felt that they needed regular face to face/one to one support and specialist trauma services for their mental health support to be most effective for them.
- Respondents clearly linked poor mental health to their housing situation and being homeless.

Smoking, alcohol and drug use: Summary

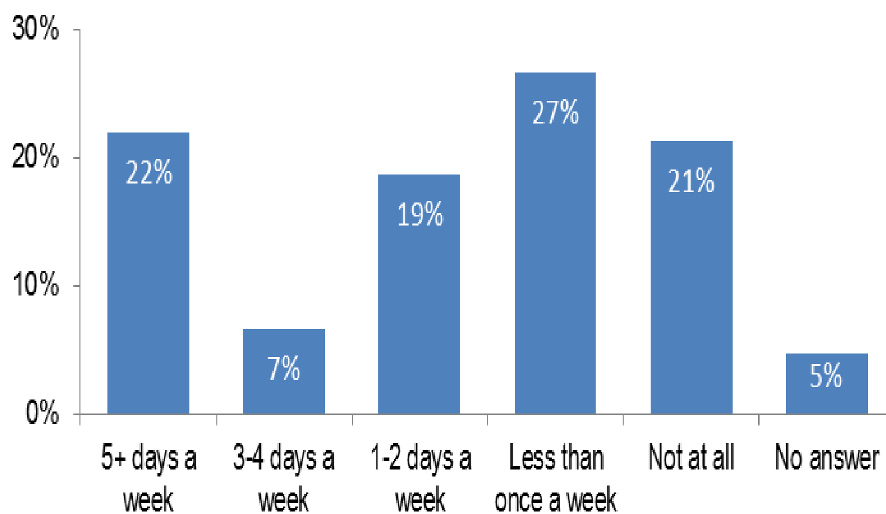
Current smoker
Reading: 84%
England: 78%

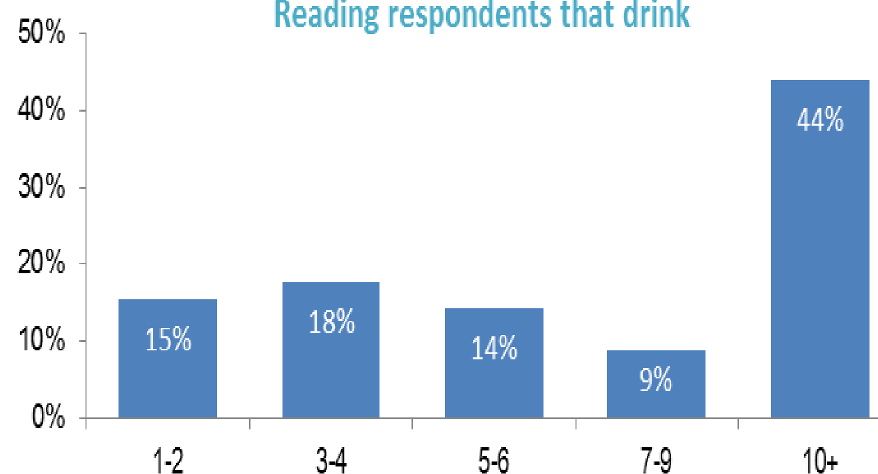
Alcohol problem
Reading: 30%
England: 27%

Drug problem or in recovery
Reading: 43%
England: 41%

22% of respondents in Reading reported that they drink alcohol five or more days a week.

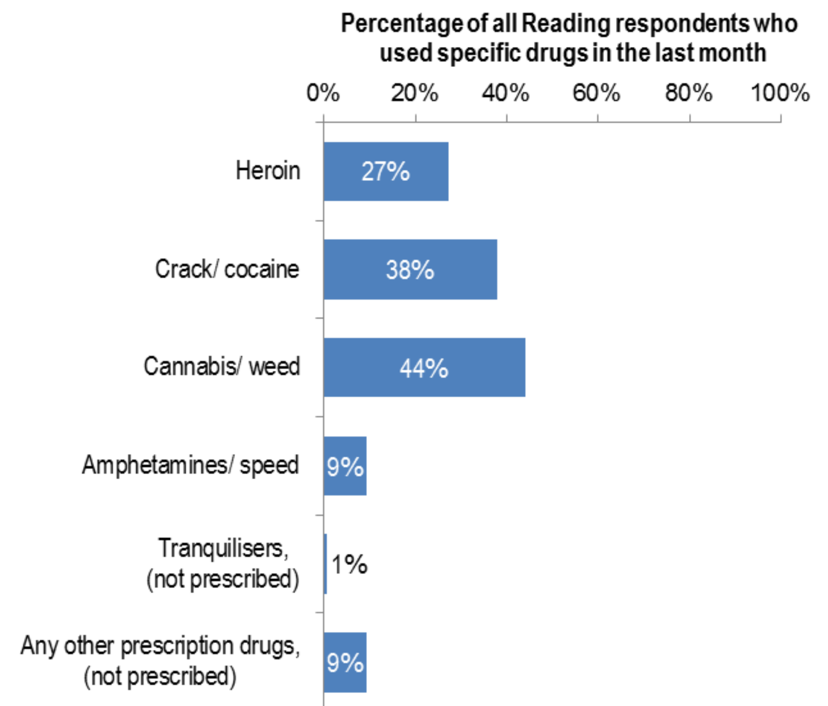
44% of those drinking alcohol in Reading consumed 10 or more units on a typical drinking day.





Summary for Reading respondents	Currently smokes	Alcohol problem	Drug problem or in recovery*
Gender			
Male:	85%	34%	50%
Female:	82%	20%	24%
Age			
18 to 25	85%	7%	15%
26 to 35:	83%	41%	54%
36 to 45:	95%	28%	63%
46 to 55:	83%	34%	34%
56 to 65:	60%	40%	0%
66 and over:	33%	33%	0%
Currently sleeping			
Hostel or supported acc:	83%	33%	43%
Emergency or temporary acc:	89%	17%	56%
Sofa surfing/squatting:	82%	27%	36%
Rough sleeping:	82%	35%	29%
Own home:	80%	20%	40%
Other:	100%	33%	67%

* an additional 14% of respondents stated that they used drugs, but did not report a 'drug problem'



23% of Reading respondents take Methadone, Subutex or other substitute drugs.

12% of these are not prescribed for the person taking them.

Smoking, drug and alcohol use: Analysis of findings

Smoking

126 out of 150 identified as smoking cigarettes, e-cigarettes, cigars or a pipe. Anecdotally, most were smoking rolling tobacco without filters as the cheapest way to fund this.

Data from 2015 published by the Office of National Statistics (ONS)[14] showed that of all adults in the UK, 17.2% smoked. Smoking is identified by the World Health Organisation (WHO) as the biggest health inequality and local data shows that the prevalence among the single homeless population in Reading is high at 84%, even when compared to other Homeless Health Needs Audits in England where 78% of respondents were smokers.

Reading's Audit data shows that there is little differentiation between the number of men and women smoking amongst Reading's homeless population. It is prevalent across genders.

Alcohol misuse

Alcohol Concern UK[15] states that there are an estimated 595,000 dependent drinkers (0.9% of the UK population), where only 17% are currently accessing treatment. Alcohol misuse is the biggest risk factor for death, ill-health and disability among 15-49 year-olds in the UK, and the fifth biggest risk factor across all ages. 7% of adults in England regularly drink over the Chief Medical Officer's low-risk guidelines and 2.5 million people report drinking over 14 units on their heaviest drinking days.

Comparing this to the homeless population generally, and to Reading's homeless population specifically, it is clear that alcohol misuse and binge drinking are prevalent among single homeless people. 29% could be determined as dependent drinkers (compared to 0.9% UK estimates) and 44% who could be considered to exceed Chief Medical Officer's low-risk guidelines (compared to 7% UK estimates).

Reading Borough Council's *Drug and alcohol misuse needs assessment* [16] from 2016 identifies that 30,000 Reading residents are drinking to hazardous levels and 4,500 are drinking to harmful levels. Reading has high rates of alcohol-specific mortality and mortality from chronic liver disease in both men and women.

Homeless Health Needs Audit data for Reading shows that alcohol misuse is more prevalent amongst: homeless men than women; amongst those aged 26 and over and those who are rough sleeping.

---

[14] Office of National Statistics (ONS) (2015) *Adult smoking habits in the UK: 2015*, London, ONS.

[15] Alcohol Concern (2017) *Alcohol Statistics* at https://www.alcoholconcern.org.uk/alcohol-statistics, accessed on 6 September 2017.

[16] Reading Borough Council (2016) *Drug and alcohol misuse needs assessment* at http://www.reading.gov.uk/media/4501/Item-15-Appendix/pdf/Item_15_Appendix.pdf, accessed on 6 September 2017.

Drug misuse

According to a report by the Home Office[17] in 2015/16 3% of adults aged 16 - 59 had taken Class A drugs in the last year, the equivalent of just under 1 million people.

3.3% of people across England and Wales identified as being a frequent drug user, with young adults aged 16 - 24 more likely to frequently use drugs than the wider age group. Cannabis was the drug most commonly used across England, with 37% of cannabis users being classed as frequent users. The Home Office's report highlighted a decrease in the use of ecstasy and powder cocaine and low prevalence of New Psychoactive Substances (NPS) with 0.7% of adults aged 16 - 59 having used NPSs in the last 12 months.

Key findings from the Home Office report showed that young people are more likely to take drugs than older people; men are more likely to take drugs than women and people living in urban areas reported higher levels of drug use than those living in rural areas.

The data from Reading's Audit shows that drug misuse within Reading's homeless cohort is predominantly affecting those aged 26 - 45 which differs from national findings for the whole population of England and Wales. However, where Class A intravenous drug use is more prevalent amongst those who are homeless and heroin and crack cocaine are more addictive, leading to longer term use, the age range for Class A drug misuse is representative.

Data from Reading's 2016 Joint Strategic Needs Assessment (JSNA) shows that Reading has a higher rate of opiate and/or crack cocaine users per 1,000 of the population at 11.7% compared to the rest of England and Wales at 8.4%. The rate of injecting drugs in Reading is twice as high as the England average at 4.98%. This is has been reflected in the Homeless Health Needs Audit data.

Reading's Audit showed that cannabis use was most prevalent amongst those aged 18 - 25; that men were more likely to be misusing drugs than women and that the use of NPSs was minimal which is synonymous with the Home Office findings from 2015/16. Reading's Audit findings showed that the group most likely to have a drug problem or be recovering from a drug problem are those in temporary accommodation or supported accommodation, rather than those who are sofa surfing or rough sleeping. However, as stated in the section of the report titled *Barriers to and limitations of the Audit* the Audit sample does over-represent those living in supported accommodation, rather than individuals who are sofa surfing or sleeping rough. Those who rough sleep and sofa surf have more chaotic and complex lives and are harder to reach. Therefore, communicating about the availability of the Audit and then arranging to complete questionnaires with these individuals proves to be more difficult. For this Audit, less people who were sofa surfing and rough sleeping were represented in the Audit sample. Information from Reading's Street Outreach Team suggests that Class A drug use amongst those who are rough sleeping is prevalent. Often those who are rough sleeping will not disclose details regarding drug and alcohol use until they are within accommodation where they have a built up a trusted relationship with a support professional.

Drug and alcohol use and mental health

82 out of 150 respondents (55%) identified with using drugs and/or alcohol as a means to cope with mental health or trauma.

[17] Home Office (2016) *Drug Misuse: Findings from the 2015/16 Crime Survey for England and Wales, second edition*

Access to health services: Summary

Primary healthcare registration and service use

Registered with GP

Reading: 86%
England: 92%

Registered with dentist

Reading: 49%
England: 58%

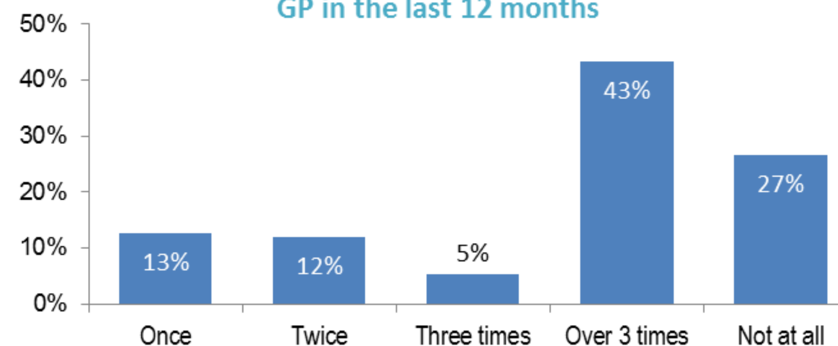
Refused registration to GP or dentist in last 12 months

Reading: 9% **England:** 18%

Summary for Reading respondents	Registered with GP or homeless health care	Registered with dentist	Refused registration
Gender			
Male:	82%	40%	9%
Female:	96%	69%	11%
Age			
18 to 25	89%	59%	19%
26 to 35:	83%	41%	4%
36 to 45:	88%	43%	13%
46 to 55:	86%	66%	7%
56 to 65:	80%	20%	0%
66 and over:	100%	67%	0%
Currently sleeping			
Hostel or supported acc:	91%	56%	8%
Emergency or temporary acc:	50%	33%	0%
Sofa surfing/squatting:	91%	55%	18%
Rough sleeping:	88%	29%	18%
Own home:	100%	40%	20%
Other:	100%	33%	0%

73% of Reading respondents had visited a GP in the last 12 months.

43% had seen a GP over 3 times in the last 12 months.



Secondary healthcare service use

In the last 12 months:

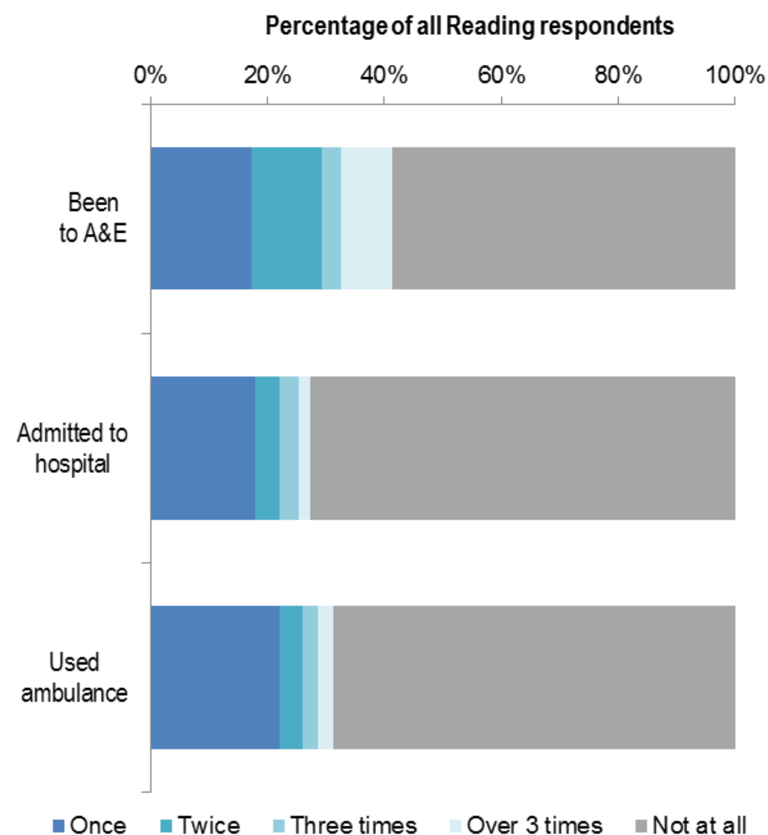
Been to A&E
Reading: 41%

Been admitted to hospital
Reading: 27%

Used an ambulance
Reading: 31%

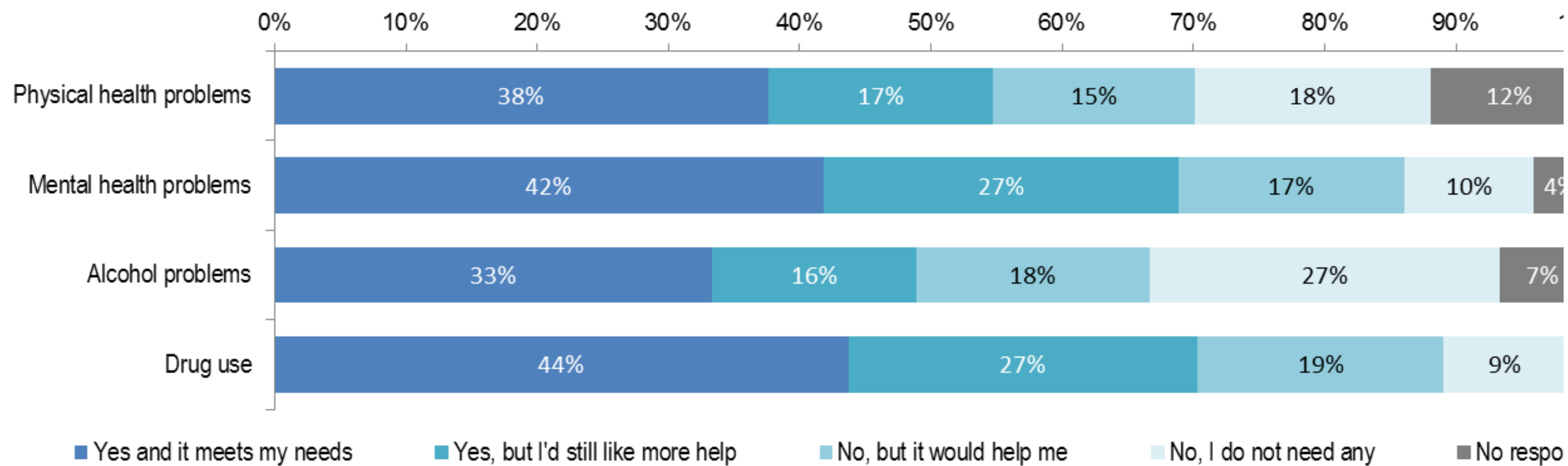
Summary for Reading respondents	Been to A&E	Been admitted to hospital	Used an ambulance
Gender			
Male:	38%	28%	26%
Female:	47%	27%	42%
Age			
18 to 25	63%	30%	41%
26 to 35:	39%	20%	30%
36 to 45:	25%	33%	25%
46 to 55:	41%	31%	31%
56 to 65:	60%	20%	20%
66 and over:	67%	33%	67%
Currently sleeping			
Hostel or supported acc:	46%	29%	30%
Emergency or temporary acc:	22%	11%	17%
Sofa surfing/squatting:	45%	27%	36%
Rough sleeping:	18%	29%	29%
Own home:	80%	20%	80%
Other:	67%	67%	67%

Number of times Reading respondents have used health services in the last 12 months



Support and treatment

96% of respondents in Reading identified that they had a physical health, mental health, alcohol or drug problem. These respondents were asked if they received support or treatment to help with these problems and whether this met their needs.



Access to health services: Analysis of findings

Primary healthcare registration and service use

Reading's Audit has shown a slightly lower figure for GP registrations than other Audits in England at 86% and just under half of respondents were registered with a dentist, although Public Health England advised that people have not been required to be registered with a dentist since 2006.

Registrations with GPs amongst the Audit population may be lower due to the Walk-in Centre facility in the borough as detailed under the *Homelessness and healthcare provision in Reading* section. Qualitative feedback from respondents shows that the Walk-in Centre is clearly valued and frequently used by this particular population in Reading. Anecdotal information from Reading's Street Outreach Team is that it is easier to facilitate their clients in attending the Walk-in Centre on an ad-hoc basis than facilitating clients to a planned future appointment with a registered GP.

Women respondents were more likely to be registered and accessing GP and dental health services than men.

73% of Reading respondents had visited a GP in the last 12 months and 43% had engaged with a GP more than three times. 9% of respondents stated that they had been refused registration to primary healthcare services in the last 12 months; half the statistic of the experiences of homeless people Audited across England. Again, these statistics can likely be attributed to Reading's Walk-in Centre facility and/or the number of respondents who were living in supported accommodation where access to primary healthcare is an essential part of commissioned support planning.

There was clear correlation between fewer respondents living in commissioned supported accommodation services being refused access to services. This is possibly due to having an allocated and accessible advocate/key worker who is able to navigate systems where those sleeping rough or sofa surfing/squatting may be less likely to have this level of support due to having a more chaotic and less engaged lifestyle.

Audit reports from other counties across England, show that some GP practices are reluctant to register people who they consider to be transient. Additionally, homeless people will often present with a complex picture of comorbidity and social issues (physical issues, mental health issues and difficulties with substances misuse) which can be more difficult and/or time intensive for GP services to deal with effectively.

Secondary healthcare service use

Audit responses from Reading showed that the following homeless cohorts are more likely to use an ambulance and attend A&E:

- Women
- Those aged 18 - 25 or aged 66 and over
- Those living in supported accommodation (including those who stated they are living in their own home which is supported accommodation) or sofa surfing/squatting. This could be because supported housing providers and individuals who are living with/having contact with others are more likely to have their welfare monitored, resulting in encouragement to access emergency services.

According to Reading's Audit data, those sleeping rough were more likely to be admitted to hospital once emergency services had been accessed.

The most prevalent reason respondents gave for visiting A&E, using an ambulance and being admitted to hospital was relating to a physical health problem or condition.

Dental healthcare services

There are no figures available for homeless people's actual usage of dental services, but there is evidence that some homeless people may be using less appropriate and more costly A&E services instead to meet their dental health needs (Hill and Rimington 2011)[18].

In Reading 32 out of 150 respondents, over 20%, stated that there had been one or more occasions in the last 12 months that they had needed treatment for dental problems but that it had not been received. The primary reasons for this being fear of dental exams/treatment; not being able to get an appointment or not accessing services due to a lack of motivation or physical barriers such as transport links.

Only three individuals identified that they had been refused access to dental treatment in the last 12 months.

A&E and hospital admissions: Most prolific users

63 out of 150 respondents advised that they had accessed A&E at least once in the last 12 months. Five respondents stated that they had accessed A&E due to mental health problems.

18 respondents advised that they had accessed A&E three or more times in the last 12 months; 8 of these 18 respondents advised that they had used an ambulance three or more times in the last 12 months.

41 respondents advised that they had been admitted to hospital at least once in the last 12 months. Five respondents were admitted to hospital due to mental health problems.

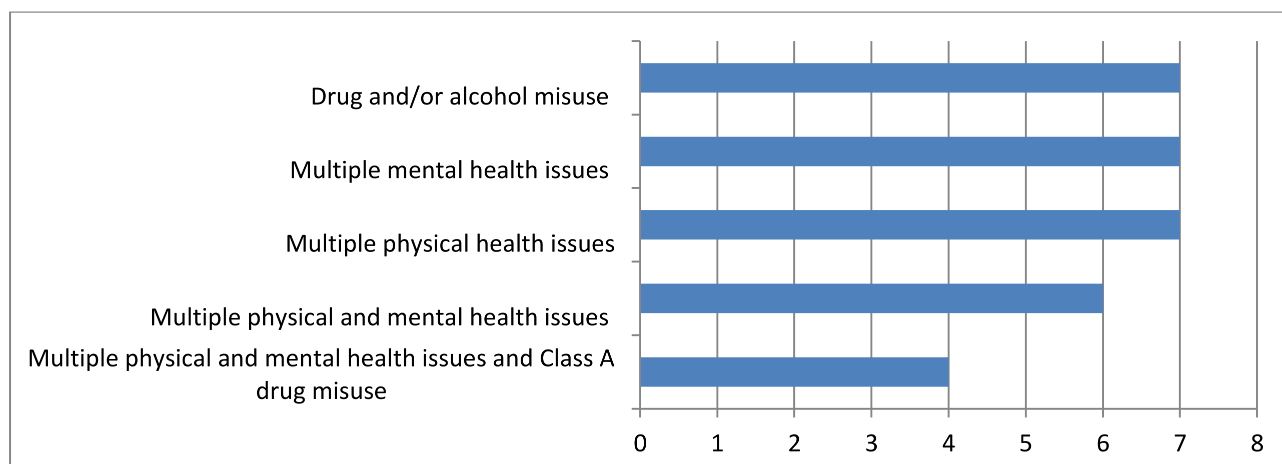
Three of those that accessed A&E due to mental health problems in the last 12 months, were also admitted to hospital. One individual was readmitted within 30 days of being discharged from hospital for a mental health problem.

Of eight individuals who advised that they had prolifically used A&E and ambulance services over the last 12 months e.g. they had used A&E and ambulance services three or more times:

- Seven out of eight respondents were living in supported accommodation commissioned by RBC; the majority of which were living in accommodation that provides a high level of support
- Seven out of eight respondents stated that they considered they had a longstanding illness, disability or infirmity
- One out of the eight respondents was sleeping rough

[18] Hill, K. B. and Rimington, D. (2011) Investigation of the oral health needs for homeless people in specialist units in London, Cardiff, Glasgow and Birmingham in *Primary Healthcare Research and Development*, 12(02): pp. 135-144.

These same eight respondents outlined the following multiple health issues, with multiple defined as two or more:



Where mental health or Class A drug misuse or chronic alcohol misuse were identified by respondents as a health need, respondents stated that this was the main reason for using emergency services and being admitted to hospital rather than an identified physical symptom from the list of ailments.

Where respondents stated that they were prolifically using A&E and ambulance services, the majority were admitted to hospital (seven out of eight) and the majority had accessed GP services 3+ times in the last 12 months. One of the eight individuals, within supported accommodation, stated that they had been refused access to GP services due to not having ID.

Half of all eight respondents advised that they had one of the following physical health problems:

- Joint aches, problems with bones and muscles
- Fainting or blackouts
- Epilepsy or seizures
- Liver problems
- Stomach problems

All but one identified as having depression *and* anxiety as well as at least one other mental health diagnosis. These other diagnoses were primarily Personality Disorder (five out of seven) and dual diagnosis (five out of seven). Six out of eight identified with using drugs and/or alcohol to alleviate symptoms of mental health.

Support and treatment

Physical health problems

55% of respondents advised that they were engaging with support or treatment for their physical health problems with 32% stating that they would like more support with managing their conditions.

39 respondents advised that they had required, but had not received, a medical examination or treatment in the last 12 months with the primary reason being they felt it was difficult getting an appointment with their GP.

Mental health problems

69% of respondents advised that they were engaging with support or treatment for their mental health problems with 44% stating that they would like more support with managing their conditions.

47 respondents advised that they required, but had not received, an assessment or treatment for their mental health in the last 12 months. The primary reasons given were that they felt waiting times for assessment were long; they felt that they had not being able to get an appointment and were feeling unmotivated to contact services due to their mental health condition.

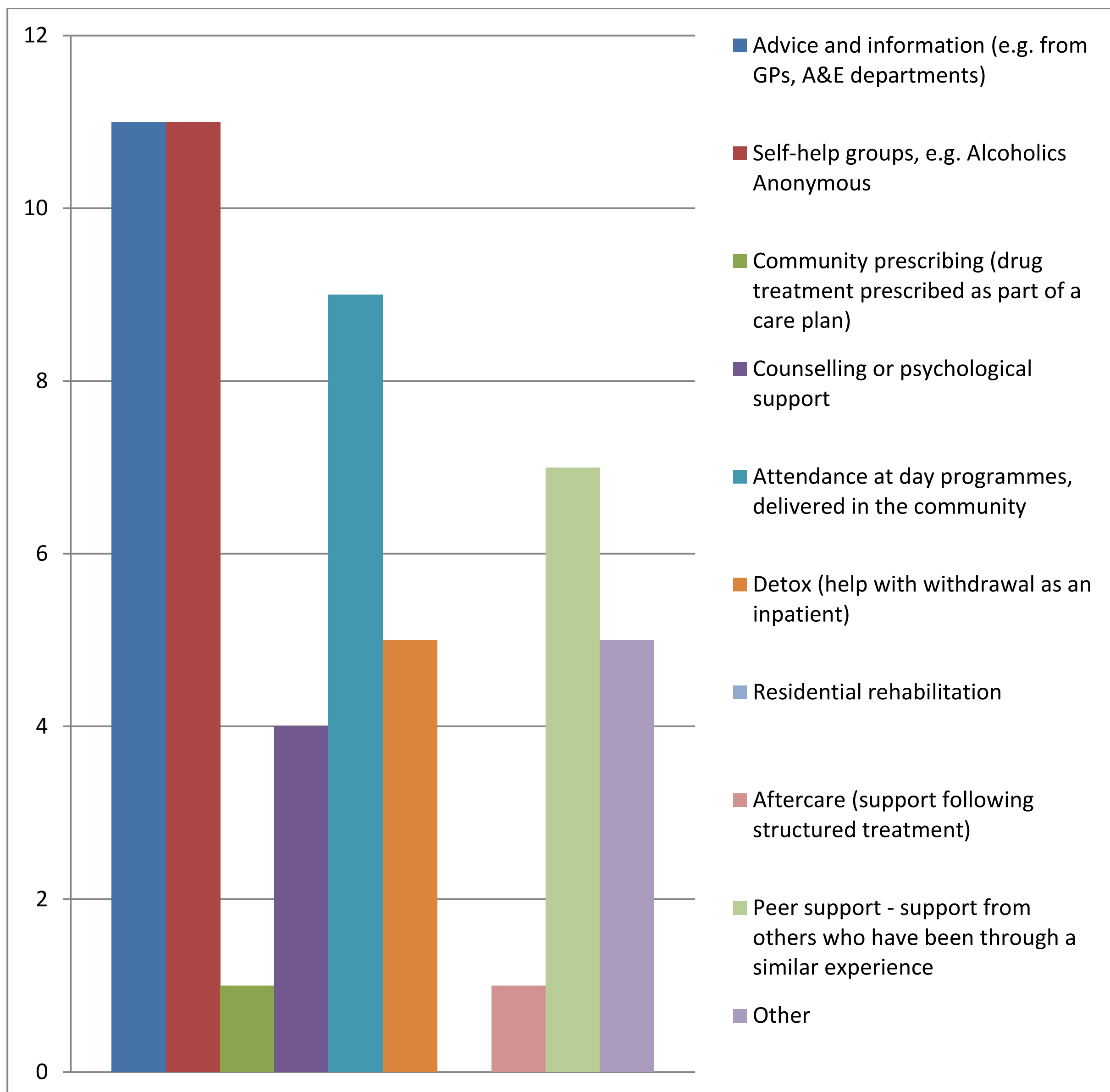
Predominantly respondents stated that they were being supported with their mental health through prescribed medication, with fewer people reporting that they were being supported by specialist mental health workers, counselling, activities or peer support.

35 respondents advised that they were receiving counselling support. Five respondents living in Launchpad accommodation were receiving in-house counselling services rather than NHS funded services.

Alcohol and drug use

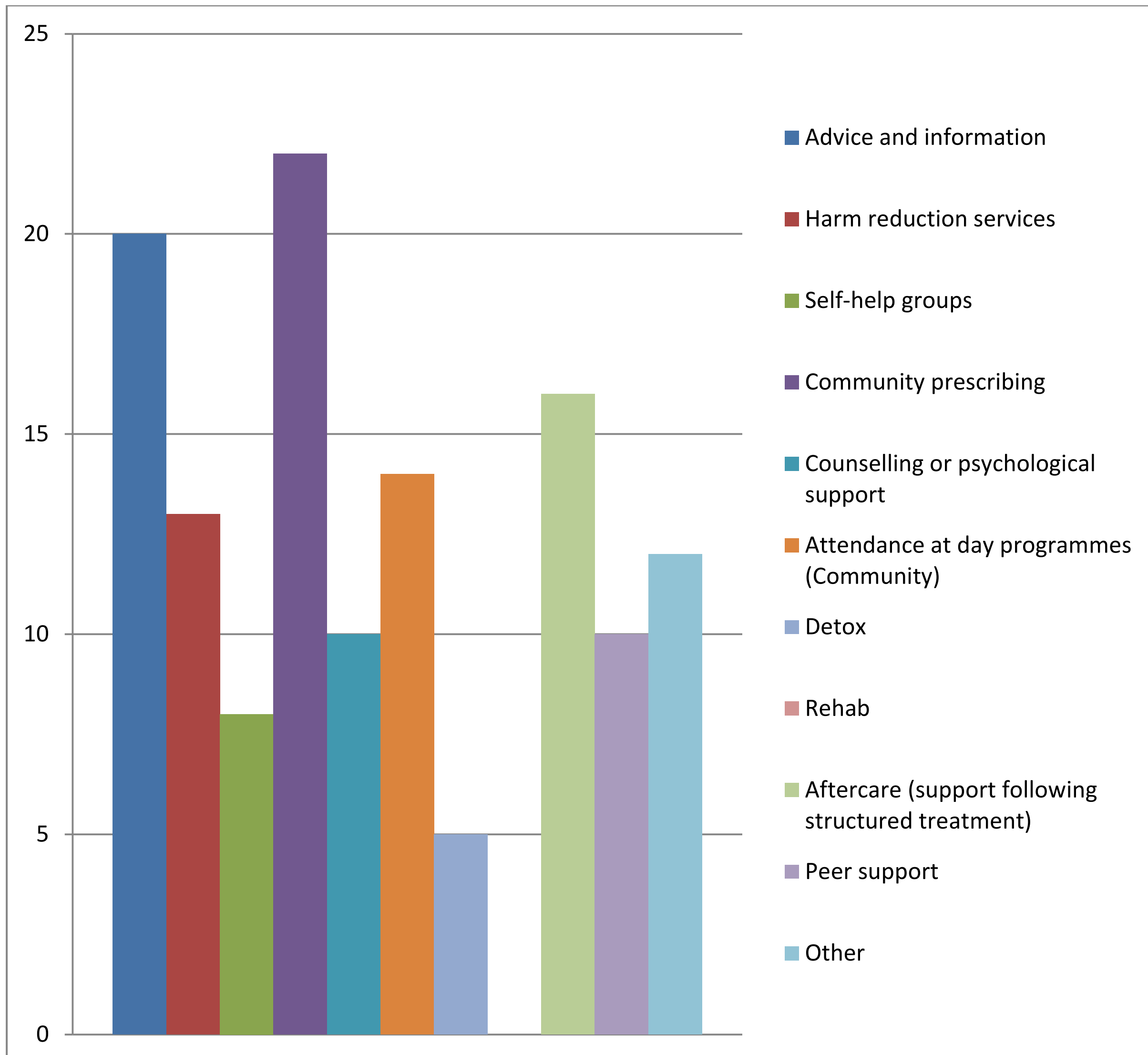
49% of respondents were engaging with support or treatment for their alcohol use with 34% stating that they would like more support with managing their alcohol misuse.

The graph below shows the types of support respondents are receiving for their alcohol misuse with advice and information, self-help groups and community day programmes being accessed the most.


12
10
8
6
4
2
0
Advice and information (e.g. from GPs, A&E departments)
Self-help groups, e.g. Alcoholics Anonymous
Community prescribing (drug treatment prescribed as part of a care plan)
Counselling or psychological support
Attendance at day programmes, delivered in the community
Detox (help with withdrawal as an inpatient)
Residential rehabilitation
Aftercare (support following structured treatment)
Peer support - support from others who have been through a similar experience
Other

73% of respondents were engaging with support or treatment for their drug misuse, with 46% stating that they would benefit from more support in addressing their drug misuse issues.

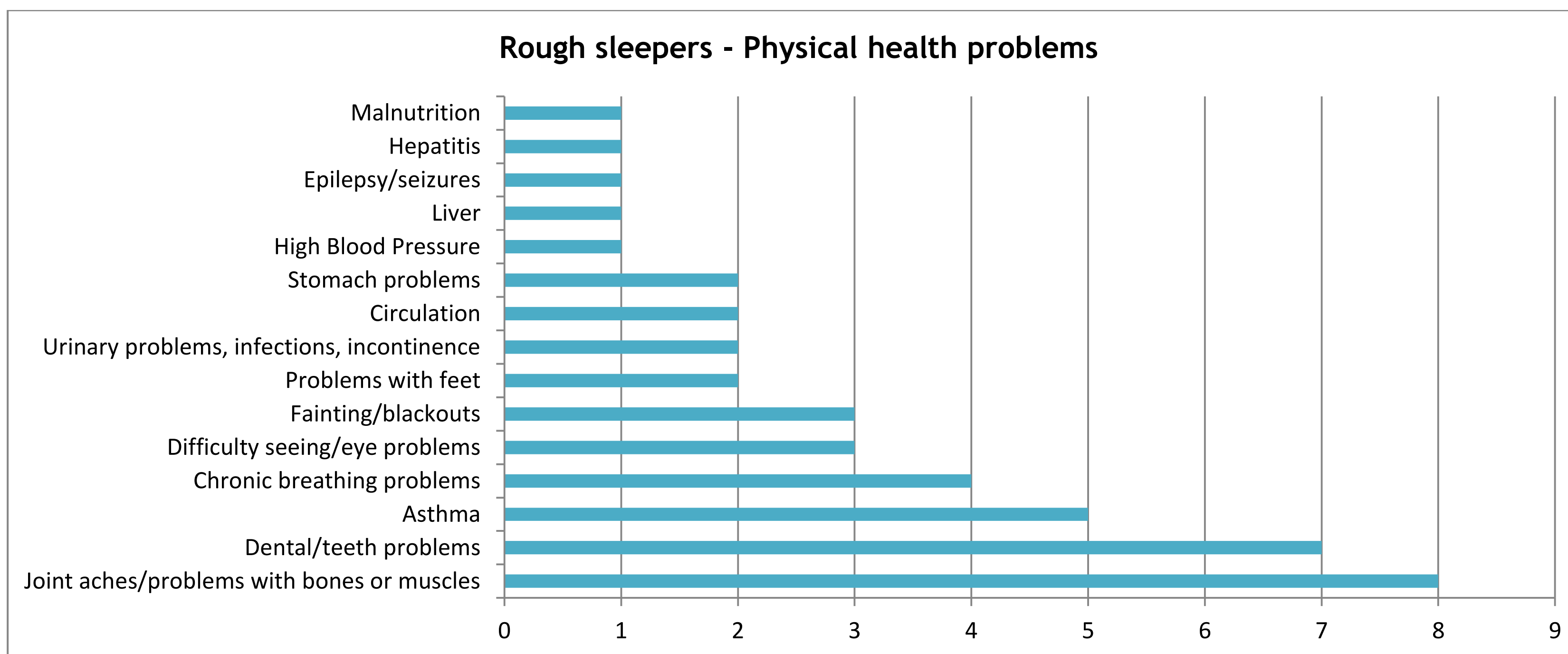
The graph below shows the types of support respondents are receiving for their alcohol misuse with community prescribing, advice and information and self-groups being accessed the most.



Focus on rough sleepers' health needs: Accessing primary and secondary healthcare services

17 respondents (11%) identified that they were currently sleeping rough and of this group, although there were a breadth of reasons for individuals becoming homeless, the main reasons identified by individuals were the end of a tenancy in the private or social rented sector (3); debt related issues (3); unemployment (2); non-violent relationship breakdown (2) and mental or physical health problems (2).

13 of 17 respondents who identified that they were rough sleeping also identified as having a physical health problem that would likely need regular monitoring by a GP or health professional to prevent deterioration, or that could result in the need for an emergency response at a later date if symptoms were exacerbated by continued rough sleeping. Six out of 17 respondents identified that they had a long-standing illness, disability or infirmity with the most commonly identified physical health problems being asthma or chronic breathing problems; joint aches/problems with bones and muscles and dental/teeth problems.

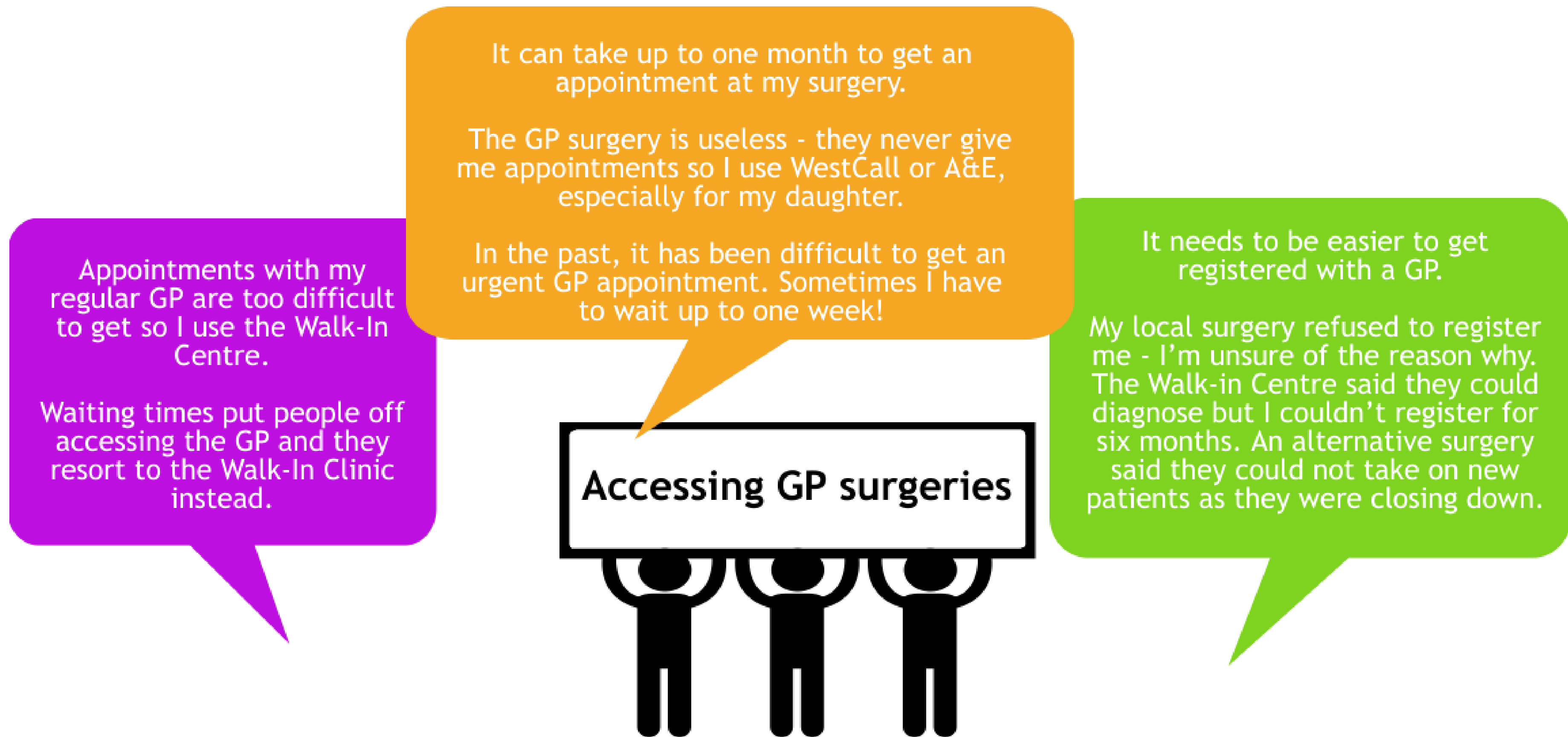


Five out of 17 respondents sleeping rough stated that they had a mental health diagnosis and four stated that they were using Class A drugs.

Respondent patterns of accessing GP services; accessing A&E; using an ambulance and/or being admitted to hospital show that those who had been sleeping rough for six months or less were more likely to access GP services. The Audit data shows a correlation between the length of time rough sleeping and a decrease in accessing GP services - e.g. the longer someone sleeps rough the less likely they are to access GP services.

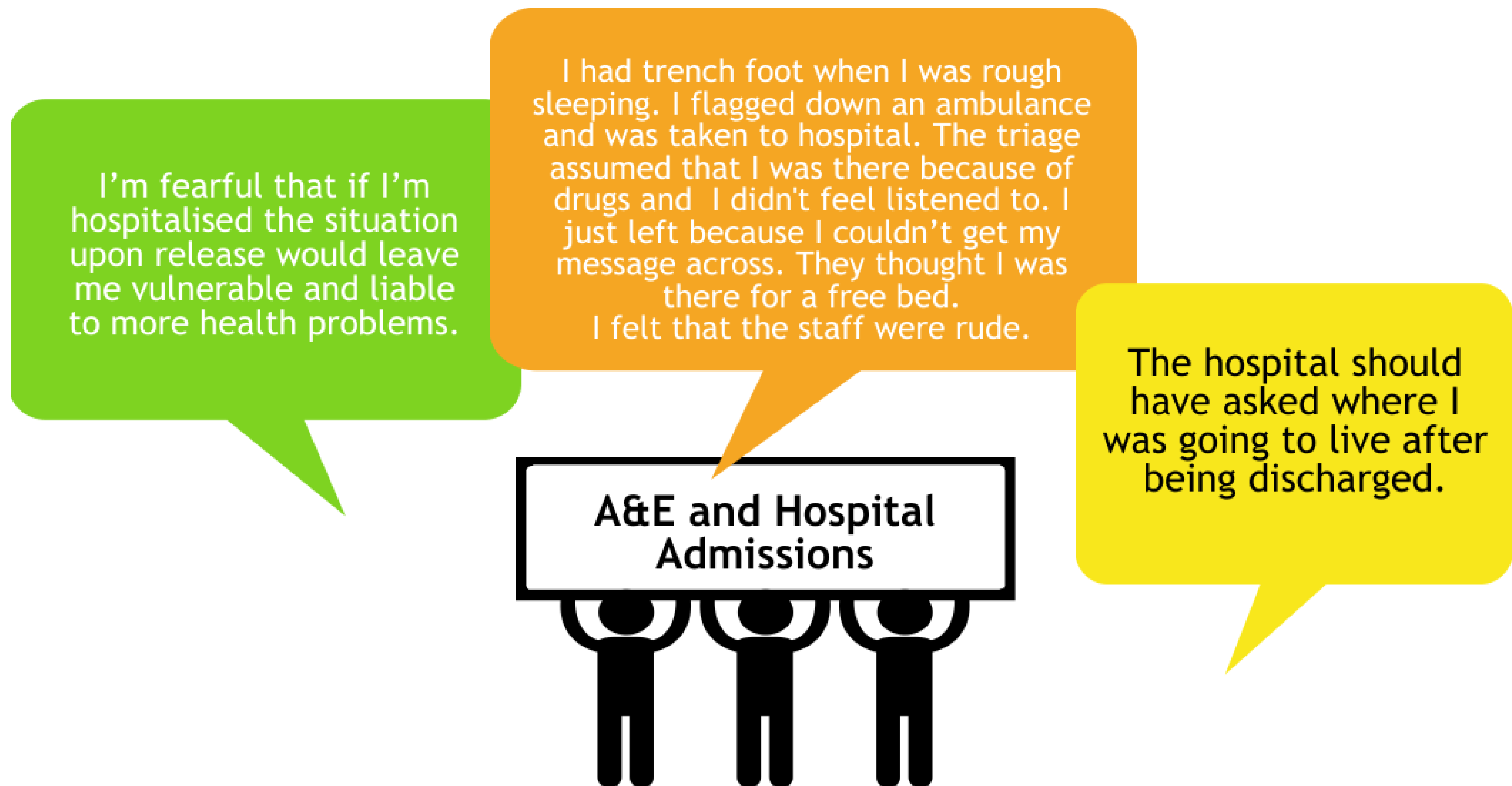
Five respondents had been sleeping rough for four or more months and had accessed A&E, used an ambulance and/or been admitted to hospital. Most went to A&E, used an ambulance and were admitted to hospital due to physical health symptoms, rather than attributing it to mental health or drugs/alcohol use. Respondents who had been sleeping rough for four or more months showed an increased propensity to access emergency services and to be admitted to hospital.

Hospital discharges to rough sleeping: Re-admissions
Of 41 respondents who stated that they had been admitted to hospital and then discharged onto the streets within the last 12 months, two were re-admitted within 30 days of being discharged.



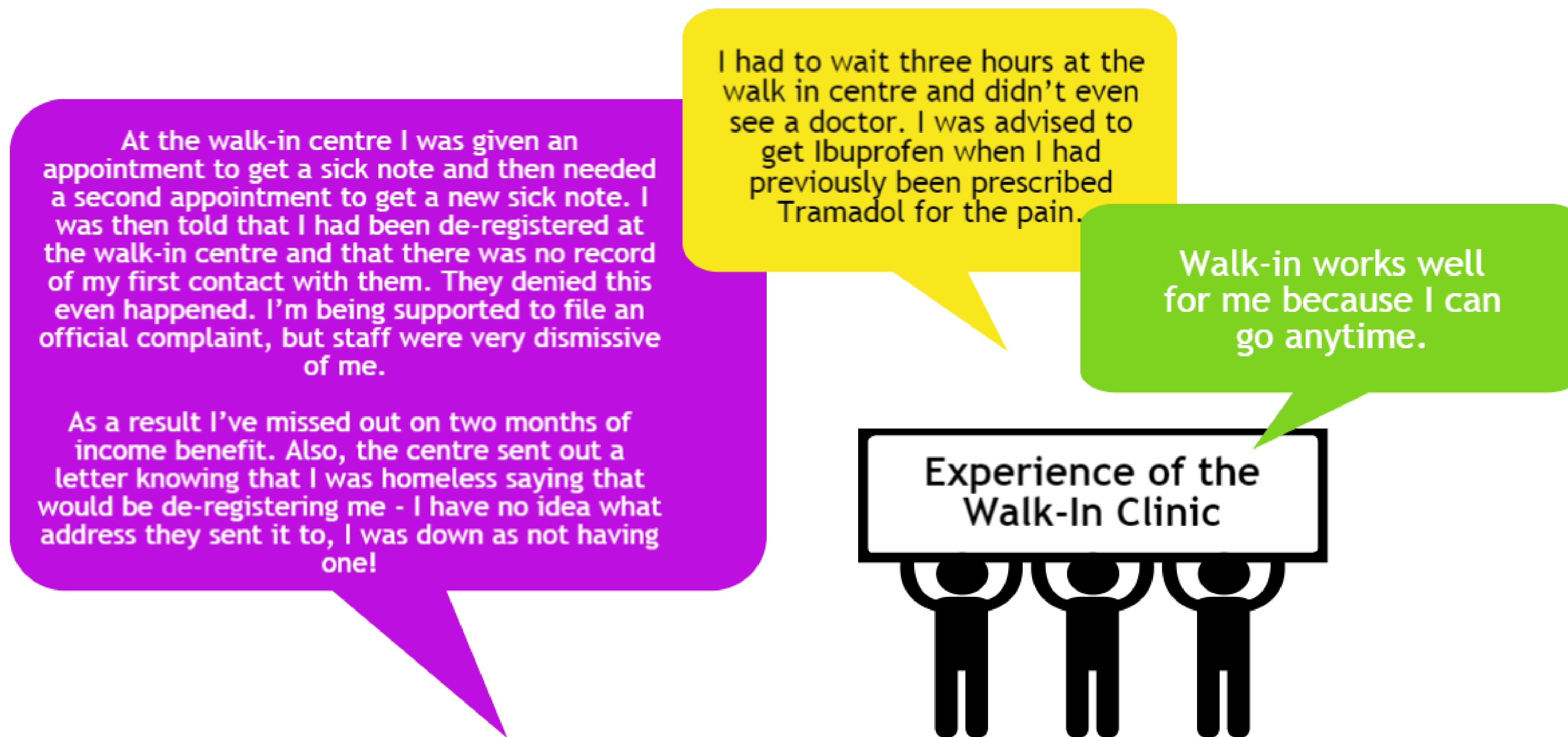
Key messages from respondents: Getting appointments and registration

- Where respondents answered the question *"What works well with health care services in Reading?"* it was clear from respondents that having appointments with a regular and familiar GP was greatly valued.
- When asked what could be improved within health care services, not seeing the same GP and frustrations with getting an appointment in a timely way featured heavily amongst respondent comments.



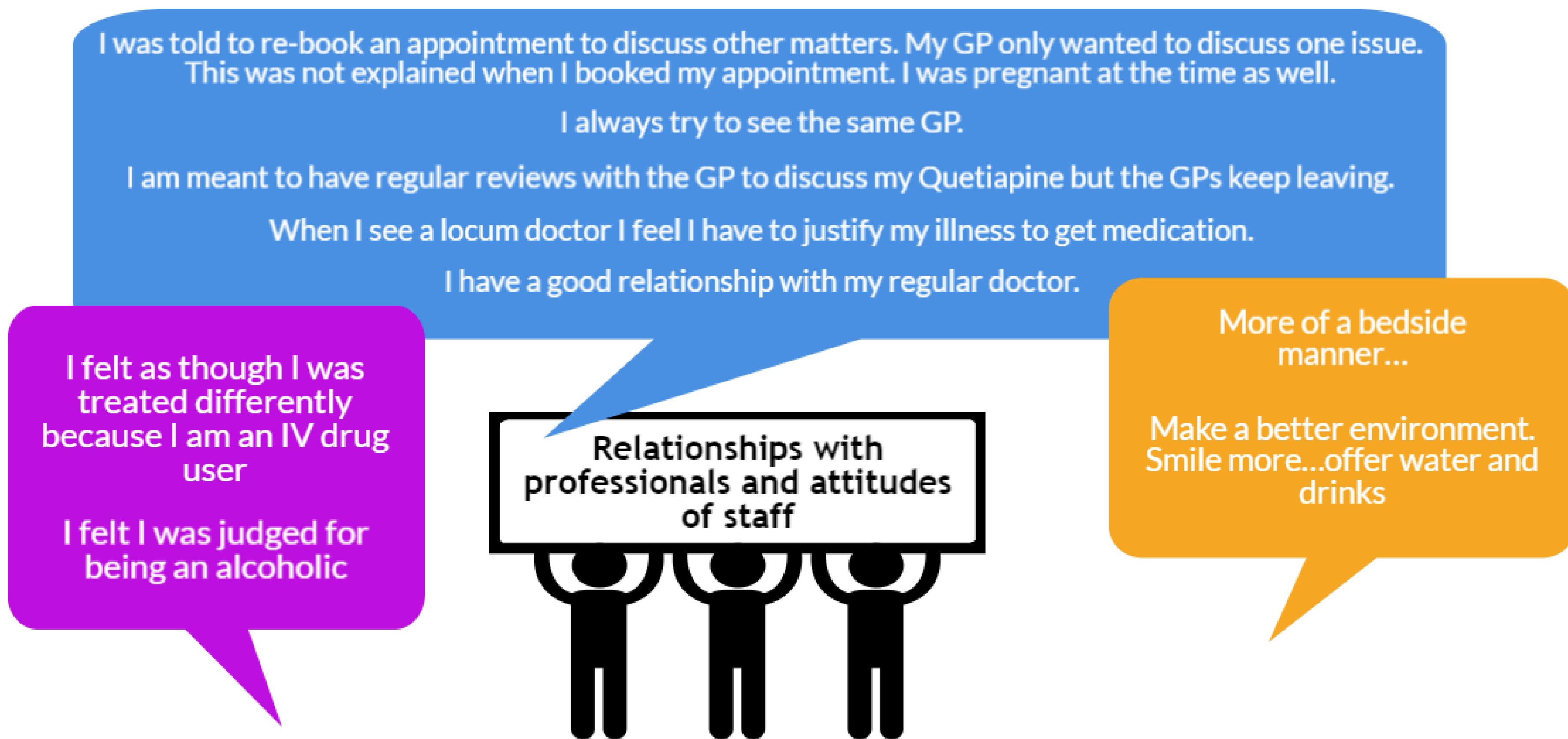
Key messages from respondents: A&E and hospital admissions

- Respondents that commented upon their use of emergency services and A&E provided examples of feeling disbelieved when presenting with physical symptoms and perceived that they were being judged when attending hospital whilst under the influence of drugs or alcohol. It is difficult in these circumstances to differentiate between individual perceptions and actual attitudes of professionals towards those who are homeless and accessing emergency services.
- Some respondents felt more could be done by discharge staff regarding establishing a patient's housing situation.



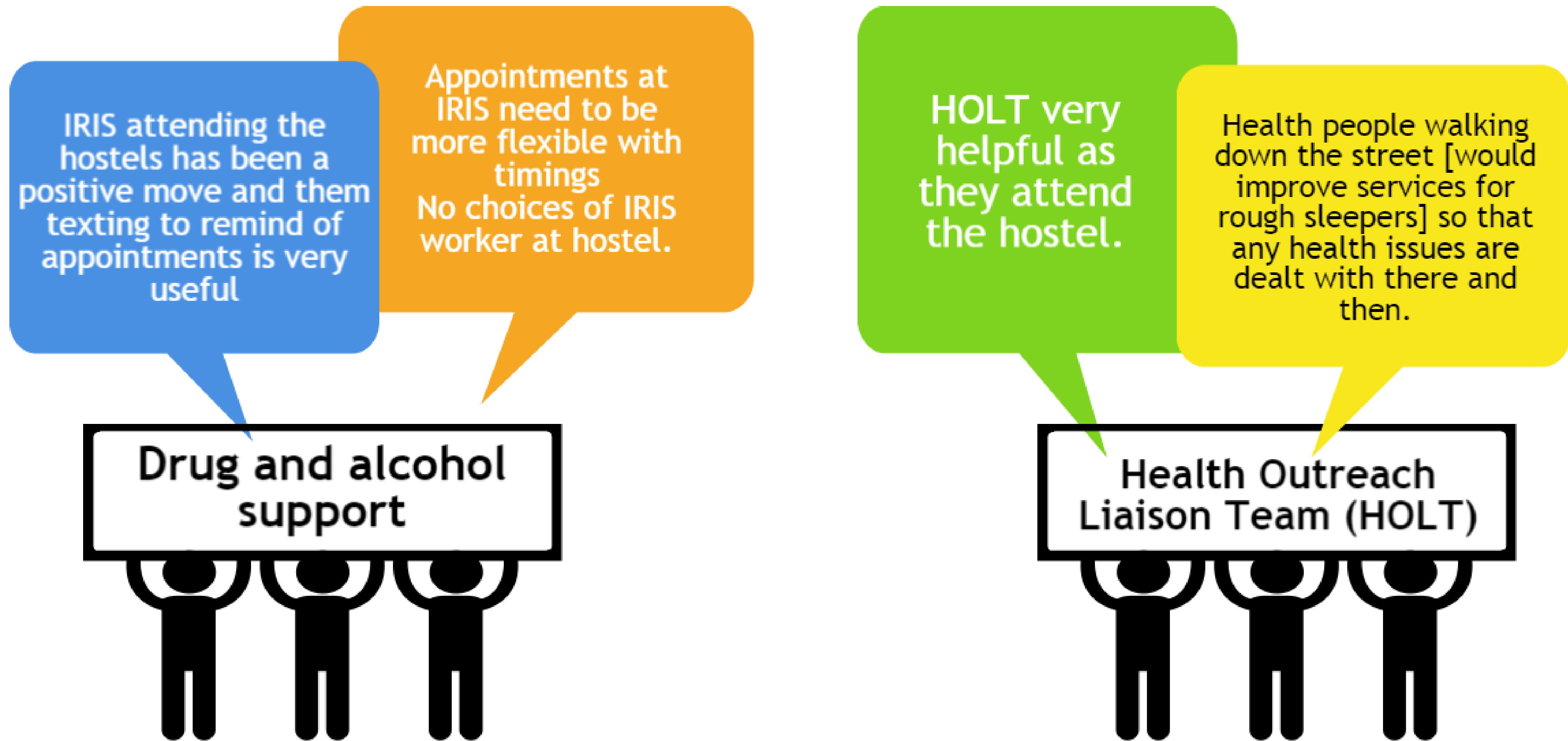
Key messages from respondents: Experience of the Walk-in Clinic in Reading

- It was of significance that the Walk-in Centre in Reading was identified specifically as a positive and flexible option by a number of those who responded to the question *"What works well with health care services in Reading?"*
- Some respondents outlined specific frustrations (quoted above) regarding the Walk-in Centre facility, but as illustrated under *Accessing GP Surgeries* responses, respondents are accessing the Walk-in Centre where they are not accessing their GP and the Centre has limitations in the face of high demand from registered and unregistered patients across Berkshire.



Key messages from respondents: Relationships with professionals and attitudes of staff

- Respondents advised that they perceived, or felt experiences of, being treated differently and being judged by GP and hospital staff due to appearing to be misusing substances.
- Seeing the same doctor and having a consistent relationship with health professionals was important to respondents. It affected their perception of the quality of healthcare being received and the likelihood that they would engage with primary healthcare services.
- Respondents stated they had felt rushed during their GP appointments; they felt that staff could be more engaging and that feeling welcomed could have an effect on the likelihood of them engaging with primary healthcare services.



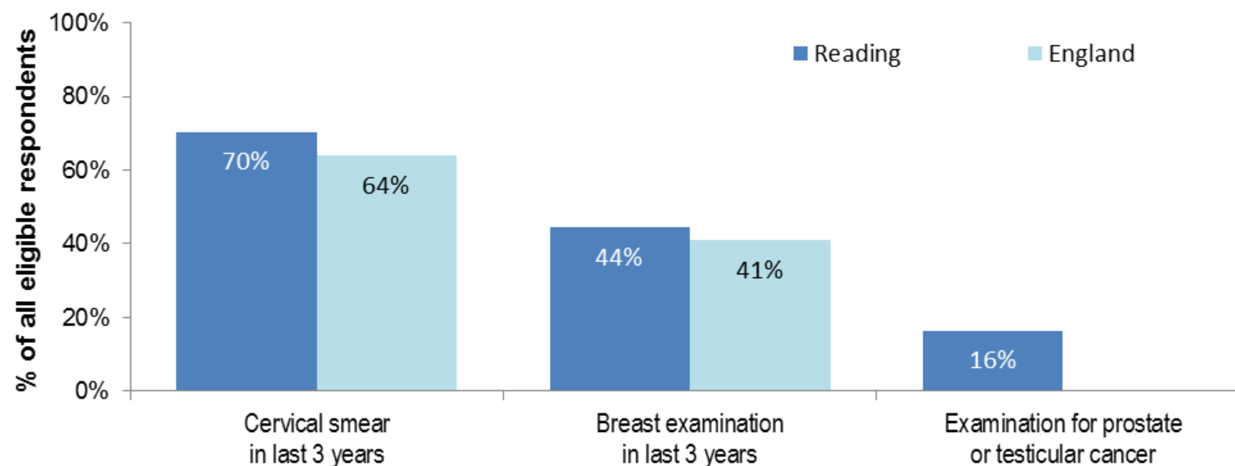
Key messages from respondents: Drug and alcohol support and HOLT

- Around a sixth of those who responded to the question *"What works well within health care services in Reading?"* felt that health care outreach services from HOLT and health care in-reach services to supported accommodation from IRIS, sexual health services and counselling (commissioned by Launchpad for their service users) were positive and effective in providing them with flexibility and continuity.
- Peer support groups for substance misuse were highlighted by many as a valued avenue of support.

Prevention Opportunities - Immunisations, sexual health screening and those leaving custody: Summary

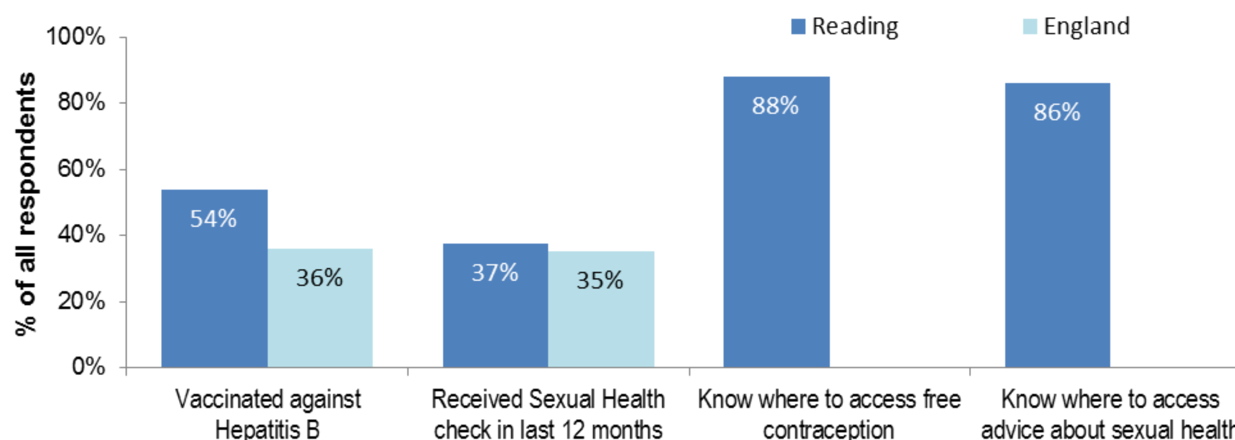
70% of eligible respondents in Reading had received a cervical smear test in the last three years and 44% had received a breast examination. These were both similar to findings from the other Health Needs Audits in England.

16% of men in Reading had received an examination for prostate or testicular cancer.



54% of respondents in Reading had been vaccinated against Hepatitis B, compared to 36% in other Health Needs Audits across England.

37% of respondents in Reading had received a sexual health check in the last 12 months, with 86-88% stating that they knew where to access free contraception and advice about sexual health.



Prevention Opportunities - Immunisations, sexual health screening and those leaving custody: Analysis of findings

Health promotion: Access to screening and disease prevention

There is limited data on the uptake of screening and vaccination programmes by those who are homeless. From what we understand of the homeless population - usually screenings and vaccinations are administered amongst the homeless population in an opportunistic way, rather than in a planned way, for example as part of an initial registration process or health check.

Female specific health

Uptake of cervical smear tests and breast examinations in Reading were above the average across other Homeless Health Needs Audits in England at 70% and 44% respectively.

Male specific health

16% of male respondents had received an examination for testicular and prostate cancer in the last 12 months. Whilst there is no Health Needs Audit data comparison for England, this seems to be a low screening rate for those eligible for this examination.

Sexual health

Whilst 37% of respondents had undergone a sexual health check in the last 12 months, which is slightly higher than the average across other Audits, a high percentage of respondents were confident that they knew how to access contraception and advice about their sexual health.

HIV

No respondents reported a diagnosis of HIV.

Tuberculosis (TB)

One respondent stated that they had a diagnosis of TB in the last 12 months and that they were not engaging in treatment for this. Two respondents advised that they had been diagnosed with TB 12 or more months ago and had engaged with treatment.

Hepatitis B

This is a blood-borne viral infection that often arises as a complication of injecting illicit drugs. Hepatitis B is thought to be prevalent among the homeless population. The three dose series of the vaccination is a highly effective way of producing long lasting protective levels of antibodies against the virus; therefore the disease is viewed as largely preventable. Those who have been in custody for a period of time are most likely to have engaged with the three dose vaccination.

Hepatitis B & C are sensitive conditions that are likely to be underreported generally. At 54% of respondents, Reading has significantly higher levels of engagement with the vaccination than other Audits in England.

Hepatitis C

This is also a blood borne viral infection where it is thought that over half of intravenous drug users will have this disease. There is no vaccination for Hepatitis C but 90% of cases will respond to treatment.

The estimated total infected with Hepatitis C in Reading is 665[19]. 14 respondents to Reading's Audit advised that they had a diagnosis of Hepatitis C. Half were engaging with or had engaged with treatment; whilst four had been offered treatment and refused and two stated that they had not been offered treatment. Those that had refused treatment were either currently rough sleeping or had recently accessed hostel accommodation. Almost all respondents that stated they had previously or currently had Hepatitis C were Class A drug users.

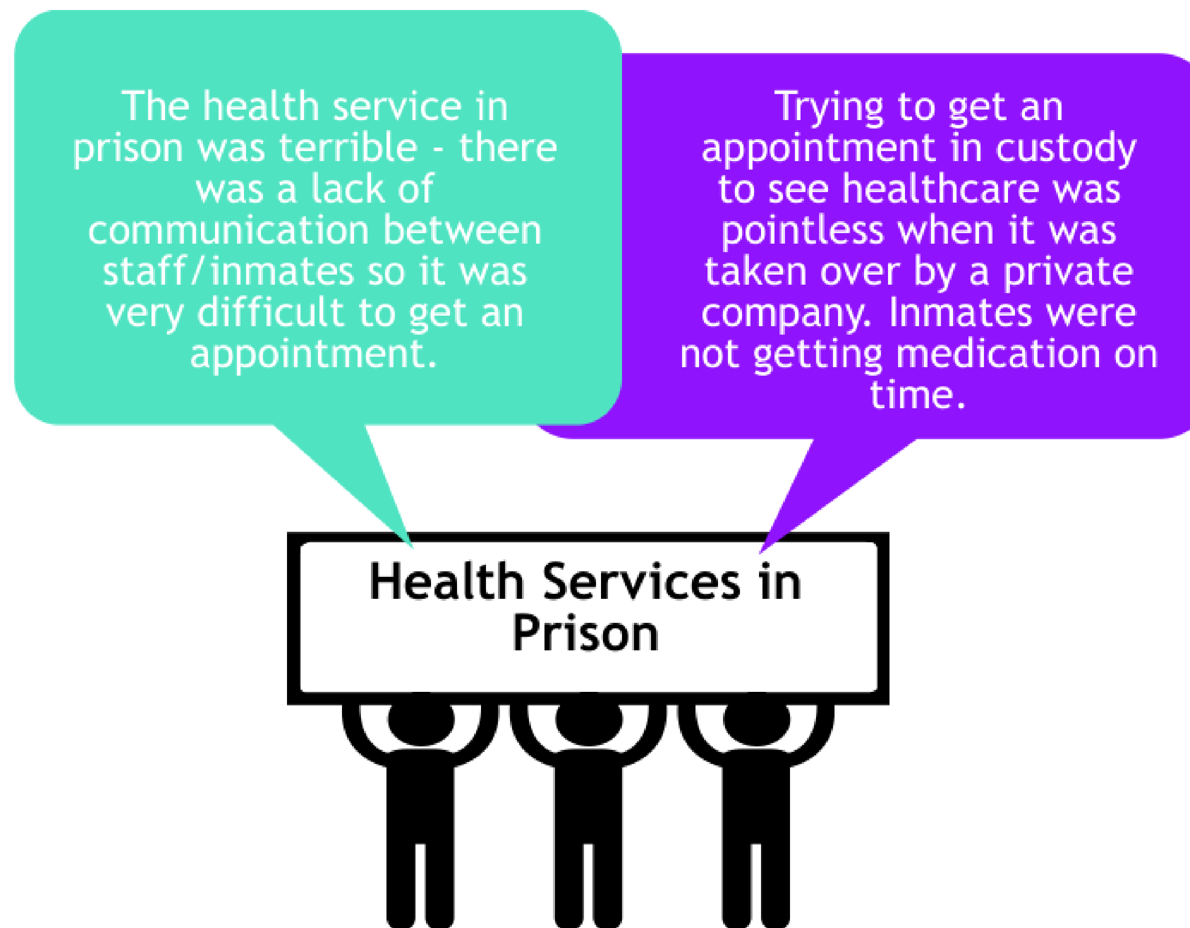
Health needs of those who were homeless upon leaving custody

20 out of 150 respondents stated that their most recent and primary reason for their current homelessness situation was leaving custody.

11 out of 20 individuals who were homeless due to leaving custody were living in supported accommodation; six were accommodated within Approved Premises; two were accessing Bed for the Night winter night shelter and one was sleeping rough.

Just over half of those who stated that the reason for their homelessness was leaving custody had served custodial sentences for three months or less. Two respondents had been in custody for over a year. Most individuals had undertaken custodial sentences of 12 months or less.

[19] Reading Borough Council (2017) *JSNA - Liver Disease* at http://www.reading.gov.uk/jsna/liver-disease, accessed on 6 September 2017.



Key messages from respondents: Health services in prison

- Responses regarding feelings about health services whilst in prison were smaller in number, but significant when considering that being homeless upon leaving custody was cited as one of the top three reasons for homelessness within the Audit. Respondents gave a clear message that they felt their health and well-being needs had not been addressed whilst in custody in preparedness for their release.

Case study comparison: Health needs of long-term/entrenched rough sleepers and those who are new to the streets

At the request of the project sub-group a case study comparison of two respondents who had been sleeping rough for 25+ months (long-term/entrenched) and two respondents who had been sleeping rough for three months or less (new to the streets).

All case study examples were male, heterosexual, UK Nationals that were smokers, had been abusing substances (drugs or alcohol) in the last 12 months and none had been examined for prostate or testicular cancer in the last three years. All were surveyed whilst accessing services set-up by faith and voluntary sectors to meet the basic needs of single homeless people.

Key themes from this case study sample show that longer-term rough sleepers are more likely to:

- Access the Walk-In Centre and emergency services, having disengaged from primary health care, drug/alcohol support and mental health services. When accessing emergency services, those rough sleeping are not being asked about their accommodation situation upon discharge.
- Have long-standing illnesses and more chronic issues associated with sleeping rough - e.g. moderate-extreme joint pain, breathing difficulties, dental problems. The list of ailments is longer for those who have slept rough for longer.
- Have alcohol misuse issues, whilst those newer to rough sleeping have Class A drug addictions and no alcohol misuse.
- Have a longer-term mental health diagnosis of depression and/or anxiety.

Comparison of two respondents sleeping rough for 25+ months (longer-term/entrenched)		
Commonalities:	**Differences:**	
	Respondent A **Client ID: 36**	**Respondent B** **Client ID: 54**
Slept rough for two or more years. Surveyed at CIRDIC day centre. Male, Heterosexual, White British, UK National. Indication of experiencing homelessness and entering homelessness services/provision at a young age.	43 years old First ‘sofa surfed’ and slept rough at 21. First entered supported housing at 28.	61 years old Slept rough for the first time at 57. First entered supported housing and experienced homelessness at 15.
Regularly using Reading’s Walk-In Centre and reported positive experiences of this. Accessed GP once or more in the last 12 months.	Used an ambulance and accessed A&E once in the last 12 months due to self-harm/suicide attempt.	Used an ambulance and accessed A&E twice in the last 12 months due to alcohol misuse. Was admitted to hospital on both occasions.
Stated that was discharged from hospital onto the streets without being asked if they had suitable accommodation to go to	Not admitted to hospital from A&E.	Was readmitted to hospital within 30 days.

Feel they have long-standing illnesses which are: • Joint aches/problems with bones and muscles • Some issues with mobilising • Feeling moderate - extreme pain and discomfort day-to-day Both are long-term smokers. Neither have had a prostate or testicular cancer exam in the last three years.	Longer term illnesses stated as: • Asthma • Problem with feet Is receiving support with physical health, but feels that could benefit from more. Did not identify any point in the last 12 months where needed a physical or mental health exam or treatment and this was not received.	Longer term illnesses stated as: • Difficulty seeing/eye problems • Fainting/blackouts • Urinary problems • Liver problems • Dental/teeth problems • Epilepsy/seizures • Malnutrition Is not receiving support with physical or mental health, but feels could benefit from more support. Did not access examination/treatment for physical health in the last 12 months due to feeling depressed. Not currently receiving treatment for dental problems but would like it - has not accessed due to historical fear of dentists.
Diagnosis of depression. Feelings of being unsupported with mental health conditions.	Diagnosis of depression in the last year. Does not feel anxious or depressed.	Longer term diagnosis of depression plus diagnosis of anxiety disorder/phobia; dual diagnosis and potentially psychosis/schizophrenia. Feels extremely anxious or depressed. States that was refused an assessment/ treatment for mental health in the last 12 months.

Did not identify any drug use in the last 12 months.	Considers self to be in recovery from a former alcohol issue. However has been admitted to hospital twice in the last 12 months due to alcohol.	States that drinking alcohol almost every day - up to 40 units per day. Considers alcohol to be a problem. Is not currently receiving support for this, but feels would benefit from some.

Comparison of two respondents sleeping rough for less than three months (new to rough sleeping)		
Commonalities:	**Differences:**	
	Respondent C **Client ID: 50**	**Respondent D** **Client ID: 88**
Slept rough for less than three months. Male, Heterosexual, UK National	Surveyed at CIRDIC day centre 49 years old Other ethnic origin (not stated) First slept rough and applied to the Council at 36; first accessed supported accommodation at 37.	Surveyed at Bed for the Night (winter night shelter) 31 years old Black British: Caribbean History of rough sleeping and accessing supported accommodation not recorded.

Registered with both GP and dentist - no incidents of refusal of registration, treatment or examination for physical or mental health conditions in the last 12 months. No mention of using Reading's Walk-In Centre by either respondent. No use of A&E, ambulance or admissions to hospital.	Used GP services three or more times in the last 12 months. Has not accessed dental treatment as did not have income benefits in place to prove exemption.	Used GP services twice in the last 12 months.
Neither associate with having a long-standing illness. Both are smokers. Neither have had a prostate or testicular cancer exam in the last three years. No issues with mobilising or self-care	Health needs identified for 12+ months and prior to rough sleeping as: • High blood pressure • Stomach problems, including ulcers • Dental/teeth problems • Depression • Dual diagnosis More recent health needs (in the past 12 months) as: • Joints aches/problems with bones and muscles • Difficulty seeing/eye problems Has moderate pain/discomfort and moderate anxiety/depression. Receiving support for mental health issues, but feels could benefit from more support if offered - main source of support is IRIS.	No long term or recently diagnosed physical or mental health problems stated.

Class A drug use in the last 12 months. No identified issues with alcohol misuse in the last 12 months.	Multiple Class A and B drug use in the last 12 months. On a Methadone script and considers self to be in recovery. Engaging with IRIS drug and alcohol support, but feels could benefit from more support.	Heroin (IV) use only Considers that has a current drug problem. Not engaging with IRIS drug and alcohol support, but feels this would help.

Conclusions

This Audit report has outlined the cross-sector partnership approach taken to conducting an audit of the health needs of those who are single, or part of a couple without dependent children, who are homeless - for example, those who are rough sleeping, sofa surfing, living in supported accommodation, refuges or bail hostels.

Commissioned by partners of Reading's Homelessness Forum, the Audit aimed to listen to and take account of single homeless people's views on their health; provide an evidence base and fill in any information/evidence gaps; contribute to Reading's Joint Strategic Needs Assessment (JSNA); consider what is currently working well within services, with a view that this could inform improvements and develop a case for change for homeless people in Reading.

A snapshot of the health needs of 150 single homeless individuals was taken over a five week period and this report has analysed the data and findings.

The report is intended as a research piece to inform improvement and service development across sectors. Key issues from respondents have been highlighted and management within sector services are invited to set out their responses to these findings and develop subsequent action plans.

Decisions should be made by health and homelessness services regarding whether it would be valuable to conduct the Audit on a regular basis as part of mapping trends and progress. If considered valuable, it will be important to determine how often and whether a full Audit would be necessary, or if an alternative and/or complementary research would be beneficial. Learnings from this first Audit should be carried forward to inform any future Audit projects.

The main areas for focus within this report were:

- Statements of health
- Physical and mental health
- Smoking, drug and alcohol use
- Access to health services
- Focus on rough sleepers' health needs
- Prevention opportunities

Under each of these headings the reports key finding have been set out below:

Key findings regarding statements of health

- Compared to concerns about mobility, self-care, being able to go about daily activities and pain and discomfort, respondents showed particular concerns about managing their mental health needs where a majority stated that they felt moderately or extremely anxious on a day-to-day basis.

Key findings regarding physical health

- The top three recent and longer-term physical health diagnoses identified by homeless people in Reading corresponded with the national picture and were: (1) joint aches or problems with bones/muscle; heart problems or chronic breathing problems and dental/teeth problems.
- Male respondents reported higher levels of physical health problems than women and this is likely attributed to local responses to the vulnerability of women sleeping rough.

- A third of respondents reported problems with their teeth or mouth with few receiving treatment for their issues.

Key findings regarding mental health

- 80% of single homeless respondents to the Audit reported having a mental health problem.
- Women identified as having much higher levels of mental health problems than men, with women aged 18 - 25 having the highest levels.
- A diagnosis of anxiety and depression were respondent's main mental health issue with 44 out of 150 stating that they had a dual diagnosis.
- There seemed to be no significance in the levels of mental health problems experienced within different housing situations.
- Of significance, respondents stated that:
    - They had experienced difficulties in accessing mental health services
    - They would rather have face-to-face assessments and ongoing support
    - Not having accommodation and substance misuse are a barrier in accessing mental health services
    - Waiting times are long and there can be feelings of uncertainty between arranged appointments
    - Specialist trauma services are needed
    - Poor mental health is exacerbated by being homeless.

Key findings regarding smoking, alcohol and drug use

- Compared to national and other health need audit data, a significantly higher number of respondents stated that they currently smoked.
- Respondents that considered they had a drug or alcohol problem were at 43% and 30% respectively and this was in line with other health need audit responses.
- Reading's Audit data shows that:
    - Alcohol misuse is more prevalent amongst homeless men than women; amongst those aged 26 and over and those who are rough sleeping.
    - Drug misuse within Reading's homeless cohort is predominantly affecting those aged 26 - 45 which differs from national findings for the whole population of England and Wales. However, where Class A intravenous drug use is more prevalent amongst those who are homeless and where heroin and crack cocaine are more addictive, leading to longer term use, the age range for Class A drug misuse is representative.
    - Cannabis use was most prevalent amongst those aged 18 - 25
    - Men were more likely to be misusing drugs than women
    - Use of NPSs was minimal which is synonymous with national data
    - Over half of respondents stated that they were using drugs and/or alcohol as a means to cope with mental health or trauma.

Key findings regarding access to health services

- Compared to other health needs audits, Reading's respondents had a slightly lower GP registration rate and significantly lower registration refusals. Considering overall feedback, this can be attributed to Reading having a well-used Walk-In Centre facility.
- Women were more likely to be registered and accessing GP and dental services than men.
- Those within supported accommodation were more likely to be accessing primary health care and less likely to be refused access to services.
- Women aged 18 - 25 or aged 66 and over and living in supported accommodation or sofa surfing/squatting were more likely to use an ambulance and attend A&E.

- Respondents who were sleeping rough were more likely to be admitted to hospital once emergency services had been accessed.
- 20% of respondents stated that they had not received treatment for dental health problems in the last 12 months primarily due to fear of examination; not being able to get an appointment and not feeling motivated to get treatment.
- Over a third of respondents stated that they had accessed A&E at least once in the last year; with just under a third admitted to hospital from A&E.
- Those most prolifically using A&E and ambulance services over the last year were primarily living in supported accommodation; had multiple and longstanding health issues and only one was sleeping rough. All but one respondent identified as having depression and anxiety as well as at least one other mental health diagnosis - primarily Personality Disorder and a dual diagnosis (alcohol/drug misuse and a mental health diagnosis).
- Over a third of those who stated that they had a physical or mental health or substance misuse problem stated that they would like more support with managing this problem.
- Respondents stated that they valued having appointments with a regular and familiar GP; were frustrated with not being able to get an appointment with a GP in a timely way; sometimes felt disbelieved and judged when presenting with symptoms at A&E and felt that discharge staff could do more in establishing a patient's housing situation.

Key findings regarding prevention opportunities

- Uptake of cervical smear tests and breast examinations in Reading were above the average across other Homeless Health Needs Audits in England at 70% and 44% respectively.
- Sexual health checks and confidence about accessing sexual health advice were higher than in other health needs audit areas.
- Reports of HIV, TB and Hepatitis B and C were very low. Uptake of the Hepatitis B vaccination was significantly higher than other local authority areas.
- Feedback from those who had recently been in custody stated that they considered their health and wellbeing needs had not been addressed whilst in custody in preparedness for their release.

Key findings regarding rough sleeper case study comparison

Key themes from case study samples showed that longer-term rough sleepers are more likely to:

- Access the Walk-In Centre and emergency services, having disengaged from primary health care, drug/alcohol support and mental health services. When accessing emergency services, those rough sleeping are not being asked about their accommodation situation upon discharge.
- Have long-standing illnesses and more chronic issues associated with sleeping rough - e.g. moderate-extreme joint pain, breathing difficulties, dental problems. The number of ailments increases for those who have slept rough for longer.
- Have alcohol misuse issues having slept rough for longer, whilst those newer to rough sleeping tended to have Class A drug addictions and no alcohol misuse.
- Have a longer-term mental health diagnosis of depression and/or anxiety.

Positive feedback from respondents

There were several examples of responses from those who partook to highlight the following positive experiences of health care and support in Reading:

- Availability and accessibility of Reading's Walk-In Centre.

- Accessibility due to in-reach services provided by the Health Outreach Liaison Team (HOLT).
- Peer support services in support of those with substance misuse issues.
- High levels of respondents knowing how to access contraception and advice about sexual health.

Respondents showed that they would like to see improvements in the following areas:

- Obtaining GP appointments and wanting consistency of support from the same GP.
- Access to accommodation and a feeling of home to improve overall mental health and well-being.
- How mental health support is obtained, delivered and it's availability
- Access to more support, including peer support and specialist trauma support, for mental health and/or substance misuse.
- Attitudes of health care staff towards those who have physical and/or mental health issues alongside substance misuse issues; wanting to feel believed, not judged, and given time by professionals.
- Feeling able and comfortable in accessing dental health services.

Actions taken to improve support and services for homeless individuals

Recommissioning of homelessness support services

Currently the Council commissions the following homelessness support services in Reading at a cost of £1.49m per annum:

- A rough sleeper street outreach service that supports rough sleepers to access supported accommodation or reconnect to their area of origin.
- 217 supported accommodation bed spaces for individuals/couples, who are homeless, currently collectively referred to as the Homelessness Pathway. The Pathway comprises 73 units offering intensive support within a 24-hour staffed environment and 132 units of move-on accommodation where individuals develop their basic living skills to move-on into independent accommodation. There are also seven assessment units and five units used for longer term clients.
- A cross-tenure floating support service which supports individuals, couples and families with tenancy sustainment and homelessness prevention.

From September 2018, the Council will be re-modelling current homelessness support services to provide more flexible and innovative ways of delivering services that better meet the needs of single homeless people and those at risk of homelessness. The aim is for the revised service model to encompass new ideas and national best practice that will optimise outcomes for individuals and value for money.

Due to the Council's current overall financial position and its need to deliver significant budget savings, in remodelling Homelessness Support Services the Council is reducing the budget for these services by £245,000 per annum from £1.49m to £1.25m. With this reduction in budget there will be a reduction in bed spaces within supported accommodation services. However, the new model intends to improve the efficiency of Council funded services to minimise the impact upon individuals that use these services.

Due to a reduction in the budget for homelessness support services in Reading there will be a reduction in bed spaces within supported accommodation. However, the new model proposes to improve the cost and effectiveness of commissioned services with the aim of minimising the impact upon individuals that use these services.

National guidance, new ways of tackling homelessness and best practice from other local authority areas have been considered and explored to inform the reshaping and redevelopment of homelessness support services. The following principles will underpin new services:

(1) Immediate and emergency responses to those who are homeless or rough sleeping.

Key features of this would be a:

- A hub that centralises accommodation and support services available to those who are homeless or rough sleeping, including emergency assessment beds and hostel accommodation for those that need 24/7 on-site staffing support.
- Rough sleeper outreach team focussed on supporting rough sleepers into accommodation and reconnecting those without a local connection to their area of origin.
- No Second Night Out (NSNO) model to ensure that anyone who is sleeping rough for the first time receives a rapid response offer to prevent them sleeping out for a second night.
- Severe Weather Emergency Protocol (SWEP) to provide emergency bed spaces for rough sleepers, regardless of their immigration or local connection status, during short periods of high risk weather.

(2) Housing and support offers to address the differing needs of single homeless people

Key features of this would be:

- Shared supported accommodation that provides a high level of support where staff are not on site but available when required 24/7, as well as shared accommodation for people who do not require a high level of support, but are presently unable to manage independent living.
- Some accommodation under Housing First principles where an unconditional offer of stable, independent housing is made alongside intensive support for people with multiple and complex needs where more conventional supported accommodation offers have been unsuccessful.
- A Making Every Adult Matter (MEAM) approach across services for complex individuals that have ineffective contact with statutory and support services where cross-sector partners find shared, flexible solutions and develop a coordinated approach.
- Psychologically and trauma informed practice and principles within all services to take into account the psychological make-up, experiences and needs of its users. This is effective for those who have experienced complex trauma in child or adulthood.
- The delivery of gender informed homelessness support services that understand that women experience homelessness and interact with support in ways that are unique to their gender.
- Wrap-around support to ensure that if an individual’s needs increase, a move into alternative accommodation is a last resort.

(3) Services that pre-empt and prevent homelessness

Key features of this principle would be a:

- Cross-tenure floating support service that offers support to those who are at risk of homelessness, require support sustaining their accommodation or with accessing alternative accommodation.

- No First Night Out (NFNO) approach to explore why individuals are sleeping rough for the first time and create locally tailored pre-emptive measures to identify ‘pre-rough sleepers’ at a phase of their housing crisis which precedes rough sleeping.

Housing First: Two year pilot with St. Mungo’s

In June 2017, a two year Housing First pilot began in Reading, funded by St. Mungo’s who currently provide the borough’s rough sleeper outreach team, where the pilot is co-ordinated collaboratively with the Council.

The Housing First model acknowledges that conventional ‘staircase’ or ‘pathway’ models of accommodation with support, that have a treatment first approach to securing accommodation, do not work for some individuals. It argues that, for some, communal hostels can cause conflict resulting in eviction or abandonment and that there is often a mixture of clients at different stages of recovery for substance and alcohol addictions. The Housing First model aims to provide sustainable housing solutions for complex and long term rough sleepers and more difficult to engage rough sleepers and individuals that have experienced multiple evictions/abandonments from traditional accommodation with support models.

The aims of Reading’s Housing First pilot are to:

- Enable clients to manage and maintain accommodation and improve their quality of life
- Assist clients to actively engage with their local community enabling a sustained living situation
- Empower clients to make positive and informed choices around their engagement
- Collate outcomes information to support if and how Housing First might be funded and commissioned in Reading in the future

St. Mungo’s have a full-time Housing First Worker to work specifically with Housing First clients. Independent tenancies will be provided to Housing Frist clients via social housing and the private rented sector. St. Mungo’s are providing intensive personalised support to between 8 – 10 clients over the pilot period. All properties will be sought and let sensitively to ensure that any identified anti-social or dependency issues clients have will have minimum impact upon their chances of successfully sustaining a tenancy; upon other residents and upon the wider community.

Reading Housing First clients will have access to a personal budget, funded by St. Mungo’s, to purchase services and items that support their resettlement. They will receive robust, intensive and tailored support with a view that they will graduate from the service at which point support from the Housing First Worker will become ‘dormant’.

Appendix 1

Homeless Health Needs Audit Project Group
Terms of Reference - Agreed on 27 October 2016

Purpose

The aims of the Homeless Health Needs Audit itself are as follows:

- To listen to, take account of and record the views of single homeless people regarding their health needs using relevant evidence gathering procedures.
- To provide an evidence base on the health needs of single homeless people by building a comprehensive dataset on Reading's local homeless population to fill in any information or evidence gaps.
- To contribute to Reading's Joint Strategic Needs Assessment (JSNA).
- To demonstrate the value of homelessness services in contributing to the health agenda and vice versa – identifying what we are doing well and where improvements could be made.
- To improve service access and delivery for single homeless individuals in Reading and ultimately improve their overall health.
- To develop a case for change by considering the development of new services; service remodelling; new or better partnerships and systems, or additional training for targeting and engaging single homeless individuals.

The role of the Homeless Health Needs Audit Project Group is as follows:

- To implement and monitor the progress of the Audit for Reading.
- To ensure that the Audit is delivered to prescribed timescales.
- To develop an Action Plan for the dissemination of data collated from the Audit and how this information can be utilised to meet the overall aims of the Audit (as above).
- To work in partnership to provide the resources to conduct, review and follow-up actions from the Audit.

Membership

Lead members, as recommended by Homeless Link, as:

- RBC Housing and Adult Social Care Commissioning Teams
- Health Outreach Liaison Team (HOLT)
- Street Outreach Team (SOT)
- Public Health and Clinical Commissioning Group (CCG)
- Substance misuse services - IRIS
- Mental health services
- Probation and NPS
- Voluntary/community sector representation
- Peer mentor
- Any other relevant local health, social care and housing services

Members are to provide alternative representation if they are unable to attend a meeting. Membership may be extended as and when required.

Meeting Arrangements

Meetings will be scheduled for every two months. Additional/more frequent meetings to be agreed as required.

Review

These Terms of Reference will be regularly reviewed and revised should the role and agenda of the group change significantly.

Appendix 2
Homeless Health Needs Audit Questionnaire for Reading

Homeless Health Needs Audit

Printable version of the survey

Welcome to the Health Needs Audit. This is the paper version of the audit questions. If you are using the paper version, please input the responses afterwards onto the online tool.

This survey asks clients questions about their health needs and access to health services in your local area. Please refer to the Guidance to help you carry out the survey. Make sure that the client has read Appendix Two of the Guidance, **Information for participants** and that they understand how this information will be used.

Questions marked with an asterisk (*) are mandatory. If the client does not wish to answer the question, please tick the 'No answer' option.

INTRODUCTION

Before you get started, please ask the client to confirm that they understand how their data will be used and that they have not already completed a survey for the current audit. Please also confirm which local authority they reside in:

☐ I (the client) understand how this information will be used and am happy to go ahead

☐ I have not previously undertaken this survey

WHICH LOCAL AUTHORITY ARE YOU IN?...

A FEW QUESTIONS ABOUT YOU

1* HOW OLD ARE YOU?

…………………………………………………………………………………………..

o No answer

3* HAVE YOU EVER (IN YOUR LIFETIME) DONE ANY OF THE FOLLOWING? IF YES, PLEASE INDICATE THE AGE AT WHICH THIS FIRST OCCURRED. Tick **all** that apply:

	Yes	Age
Stayed at a hostel, foyer, refuge, night shelter or B&B hotel, or any other type of homelessness service	☐	……..
Stayed with friends or relatives because had no home of own ('sofa surfed')	☐	……..
Slept rough	☐	……..
Applied to the council as homeless	☐	……..
None of the above	☐	
No answer	☐	

4* WHERE ARE YOU CURRENTLY SLEEPING? (if this frequently changes, please say where you slept last night). Please tick **only one**:

o Sleeping rough on streets/parks
o In a hostel or supported accommodation
o Squatting
o Sleeping on somebody's sofa/floor
o In emergency accommodation, e.g. nightshelter, refuge

- O In B&B or other temporary accommodation
- O Housed - in own tenancy
- O Other (please state)…………………………………………………………………………………..
- O No answer

RD1 AND HOW LONG HAVE YOU BEEN STAYING THERE?
Please tick **only one**:
- O Less than 1 month
- O 1-3 months
- O 4-6 months
- O 7-12 months
- O 13-18 months
- O 19-24 months
- O 25+ months

5 THINKING ABOUT THE MOST RECENT TIME YOU BECAME HOMELESS, WHAT WAS THE MAIN REASON FOR THIS? Please give **one primary** reason and **one secondary** reason if applicable.

	Primary reason	Secondary reason
Parents / care-givers no longer able or willing to accommodate	O	O
Other relatives or friends no longer able or willing to accommodate	O	O
Non-violent relationship breakdown with partner	O	O
Abuse or domestic violence	O	O
Overcrowded housing	O	O
Eviction or threat of eviction	O	O
Rent or mortgage arrears	O	O
Other debt-related issues	O	O
End of tenancy (social housing)	O	O
End of tenancy (private rented sector)	O	O
Financial problems caused by benefits reduction	O	O
Unemployment	O	O
ASB (anti-social behaviour) or crime	O	O
Drug or alcohol problems	O	O
Mental or physical health problems	O	O
Leaving institutional care (e.g. hospital, prison, care etc.)	O	O
Other (please state)…………………………………………………………..	O	O

7* WHAT IS YOUR GENDER? Please tick **only one**:
- O Male
- O Female
- O Other (please state)……….……………………………
- O No answer

8 WHICH OF THE FOLLOWING BEST DESCRIBES YOUR SEXUAL ORIENTATION?
Please tick **only one**:
- O Heterosexual or straight
- O Gay or lesbian
- O Bi-sexual
- O Other (please state)……………………..

9* **WHAT IS YOUR ETHNIC GROUP?** Please tick **only one:**

White				Mixed/Multiple ethnic groups				Asian/Asian British					Black/Black British			Other ethnic group	
English / Welsh / Scottish / Northern Irish / British	Irish	Gypsy or Irish Traveller	Other white	White & Black Caribbean	White & Black African	White & Asian	Other mixed	Indian	Pakistani	Bangladeshi	Chinese	Other Asian	African	Caribbean	Other black	Arab	Any other ethnic group
O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O Please state: ………………

O No answer

10 **WHAT IS YOUR IMMIGRATION STATUS?** Please tick **only one:**

- O UK National
- O European Economic Area (EEA) national
- O National from outside of the EEA
- O Asylum Seeker
- O Refugee
- O Permanent residence/Indefinite leave to remain
- O Unknown
- O Other (please state)…………………………………………………………………………………

12* **DO YOU HAVE ANY LONG-STANDING ILLNESS, DISABILITY OR INFIRMITY?** By long-standing I mean anything that has troubled you over a period of time or that is likely to affect you over a period of time. Please tick **only one**:

O Yes O No O No answer

SOME QUESTIONS ABOUT YOUR PHYSICAL HEALTH

13* **HAS A DOCTOR OR HEALTH PROFESSIONAL EVER TOLD YOU THAT YOU HAVE ANY OF THE FOLLOWING PHYSICAL HEALTH PROBLEMS?** Please choose the appropriate response for each item:

	Yes, in past 12 months	Yes, 12 months + ago	No	No answer
Heart problems (heart attack, angina, murmur or abnormal heart rhythm)	☐	☐	☐	☐
Chronic breathing problems (bronchitis, emphysema, obstructive airways disease)	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Joint aches/problems with bones and muscles	☐	☐	☐	☐
Difficulty seeing/eye problems	☐	☐	☐	☐
Skin/wound infection or problems	☐	☐	☐	☐

Problems with feet	☐	☐	☐	☐
Fainting/blackouts	☐	☐	☐	☐
Urinary problems/ infections/ incontinence	☐	☐	☐	☐
Circulation problems/blood clots	☐	☐	☐	☐
Liver problems	☐	☐	☐	☐
Stomach problems, including ulcers	☐	☐	☐	☐
Dental/teeth problems	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Epilepsy/seizures	☐	☐	☐	☐
HIV	☐	☐	☐	☐
Tuberculosis (TB) (*go to Q13a)*	☐	☐	☐	☐
Hepatitis C (*go to Q13b)*	☐	☐	☐	☐
Other (please state)……………………………………	☐	☐	☐	☐

13a ***IF YES TO TB*, HAVE YOU RECEIVED ANY TREATMENT?** Please tick **only one**:

O Yes O No

13b ***IF YES TO HEPATITIS C*, HAVE YOU RECEIVED ANY TREATMENT?** Please tick **only one**:

O Yes O No, offered but didn't take it up O No, not offered any

13c ***IF YES TO ANY PHYSICAL HEALTH NEED*, ARE YOU RECEIVING SUPPORT/ TREATMENT TO HELP YOU WITH YOUR PHYSICAL HEALTH PROBLEM?** Please tick **only one**:

O Yes, and it meets my needs O Yes, but I'd still like more help

O No, but it would help me O No, I do not need any

14 **WAS THERE ANY TIME DURING THE PAST TWELVE MONTHS WHEN, IN YOUR OPINION, YOU NEEDED A MEDICAL EXAMINATION OR TREATMENT FOR A PHYSICAL HEALTH PROBLEM BUT YOU DID NOT RECEIVE IT?** Please tick **only one**:

O Yes, there was at least one occasion O No, there was no occasion (*go to Q15*)

14a ***IF YES TO Q14*, WHAT WAS <u>THE MAIN REASON</u> FOR NOT RECEIVING THE EXAMINATION OR TREATMENT (THE MOST RECENT TIME)?** Please tick **only one**:

O Couldn't get an appointment
O Waiting list
O Have been banned from the service
O Too far to travel/no means of transportation
O Fear of doctor/hospitals/examination/ treatment
O Wanted to wait and see if problem got better on its own
O Was refused treatment/examination
O Other (please state)…………………………………………………………………………………..

15* **DO YOU SMOKE CIGARETTES, CIGARS OR A PIPE?** Please tick **only one**:

O Yes O No O No answer

RD 2 **FEMALE CLIENTS ONLY: ARE YOU PREGNANT?**

O Yes O No O No answer

SOME QUESTIONS ABOUT MENTAL HEALTH AND DEVELOPMENT

16* **HAS A DOCTOR OR HEALTH PROFESSIONAL EVER TOLD YOU THAT YOU HAVE ANY OF THE FOLLOWING MENTAL HEALTH OR BEHAVIOURAL CONDITIONS?** Please choose the appropriate response for each item:

	Yes, in past 12 months	Yes, 12 months + ago	No	No answer
Depression	☐	☐	☐	☐
Anxiety disorder or phobia	☐	☐	☐	☐
Psychosis (incl. schizophrenia or bipolar disorder)	☐	☐	☐	☐
Personality disorder	☐	☐	☐	☐
Post traumatic stress disorder (PTSD)	☐	☐	☐	☐
Eating disorder	☐	☐	☐	☐
Dual diagnosis - a mental health problem alongside drug or alcohol use	☐	☐	☐	☐
ADHD (attention deficit hyperactivity disorder)	☐	☐	☐	☐
Learning disability or difficulty	☐	☐	☐	☐
Autism/Asperger's	☐	☐	☐	☐
Other (please state)……………………..........................	☐	☐	☐	☐

16a ***IF YES TO ANY MENTAL HEALTH NEED*, ARE YOU RECEIVING SUPPORT/ TREATMENT TO HELP YOU WITH YOUR MENTAL HEALTH PROBLEM?** Please tick **only one**:

O Yes, and it meets my needs
O Yes, but I'd still like more help
O No, but it would help me (*go to Q17*)
O No, I do not need any (*go to Q17*)

16b ***IF YES TO Q16a*, WHAT TYPE OF SUPPORT ARE YOU RECEIVING?** Tick **all** that apply:

☐ Talking to a professional like a counsellor or therapist (e.g. counselling, CBT, psychological therapies)
☐ Support from a specialist mental health worker – e.g. Community Mental Health team, Community Psychiatric Nurse
☐ A service that deals with my mental health and drug/alcohol use at the same time
☐ Activities like arts, volunteering or sport
☐ Practical support that helps me with my day to day life
☐ Training and activities to learn new skills/gain employment
☐ Medication that has been prescribed for me
☐ Peer support - support from others who have been through a similar experience
☐ Other (please state)……………………………………………………………………………….

17 **WAS THERE ANY TIME DURING THE PAST TWELVE MONTHS WHEN, IN YOUR OPINION, YOU PERSONALLY NEEDED AN ASSESSMENT OR TREATMENT FOR A MENTAL HEALTH PROBLEM BUT YOU DID NOT RECEIVE IT?** Please tick **only one**:

O Yes, there was at least one occasion
O No, there was no occasion (*go to Q18*)

17a ***IF YES TO Q17*, WHAT WAS <u>THE MAIN REASON</u> FOR NOT RECEIVING THE ASSESSMENT (THE MOST RECENT TIME)?** Please tick **only one**:

O Couldn't get an appointment
O Waiting list
O Have been banned from the service
O Due to my drug or alcohol use
O Too far to travel/no means of transportation
O Fear of doctor/hospitals/examination/ treatment
O Wanted to wait and see if problem got better on its own

- O Was refused treatment/examination
- O Other (please state)……………………………………………………………………………

18 DO YOU USE DRUGS OR ALCOHOL TO HELP YOU COPE WITH YOUR MENTAL HEALTH – this can be called ‘self-medicating’? Please tick **only one**:

O Yes O No

SOME QUESTIONS ABOUT DRUG AND ALCOHOL USE

19* IN THE PAST 12 MONTHS HAVE YOU TAKEN ANY OF THE FOLLOWING? Tick **all** that apply:

- ☐ Heroin
- ☐ Crack
- ☐ Cocaine
- ☐ Cannabis/weed
- ☐ Amphetamines/speed
- ☐ Tranquilisers, such as benzodiazepines/benzos, not prescribed for you
- ☐ Any other prescription drugs, not prescribed for you
- ☐ New Psychoactive Substances (also known as legal highs)
- ☐ IV drugs (drugs you inject)
- ☐ No drug use in the past 12 months
- ☐ Other (please state)……………………………………………………………………………
- ☐ No answer

20 DO YOU TAKE METHADONE, SUBUTEX OR ANY OTHER SUBSTITUTE DRUGS? Please tick **only one**:

O Yes, it is prescribed for me O Yes, but it is not prescribed for me O No

21* DO YOU HAVE OR ARE YOU RECOVERING FROM A DRUG PROBLEM? Please tick **only one**:

O Yes, I have a drug problem O Yes, I am in recovery O No (*go to Q22)*

21a *IF YES TO A DRUG PROBLEM,* ARE YOU RECEIVING SUPPORT/TREATMENT TO HELP YOU WITH YOUR DRUG PROBLEM? Please tick **only one**:

O Yes, and it meets my needs O Yes, but I'd still like more help
O No, but it would help me (*go to Q22)* O No, I do not need any (*go to Q22)*

21b *IF YES TO Q21a*, WHAT SUPPORT ARE YOU RECEIVING TO HELP YOU ADDRESS YOUR DRUG USE? Tick **all** that apply:

- ☐ Advice and information (e.g. from GPs, A&E departments)
- ☐ Harm reduction services, such as needle exchange
- ☐ Self-help groups (often called Mutual Aid), e.g. Narcotics Anonymous
- ☐ Community prescribing (drug treatment prescribed as part of a care plan)
- ☐ Counselling or psychological support
- ☐ Attendance at day programmes, delivered in the community
- ☐ Detox (help with withdrawal as an inpatient)
- ☐ Residential rehabilitation
- ☐ Aftercare (support following structured treatment)
- ☐ Peer support - support from others who have been through a similar experience
- ☐ Other (please state)……………………………………………………………………………

22* **HOW OFTEN HAVE YOU HAD AN ALCOHOLIC DRINK DURING THE PAST 12 MONTHS?**
Please tick **only one**:
- O Almost every day
- O Five or six days a week
- O Three or four days a week
- O Once or twice a week
- O Once or twice a month
- O Once every couple of months
- O Once or twice a year
- O Not at all in the past 12 months (*go to Q24*)
- O No answer

23* **HOW MANY UNITS DO YOU DRINK ON A TYPICAL DAY WHEN YOU ARE DRINKING?** Please refer to flashcard to work this out.

……………………………………………………………………………………………………..
- O No answer

24* **DO YOU HAVE OR ARE YOU RECOVERING FROM AN ALCOHOL PROBLEM?** Please tick **only one**:
- O Yes, I currently have an alcohol problem
- O Yes, I am in recovery
- O No (*go to Q25)*
- O No answer

24a ***IF YES TO AN ALCOHOL PROBLEM,*** **ARE YOU RECEIVING SUPPORT/TREATMENT TO HELP YOU WITH YOUR ALCOHOL PROBLEM?** Please tick **only one**:
- O Yes, and it meets my needs
- O Yes, but I'd still like more help
- O No, but it would help me (*go to Q25)*
- O No, I do not need any (*go to Q25)*

24b ***IF YES TO Q24a*****, WHAT SUPPORT ARE YOU RECEIVING TO HELP YOU ADDRESS YOUR ALCOHOL USE?** Tick **all** that apply:
- ☐ Advice and information (e.g. from GPs, A&E departments)
- ☐ Self-help groups, e.g. Alcoholics Anonymous
- ☐ Community prescribing (drug treatment prescribed as part of a care plan)
- ☐ Counselling or psychological support
- ☐ Attendance at day programmes, delivered in the community
- ☐ Detox (help with withdrawal as an inpatient)
- ☐ Residential rehabilitation
- ☐ Aftercare (support following structured treatment)
- ☐ Peer support - support from others who have been through a similar experience
- ☐ Other (please state)……………………………………………………………………………….

SOME QUESTIONS ABOUT YOUR DENTAL HEALTH

RD 3 **DO YOU CURRENTLY HAVE A PROBLEM WITH YOUR TEETH/ MOUTH?**
- O Yes
- O No
- O No answer

RD3 a ***IF YES TO RD3:*** **ARE YOU RECEIVING SUPPORT OR TREATMENT TO HELP YOU WITH YOU TEETH/MOUTH PROBLEM**
Please tick **only one**:
- O Yes, and it meets my needs
- O Yes, but I'd still like more help
- O No, but it would like to
- O No, I do not need any

RD3b ***IF YES TO RD3a:*** **WHERE ARE YOU RECEIVING SUPPORT/ TREATMENT FROM?**
Please tick **all that apply**

- O GP
- O Dental Surgery
- O A&E Department
- O Other (please state) ……………………………………………………………………………

RD4 **WAS THERE ANY TIME DURING THE PAST 12 MONTHS WHEN, IN YOUR OPINION, YOU NEEDED TREATMENT FOR A PROBLEM WITH YOUR TEETH OR MOUTH BUT YOU DID NOT RECIEVE IT?**

- O Yes, there was at least one occasion
- O No

RD4a ***IF YES TO RD4:*** **WHAT WAS THE MAIN REASON THAT YOU DID NOT RECEIVE THE EXAMINATION OR TREATMENT? (PLEASE CONSIDER THE MOST RECENT TIME)**

- O Couldn't get an appointment
- O Waiting on a waiting list
- O Have been banned from the service
- O Too far to travel/ no means of transportation
- O Fear of doctor/ hospitals/ examination/ treatment
- O Wanted to wait and see if problem got better on its own
- O Was refused treatment/ examination
- O Difficulty with receiving written correspondence due to having no fixed address
- O Attitude of staff within health services
- O Other (please state) ……………………………………………………………………………

SOME QUESTIONS ABOUT YOUR ACCESS TO SERVICES

25* **ARE YOU REGISTERED WITH THESE SERVICES IN YOUR LOCAL AREA?** Please choose the appropriate response for each item:

	Yes	No	No answer
GP or homeless healthcare service	☐	☐	☐
Dentist	☐	☐	☐

26 **HAVE YOU BEEN REFUSED REGISTRATION TO A GP/ HOMELESS HEALTHCARE SERVICE OR DENTIST IN THE PAST 12 MONTHS?** Please choose the appropriate response for each item:

	Yes	No (*go to Q27)*
GP or homeless healthcare service	☐	☐
Dentist	☐	☐

26a ***IF YES TO Q26-GP*****, WHY WERE YOU REFUSED REGISTRATION TO A GP?**

……………………………………………………………………………………………………

26b ***IF YES TO Q26-DENTIST*****, WHY WERE YOU REFUSED REGISTRATION TO A DENTIST?**

……………………………………………………………………………………………………

27* **IN THE PAST 12 MONTHS HAVE YOU-:** Please choose the appropriate response for each item:

	No	Once	Twice	3 Times	Over 3 times	No answer
Been to a GP or homeless healthcare service?	☐	☐	☐	☐	☐	☐
Been to A&E?	☐	☐	☐	☐	☐	☐
Used an ambulance?	☐	☐	☐	☐	☐	☐
Been admitted to hospital?	☐	☐	☐	☐	☐	☐

27a **IF YOU HAVE USED ANY OF A&E, HOSPITAL OR AMBULANCE IN THE PAST 12 MONTHS PLEASE ANSWER THESE QUESTIONS: What was the reason why you last used:** *Please select the reason which best fits the primary cause of using the service, or use the other box if the reason is not listed.*

	A&E	Ambulance	Admitted into hospital
Domestic violence	☐	☐	☐
Other violent incident or assault	☐	☐	☐
Accident	☐	☐	☐
Relating to a physical health problem or condition	☐	☐	☐
Relating to a mental health problem or condition	☐	☐	☐
Self-harm/attempted suicide	☐	☐	☐
Relating to drug use	☐	☐	☐
Relating to alcohol use	☐	☐	☐
Relating to childbirth or pregnancy	☐	☐	☐
Other for A&E (please state)……………………………...	☐		
Other for ambulance (please state)………………………		☐	
Other for hospital admission (please state)……………..			☐

IF YOU WERE ADMITTED INTO HOSPITAL, PLEASE ANSWER QUESTIONS 27b-27d ABOUT YOUR MOST RECENT ADMISSION:

27b **DID STAFF ASK YOU IF YOU HAD SOMEWHERE SUITABLE TO GO WHEN YOU WERE DISCHARGED?** Please tick **only one**:

O Yes O No O I can't remember

27c* **WHEN YOU WERE DISCHARGED FROM HOSPITAL WHERE DID YOU GO?** Please tick **only one**:

O I was discharged onto the street
O I was discharged into accommodation, but it was *not* suitable for my needs
O I was discharged into accommodation, and it *was* suitable for my needs
O I can't remember
O No answer

27d* **AFTER BEING DISCHARGED, WERE YOU READMITTED WITHIN 30 DAYS?** Please tick **only one**:

O Yes O No O I can't remember O No answer

SOME QUESTIONS ABOUT STAYING HEALTHY

28* **BY PLACING A TICK IN ONE BOX IN EACH GROUP BELOW, PLEASE INDICATE WHICH STATEMENTS BEST DESCRIBE YOUR OWN HEALTH STATE TODAY:**

MOBILITY Please tick **only one**:
- O I have no problems in walking about
- O I have some problems in walking about
- O I am confined to bed
- O No answer

SELF-CARE Please tick **only one**:
- O I have no problems with self-care
- O I have some problems washing or dressing myself
- O I am unable to wash or dress myself
- O No answer

USUAL ACTIVITIES Please tick **only one**:
- O I have no problems with performing my usual activities
- O I have some problems with performing my usual activities
- O I am unable to perform my usual activities
- O No answer

PAIN/DISCOMFORT Please tick **only one**:
- O I have no pain or discomfort
- O I have moderate pain or discomfort
- O I have extreme pain or discomfort
- O No answer

ANXIETY/DEPRESSION Please tick **only one**:
- O I am not anxious or depressed
- O I am moderately anxious or depressed
- O I am extremely anxious or depressed
- O No answer

28a* **To help people say how good or bad a health state is, we have a scale on which the best state you can imagine is 100 and the worst state you can imagine is marked 0. We would like you to indicate on this scale how good or bad your own health is today, in your opinion. PLEASE DO THIS BY SAYING WHERE ON THIS SCALE YOUR HEALTH STATE IS TODAY.**

....

- O No answer

31 **HAVE YOU BEEN VACCINATED AGAINST HEPATITIS B?** Please tick **only one**:
- O Yes (once) O Yes (twice) O Yes (three times)
- O Never O Don't know

34 **HAVE YOU HAD A SEXUAL HEALTH CHECK IN THE PAST 12 MONTHS?** Please tick **only one**:
- O Yes O No O Don't know

35 **DO YOU KNOW WHERE TO ACCESS FREE CONTRACEPTION?** Please tick **only one**:
- O Yes O No

36 **DO YOU KNOW WHERE TO ACCESS ADVICE ABOUT SEXUAL HEALTH?** Please tick **only one**:
- O Yes O No (*go to Q37)*

37 ***FEMALE CLIENTS OVER 25 ONLY*****: HAVE YOU HAD A CERVICAL SMEAR IN THE PAST 3 YEARS?** Please tick **only one**:
- O Yes O No O Don't know

38 ***FEMALE CLIENTS OVER 50 ONLY*: HAVE YOU HAD A BREAST EXAMINATION/ MAMMOGRAM IN THE PAST 3 YEARS?** Please tick **only one**:

O Yes O No O Don't know

RD5 ***MALE CLIENTS ONLY:* HAVE YOU HAD AN EXAMINATION FOR PROSTATE OR TESTICULAR CANCER IN THE PAST 3 YEARS?**

O YES - Prostate and Testicular
O YES - Prostate only
O YES - Testicular only
O No
O Don't Know

42 **IS THERE ANYTHING ELSE YOU WOULD LIKE TO TELL US ABOUT YOUR HEALTH & THE SUPPORT YOU RECEIVE?**

What works well?

………
………

What could be improved?

………
………

Any other comments:

………
………

Thank you for completing this survey.