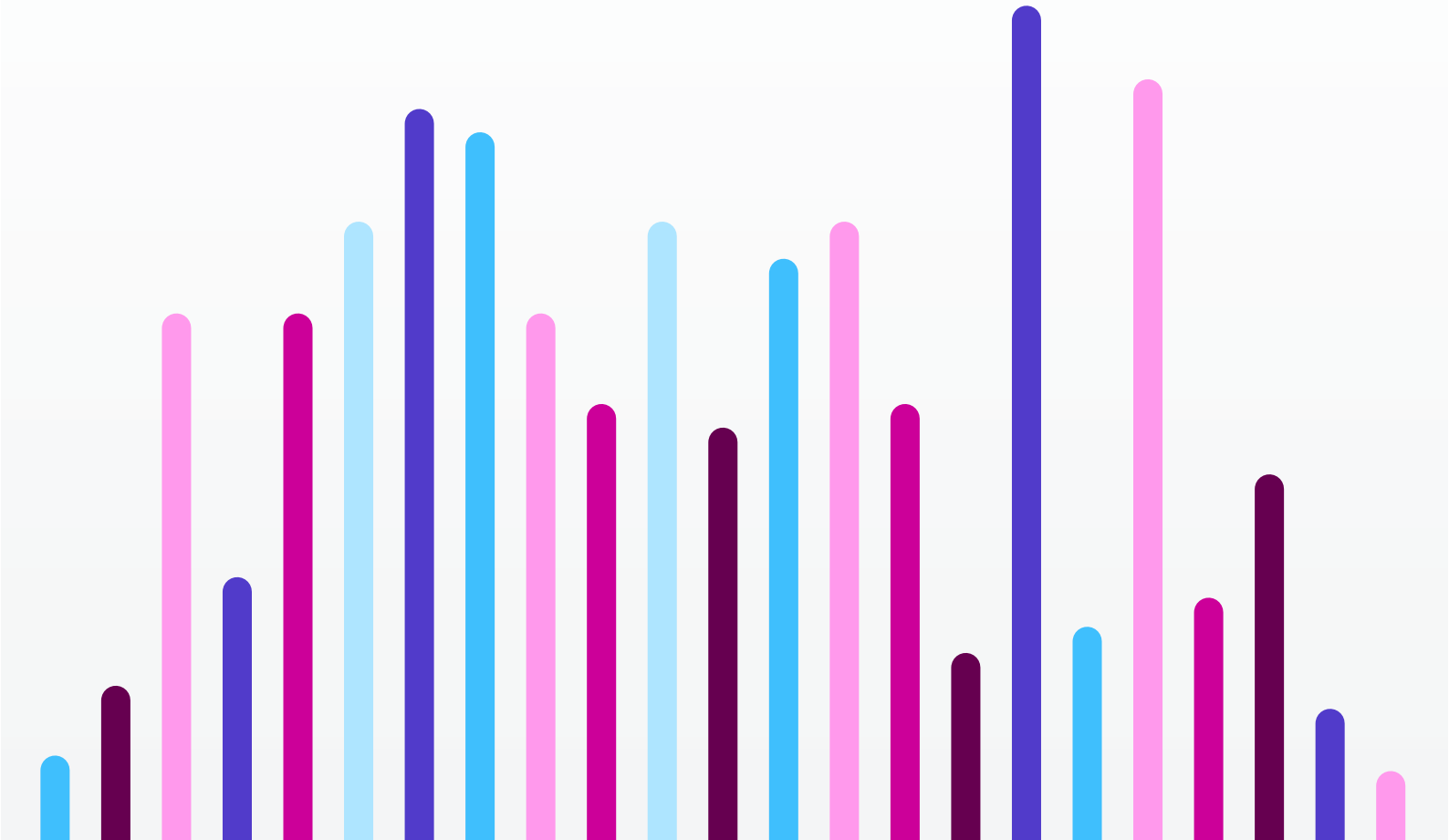
Homeless Link

Homeless Health Needs Audit

The Unhealthy State of Homelessness 2022

Findings from the Homeless Health Needs Audit



Produced by

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We are grateful to the Department for Levelling up, Housing and Communities for their support to develop and deliver the Homeless Health Needs Audit.

About Us

Homeless Link is the national membership charity for frontline homelessness services. We work to improve services through research, guidance and learning, and campaign for policy change that will ensure everyone has a place to call home and the support they need to keep it.

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Executive Summary

It is well known that people experiencing homelessness face significant health inequalities, and poorer health outcomes than the rest of the population. Diagnoses of physical and mental health conditions are much higher than the general population and many of those experiencing homelessness face early onset frailty.[1] The average age of death of someone experiencing homelessness is around 30 years lower than that of the general population.[2]

Poor health can be a cause of homelessness, as was found by recent research by Groundswell which reports that 59% of women surveyed agreed that their health had contributed to them becoming homeless.[3] More often than not people also experience poor health as a consequence of homelessness, with the associated trauma of homelessness leading to worsening mental health, poor availability of good quality food, gruelling physical conditions for those who sleep rough and the increased risk of self-medicating.[4]

This research builds on the learning of our 2014 Unhealthy State of Homelessness report.[5] The Unhealthy State of Homelessness 2014 aggregated data from 19 Homeless Health Needs Audits undertaken between 2012 and 2014 and demonstrated the stark health inequalities faced by people who experience homelessness. The Homeless Health Needs Audit (HNNA) still provides the only national dataset of its kind on this topic.[6] The HHNA is a survey and methodology used to assess the health needs of people experiencing homelessness. It was developed by Homeless Link in 2009 with support from the NHS, Local Authorities and Homeless Link members (predominantly homelessness service providers). The audit is used on an area-wide basis to understand the health needs of people experiencing homelessness.

This report aims to build on this existing knowledge, presenting up to date information on the health of people experiencing homelessness, and exploring what we know about whether the right services are available to adequately meet people's needs. The data in this report are drawn from aggregating data gathered through 31 individual Homeless Health Needs Audits completed between 2015-2021, representing 2,776 individual respondents.

1. Pathways, (2020), Premature frailty, geriatric conditions and multimorbidity among people experiencing homelessness: a cross-sectional observational study in a London hostel. Available at: https://www.pathway.org.uk/wp-content/uploads/Fraility-research-paper.pdf
2. ONS, (2020), Deaths of homeless people in England and Wales: 2019 registrations. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2019registrations
3. Groundswell, (2020), Women, Homelessness and Health: A Peer Research Project. Available at: https://groundswell.org.uk/wp-content/uploads/2020/02/Womens-Health-Research-Report.pdf
4. Groundswell, (2018), Out of Pain. Available at: https://groundswell.org.uk/wp-content/uploads/2018/10/Groundswell-Out-of-Pain-Full-Report.pdf
5. Homeless Link, (2014), The unhealthy state of homelessness. Available at: https://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf
6. For more information, please see: https://homeless.org.uk/what-we-do/research/health-needs-audit/

Homelessness has a devastating impact on people's health and wellbeing. The findings set out in this report and captured from the Homeless Health Needs Audit demonstrate a stark narrative of health inequalities. Across all forms of health care needs, both physical and mental, as well as access to necessary support, people experiencing homelessness report poorer diagnoses and greater barriers to the healthcare needed than the general population.

Physical health

- 78% of wave 3 (2018-2021) respondents reported having a physical health condition, increasing from 76% in wave 2 (2015-2017) and 73% in wave 1 (2012-2014).
- The most commonly reported condition was joint aches / problems with bones and muscles, followed by dental / teeth problems.
- 80% of those with a physical health condition reported having at least one comorbidity, with 29% having between 5 and 10 diagnoses.
- 63% of respondents in the most recent wave of data reported that they had a long term illness, disability or infirmity. This compares to 22% within the general population.

Mental Health

- The number of people with a mental health diagnosis has increased substantially from 45% of respondents in wave 1 to 82% of respondents in wave 3. This compares to a national population average of 12% (as reported via the GP Survey 2021[7]).
- This increase has been driven by the number of people reporting depression, rising from 36% in wave 1 to 72% in wave 3, and anxiety, from 6% to 60%.
- In both wave 2 and wave 3, 1 in 4 (25%) of respondents stated they had Post-Traumatic Stress Disorder.
- 81% of those with a mental health condition reported reported experiencing at least 2 mental health conditions, with 17% reporting 5 or more.
- Whilst 25% of respondents self-reported a dual diagnosis of of coexisting mental health and substance misuse needs, a further 45% reported that they self-medicate with drugs and or alcohol to help them cope with their mental health.

7. NHS, (2022), GP Patient Survey, National Report: 2022 survey. Available at: https://gp-patient.co.uk/downloads/2022/GPPS_2022_National_report_PUBLIC.pdf

Drug and alcohol use

- 38% of respondents reported that they have, or are in recovery from, a drug problem, with 29% of respondents reporting they have, or are in recovery from, an alcohol problem.
- In our most recent wave of data (wave 3), just over half of respondents (54%) reported that they had used drugs in the last 12 months. The figure is identical for wave 2 (2015-2017), where 54% reported the same. The methodology has slightly changed since data was collected in wave one, where 36% of people reported having taken drugs in the month prior to completing the audit.
- Cannabis remains the most commonly used substance with 43% of respondents in wave 2 and 41% in wave 3 reporting use in the last 12 months.
- Reported use of heroin, cocaine and crack have all increased between waves 2 and 3. Crack use has increased the most between waves 2 and 3. In wave 3 crack was the second most frequently reported drug, with 24% (126) respondents using this; in wave 2 crack was the fourth most frequently reported drug, reported by 15% (341) of respondents.

Wellbeing and preventative healthcare

- 76% of respondents reported that they smoke cigarettes, cigars or a pipe. This compared to a national figure of 13.8%. Of those who smoke, 50% (156) would like to give up, although 46% of respondents stated they had not been offered smoking cessation advice or help.
- In wave 3, a third of respondents (33%) reported on average only eating one meal a day and just 18% of people reported that they eat three or more meals per day, with 45% stating they eat an average of two meals a day. The proportion of people reporting that they eat three or more meals a day has decreased from wave 2, where 40% reported this.
- 71% of respondents reported they are currently taking some form of prescribed medication. This figure is much higher than that for the general population, for which the latest available data reports that 48% of adults had taken at least one prescribed medicine in the last week.[8]
- In wave 3, just 6% of respondents reported they were fully vaccinated against Hepatitis B, although 31% had had at least one Hepatitis B vaccine. This represents a drop in the proportion of people fully vaccinated compared to wave 2, where 12% of respondents

8. NHS Digital, (2017) Health Survey for England, 2016. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/health-survey-for-england-2016
9. NHS Digital, (2021) Cervical Screening Programme – 2020/21. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/cervical-screening-annual/england--2020-2021

had had all three hepatitis B vaccinations.

- 54% of eligible respondents in wave 3 reported being up to date with their cervical screening. This compares to 70.2% of the general population.[9]

Use of healthcare services

- In wave 3, 97% of respondents reported being registered at a GP or homeless healthcare centre, an increase from 92% in wave 2. Despite this 6% reported that they had been refused registration in the 12 months before responding to the survey.
- Dental registration levels are much lower than GP registrations, with just 53% of respondents reporting that they were registered with a dentist in wave 3. This is slightly higher than the figure for wave 2 of 49% (1055), however given that our data shows dental/ teeth problems to be the second most commonly reported physical health problem, affecting 36% (187) of respondents, a lack of access to dental services is especially important to note. 10% of respondents had been refused registration to a dental practice in the last 12 months.
- In the most recent wave of data 48% of respondents had used A&E services in the last year. On average, people experiencing homelessness in wave 3 used A&E services 0.9 times a year. The general population figure for comparison stands at 0.3 for 2020/2021[10], indicating that people experiencing homelessness use A&E services on average three times more than the general population.
- 11% of respondents in wave 3 had used A&E services over three times in the last 12 months
- In wave 3, a total of 38% of respondents had been admitted to hospital in the 12 months before participating in a Homeless Health Needs Audit. This figure has held constant since the second wave of data.
- Most common reason for hospital admission relates to a physical health condition (37%) but 28% of admissions were as a result of either a mental health condition. or self-harm or attempted suicide.
- In wave 3, almost a quarter of respondents (24%) were discharged onto the street and a further 21% of respondents were discharged into accommodation which was not suitable for their need

Experiences of homelessness are both a cause and a result of poor physical and mental health. Over half of respondents reported being diagnosed with a physical health condition after they became homeless, speaking to the negative impacts that experiences of homelessness cause. Chronic health conditions such as joint aches and problems with

10. NHS Digital, (2021), Hospital Accident & Emergency Activity 2021-21. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/hospital-accident--emergency-activity/2020-21

muscles and bones are the most commonly reported physical health need, and a reported consequence of rough sleeping and homelessness. In this context we cannot ignore homelessness as a health issue: it is a condition that results in poor physical health and it must be considered as we would any other public health concern.

Mental health conditions are much more likely to have predated experiences of homelessness, with nearly 3 in 4 respondents having had a mental health condition before becoming homeless. Homelessness exacerbates mental health needs but if it is not the primary cause then the importance of preventative healthcare is apparent. We cannot end homelessness if we are not tackling the underlying support needs that lead people to be at greater risk of losing their home.

The findings from the HHNA also highlights the barriers in access to timely and appropriate support that is leading people experiencing homelessness to access emergency services at a substantially higher rate than the general public. Overreliance on ambulances and A&E is not just costly to the health service but it also speaks to concerns that people experiencing homelessness are not able to access healthcare before their needs become an emergency.

From public health initiatives around smoking cessation or flu vaccines, to access to secondary healthcare services that don't leave people reliant on A&E, to support to prevent people from being discharged from hospital back to the streets, what is evident across the HHNA is that poor experiences and outcomes are universal across the health care system. We must understand why this is and address the systemic change needed.

The public health response to homelessness during the COVID-19 pandemic at both a national and local level demonstrated that when the system enables it, significant progress can be made. It is vital that the relationship between health and social care, and homelessness services is maintained and continues to grow.

National and local governments must work to understand why health inequalities for people experiencing homelessness are increasing and why services are still not able to meet their needs. This learning must be used to introduce the change needed to ensure that people are provided with the support that they need to recover and remain well, rather than be left in circumstances known to worsen their health.

Experiencing homelessness should not mean that someone is unable to access the healthcare they need. Nor should it mean we accept poorer health outcomes and growing health inequalities. Homelessness is a health issue and we must respond accordingly.

Chapter 1: Introduction

It is well known that people experiencing homelessness face significant health inequalities, and poorer health outcomes than the rest of the population. Diagnoses of physical and mental health conditions are much higher than the general population and many of those experiencing homelessness face early onset frailty.[11] The average age of death of someone experiencing homelessness is around 30 years lower than that of the general population.[12]

Poor health can be a cause of homelessness, as was found by recent research by Groundswell which reports that 59% of women surveyed agreed that their health had contributed to them becoming homeless.[13] More often than not people also experience poor health as a consequence of homelessness, with the associated trauma of homelessness leading to worsening mental health, poor availability of good quality food, gruelling physical conditions for those who sleep rough and the increased risk of self-medicating.[14]

People experiencing homelessness still face significant obstacles to accessing the healthcare they need. They face stigma and discrimination when accessing mainstream services; financial barriers in the need to physically attend appointments or pay for prescriptions; communication barriers when changing between care providers; and strict eligibility criteria, including exclusions from services when people do not attend appointments.[15,16,17] These barriers to access mean that people experiencing homelessness are high users of emergency services, as treatment is often not received until a crisis point is reached.

> "Homelessness is a public health issue, not only a housing issue."[18]

11. Pathways, (2020), Premature frailty, geriatric conditions and multimorbidity among people experiencing homelessness: a cross-sectional observational study in a London hostel. Available at: https://www.pathway.org.uk/wp-content/uploads/Fraility-research-paper.pdf
12. ONS, (2020), Deaths of homeless people in England and Wales: 2019 registrations. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2019registrations
13. Groundswell, (2020), Women, Homelessness and Health: A Peer Research Project. Available at: https://groundswell.org.uk/wp-content/uploads/2020/02/Womens-Health-Research-Report.pdf
14. Groundswell, (2018), Out of Pain. Available at: https://groundswell.org.uk/wp-content/uploads/2018/10/Groundswell-Out-of-Pain-Full-Report.pdf
15. Crisis, (2021), Understanding homeless health inequality in Birmingham (2021), Available at: https://www.crisis.org.uk/media/244714/crisis_health_now_birmingham_report_2021.pdf
16. Groundswell, (2018), Out of Pain. Available at: https://groundswell.org.uk/wp-content/uploads/2018/10/Groundswell-Out-of-Pain-Full-Report.pdf
17. NICE, (2021), Guideline: Integrated health and care for people experiencing homelessness. Available at: https://www.nice.org.uk/guidance/ng214/documents/draft-guideline
18. NICE, (2021), Guideline: Integrated health and care for people experiencing homelessness. Available at: https://www.nice.org.uk/guidance/ng214/documents/draft-guideline

The COVID-19 pandemic was a crucial turning point; it forced the system to recognise homelessness as a public health issue. In response to a global pandemic, the government took a range of measures to prevent needless death and illness amongst those experiencing homelessness, acknowledging that this population is particularly vulnerable and that a public health approach was necessary to support. This included efforts to ensure people had access to accommodation through the Everyone In initiative, which began in March 2020 and had accommodated more than 45,000 people by December 2021,[19] increasing access to vaccines through the Protect and Vaccinate scheme,[20] and a range of measures to help prevent homelessness such as a pause on evictions and the £20 Universal Credit uplift.

This led to an increased number of partnerships and workstreams that have bridged gaps between the homelessness and health sectors and helped connect people with essential services. A survey of homelessness service representatives conducted by Homeless Link on behalf of the Department for Levelling Up, Housing and Communities (DLUHC) found that 69% of respondents reported an increase in partnership working coming out of the pandemic.[21] According to a report by the National Housing Federation (NHF), many across the sector felt that this closer working has led to a greater understanding within the health sector of the health-related issues faced by those experiencing homelessness.[22]

However, the pandemic also exacerbated some of the health challenges that those experiencing homelessness were already facing. These include the emphasis on short-term health needs causing delays and limitations in preventative and long-term care. While many reported increased joint and partnership working with the health sector, some across the sector also as described how the focus on the pandemic made it harder to access some essential health sector services, particularly mental health support.[23,24] At the same time, the proportion of people experiencing homelessness who have a mental health support need has increased, likely impacted by the isolation experienced during lockdowns as well as the general stress and anxiety caused by the pandemic.

It is now more than two years since the start of the pandemic. Measures to support people during the pandemic have ended as we learn to live with COVID-19. It is vital that we continue to build on the lessons learned during the pandemic that brought effective

19. Department for Levelling Up, Communities and Housing, (2022), Annex A: Official Statistics: support for people sleeping rough in England 2021 (not official statistics). Available at: https://www.gov.uk/government/statistics/rough-sleeping-snapshot-in-england-autumn-2021/annex-a-support-for-people-sleeping-rough-in-england-2021-not-official-statistics
20. DLUHC, (2021), Push to protect and vaccinate rough sleepers with £28 million government funding boost. Available at: https://www.gov.uk/government/news/push-to-protect-and-vaccinate-rough-sleepers-with-28-million-government-funding-boost.
21. Homeless Link, (2020), Working Together: the sector's path beyond COVID-19. Available at: https://www.homeless.org.uk/sites/default/files/site-attachments/Homeless%20Link%20-%20Working%20together%20v5.pdf.
22. National Housing Federation, (2021), Partnership Working Around Homelessness: Lessons Learnt and Action for the Future. Available from: https://www.housing.org.uk/globalassets/files/lga-event-report-final.pdf.
23. Homeless Link, (2020), Working Together: the sector's path beyond COVID-19. Available at: https://www.homeless.org.uk/sites/default/files/site-attachments/Homeless%20Link%20-%20Working%20together%20v5.pdf.
24. Homeless Link, (2020), Working Together: the sector's path beyond COVID-19. Available at: https://www.homeless.org.uk/sites/default/files/site-attachments/Homeless%20Link%20-%20Working%20together%20v5.pdf.
25. DLUHC, (2021), Statutory Homelessness Annual Report 2020-2021, England. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1016146/Annual_Statutory_Homelessness_2020-21.pdf

collaborative working between health and homelessness. Changes to health structures in England bring further opportunity to embed this, as Integrated Care Systems create a requirement for local healthcare commissioners to consider the health needs of inclusion groups, including people experiencing homelessness. It will be vital for Integrated Care Systems to have access to good information in making these decisions so that they can truly improve the health outcomes of people who experience homelessness. The Homeless Health Needs Audit (HHNA) is well placed to support areas in their aim to commission services that meet the specific healthcare needs of people experiencing homelessness in their area.[26]

This research builds on the learning of our 2014 Unhealthy State of Homelessness report.[27] In this report, we present aggregated data from 31 Homeless Health Needs Audits undertaken between 2015 and 2021. The data presented makes it clear that people experiencing homelessness need access to more and better healthcare. People experiencing homelessness face worse physical and mental health than the general population and on many measures the situation has worsened since 2014. Homelessness should only ever be a temporary state, but the impact of poor mental and physical health can only make recovery more complex.

26. To find out more about the Homeless Health Needs Audit, including doing an audit please visit: https://homeless.org.uk/what-we-do/research/health-needs-audit/
27. Homeless Link, (2014), The unhealthy state of homelessness, available at: https://homelesslink-1b54.kxcdn.com/media/documents/The_unhealthy_state_of_homelessness_FINAL_1.pdf

Chapter 2: Aims and objectives of the research

This research builds on the learning of our 2014 Unhealthy State of Homelessness report.[28] The Unhealthy State of Homelessness aggregated data from 19 Homeless Health Needs Audits undertaken between 2012 and 2014 and demonstrated the stark health inequalities faced by people who experience homelessness. The Homeless Health Needs Audit still provides the only national dataset of its kind on this topic.[29]

This report aims to build on this existing knowledge, presenting up to date information on the health of people experiencing homelessness, and exploring what we know about whether the right services are available to adequately meet people's needs. It presents the aggregated data from 31 health needs audits undertaken between 2015-2021.

New to this report, we will present time series data in three groups: wave 1 (2012-2014), wave 2 (2015-2017), and wave 3 (2018-2021). This enables us to explore whether and how the health needs of people experiencing homelessness have changed over time. Whilst by no means an evaluation, time series data may also indicate the impact of particular changes to policy or practice. For example, data on GP registrations and refusals may indicate the success of programmes to reduce barriers to accessing GP care.[30]

Finally, through comparison with general population data, this research aims to improve and update our understanding of how the health needs of people experiencing homelessness differ from the general population.

28. Homeless Link, (2014), The unhealthy state of homelessness. Available at: https://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf
29. For more information, please see: https://homeless.org.uk/what-we-do/research/health-needs-audit/
30. For example Groundswell's My Right To Healthcare cards, which were developed as the result of peer research undertaken in 2016. The My Right To Healthcare cards are supported by NHS England, and are available at: https://groundswell.org.uk/all-resources/healthcare-cards/

Chapter 3: Methodology

The data in this report are drawn from aggregating data gathered through 31 individual Homeless Health Needs Audits completed between 2015-2021, representing 2,776 individual respondents. The composition of this dataset is detailed below.

3.1 The Homeless Health Needs Audit

The Homeless Health Needs Audit (HHNA) is a survey and methodology used to assess the health needs of people experiencing homelessness. It was developed by Homeless Link in 2009 with support from the NHS, Local Authorities and Homeless Link members (predominantly homelessness service providers).

The audit is used on an area-wide basis to understand the health needs of people experiencing homelessness. The survey is administered by local homelessness service staff and as many local homelessness service providers as possible are encouraged to be involved in data collection. High levels of service participation ensures that the resulting data represents as many people's experiences as possible and should usually include: accommodation services, outreach, day centres, night shelters, and specialist support services. Surveys take approximately 30 minutes to complete and most often take part in 1:1 case work sessions.

One lead organisation from each HHNA area has access to their local data through the online platform LimeSurvey. When the data collection is complete, results and analysis are considered by a local strategic group, with data used to build and strengthen partnerships and to make and influence health commissioning decisions.

With permission, the data from each HHNA is aggregated into a national dataset held by Homeless Link. This data is the only dataset of its kind, focussed on the health needs and experiences of people experiencing homelessness. The data presented in this report is drawn from this aggregate dataset.

3.2 The Homeless Health Needs Audit dataset

Data for analysis was initially drawn from 43 Homeless Health Needs Audits undertaken between 2015 and 2021.

All audit questionnaires were completed by people currently experiencing homelessness. Surveys were carried out with the support of staff from local homelessness service

providers, including accommodation services, day centres and outreach teams.

There have been two updates to the Homeless Health Needs Audit survey within the time period 2015-2021, the first in 2015 and the second in 2020. These updates are essential to ensure that the data collected produces the knowledge required to make meaningful changes that benefit the health of people experiencing homelessness. The latest update was supported by several expert roundtables undertaken in 2019, including a Clinician's roundtable, a policy roundtable and a lived experience roundtable. Drawing on this expertise, the survey was amended to better reflect individual experiences of healthcare services and to capture the additional support and services that individuals would like to access.

In addition to these global changes, areas are able to personalise the survey for their own locality. Whilst these activities are crucial for the validity and effectiveness of the audit, it does make analysis more complex as the data cannot simply be aggregated. To account for this, data are grouped, and where this is not possible data are excluded.

3.5 Data inclusion criteria

Since 2014, 43 Homeless Health Needs Audits have been undertaken with the support of Homeless Link. This represents a total of 5,916 individual survey respondents. Of this dataset, 31 audits went on to be analysed, representing a total of 4,297 respondents. The audits that were not included for analysis fell into one of three groups. The first group comprised one audit undertaken in Wales, which was deemed to be outside of the scope of this report. The second group includes five audits from 2015 which used an earlier and significantly different version of the HHNA; this was deemed to contain too few comparable fields to meaningfully contribute to the dataset. The final group includes audits with fewer than 20 respondents. These were not aggregated into the dataset because the low number of responses indicate that the data may not be robust or that the audit process may have stalled in these areas. Table 1 below presents this data:

Table 1: Overview of audits completed between 2015-2021

	Audits	Responses
Audits going on to analysis	31	4,297
Audit excluded: based on old version of HHNA	5	1,196
Audits excluded: out of scope	1	365
Audits excluded: fewer than 20 responses	6	58
Total: 2015-2021	43	5,916

The resulting data for analysis underwent initial cleaning to remove partial responses and responses without consent for use. This process saw usable responses reduce from 4,297 to 2,792, with the drop largely driven by a lack of consent for data to be used for research purposes. Each respondent is given the opportunity to consent for their data to be used by the local area for the purposes of that particular HHNA, and then separately for their data to be included in the aggregated dataset for use by Homeless Link. It is interesting to note that as high as 35% of respondents did not consent for their data to be used in this way. An overview of the data included is presented in Table 2 below. This also includes wave 1 data, presented in The Unhealthy State of Homelessness 2014.

Table 2: HHNA responses by time period

Time period	Total usable responses	Total audits
Wave 1 (2012-2014)	2,590	19
Wave 2 (2015-2017)	2,270	23
Wave 3 (2018-2021)	522	8

Please note that in some cases the figures reported here from wave 1 differ from those reported in the 2014 report The Unhealthy State of Homelessness.[31] This is due to the 2014 report presenting data about some health conditions only where respondents reported having had the condition for more than 12 months; with those who report having the condition for fewer than 12 months excluded. In this report we present data about new and longstanding conditions to create consistency between all three waves of data.

3.3 Limitations of the data

The latest cohort of data, 2018-2021, presents a smaller amount of individual data when compared to previous cohorts with a total of 522 usable responses. This reflects limited activity on the HHNA while it was updated and piloted between 2019-2020. Very soon after this, the onset of COVID-19 impacted the use of the HHNA as the sector faced reduced capacity to deliver amidst the intensive work being carried out to support people experiencing homelessness through the pandemic. The extraordinary resources required to support people through COVID-19, together with the impact of COVID-19 on the workforce, has meant that many fewer areas were able to set resources aside to complete an audit. Of those audits that were completed, many were not straightforward, with data collection needing to be paused and reopened as the impact of COVID-19 was felt.

31. Homeless Link, (2014), The Unhealthy State of Homelessness. Available at: https://homelesslink-1b54.kxcdn.com/media/documents/The_unhealthy_state_of_homelessness_FINAL_1.pdf

Chapter 4: Profile of respondents

This section outlines the profile of respondents to the Homeless Health Needs Audit. We present data on where people were sleeping at the time of responding, as well as their homeless history, demographics and whether they have experienced any of a number of life experiences which have been shown to correlate with a higher risk of homelessness. In this section we compare HHNA data to other homelessness data to understand how representative our sample is of the wider homeless population. Where possible, data is also compared to the general population to identify the inequalities and risk factors associated with experiencing homelessness.

4.1 Housing status

All respondents were asked where they were sleeping at the time of the audit. Where this changed regularly, respondents were asked where they slept last night. The results for waves 2 and 3 are presented in Table 3 below, and show that the majority of people were sleeping in a hostel or supported accommodation service.

Table 3: Respondents current housing situation

	Wave 2		Wave 3	
Current sleep site	**Count**	**%**	**Count**	**%**
In a hostel or supported accommodation	1295	58%	336	68%
In emergency accommodation	145	6%	55	11%
Rough sleeping	216	10%	32	6%
In B&B or other temporary accommodation	116	5%	20	4%
Housed - in own tenancy	227	10%	19	4%
Sleeping on somebody's sofa/ floor	163	7%	17	3%
Squatting	12	1%	2	0%
Staying with friends / family	16	1%	0	0%
Vehicle or caravan on the side of the road or car park	0	0%	0	0%
Other	54	2%	14	3%
N:	2244		495	

The number of people sleeping in emergency accommodation increased by 83% between wave 2 and wave 3, this likely reflects that wave 3 covered the Everyone In response to the COVID-19 pandemic, which brought many people rough sleeping into emergency accommodation that did not exist prior to the pandemic.[32] The reduction to zero of people staying with friends/ family may also be reflective of changes made to peoples' living situations when the COVID-19 pandemic and lockdowns hit.

4.2 Homeless history

Participants were asked whether they had ever faced any of a range of experiences of homelessness, including rough sleeping, sofa surfing and staying at an accommodation service. In wave 3 the majority of respondents, 85% (434), had stayed at a homelessness accommodation service (including hostels, foyers and refuges). Around two thirds of respondents had sofa surfed (69%, (353)), applied to the council as homeless (68%, (349)) and slept rough (66% (339)). The full data is presented in Table 4 below.

Table 4: Experiences of different forms of homelessness

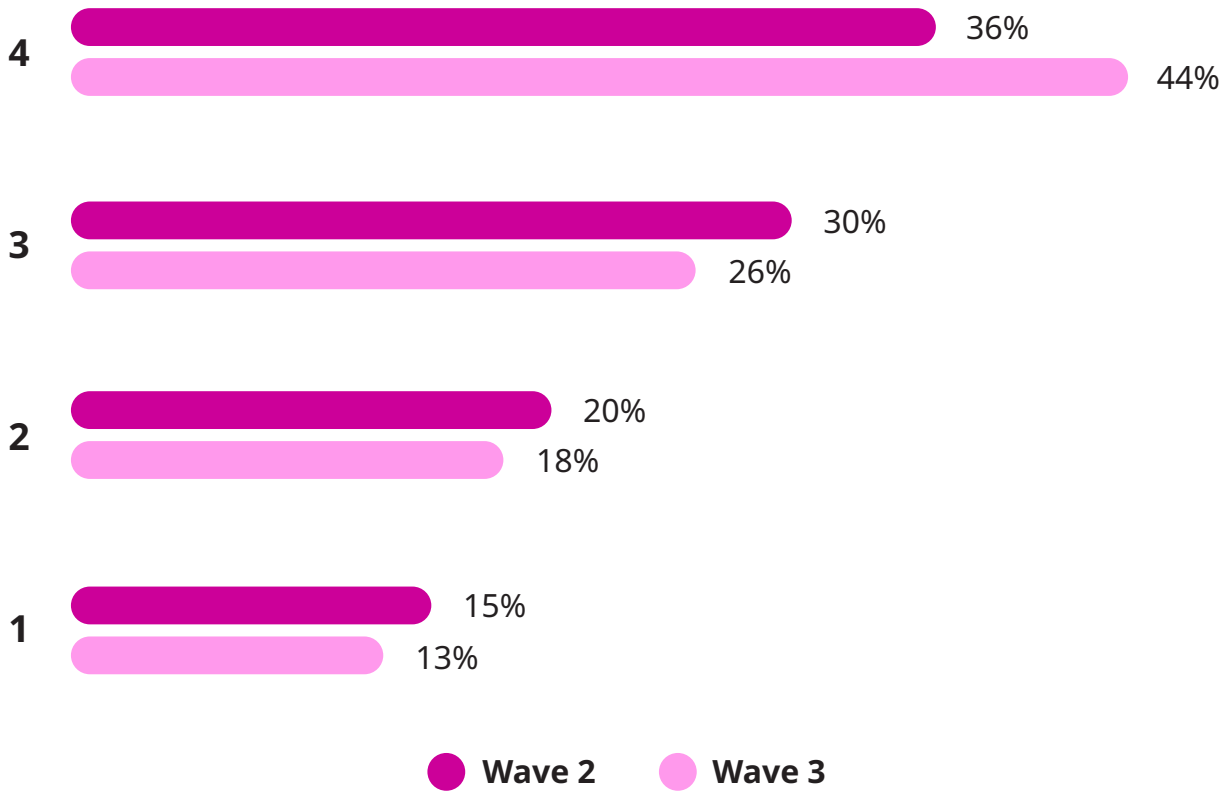
	Wave 2		Wave 3	
Experience	**Count**	**%**	**Count**	**%**
Stayed at a hostel, foyer, refuge or any other type of homelessness service	1845	82%	434	85%
Sofa surfed	1559	69%	353	69%
Applied to the council as homeless	1449	65%	349	68%
Slept rough	1400	62%	339	66%
None	65	3%	15	3%
N:	2246		513	

32. More detail can be found at: Department for Levelling Up, Housing and Communities, (2022), Annex A: Support for people sleeping rough in England (not official statistics). Available at: https://www.gov.uk/government/statistics/rough-sleeping-snapshot-in-england-autumn-2021/annex-a-support-for-people-sleeping-rough-in-england-2021-not-official-statistics

The disparity between the number of people reporting that they had ever slept rough, or sofa surfed compared to the number reporting this being their current situation may indicate that the HHNA data underrepresents this group. This is a common problem amongst homelessness data, and although HHNA coordinators do work with outreach teams, Day Centres and other services who are in contact with people experiencing these forms of homelessness, these populations nevertheless remain more difficult to capture as they tend to have less contact with services.[33]

The majority of respondents had experienced more than one of the forms of homelessness asked about. Excluding those who had not experienced any of the forms of homelessness included in the survey, 44% (215) of respondents had experienced all four of these forms of homelessness in wave 3. In wave 2 fewer people had experienced all four forms of homelessness asked about, at 36% (779). Just 13% (63) of respondents in wave 3 had experienced only one of these forms of homelessness, the most common of which was 'stayed at a hostel, foyer, refuge or any other type of homelessness service' 54% (34). Chart 1 below presents this data.

Chart 1: Number of forms of homelessness experienced by respondents



33. Crisis, (2011), The Hidden Truth About Homelessness. Available at: https://www.crisis.org.uk/media/236816/the_hidden_truth_about_homelessness_es.pdf

4.3 Age

The majority of respondents in both waves 2 and 3 were between the ages of 25-54, at 69% (339) in wave 3 and 64% (1436) in wave 2. There has been some change in other age groups. There were more older respondents in wave 3, at 16% (82) in the most recent data, compared to 10% (228) in wave 2. Additionally, fewer younger people responded in the most recent data, with 14% (71) of respondents being aged 18-24 in wave 3, compared to 23% (510) in wave 2 data. Full results can be seen in Table 5 below.

Table 5: Respondents Age

	Wave 2		Wave 3	
Age	**Count**	**%**	**Count**	**%**
15-17	63	3%	1	0%
18-24	510	23%	71	14%
25-54	1436	64%	339	69%
55-74	221	10%	81	16%
75+	7	0%	1	0%
N:	2237		493	

Statutory data about people owed a prevention or relief duty by any English local authority in the financial year 2020/21 shows that nationally the percentage of people owed a duty who were aged 25-54 is very similar to that found in our data, at 68% (182,340)[34]. There is more divergence in other age groups, with young people aged 18-24 representing 22% (58,830) of people owed a duty in England during this time,[35] compared to 15% (71) in our most recent data. In 2020/21 the statutory data on people owed a prevention or relief duty shows that 9% (22,450) of people were aged 55+,[36] compared to 16% (82) in our data. There are a few possible explanations for this variation. It may be that fewer youth specific services have taken part in the data collection for a Homeless Health Needs Audit during this time, or it may be that the age profile of the 'static' homeless population (i.e. people who have not presented to a local authority in the last year) is slightly older.

34. Gov.UK, (2021), statutory homelessness in England: financial year 2020-21. Available at: https://www.gov.uk/government/statistics/statutory-homelessness-in-england-financial-year-2020-21
35. Gov.UK, (2021), statutory homelessness in England: financial year 2020-21. Available at: https://www.gov.uk/government/statistics/statutory-homelessness-in-england-financial-year-2020-21
36. Gov.UK, (2021), statutory homelessness in England: financial year 2020-21. Available at: https://www.gov.uk/government/statistics/statutory-homelessness-in-england-financial-year-2020-21

4.4 Ethnicity

The majority of respondents in wave 3 (2018-2021) were white (93%, 461), with 3% (17) being of mixed/ multiple ethnicity and a further 2% (11) being Black, Black British, Caribbean or African, and 1% (6) being Asian/ Asian British. Table 6 presents this data in full.

Table 6: Ethnicity of respondents

	Wave 2		Wave 3		Population estimate 2019[37]
Ethnicity	**Count**	**%**	**Count**	**%**	
White	1936	87%	461	93%	84.8%
Mixed/ multiple ethnic groups	82	4%	17	3%	1.8%
Black, Black British, Caribbean or African	49	2%	11	2%	3.5%
Asian/ Asian British	137	6%	6	1%	8%
Other	34	2%	5	1%	1.9%
N:	2238		495		

Comparing this data to the statutory data on people owed a homelessness prevention or relief duty in the financial year 2020/21 indicates an overrepresentation in our data of people whose ethnicity is White. 64% (172,600) of people identified their ethnicity as White in the statutory data, compared to 93% in our data. Comparison with statutory data also suggests that our data underrepresents people whose ethnicity is Black/ African/ Caribbean/ Black British – a figure which stands at 10% (25,920) in the statutory data, and 2% (11) in our data. Our data also appears to underrepresent people whose ethnicity is Asian/ Asian British, a figure which stands at 6% (15,150) in the statutory data and 1% (6) in our data.[38] These discrepancies are likely to be influenced by the locations in which the Homeless Health Needs Audits took place during 2018-2021. When we compare these figures to national population estimates, we see a similar trend of our data over-representing people who identify their ethnicity as White. When comparing the statutory data to population level data we can see a clear overrepresentation of people who identify their ethnicity as Black/ African/ Caribbean/ Black British approaching their local authority for homelessness assistance.

37. Data taken from: Office for National Statistics, Population estimates by ethnic group and religion, England and Wales: 2019. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/articles/populationestimatesbyethnicgroupandreligionenglandandwales/2019#ethnicity-in-england-and-wales

38. Gov.UK, (2021), statutory homelessness in England: financial year 2020-21. Available at: https://www.gov.uk/government/statistics/statutory-homelessness-in-england-financial-year-2020-21

4.5 Gender

Respondents were asked to identify their gender. In wave 3 (2018-2021), 68% (340) of respondents identified as male and 30% (153) as female. 1% (5) of respondents identified as transgender and a further 1% (3) identified as non-binary. This data is presented in Table 7 below.

Table 7: Gender of respondents

	Wave 2		Wave 3	
Gender	**Count**	**%**	**Count**	**%**
Male	1646	73%	340	68%
Female	607	27%	153	30%
Transgender	2	0%	5	1%
Non binary	0	0%	3	1%
Other	1	0%	2	0%
N:	2256		503	

It is important to understand the gender of respondents as gender is highly relevant to the experiences that can cause homelessness and to the kinds of support needs that people may have. We know that women are more likely to be hidden homeless and that when they access services the needs of women are often higher and more complex than that of men experiencing homelessness.[39,40] Likewise, women face specific health needs particularly around reproductive health, and maternity care.

39. Bretherton J., and Pleace, N., (2018), 'Women and Rough Sleeping: A critical review of current research and methodology', St Mungo's. Available at: https://www.mungos.org/publication/women-and-rough-sleeping-a-critical-review/
40. Goundswell, (2020), 'Women, homelessness and health: a peer research project'. Available at: https://groundswell.org.uk/wp-content/uploads/2020/02/Womens-Health-Research-Report.pdf

4.6 Sexuality

Our understanding of the experience of homelessness for those within the LGBTQ+ community is growing, with reports such as 'The lgbtq+ youth homelessness report' by akt revealing specific challenges both leading to homelessness, and in accessing services.[41] It is because of the importance of capturing the differential experiences of this community that the HHNA asks respondents about their sexual orientation. The results are presented in table 8 below:

Table 8: Sexual orientation of respondents

	Wave 3	
Sexual orientation	**Count**	**%**
Heterosexual or straight	423	89%
Bisexual	21	4%
Gay or lesbian	18	4%
Pansexual	6	1%
Other	7	1%
N:	475	

Statutory data on homelessness records the sexual orientation of all those owed a homeless prevention or relief duty. In the financial year 2020/2021, 69% (268,560) of those owed a prevention or relief duty identified as heterosexual. 1% (4000) of people owed a prevention or relief duty identified as gay/ lesbian, and 3% (7,320) as 'other'. A further 23% (61,840) preferred not to say and the sexual orientation of 4% (10,190) of those owed these duties was recorded as 'not known'[42].

It is difficult to meaningfully benchmark HHNA data against national data when as high as 27% of responses to local authority data are missing due to people either choosing not to say or their sexuality being recorded as 'not known'. This further highlights the gap in the data held on LGBTQ+ people who experience homelessness.

41. akt, 2021, 'The lgbtq+ youth homelessness report'. Available at: https://www.akt.org.uk/Handlers/Download.ashx?IDMF=59eae91c-ee80-4b6b-8ecb-158edfeeaccd
42. Gov.UK, (2021), statutory homelessness in England: financial year 2020-21. Available at: https://www.gov.uk/government/statistics/statutory-homelessness-in-england-financial-year-2020-21

4.7 Immigration status

Respondents were asked their immigration status. This is relevant because non-UK nationals are more vulnerable to homelessness than those with UK citizenship, and those with restricted or undetermined eligibility for funds are even more so.[43] Those with undetermined or restricted eligibility may have less access to accommodation services and may therefore experience homelessness and the health impact of homelessness differently. Additionally, although GP and emergency healthcare is available regardless of immigration status, access to some secondary NHS services is dependent on immigration status. This means that some people with restricted or undetermined eligibility may not have access to all NHS services.[44] As HHNA data is drawn from participating services in local areas some of the statutory provided services may only be accessible to those with recourse, it is possible that this data underrepresents non-UK nationals with restricted or undetermined eligibility. Results from waves 2 and 3 are presented in table 9 below.

It is important to note that changes to immigration rights for EEA citizens changed during the period covered by this research with the introduction of the EU Settled Status scheme (EUSS) in 2019. Due to mixed data available on this during the HHNA data collection period further data breakdown are not possible for this report.

Table 9 Respondents' immigration status

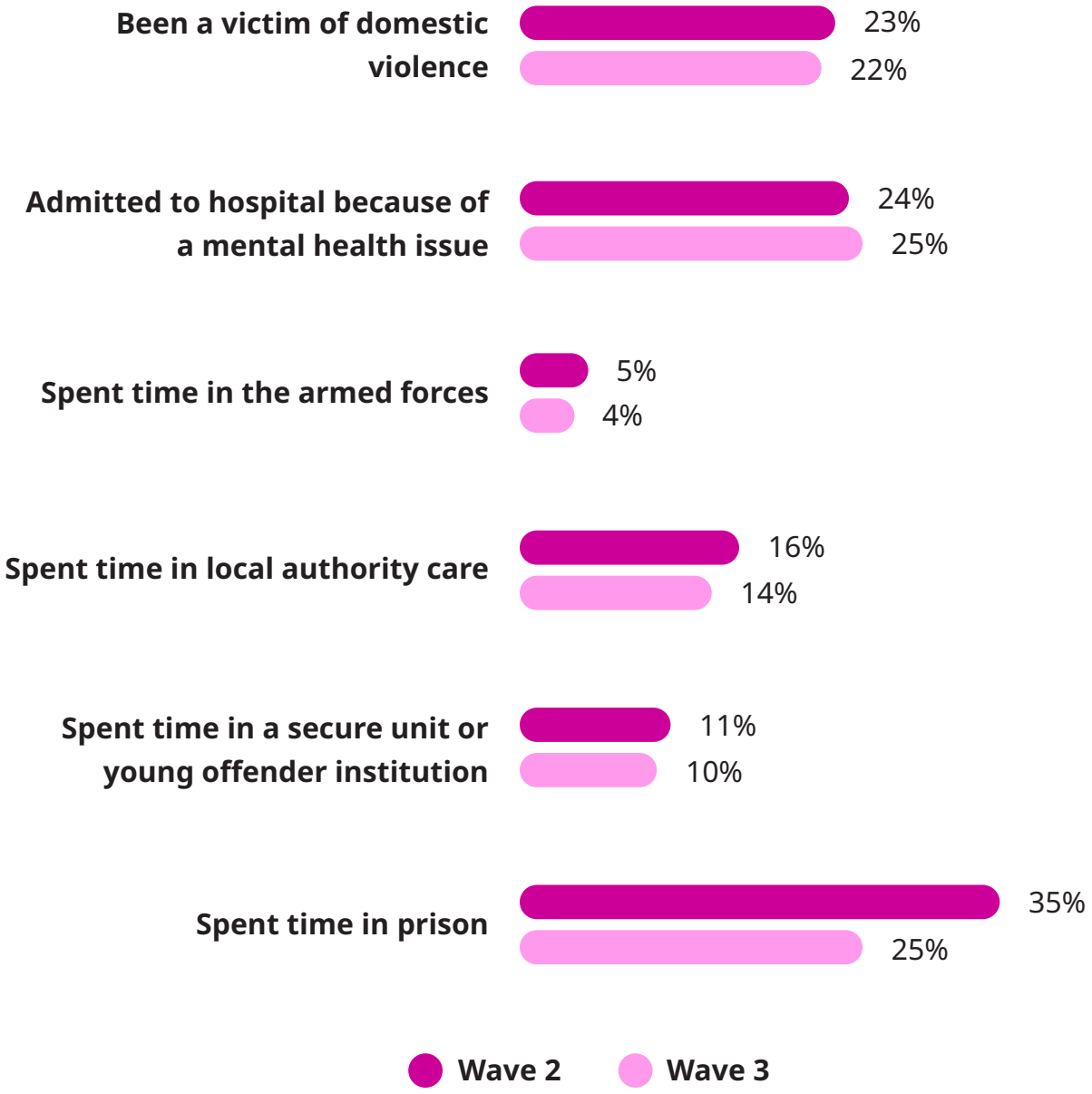
	Wave 2		Wave 3	
Gender	**Count**	**%**	**Count**	**%**
UK National	1883	93%	460	92%
European Economic Area (EEA) national	73	4%	24	5%
Permanent residence/Indefinite leave to remain	6	0%	8	2%
National from outside of the EEA	32	2%	1	0%
Asylum Seeker	6	0%	0	0%
Refugee	9	0%	1	0%
Unknown	12	1%	3	1%
Other	7	0%	3	1%
N:	2029		500	

43. Boobis, S., Jacob, R., and Sanders, B. (2019). A Home For All: Understanding Migrant Homelessness in Great Britain. London: Crisis
44. Full information of who is eligible for free NHS care is provided by the NHS: https://www.gov.uk/guidance/nhs-entitlements-migrant-health-guide#nhs-entitlements-animation

4.8 Life experiences associated with homelessness

Respondents were asked whether they have ever faced six different life experiences. These life experiences are over-represented amongst those experiencing homelessness and indicate the multiple challenges that many people face, and the associated trauma that may occur.[45] In wave 3, two thirds of respondents (66% (344)) had experienced at least one of these life experiences, and almost a third (31% (164)) of respondents had faced more than one. Chart 2 presents the findings from waves 2 and 3. Data for wave 1 is unavailable.

Chart 2: Life experiences and risk factors



45. FEANTSA, (2017), Recognising the link between trauma and homelessness. Available at: https://www.feantsa.org/download/feantsa_traumaandhomelessness03073471219052946810738.pdf

Many of the associated risk factors and life experiences asked about have remained consistent across waves 2 and 3. The main change seen between the two waves is a ten percent reduction of respondents having ever spent time in prison in wave 3 compared to wave 2. Available statutory data on people who applied to a local authority as homeless in 2020/21 shows that these data are consistent with ours on the proportion of people who have ever been a victim of domestic violence, at 22%.[46] Data on other life experiences and risk factors differs slightly, suggesting a higher proportion of people in our data having ever spent time in prison, spent time in local authority care, or spent time in the armed forces. Table 10 below presents this data.

Table 10: Life experiences and risk factors

	Wave 3		Statutory homelessness figures
Life experience	**Count**	**%**	
Spent time in prison	160	25%	20%[47]
Admitted to hospital because of a mental health issue	161	25%	
Been a victim of domestic violence	139	22%	22%
Spent time in local authority care	88	14%	5%[48]
Spent time in a secure unit or young offender institution	64	10%	
Spent time in the armed forces	23	4%	1%[49]
N:	635		

(Please note that respondents could select more than one option and so N is larger than the population)

46. At risk of/ has experienced domestic violence. Figures from Gov.UK, (2021), statutory homelessness in England: financial year 2020-21. Available at: https://www.gov.uk/government/statistics/statutory-homelessness-in-england-financial-year-2020-21
47. Offending history figures from Gov.UK, (2021), statutory homelessness in England: financial year 2020-21. Available at: https://www.gov.uk/government/statistics/statutory-homelessness-in-england-financial-year-2020-21
48. Care leaver. Figures from Gov.UK, (2021), statutory homelessness in England: financial year 2020-21. Available at: https://www.gov.uk/government/statistics/statutory-homelessness-in-england-financial-year-2020-21
49. Figures from Gov.UK, (2021), statutory homelessness in England: financial year 2020-21. Available at: https://www.gov.uk/government/statistics/statutory-homelessness-in-england-financial-year-2020-21

Chapter 5: Homeless health

This section presents findings across four areas: physical health, mental health, drug and alcohol use, and wellbeing. Where available we present national data for comparison, in order to understand the true extent of the health inequalities faced by people experiencing homelessness.

Chapter 5 reports key health statistics across each of these areas, in later sections of this report we go on to explore how people experiencing homelessness use healthcare services and the extent to which available healthcare services meet the needs of people experiencing homelessness.

Key findings:

Physical health

- 63% of respondents in wave 3 reported that they had a long term illness, disability or infirmity. This compares to 22% within the general population.
- 78% (408) of respondents reported having a physical health condition.
- 80% of those with a physical health problem have more than one such condition, with 29% having between 5-10 diagnoses.
- Across all waves of data joint aches/ problems with bones and muscles was the most commonly reported physical health condition – at 37% (194) in wave 3.
- Across all waves of data dental/ teeth problems was the second most commonly reported physical health condition – at 36% (187) in wave 3.

Mental health

- The number of people with a mental health diagnosis has increased substantially from 45% (1005) of respondents in wave 1 to 82% (401) in wave 3.
- 81% (266) of those with a mental health condition experience comorbidities, with 27% (87) of respondents experiencing 2 such conditions.
- 72% (291) of respondents reporting experiencing depression, compared to a national rate of 10% pre-pandemic.
- 45% (211) of respondents self-medicate with drugs or alcohol to help them cope with their mental health.

Drug and alcohol use

- 54% (281) of respondents had used drugs in the 12 month prior to taking part in a HHNA.
- Crack use has increased the most between waves 2 and 3. In wave 3 crack was the second most frequently reported drug, with 24% (126) respondents using this; in wave 2 crack was the fourth most frequently reported drug, reported by 15% (341) of respondents.
- 38% (143) of respondents report that they have, or are recovering from, a drug problem.
- 20% of respondents regularly exceed the low risk drinking guidelines, this compares to 24% of the general population.
- 29% of respondents have, or are in recovery from, an alcohol problem.

Wellbeing

- 76% (378) of respondents reported that they smoke cigarettes, cigars or a pipe. This compared to a national figure of 13.8%.
- Of those who smoke, 50% (156) would like to give up.
- 33% (153) of respondents typically eat one meal a day and 3% (16) of respondents do not eat any meals.
- 66% (301) of respondents ate one or fewer portions of fruit or veg per day. Just 4% (17) ate the recommended 5 or more.

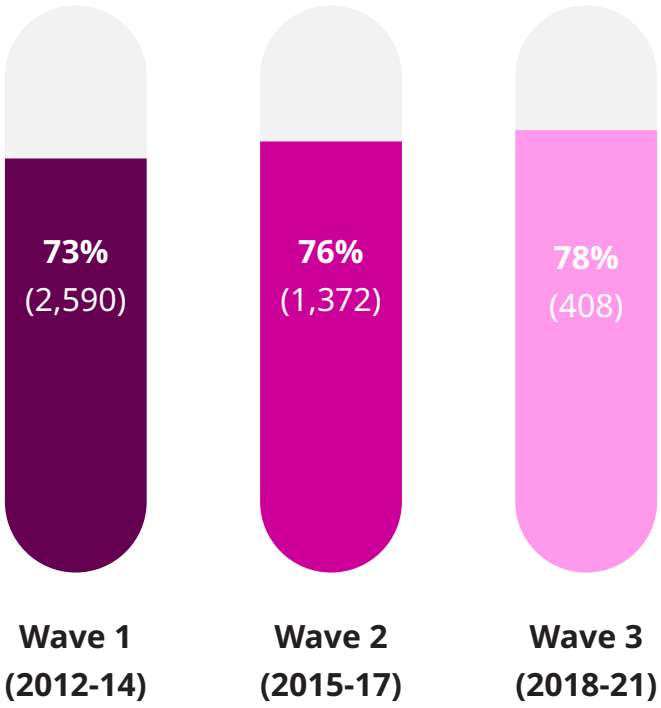
5.1 Physical health

This section presents findings related to the physical health of HHNA respondents. The data presented explores the prevalence of specific physical health conditions, and how this has changed over time. We also explore data on comorbidities and present data on respondents reporting a longstanding illness, disability or infirmity.

Physical health conditions

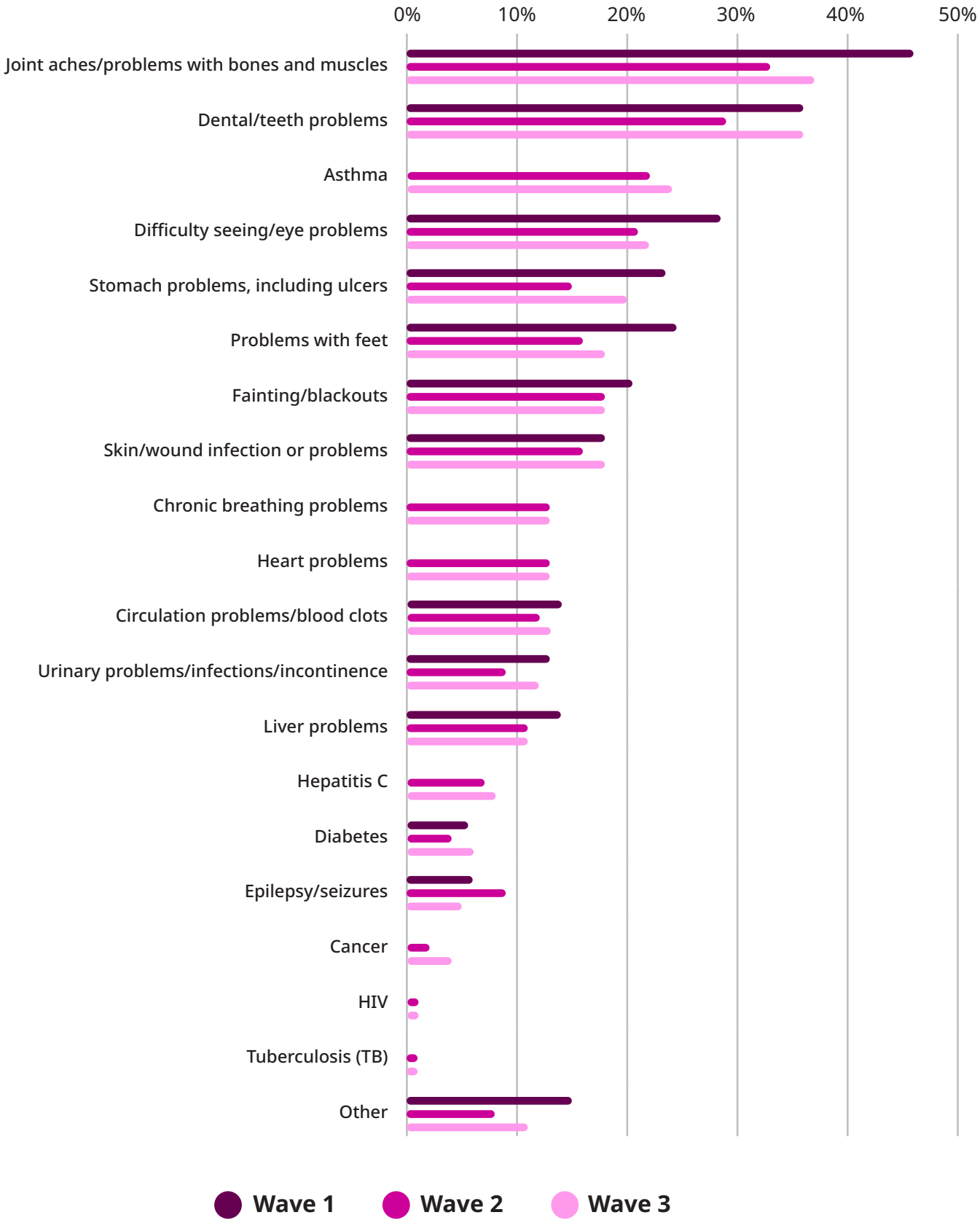
78% (408) of respondents reported having a physical health condition in wave 3. This figure has slightly increased over time, with 73% of respondents reporting the same in wave 1 and 76% in wave 2. Chart 3 below presents the data from each of the three waves of HHNA data.

Chart 3: Proportion of respondents with a diagnosed physical health condition



The physical health conditions captured by the HHNA have changed and expanded over time. The data presented in Chart 4 presents data on the prevalence of physical health conditions across all three waves where possible, where this is not possible data is presented from waves 2 and 3.

Chart 4: Frequency of physical health conditions



The most common health conditions have remained constant across the three waves of data, with the most common physical health condition reported as 'joint aches/ problems with bones and muscles' across all waves, followed by dental/ teeth problems. Asthma was the third most commonly reported physical health condition in waves 2 and 3. Data is not available on asthma in wave 1. Interestingly, a number of health conditions show a drop in prevalence between waves 1 and 2, with a subsequent increase in wave 3. For example, joint aches/ problems with bones and muscles was reported by 46% of respondents in wave 1, dropping to 33% of respondents in wave 2 and then rising again in wave 3 where this condition was reported by 37% of respondents.

Table 11 presents the ten most common health conditions reported in the most recent wave of data.

Table 11: Ten most common health conditions

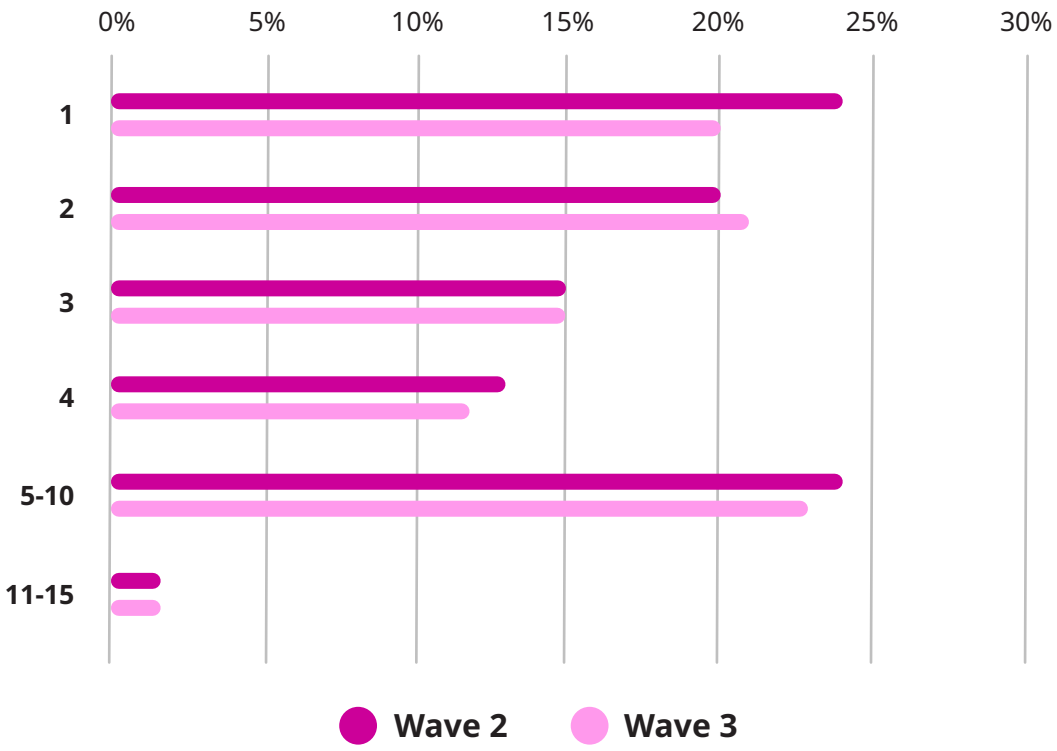
Health condition (N=522)	**Count**	**%**
Joint aches/problems with bones and muscles	194	37%
Dental/teeth problems	187	36%
Asthma	125	24%
Difficulty seeing/eye problems	114	22%
Stomach problems, including ulcers	104	20%
Problems with feet	95	18%
Fainting/blackouts	93	18%
Skin/wound infection or problems	92	18%
Chronic breathing problems	70	13%
Heart problems	68	13%

Comorbidities

Whilst 20% (144) of respondents who reported a physical health problem had one health condition, many more lived with comorbidities. Analysis is not available for wave 1, but in wave 2 the percentage of respondents reporting just one physical health condition was slightly higher, at 24%. Across both waves it was more common for respondents with a diagnosed physical health condition to be managing comorbidities.

In the latest wave of data 29% (119) of people with a physical health condition reported between 5 and 10 different diagnoses. 21% (86) of respondents with a physical health condition had two diagnoses, 15% (60) had three diagnoses, and 12% (50) had four physical health diagnoses. Chart 5 below presents data on comorbidities for waves 2 and 3.

Chart 5: Frequency of physical health conditions



The difficulty of managing numerous health conditions whilst experiencing homelessness cannot be understated. Managing the associated appointments, medications and symptoms adds to an already complex job of navigating the homelessness system and may make finding suitable accommodation more challenging.

Disability

In addition to being asked about their experience of specific health conditions, respondents were also asked whether they had a longstanding illness, disability or infirmity. Our data shows that in wave 3 just under two thirds of people (63% (306)) had a longstanding illness, disability or infirmity. This figure has decreased slightly from wave 2, when 67% of respondents (1464) reported having a disability, illness or infirmity. Data is not available on this from wave 1.

The latest estimates from the Family Resources Survey (FRS) indicate that 14.6 million people in the UK had a disability in the 2020/21 financial year. This represents 22% of the total population[50], a figure substantially lower than that reported by people experiencing homelessness. This highlights the extent of health inequalities faced by this group. Table 12 presents the results for waves 2 and 3 in full.

Table 12: Respondents with a longstanding illness, disability or infirmity

	Wave 2		Wave 3	
Disability	**Count**	**%**	**Count**	**%**
Yes	1464	67%	306	63%
No	730	33%	179	37%
N:	2194		485	

Taken together, the data presented here demonstrates that people experiencing homelessness still face significant health inequalities. They are almost three times more likely to report having a longstanding illness, disability or infirmity than the general population and most of those with a diagnosed physical health condition are managing multiple comorbidities. When we consider that many people are managing complex health conditions, together with the challenges brought by homelessness, we can see that recovery is manifestly difficult without adequate support.

We will go on to explore the data on whether people receive the level of support that they need for their physical health in section 8, and will explore people's reported ability to take measures that help support their health in chapter's 6 and 8 of this report.

50. Department for Work and Pensions, (2022), Family Resources Survey: Financial year 2020 to 21. Available at: https://www.gov.uk/government/statistics/family-resources-survey-financial-year-2020-to-2021/family-resources-survey-financial-year-2020-to-2021

5.2 Mental health

In this section we present data on the number of people with a diagnosed mental health condition, exploring how this figure has changed across waves of data collection and how it compares with the general population. We present findings on the most common mental health conditions experienced by respondents, and demonstrate the rate of comorbidities. New to this report, we present data on the difference between diagnosed and self-reported mental health conditions. Finally, we present data on the number of respondents who self-medicate with drugs or alcohol to help them to cope with their mental health.

The HHNA survey asks respondents to identify whether they experience any of a listed set of mental health conditions. We separately ask respondents whether they have any diagnosed mental health conditions. It should be noted that results relating to individual conditions in wave 3 are self-identified, whilst the number of respondents with a diagnosed mental health condition is clearly identified below. Methodological changes also mean that data for some mental health conditions is not available for wave 1, this is made clear where data are reported.

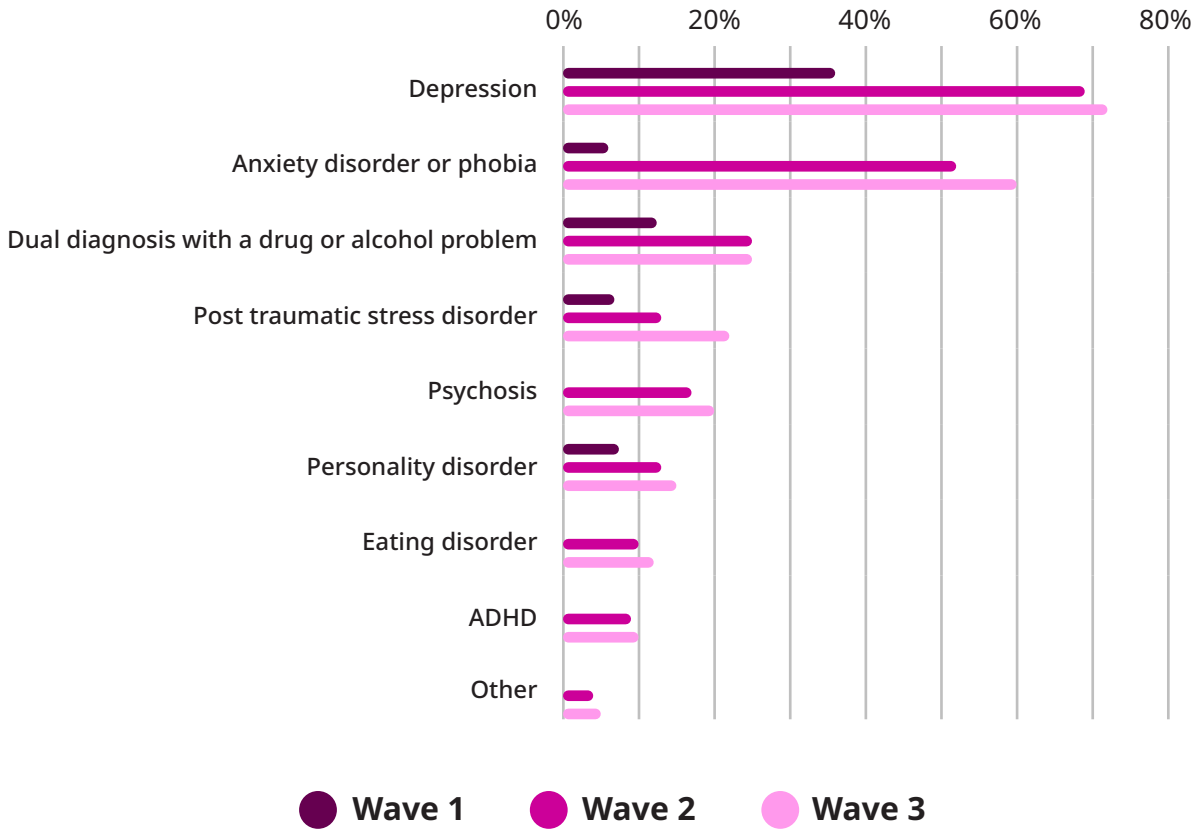
Mental health conditions

The number of people reporting a diagnosed mental health condition has soared since the first wave of data collection in 2012-2014. Then, 45% (1005) of respondents had a diagnosed mental health condition; a figure that now stands at 82% (401). Using the GP Survey 2021 as a national population comparison, we can see that 12% of respondents reported having a mental health condition in 2022[51], a difference of 70 percentage points emphasising the harsh health inequalities in this area.

For waves 2 and 3 the most frequently reported mental health conditions were: depression, anxiety disorder or phobia, and dual diagnosis with a drug or alcohol problem. Chart 6 below presents data from all three waves of data where possible, excluding wave 1 data where it in unavailable. Where data from wave 1 is available, it demonstrates a sharper rise in reported mental health conditions between waves 1 and 2, with a smaller increase between waves 2 and 3.

51. NHS, (2022), GP Patient Survey, National Report: 2022 survey. Available at: https://gp-patient.co.uk/downloads/2022/GPPS_2022_National_report_PUBLIC.pdf

Chart 6: Frequency of mental health conditions



Looking in more detail at wave 3 data, we can see that among the 9 mental health conditions that the survey asks about, the predominance of depression is very stark, with 72% (291) of respondents reporting experiencing depression, compared to a national rate of 10% pre-pandemic.[52] The second most commonly reported mental health condition was anxiety disorder or phobia, reported by 60% (244) of respondents in wave 3. The third most commonly reported mental health condition was dual diagnosis (a mental health problem alongside drug or alcohol use) and was experienced by 25% (101) of respondents. For people with dual diagnosis it can be extremely challenging to access support, as they can be refused access to mental health services until they have 'dealt with' their substance use; and refused access to substance use services because of mental ill health.[53]

52. 2021, ONS, Coronavirus and Depression in Adults, Great Britain: January to March 2021. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/coronavirusanddepressioninadultsgreatbritain/januarytomarch2021#prevalence-of-depressive-symptoms-over-time

53. Petra K. Staiger, Anna C. Thomas, Lina A. Ricciardelli, Marita P. Mccabe, Wendy Cross & Greg Young, (2011) Improving services for individuals with a dual diagnosis: A qualitative study reporting on the views of service users, Addiction Research & Theory, 19:1, 47-55

Table 13: Reported mental health

	Wave 3	
Disability	**Count**	**%**
Depression	291	72%
Anxiety disorder or phobia	244	60%
Dual diagnosis with a drug or alcohol problem	101	25%
Post traumatic stress disorder	87	22%
Psychosis	82	20%
Personality disorder	59	15%
Eating disorder	47	12%
Other	22	5%

Self-reported mental health conditions

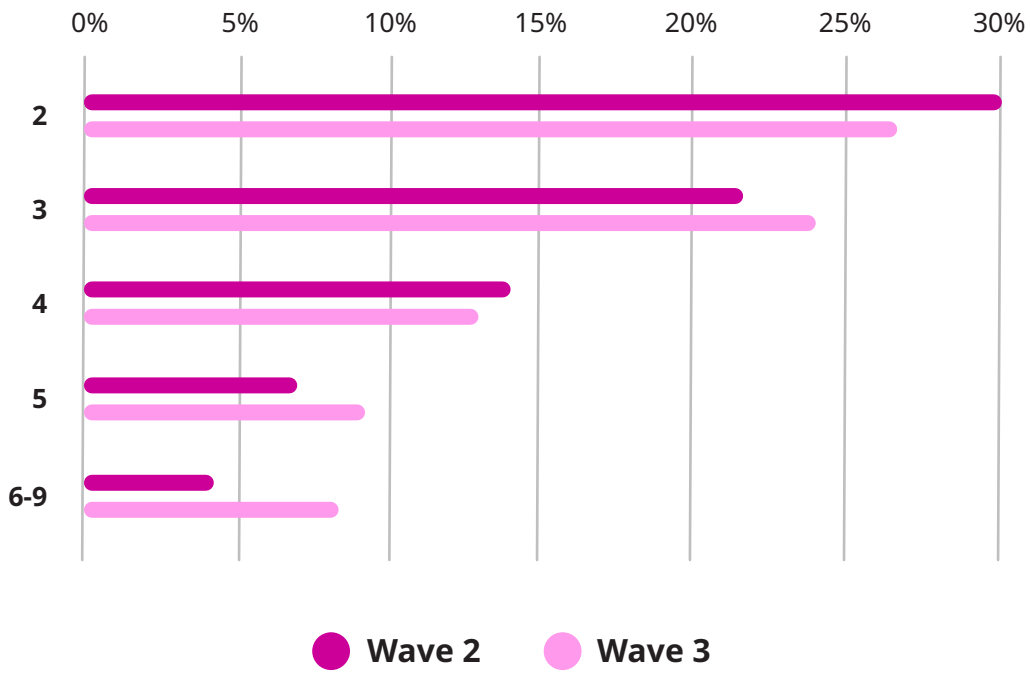
In wave 3 for the first time we asked respondents to self-identify whether they had any of a range of mental health conditions, and then separately whether they had any mental health condition that had been diagnosed by a medical professional.

There was only 1% difference between respondents with diagnosed and undiagnosed mental health conditions: 82% (401) and 81% (328) respectively. It is important to note that we do not know whether people had been able to get diagnoses for all of the symptoms that they experience, however these results indicate a close relation between people's perception of their own mental ill health and diagnosable mental ill health.

Comorbidities

It was very common for respondents to report experiencing multiple mental health conditions. Of those who reported having a mental health condition, just 19% reported experiencing just one, with 81% experiencing mental health comorbidities. It was most common for people to report two (27% (87)) or three (24% (80)) mental health conditions. Data on comorbidities are available for waves 2 and 3 only as a result of changes to data collected in wave 1. The data is presented in Chart 7 below.

Chart 7: Mental health comorbidities



The complexity, both for individuals and the services that support them, of supporting people with complex mental health conditions cannot be understated. Our data suggests that the support respondents receive often falls short of what they need, with significant impact on both the individuals involved and on emergency healthcare services.

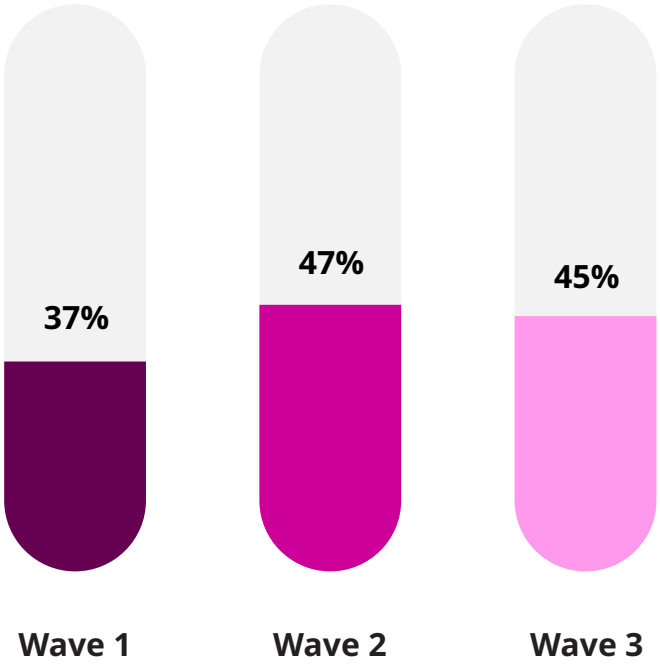
Self-medication

We ask respondents whether they self-medicate with drugs or alcohol to help them cope with their mental health. In wave 3 45% (211) of respondents indicated that they did self-medicate in this way. This figure may indicate that despite high rates of diagnosis this does not guarantee access to sufficient support and treatment options, leading people to continue to self-medicate.

The number of people reporting that they use drugs or alcohol to help them cope with their mental health has remained relatively stable across all waves of data: in wave 2 (2015-2017) 47% (898) of respondents reported using drugs or alcohol to help them cope with their mental health, and in 2010-2014 the figure was 41%[54]. Chart 8 below presents this data across all waves.

54. Homeless Link, (2014), The unhealthy state of homelessness, available at: https://homelesslink-1b54.kxcdn.com/media/documents/The_unhealthy_state_of_homelessness_FINAL_1.pdf

Chart 8: Use of self-medication to manage mental health



As this report goes on to explore, our findings show a shortfall in the support needed for mental health versus that received. We explore this data further in chapter 7, where we report that almost half of respondents with a mental health condition (49%, 207) would like more support than they currently receive, and 37% (175) report that there was at least one occasion in the last 12 months when they needed an assessment or treatment for a mental health condition but did not receive it.

This data comes in the context of what has been called a national 'mental health crisis', with rates of adults and children in the UK seeking mental health support rapidly increasing since the onset of COVID-19.[55] We need to make sure that while mental health services are under incredible pressure to support an ever-increasing number of people, the acute need for services available to people experiencing homelessness are considered as a core part of any inclusion health strategy and service development.

55. Royal College of Psychiatrists, (2021), Country in the grip of a mental health crisis with children worst affected, new analysis finds. Available at: https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2021/04/08/country-in-the-grip-of-a-mental-health-crisis-with-children-worst-affected-new-analysis-finds Guardian, (2021),
Extent of mental health crisis in England at 'terrifying' level. Available at: https://www.theguardian.com/uk-news/2021/apr/09/extent-of-mental-health-crisis-in-england-at-terrifying-level?CMP=Share_AndroidApp_Other

5.3 Drug and alcohol use

This section presents data about respondents' drug and alcohol use. It looks at the substances being taken, as well as how respondents view their use. It also looks at rates of drinking alcohol above the national guidelines.

Drug use

In our most recent wave of data (wave 3), just over half of respondents (54%, (281)) reported that they had used drugs in the last 12 months. The figure is identical for wave 2 (2015-2017), where 54% (1222) reported the same. The methodology has slightly changed since data was collected in wave one, where 36% of people reported having taken drugs in the month prior to completing the audit. It is not clear whether the jump in reported drug use between wave 1 and waves 2 and 3 is due to this change in methodology, or whether it reflects a true increase in drug use. However, our data does show that drug use has remained static and high between 2015-2021. The figure of 54% reported here is far higher than the general population estimate of 8% using illegal drugs in the last year.[56]

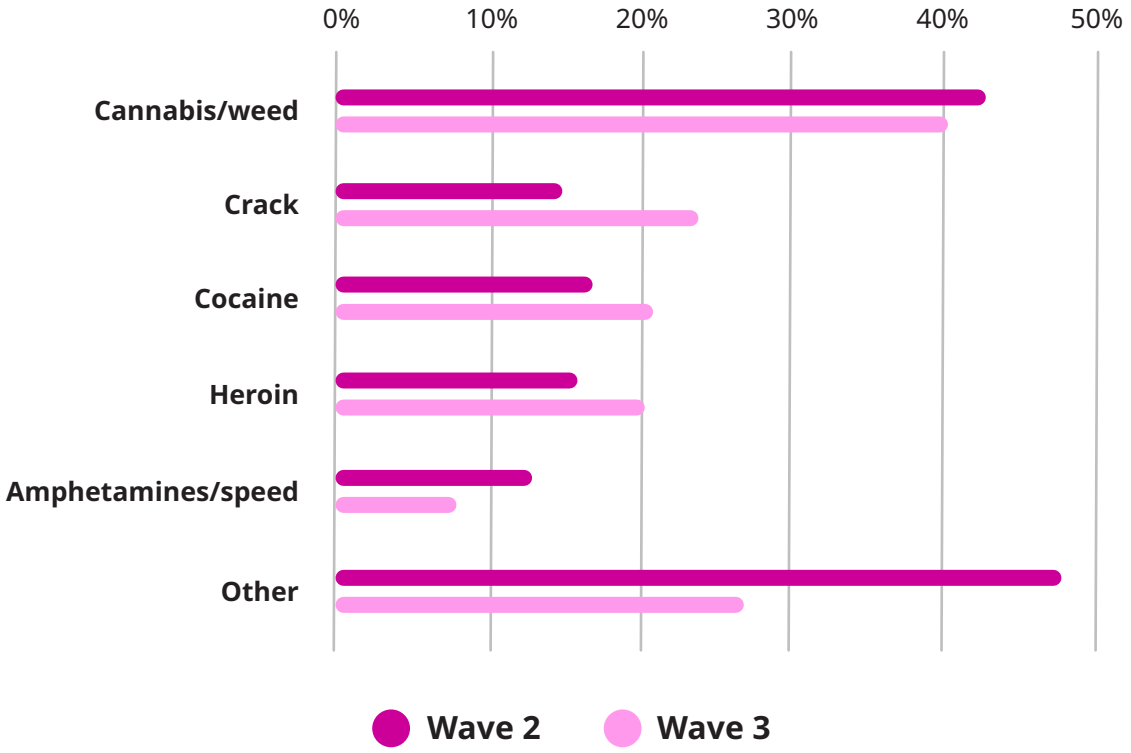
Table 14: Substance use in the past 12 months

Substance N:522	Count	%
Cannabis/weed	213	41%
Crack	126	24%
Cocaine	108	21%
Heroin	105	20%
Amphetamines/speed	42	8%
Other	139	27%

In comparison to data from wave 2 (2015-17), rates of use of several of these drugs have increased. Use of cannabis/ weed has remained similar at 41% in 2018-2021, compared to 42% (971) in 2015-2017). Rates of crack, cocaine and heroin have all risen between waves 2 and 3. Chart 9 below presents this information.

56. Drugwise, How many people use illegal drugs? Available at: https://www.drugwise.org.uk/wp-content/uploads/PrevalenceInfographic-2.png

Chart 9: Proportion of respondents using illegal substances



Self-reported problematic drug use

In our most recent data 38% (143) of people reported that they have, or are recovering from a drug problem. This has increased from wave 2 data (2015-2017), in which 30% (665) of respondents reported the same. Comparable data is not available for wave 1.

The increase in people reporting their use as a problem is concerning, particularly in the context of the finding that 45% of respondents use drugs or alcohol to cope with their mental health. This, together with the high prevalence of dual diagnosis risks further compounding the health impact of homelessness and making providing adequate support increasingly challenging. In chapter 6 we go on to explore the support that people are receiving for drug use that they identify as a problem. We identify that 40% of people are not receiving support the level that they feel is needed.

Alcohol

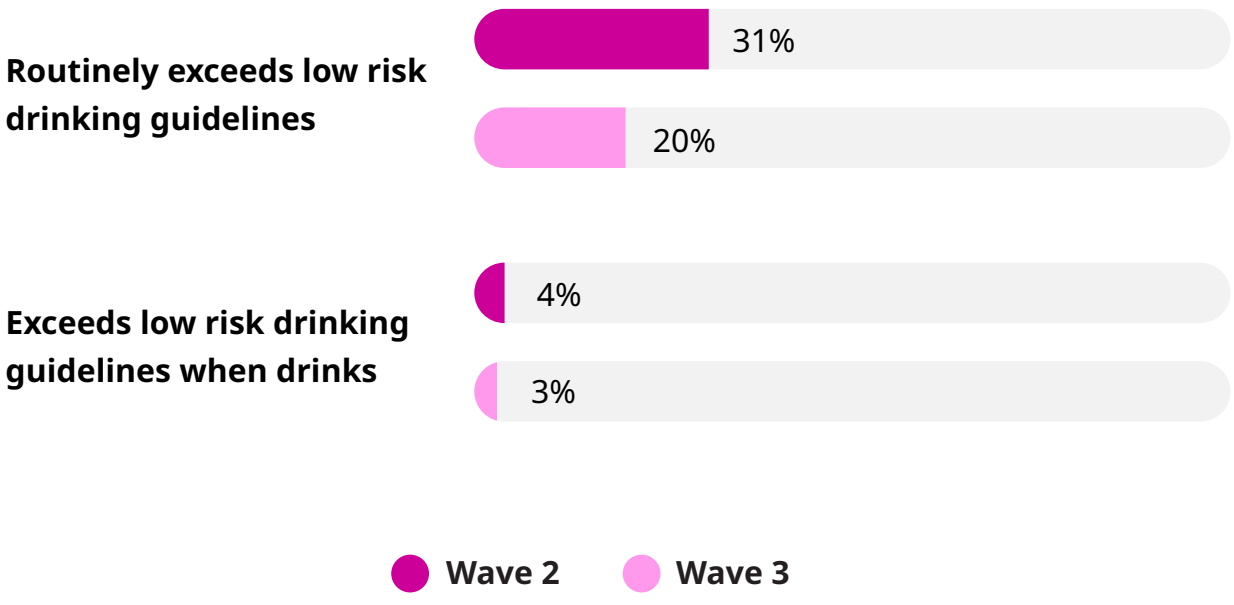
Alcohol use over England's low risk guidelines

In England, the Chief Medical Officer's low risk drinking guidelines state that "To keep health risks from alcohol to a low level it is safest not to drink more than 14 units a week on a regular basis".[57] We use this guidance to identify levels of alcohol use amongst HHNA respondents. Using the average number of units of alcohol consumed in a week, respondents were identified who either:

- Routinely consume more than 14 units of alcohol per week. This group is identified as 'routinely exceeds safe drinking guidelines'; or
- Do not drink every week, but drink more than 14 units when they do drink (either once or twice a month, or once every couple of months). This group is identified as 'exceeds safe drinking guidelines when drinks'.

This data is available for waves 2 and 3 only. Chart 10 below presents data on levels of drinking above England's low risk guidelines.

Chart 10: Proportion of respondents consuming alcohol above low risk guidelines



57. Department of Health, (2018), UK Chief Medical Officers' Low Risk Drinking Guidelines. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/545937/UK_CMOs__report.pdf

The proportion of respondents who exceed low risk drinking guidelines when they drink has remained steady between waves 2 and 3, with a reduction of 1 percentage point, from 4% in wave 2 to 3% in wave 3. This percentage is much lower than the general population, where across England and Scotland 27% of people who drink alcohol binge-drink on their heaviest drinking days.[58]

The percentage of respondents who routinely exceed the low risk drinking guidelines has dropped considerably between waves 2 and 3, from 31% in wave 2 to 20% in wave 3. This figure also suggests that people experiencing homelessness are less likely than the general population to regularly drink above the low risk guidelines. Across the general population, 24% of adults regularly drink over the Chief Medical Officer's low-risk guidelines.[59]

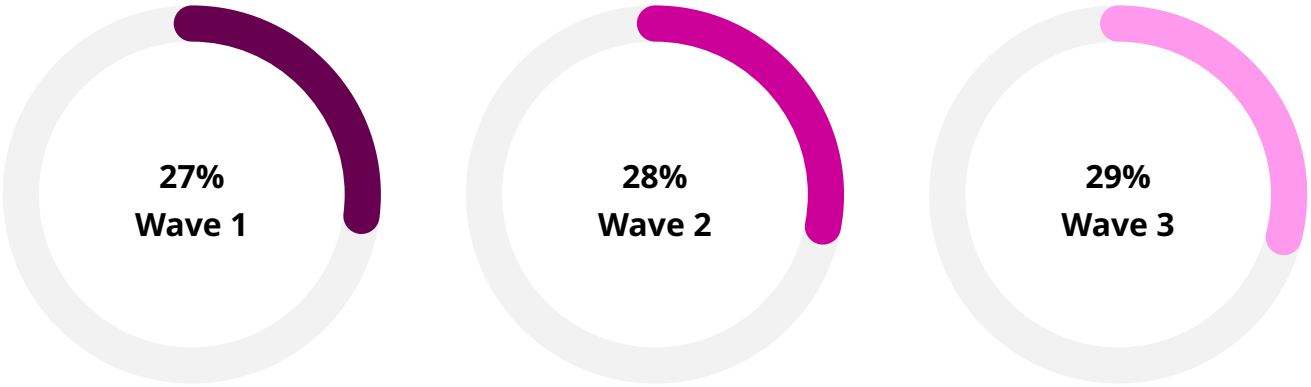
These are surprising results. It is not clear why levels of alcohol use above the low risk guidelines dropped by 11 percentage points between waves 2 and 3. It may be that lockdown had some impact on the availability of alcohol, it may also be that this reduction is due to differences between the areas that took part in the audit in waves 2 and 3. It is also surprising to find that levels of low risk drinking among this population are lower than those seen in the general population. There is a need for further investigation to better understand levels of alcohol use amongst people experiencing homelessness, and why these may, or not may not, differ from the general population.

Self-reported problematic alcohol use

The audit asks respondents whether they have, or are recovering from, an alcohol problem. It is important to note that not everyone who regularly drinks above the low risk guidelines will identify themselves as having an alcohol problem, and some people with an alcohol problem will drink little or no alcohol. Chart 11 below presents responses from all three waves of data collection.

58. https://alcoholchange.org.uk/alcohol-facts/fact-sheets/alcohol-statistics
59. https://alcoholchange.org.uk/alcohol-facts/fact-sheets/alcohol-statistics

Chart 11: Proportion of respondents who have/are recovering from an alcohol problem



The data shows a very slight increase year on year in the percentage of respondents who have or are recovering from an alcohol problem, with 29% of respondents identifying themselves as having/ recovering from an alcohol problem in the latest wave of data.

Chapter 6: Wellbeing and preventative healthcare

In this chapter we present findings relating to the wellbeing of respondents and the extent to which people experiencing homelessness are able to take proactive steps to support their health.

Wellbeing topics cover smoking behaviours, nutrition and access to medication. As part of preventative healthcare we consider female health issues, including mammograms, cervical smear tests and access to sanitary products, as well as sexual health, vaccinations and screening.

This chapter also presents data on peoples' ratings of their own health now compared to last year.

Due to changes in methodology, data is not available for wave 1 throughout this section.

These findings are key factors in understanding determinants of health inequalities. They demonstrate ways in which it can be more difficult for people experiencing homelessness to engage in preventative health measures and move away from unhealthy behaviours when compared to the general population, further increasing health inequalities.

Key findings:

Wellbeing:

- 76% (378) of respondents in wave 3 reported that they smoke cigarettes, cigars or a pipe. This compares to 13.8% of adults in the general population who are either 'occasional' or 'regular' smokers.
- 50% of respondents who smoke want to give up smoking.
- 18% of respondents in wave 3 eat three or more meals per day, a figure which has dropped 5 percentage points from 23% in wave 2.
- 71% (331) of respondents in wave 3 report taking some form of prescribed medication, compared to 48% of adults in the general population.

Preventative healthcare:

- In wave 3 just 6% (27) of respondents were fully vaccinated against Hepatitis B.
- Women experiencing homelessness are much less likely than the general population

to access cervical or breast screenings. Just 37% (17) of females in wave 3 had had a breast screening within the relevant time period, compared to 61.8% of the general population.

- 24% (110) of respondents in wave 3 had had a sexual health check in the year before taking part in the audit.

6.1 Wellbeing

Smoking and smoking cessation

Across those surveyed in wave 3 of our data, 76% (378) reported that they smoke cigarettes, cigars or a pipe. National data tells us that 13.8% of adults are either 'occasional' or 'regular' smokers.[60] The dramatic difference between these two figures indicates a significant overrepresentation of adults who experience homelessness that smoke when compared to the national population.

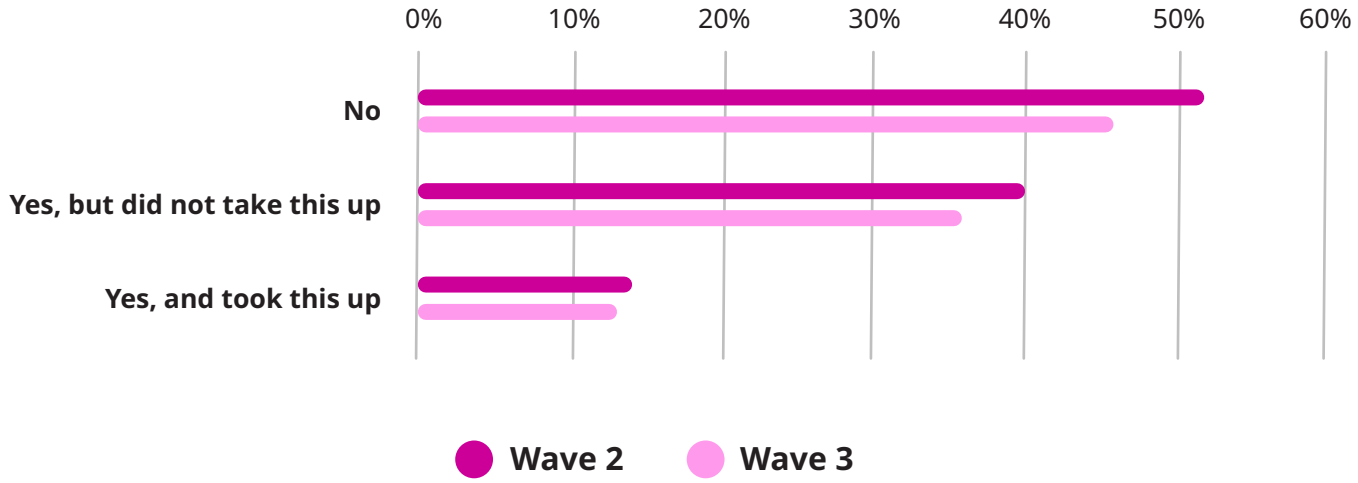
This high proportion of people smoking is consistent throughout all three waves of data, with 79% (1765) of respondents reporting that they smoked cigarettes, cigars or a pipe in wave 2 (2015-2017) and 77% of people reporting the same in wave 1 (2010-2014).[61]

Smoking is known to cause poor health and to exacerbate existing health conditions. A Groundswell report on the respiratory health of people experiencing homelessness found that smoking contributes significantly to the "incredibly poor" respiratory and lung health of people experiencing homelessness.[62] This indicates that people experiencing homelessness can be doubly disadvantaged: both more likely to smoke, and more likely to experience negative health outcomes arising from smoking in combination with the detrimental health impacts of homelessness.

Of those who smoke, 50% (156) of respondents in wave 3 report that they would like to give up. The availability of smoking cessation advice appears to be varied, with 46% (150) of respondents stating that they had not been offered help to stop smoking. Of those who had been offered support, 40% (133) had not taken up the offer of support and 14% (46) had been offered support which they had taken up. Chart 12 presents this data below.

60. NHS, (2022), GP Patient Survey, National Report: 2022, Available at: https://gp-patient.co.uk/downloads/2022/GPPS_2022_National_report_PUBLIC.pdf
61. Homeless Link, (2014), The unhealthy state of homelessness. Available at: https://homelesslink-1b54.kxcdn.com/media/documents/The_unhealthy_state_of_homelessness_FINAL_1.pdf
62. Groundswell, (2017), Room to breathe. Available at: https://groundswell.org.uk/wp-content/uploads/2017/10/Groundswell-Room-to-Breathe-Full-Report.pdf

Chart 12: Proportion of respondents offered smoking cessation advice



This data indicates that more needs to be done to increase the availability and accessibility of smoking cessation services for people experiencing homelessness

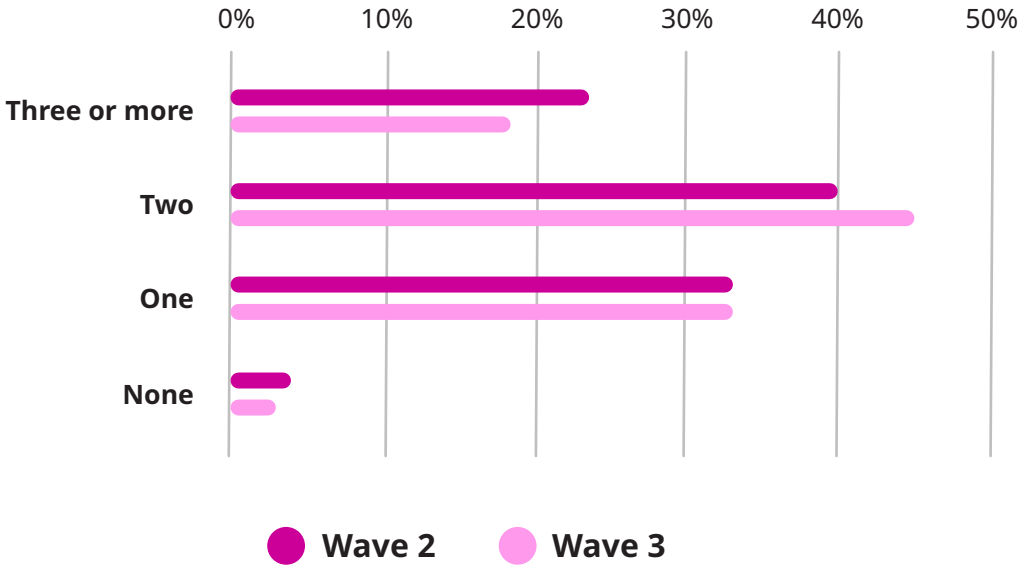
Nutrition

The survey asks two questions about nutrition; how many meals respondents eat per day and how many portions of fruit or veg respondents eat in an average day. In both cases, respondents are invited to answer for yesterday if they cannot provide an average figure. Poor diet and food insecurity are key indicators of health inequalities, with diet inequality one of the leading causes of avoidable harm to health.[63] Data is presented for waves 2 and 3 in this section, data is not available for wave 1 due to changes in methodology.

In wave 3 a third of respondents (33%, 153) reported on average only eating one meal a day and just 18% (85) of people reported that they eat three or more meals per day, with 45% (206) stating they eat an average of two meals a day. The proportion of people reporting that they eat three or more meals a day has decreased from wave 2, where 40% (759) reported this. The results of this question for waves 2 and 3 is presented below.

63. Department for Environment, Food & Rural Affairs (2021) National Food Strategy: Part Two. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1025825/national-food-strategy-the-plan.pdf

Chart 13: Average number of meals eaten per day



Data from the general population shows that in April 2022 13.8% of households had experienced at least one form of food insecurity, a term which refers to the state of being without reliable access to a sufficient quantity of affordable, nutritious food.[64] According to data from the food foundation 4.6% of households had not eaten for a whole day because they could not afford or get access to food.[65] Whilst this data is not directly comparable, it does indicate that whilst this is certainly a growing issue in the wider population, it is much more prevalent for people experiencing homelessness.

Further indicating the challenge that people experiencing homelessness face in eating well, 66% (301) of respondents ate one or fewer portions of fruit or veg per day. Just 4% (17) of respondents ate the recommended 5 or more portions of fruit or veg per day. Table 15 below presents the full results of this question for waves 2 and 3.

64. https://www.foodfoundation.org.uk/press-release/millions-adults-missing-meals-cost-living-crisis-bites
65. https://www.foodfoundation.org.uk/press-release/millions-adults-missing-meals-cost-living-crisis-bites

Table 15: Number of portions of fruit or vegetables eaten on an average day

	Wave 2		Wave 3	
Number of portions	**Count**	**%**	**Count**	**%**
Less than 1	778	41%	187	41%
One portion	418	22%	114	25%
Two portions	343	18%	61	13%
Three portions	183	10%	54	12%
Four portions	88	5%	22	5%
Five portions or more	93	5%	17	4%
N:	1903		455	

Prescribed medications

Respondents were asked whether they are currently taking any medication prescribed to them. In the most recent wave of data, 71% (331) of respondents reported that they were taking some form of prescribed medication.

This figure is much higher than that for the general population, for which the latest available data reports that 48% of adults had taken at least one prescribed medicine in the last week.[66] National data identifies that people living in more deprived areas are more likely to be taking prescribed medicines, and 54% of those in the most deprived areas of the UK took at least one prescribed medication.[67] This national data demonstrates the link between health inequalities and low income; the fact that people experiencing homelessness report taking prescribed medications at a rate 17 percentage points higher than those in the most deprived areas of the UK suggests that this effect is even stronger for people experiencing homelessness, who are at the sharpest end of poverty and destitution.

In wave 3 we asked respondents for the first time whether they were able to access their medication. 93% (137) were able to access their medication, indicating that there is a small need to increase access to medications for the 7% (10) of respondents who could not access prescribed medication. This area would benefit from further research to identify what specific interventions which would increase access to medicines.

66. NHS Digital, (2017) Health Survey for England, 2016. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/health-survey-for-england-2016
67. NHS Digital, (2017), Health Survey for England, 2016: prescribed medications. Available at: https://files.digital.nhs.uk/pdf/3/c/hse2016-pres-med.pdf

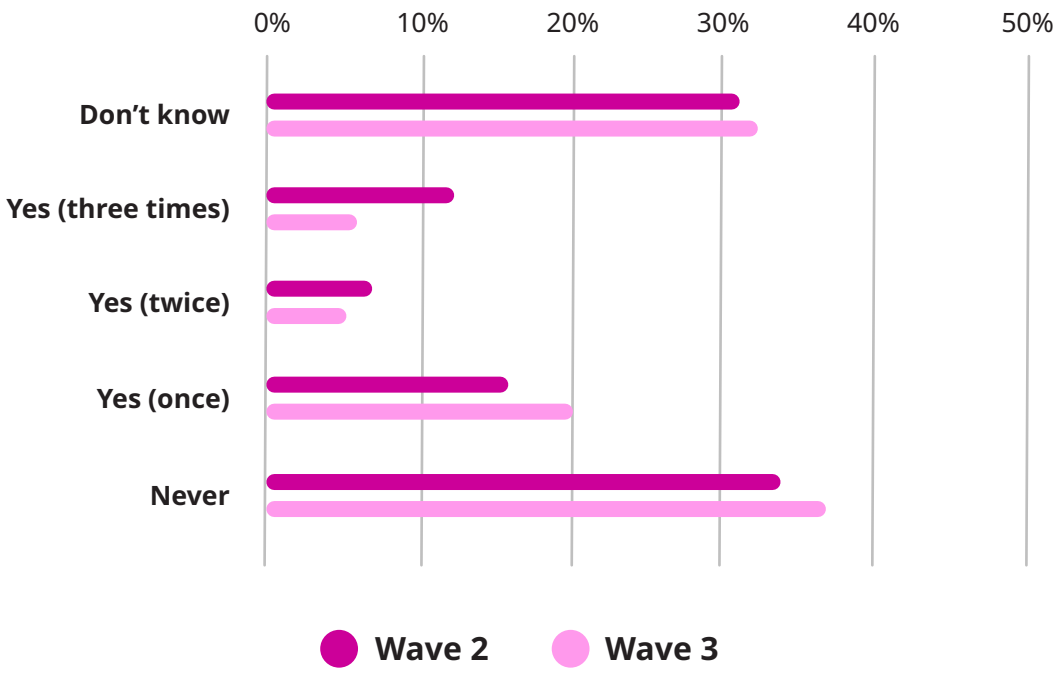
6.2 Preventative healthcare

Vaccinations

The Homeless Health Needs Audit asks respondents whether they have been vaccinated against hepatitis B and the flu.

In wave 3 just 6% (27) of respondents were fully vaccinated against Hepatitis B, and a further 31% (144) of respondents had had at least one vaccination against hepatitis B. 37% (172) of respondents had never had a vaccination and 32% (147) could not remember. This represents a drop in the proportion of people fully vaccinated compared to wave 2, where 12% (246) of respondents had had all three hepatitis B vaccinations. The proportion of people who had had at least one Hepatitis B vaccination was slightly lower in wave 2, at 35% (701). The results are presented in Chart 14 below:

Chart 14: Levels of vaccination against Hepatitis B



Respondents were also asked whether they had been vaccinated against the flu. Free access to the flu vaccine is not consistent across the country. In London anyone experiencing homelessness is eligible, however in other parts of the country this varies and people experiencing homelessness can be subject to the same eligibility criteria as the general population. For this reason it is difficult to assess what the take up rate of the flu vaccine is, as we cannot be sure what proportion of respondents would have been eligible. In the most recent wave of data (wave 3), 18% (52) of respondents had been vaccinated in the last year, a slightly lower figure than reported in wave 2 (21% (409)). The full results for this question are presented in Table 16 below.

Table 16: Proportion of respondents who received a flu vaccine

	Wave 2		Wave 3	
Flu vaccinations	**Count**	**%**	**Count**	**%**
Never	943	48%	156	53%
Yes (more than a year ago)	322	16%	45	15%
Yes (in the last year)	409	21%	52	18%
Don't know	288	15%	43	15%
N:	1962		296	

Female health

Female health questions explore whether people experiencing homelessness have attended routine, life saving, cancer screenings. Appointments for these routine screenings are sent by post to anyone registered with a GP surgery, however, everyone may not have an address at which to receive a letter and evidence shows that forward planning of appointments can be very difficult for people experiencing homelessness.[68,69] The data we report here does not capture the reasons that people do or do not attended screenings, but does indicate that current processes should be reconsidered to increase rates of screening among people experiencing homelessness.

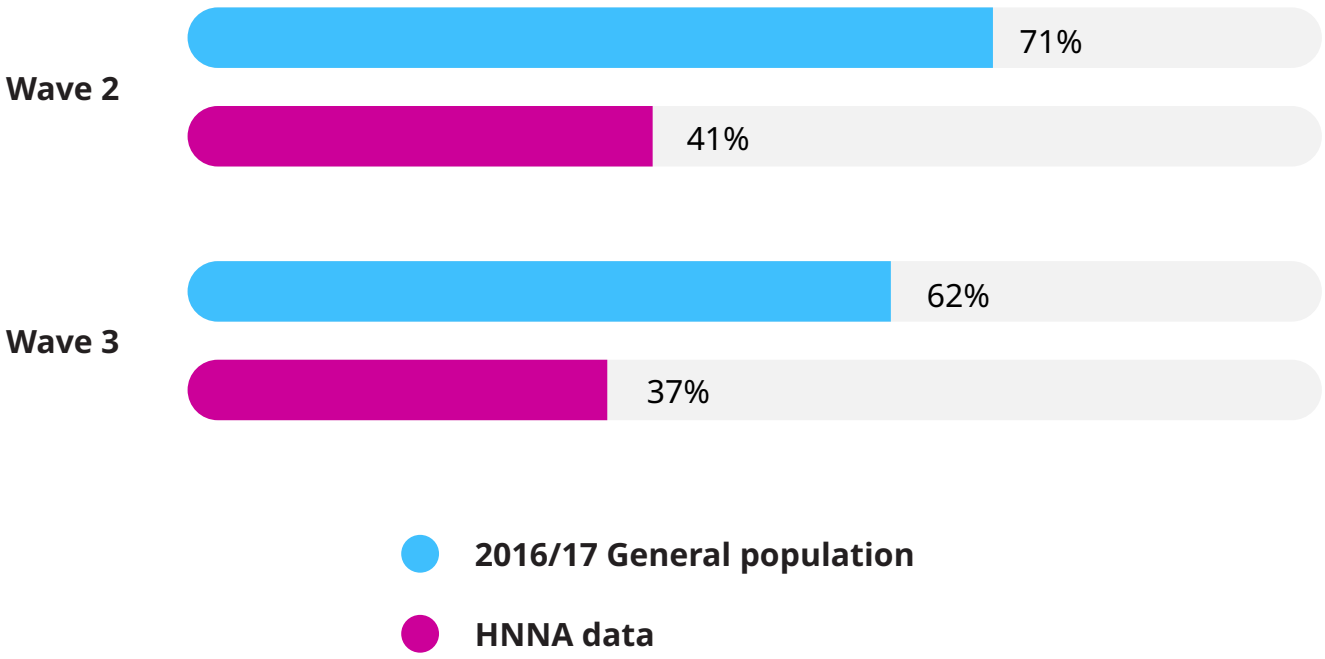
68. Byrne, G (2018) The postal paradox: How having no address keeps people homeless. Available at: https://www.citizensadvice.org.uk/Global/CitizensAdvice/Post%20and%20Telecoms/Homelessness%20report%20-%20Final.pdf

69. Elwell-Sutton, T., Fok, J., Albanese, F., Mathie, H and Holland, R. (2017) Factors associated with access to care and healthcare utilization in the homeless population of England, Journal of Public Health, Volume 39, Issue 1, March 2017, Pages 26–33,

Breast screening

All females over the age of 50 are invited for breast screening by the NHS every three years between the ages of 50 and 71.[70] The HHNA asks all those eligible whether they have had a breast screening in the past 3 years. Just 37% (17) of females had had a breast screening during this timeframe in the most recent wave of data (wave 3: 2018-2021). The figure for wave 2 stood slightly higher than wave 3 at 41% (30). Among the general population in 2020/21, 61.8%[71] of females took up a breast screening invitation, indicating that people experiencing homelessness are much less likely to receive the protective benefits of breast screening. Chart 15 below presents this data, using general population figures for comparison from 2020/21 for wave 3 and 2016/17 for wave 2[72].

Chart 15: Breast screening uptake in HHNA population and general population



70. Information on NHS breast screening is available at: https://www.nhs.uk/conditions/breast-screening-mammogram/when-youll-be-invited-and-who-should-go/

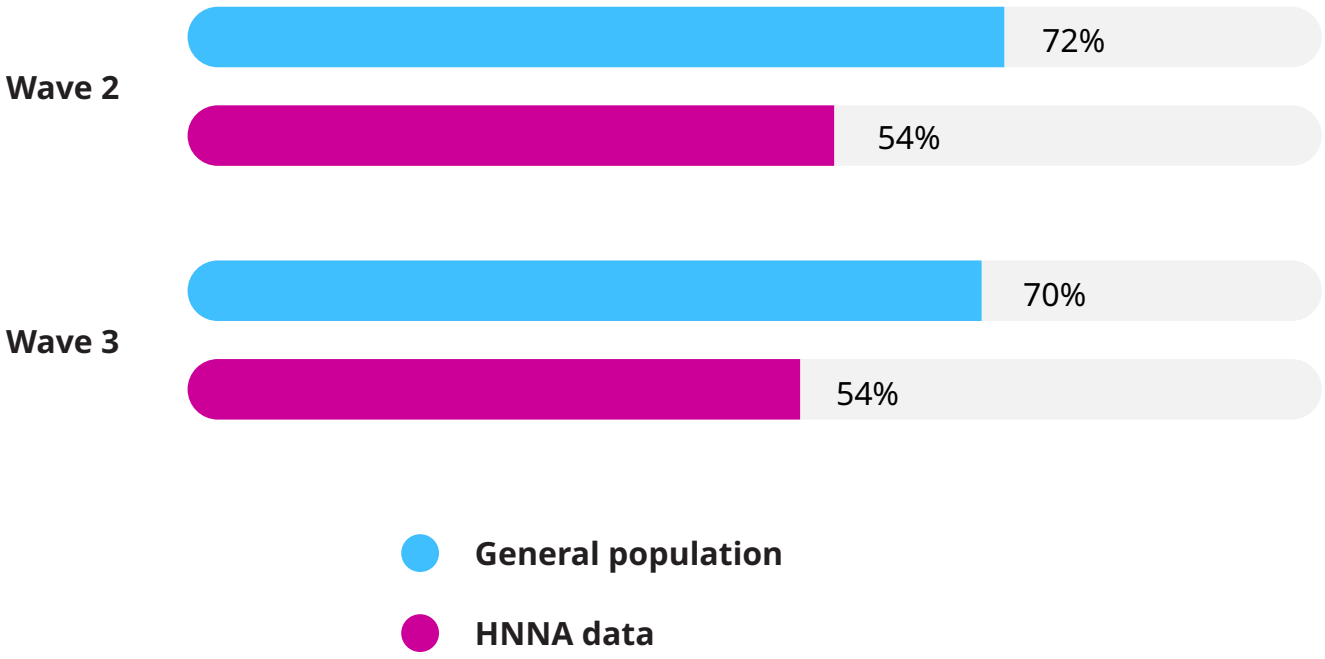
71. NHS Digital, (2022), Breast screening programme, England 2020-21. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/breast-screening-programme/england---2020-21

72. NHS Digital, (2018), Breast screening programme England – 2016-17. Available at: Breast Screening Programme, England - 2016-17 [PAS] - NHS Digital https://digital.nhs.uk/data-and-information/publications/statistical/breast-screening-programme/england---2020-21

Cervical screening

All people with a cervix aged between 25 and 64 are invited for cervical screening by the NHS every 3 or 5 years, depending on age.[73] The HHNA asks all those in this age group who are eligible whether they have attended a cervical screening in the past 3 years. 54% (66) of respondents in wave 3 (2018-2021) had received cervical screening, compared to 57% (183) in wave 2 (2015-2017). Whilst wave 3 figures may have been affected by changes in healthcare provision resulting from the COVID-19 pandemic, when compared to general population figures from 2020/2021 (a period also covering the interruption to NHS services due to COVID-19) we can see that people experiencing homelessness still had a lower rate of take up when compared to 70.2% of the general population.[74] Chart 16 below presents this data, using general population data for comparison.[75]

Chart 16: Cervical screening uptake HHNA population and general population



There are numerous potential barriers to accessing these routine screenings for people experiencing homelessness. We know not all females experiencing homelessness will either be registered with a GP, or have an address to receive their invitation. Added to this, wider research tells us that it can be more difficult for people experiencing homelessness to attend advance booked appointments. This, together with our finding that people experiencing homelessness have lower rates of screening than the general population, suggests that more work needs to be done to better understand what is

73. Information on NHS cervical screening is available at: https://www.nhs.uk/conditions/cervical-screening/when-youll-be-invited/
74. NHS Digital, (2021) Cervical Screening Programme – 2020/21. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/cervical-screening-annual/england--2020-2021
75. NHS Digital, (2017), Cervical Screening Programme, England – 2016/17. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/cervical-screening-annual/cervical-screening-programme-england-2016-17

causing this differential rate of screening. These screenings exist to protect women from the worst experiences of cancer and lower rates of access to screenings only widen health inequalities faced by those experiencing homelessness.

The data presented in this chapter indicate the people who experience homelessness fare worse on basic wellbeing indicators than the general population, and access preventative healthcare at lower rates than the wider population. It is fair to suggest that this will exacerbate health inequalities, as levels of smoking and poor nutrition affect wider health inequalities and lower take up of vaccinations and screenings increase the risk of illness and disease. Some of the barriers to accessing these kinds of services are well known and more must be done to understand how we can increase access to and take up of these important services.

Chapter 7: Use of healthcare services

This chapter looks at how people experiencing homelessness use health services. In this chapter we first look at primary health care services, including GP and dental access and registration levels. Comparing changes to data over the 3 waves allows us to explore the possible impact of key interventions in this area. We then consider use of acute health services and present data on the frequency and reasons for use. By comparing our data to general population figures we can better understand whether and how people experiencing homelessness use services differently to the general population.

Finally, this section presents data relating to the advice and information that respondents received in hospital, and whether they were discharged from hospital into appropriate accommodation.

Key findings:

Primary healthcare

- 97% (450) of respondents are registered at a GP or homeless healthcare centre
- 53% (246) of respondents were registered with a dentist in wave 3 (2018-2021). This is low, especially considering that dental/ teeth problems is the second most commonly reported physical health problem.
- 10% of respondents had been refused registration to a dental practice in the last 12 months.

Acute healthcare

- Respondents used A&E services three times more often than the generation population.
- 11% of respondents in wave 3 had used A&E services more than three times in the last 12 months.
- Taken together, mental health problems and attempted suicide/ self-harm are responsible for 32% (62) of latest A&E presentations. This comes second only to issues related to a physical health problem 32% (63).
- In wave 3 almost a quarter of respondents (24% (37)) were discharged onto the street and a further 21% (33) of respondents were discharged into accommodation which was not suitable for their needs.

7.1 Primary care

It has been true for some time that people experiencing homelessness face barriers to accessing GP and dental surgeries due to a range of factors, including being incorrectly turned away due to having no fixed address or lacking identification. In recognition of this, much work has been done in recent years to increase registration at these services, for example Groundswell's My Right to Healthcare cards provide people with information they can pass onto GPs to advocate for their right to GP registration and therefore to access support.[76] Despite this, our data shows that a small proportion of people still face barriers accessing GP services, and a much larger group do not access dental services.

GP or specialist homeless healthcare service registration

Our most recent data shows that a majority of respondents are registered at a GP or homeless healthcare centre (97% (450)). This is an increase in the number of people registered at a GP or homeless healthcare centre in wave 2 (2015-2017), a figure which then stood at 92% (2029).

Some respondents had been refused registration at a GP or homeless healthcare service, with 6% (30) reporting that they had been refused in the 12 months before responding to the survey. When asked why, the reasons reported include "no photo ID", "no address" and "told I was out of the area". Everyone in the UK has the right to register with a GP, regardless of whether they have ID or an address; it should also usually be possible to register at a GP which is not near to your home.[77] These findings then illustrate than in some cases people are still being refused GP care erroneously.

Dental registration

Dental registration levels are much lower than GP registrations, with just 53% (246) of respondents reporting that they were registered with a dentist in wave 3. This is slightly higher than the figure for wave 2 of 49% (1055), however given that our data shows dental/ teeth problems to be the second most commonly reported physical health problem, affecting 36% (187) of respondents, a lack of access to dental services is especially important to note.

In wave 3, 10% (45) of respondents had been refused registration to a dental practice, sighting surgeries not taking on new NHS patients, and refusal due to missed appointments as well as having "no address". The gap between those not registered and those who had been refused registration indicate a group of people who are not engaging

76. Information on Groundswell's My Right to Healthcare Cards is available at: https://groundswell.org.uk/all-resources/healthcare-cards/#:~:text=We%20want%20to%20spread%20the,access%20for%20everyone%20in%20England.

77. NHS GP registration entitlements are outlined here: https://www.nhs.uk/nhs-services/gps/how-to-register-with-a-gp-surgery/

with dental care at all. More needs to be done to understand why this is and how to improve access to these services.

Groundswell's 'Healthy Mouths' report details a range of dental issues faced by people experiencing homelessness[78], outlining that people who experience homelessness have poorer dental health than the general population and that experience of homelessness itself leads to dental issues. Health inequalities related to poor access to dental care has a significant impact on the wider health of people experiencing homelessness, it is important that dentistry is not forgotten when considering the health needs of this population.

7.2. Acute health care

Historically, it has been true that people experiencing homelessness use emergency services more often than the general population. This is due both to greater likelihood of experiencing poor health and because exclusion from primary care services means people do not always receive support before they reach crisis mode.[79] This section explores data relating to respondents' use of ambulance and A&E services, as well as hospital admissions within the 12 months prior to taking part in the audit.

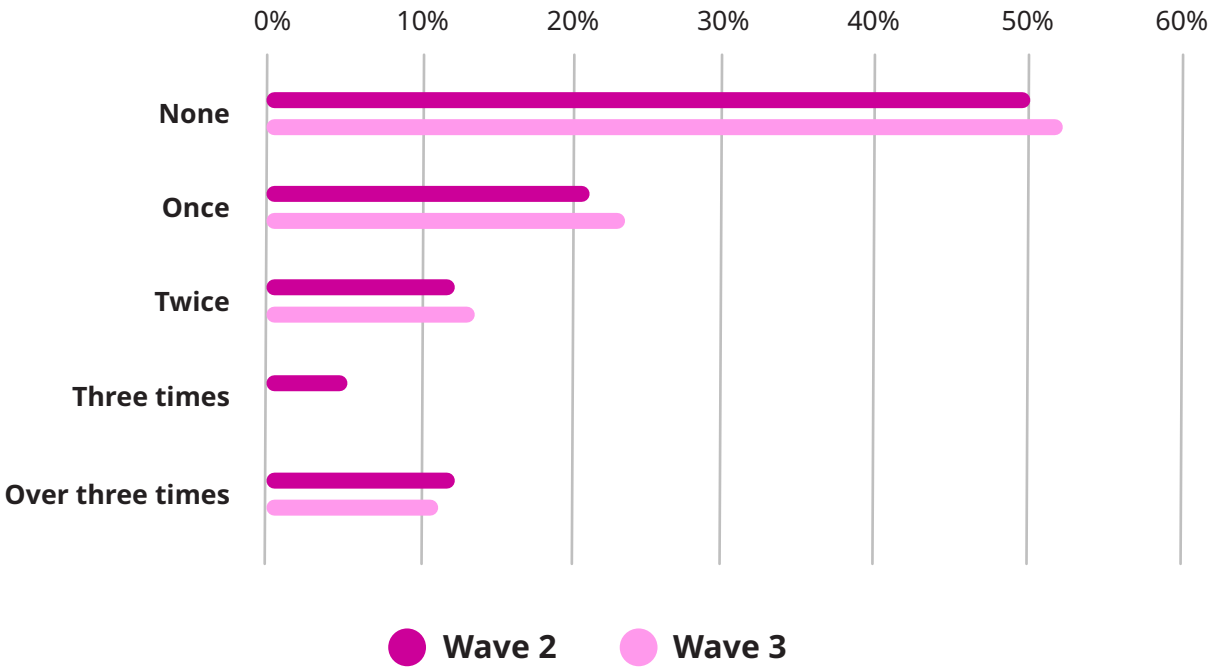
Due to a change in methodology, this section presents data from waves 2 and 3 only. In wave 1 participants were asked about the 6 months prior to participation and data are therefore not directly comparable.

A&E

In the most recent wave of data almost half of respondents, at 48% (202), had used A&E services at least once in the last year. This is slightly down from wave 2 (2015-2017), in which 50% (1057) of respondents had used A&E services at least once in the year prior to taking part in the audit. The frequency of A&E use remained fairly similar between waves 2 and 3, with the greatest change seen in people using A&E the most often. In wave 2, 5% (105) of respondents used A&E services three times in the last year, compared with 0% (0) in wave 3. Full data on frequency of A&E use in waves 2 and 3 is presented in Chart 18 below.

78. Goundswell, (2018), Health Mouths. Available at: https://groundswell.org.uk/wp-content/uploads/2018/10/Groundswell-Healthy-Mouths-Report-Full-Report-Web.pdf
79. Iacobucci G., (2019), Homeless people's A&E visits treble in seven years, BMJ 2019; 364 :l323

Chart 17: Frequency of A&E use in the 12 months prior to taking part in a HHNA



On average, people experiencing homelessness in wave 3 used A&E services 0.9 times a year. This is a cautious estimate, as it assumes that everyone who responded 'over three times' used A&E services 4 times. The general population figure for comparison stands at 0.3 for 2020/2021[80], indicating that people experiencing homelessness use A&E services on average three times more than the general population. This figure is likely driven in part by the stark health inequalities in both mental and physical health that we outlined in Chapter 5 of this report. It is likely also driven by the gap between the support that people need and that which they receive; an issue that we go on to explore in detail in Chapter 8.

The audit also asks respondents to give the reason for their most recent attendance at A&E. In wave 3, the most common reason that people attended A&E related to a physical health problem or condition (32%, 63). 18% (34) of most recent A&E attendances related to self-harm/ attempted suicide, with a further 14% (28) relating to a mental health condition. Taken together, emergency care related to mental health crises are equal to the proportion of people attending A&E due to a physical health problem or condition.

These results again attest to the urgent need to address the lack of sufficient mental health support for people experiencing homelessness. Table 18 below presents in full the reasons that respondents last attended A&E.

80. NHS Digital, (2021), Hospital Accident & Emergency Activity 2021-21. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/hospital-accident--emergency-activity/2020-21

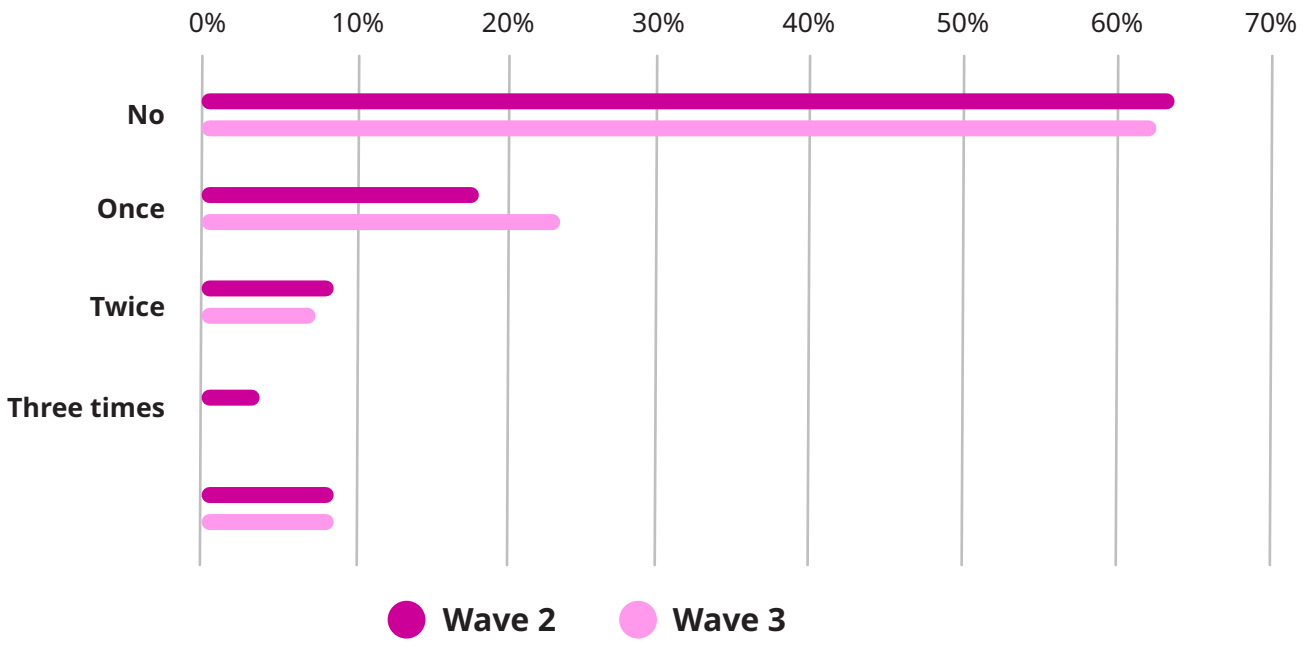
Table 17: Reason for last A&E attendance

	Wave 2		Wave 3	
Reason for use	**Count**	**%**	**Count**	**%**
Relating to a physical health problem or condition	300	29%	63	32%
Self-harm/attempted suicide	105	10%	34	18%
Relating to a mental health problem or condition	130	13%	28	14%
Accident	118	12%	20	10%
Other violent incident or assault	66	6%	14	7%
Relating to alcohol use	76	7%	14	7%
Relating to drug use	74	7%	12	6%
Domestic violence	35	3%	8	4%
Relating to childbirth or pregnancy	11	1%	1	1%
Other	107	10%	0	0%
N:	1022		194	

Ambulance use

A total of 38% (159) of respondents had used an ambulance at least once in the 12 months before taking part in the HHNA in wave 3 (2018-2021). This is almost unchanged since wave 2 (2015-2017), where 37% (770) of respondents had used an ambulance in the 12 months prior to taking part in an audit. In wave 3, it was most common for respondents to have used an ambulance once in the last year (23% (96)), with 8% (33) of respondents using an ambulance more than 3 times. Full data on frequency of ambulance use is presented in Chart 19 below.

Chart 18: Frequency of ambulance use in the 12 months prior to taking part in a HHNA



As with A&E above, the most common reason for using an ambulance is physical health problems/ conditions, which drove 38% (55) of most recent ambulance uses. However, mental health crisis is a substantial driver of ambulance use, with 27% (40) of callouts related to either self-harm or attempted suicide, or relating to another mental health problem or condition. Table 18 presents this data in full.

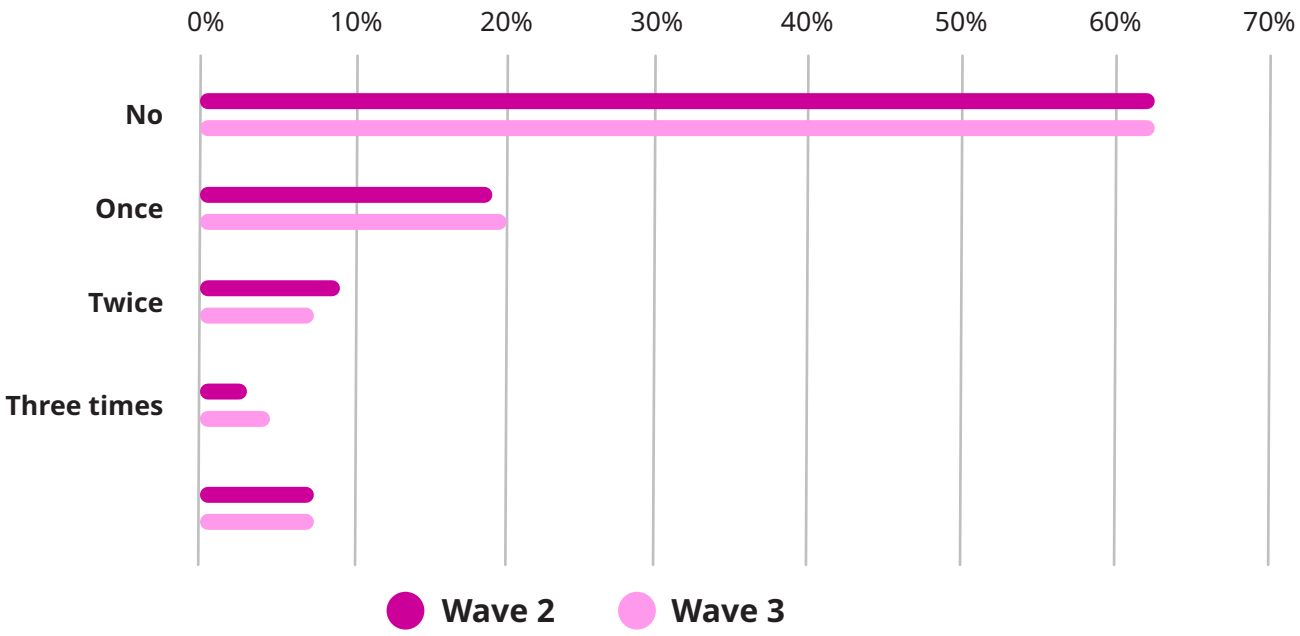
Table 18: Reason for last ambulance use

	Wave 2		Wave 3	
Reason for use (N:145)	**Count**	**%**	**Count**	**%**
Relating to a physical health problem or condition	209	29%	55	38%
Self-harm/attempted suicide	95	13%	21	14%
Relating to a mental health problem or condition	92	13%	19	13%
Relating to drug use	57	8%	17	12%
Other violent incident or assault	46	6%	13	9%
Relating to alcohol use	64	9%	9	6%
Accident	68	9%	7	5%
Domestic violence	18	2%	2	1%
Relating to childbirth or pregnancy	8	1%	2	1%
Other	67	9%	0	0%

Hospital admissions

In wave 3, a total of 38% (167) of respondents had been admitted to hospital in the 12 months before participating in a Homeless Health Needs Audit. This figure has held constant since the second wave of data (38% (795)). In wave 3 it was most common for people to have been admitted once (20% (90)), although a small group of respondents had been admitted over 3 times (7% (31)). Data on number of hospital admissions for waves 2 and 3 can be found in Chart 20 below:

Chart 19: Number of hospital admittances in the 12 months prior to taking part in a HHNA



When we look at the reasons for hospital admittance in wave 3, we see a similar pattern to that observed throughout this section, with physical health problem/ condition the most common reason for admittance (37% (53)). Hospital admittances due to a mental health problem/ condition (15% (21)) is slightly higher than those for self-harm/ attempted suicide (13% (19)), and both of these together total 28% of the total reasons that respondents were last admitted to hospital. The full response to this question can be found in Table 19 below.

Table 19: Reason for last hospital admittance

	Wave 2		Wave 3	
Reason for use	**Count**	**%**	**Count**	**%**
Relating to a physical health problem or condition	224	33%	53	37%
Relating to a mental health problem or condition	108	16%	21	15%
Self-harm/attempted suicide	83	12%	19	13%
Other violent incident or assault	28	4%	11	8%
Relating to drug use	52	8%	9	6%
Relating to alcohol use	52	8%	7	5%
Accident	49	7%	4	3%
Domestic violence	16	2%	1	1%
Relating to childbirth or pregnancy	14	2%	1	1%
Other	51	8%	16	11%
N:	677		142	

This data demonstrates that people experiencing homelessness continue to use emergency services at a higher rate than the general population, despite very high levels of GP registration. The impact of mental ill health as a driver of the use of emergency services is undeniable and adds to the urgency of providing suitable care for people experiencing homelessness.

Hospital discharge

People who experience homelessness at the time of being admitted to hospital have a much higher chance of being readmitted to hospital in an emergency than the general population. A 2020 study, which matched patients experiencing homelessness to housed patients, found that this difference cannot be explained by an individual's health. It concludes that to address this disparity other factors, including housing, need to be tackled.[81]

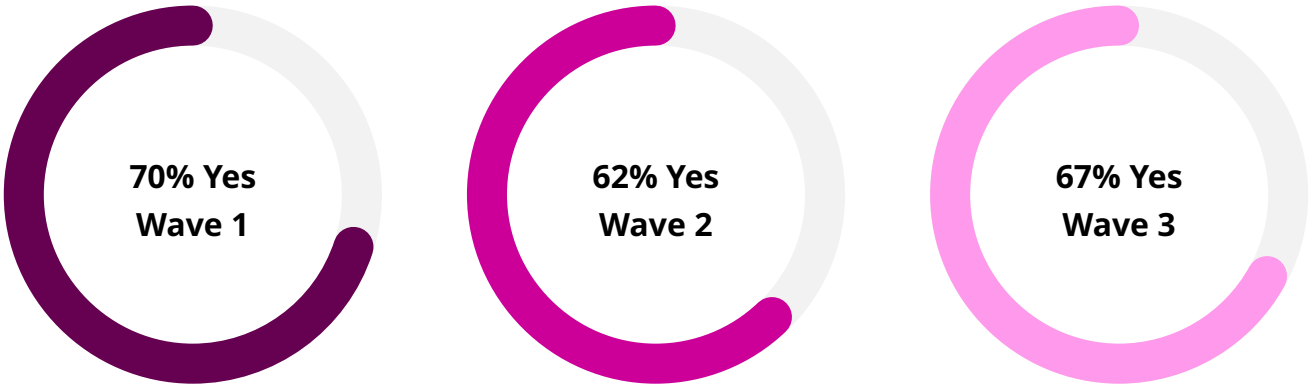
81. Lewer D, Menezes D, Cornes M, et al., (2020), Hospital readmission among people experiencing homelessness in England: a cohort study of 2772 matched homeless and housed inpatients, J Epidemiol Community Health. Available at: https://jech.bmj.com/content/jech/early/2021/01/05/jech-2020-215204.full.pdf

Here we present data relating to respondents' last hospital admission, including whether respondents were asked if they had an appropriate place to stay when they were discharged, and what their outcomes were three months later. As part of the measures introduced by the Homeless Reduction Act hospitals have a Duty to Refer people experiencing homelessness to the Local Authority for support. In the financial year 2021/2022 6% of referrals to the Local Authority were made by Hospital A&E, Urgent Care Centres or inpatient care.[82] Wave 1 did not collect data on where respondents were discharged to, and so data presented on this is from waves 2 and 3 only.

In wave 3, our data shows that 67% (93) of respondents were asked by a staff member during their most recent hospital admission whether they had somewhere suitable to stay on discharge. This is an increase of five percentage points from wave 2, in which 62% of respondents reported the same.

Data for wave 1 indicates a decrease since this wave of data collection, in which 70% of respondents were asked whether they have somewhere suitable to stay on discharge. Chart 21 below presents this data.

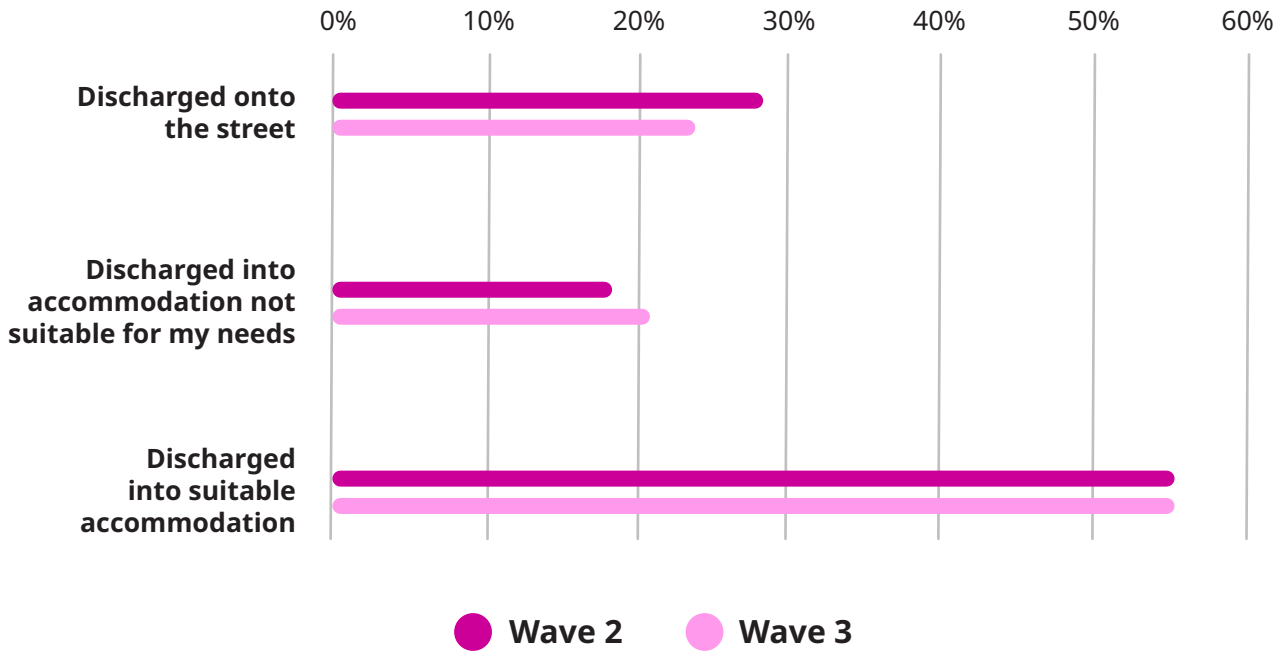
Chart 20: Proportion of respondents asked if they had somewhere suitable to go on discharge



When we consider where respondents were discharged to, the picture similarly seems to have got worse since wave 1. In wave 3, 55% (84) of respondents stated they were discharged into suitable accommodation. This figure shows no change from wave 2 (55% (386)) and has dropped since wave 1, where 64% of people had somewhere suitable to go on discharge. In wave 3 almost a quarter of respondents (24% (37)) were discharged onto the street and a further 21% (33) of respondents were discharged into accommodation which was not suitable for their needs. Chart 22 below presents data on where respondents were discharged to for waves 2 and 3.

82. Department for Communities, Housing and Local Government, (2021), Detailed local authority level tables Financial Year 2020/21. Available at: https://www.gov.uk/government/statistics/statutory-homelessness-in-england-financial-year-2020-21

Chart 21: Where respondents were discharged to after most recent hospital admission



Of those who provided a response, 26% (40) of respondents in wave 3 were readmitted to hospital within 30 days. This figure has increased slightly from wave 2, when 22% (155) of respondents had been readmitted within 30 days.

This data suggests that there is still much work to be done to ensure that when people leave hospital they have a safe and appropriate place to go to continue their recovery. Almost a third of people are not being asked whether they have an appropriate place to stay on discharge. However asking the question alone does not make sufficient appropriate accommodation available, this is a separate and aligned systemic challenge which speaks to the importance of tackling health and homelessness together.

Chapter 8: Is more help needed?

So far, this report has identified a range of health inequalities faced by people experiencing homelessness. It has demonstrated the high prevalence of mental ill health, physical ill health and the high use of emergency healthcare services compared to the general population. In this section, we come to look at the difference between the services that people felt they needed, and the support that they actually received.

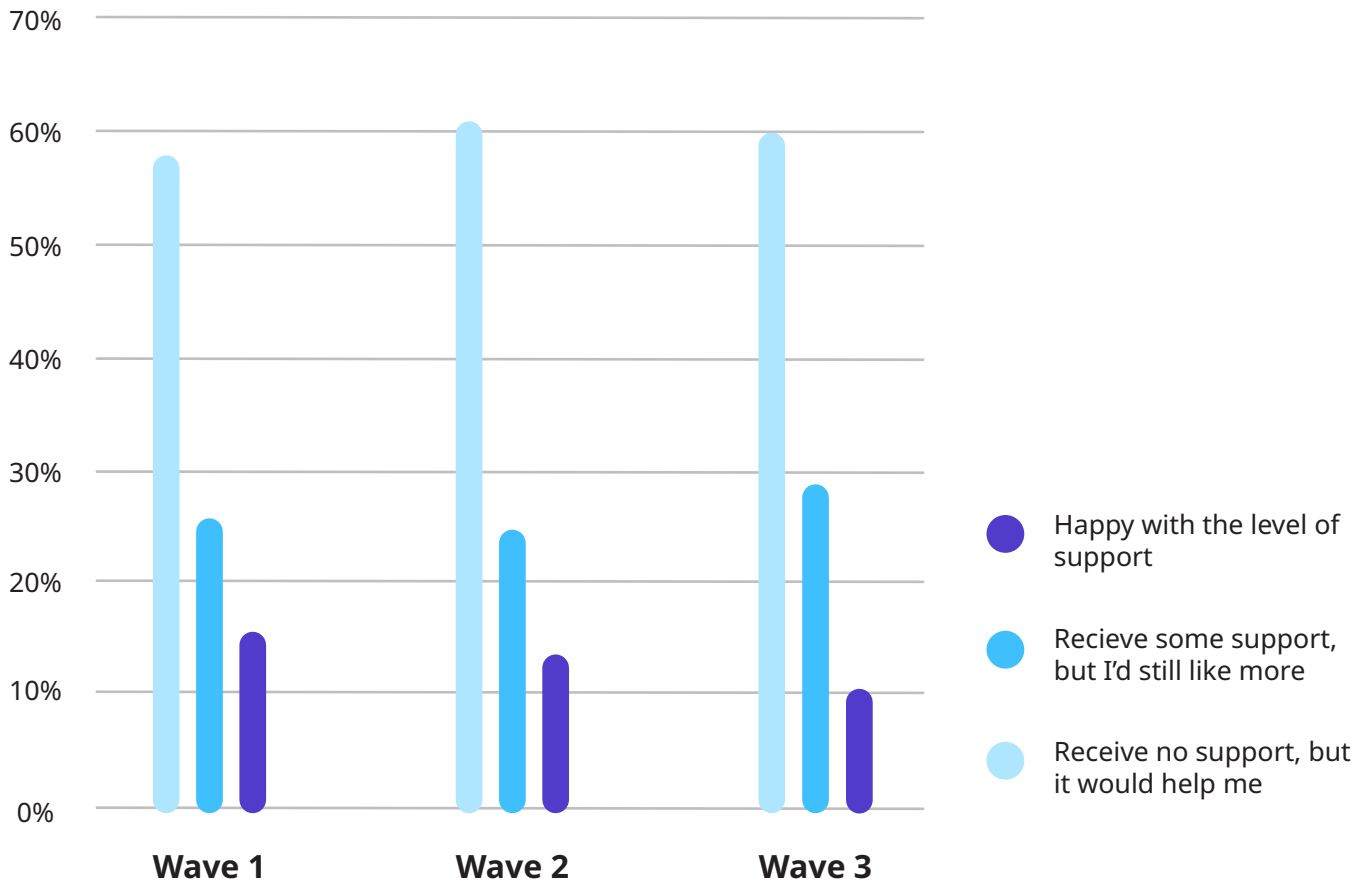
These findings allow us to consider the degree to which current services meet the needs of people experiencing homelessness and starts to identify some areas for learning and progress. In this section we take each area of health in turn, considering the extent to which available services were able to meet the needs and expectations of respondents to our survey.

8.1 Physical health

Respondents were asked whether they were accessing help for any of their physical health needs. In wave 3, 60% (214) of people were happy with their level of support. Of this group, 40% (140) of respondents were receiving support which met their needs and a further 21% (74) did not receive or want to receive any support. This is a similar picture to that seen in wave 2, in which 61% (965) were satisfied with the current level of physical health support.

At 40%, a sizeable minority of respondents to HHNAs in wave 3 reported that they needed more support for a physical health problem. Of these, 29% (101) of respondents were currently receiving some support, but were in need of more and a further 11% (39) of respondents reported that they did not receive any support, but that it would help them. Data from waves 1, 2 and 3 is presented in Chart 23 below.

Chart 22: Respondents' views on the level of support received for physical health needs



In addition to this, 27% (125) of respondents told us that they had not received a medical examination or treatment for a physical health condition when it was needed at some point within the last 12 months. This data together indicates that many people who experience homelessness are not currently receiving sufficient support to meet their physical health needs. Findings from Homeless Link's Annual Review 2021: Support for Single Homeless People in England indicate a range of barriers to accessing physical health services, with accommodation providers reporting that waiting lists, high thresholds, distance to travel and a lack of availability in the local area are barriers to accessing physical health support. Just 54% of accommodation providers reported having no problem accessing this type of support for their clients.[83]

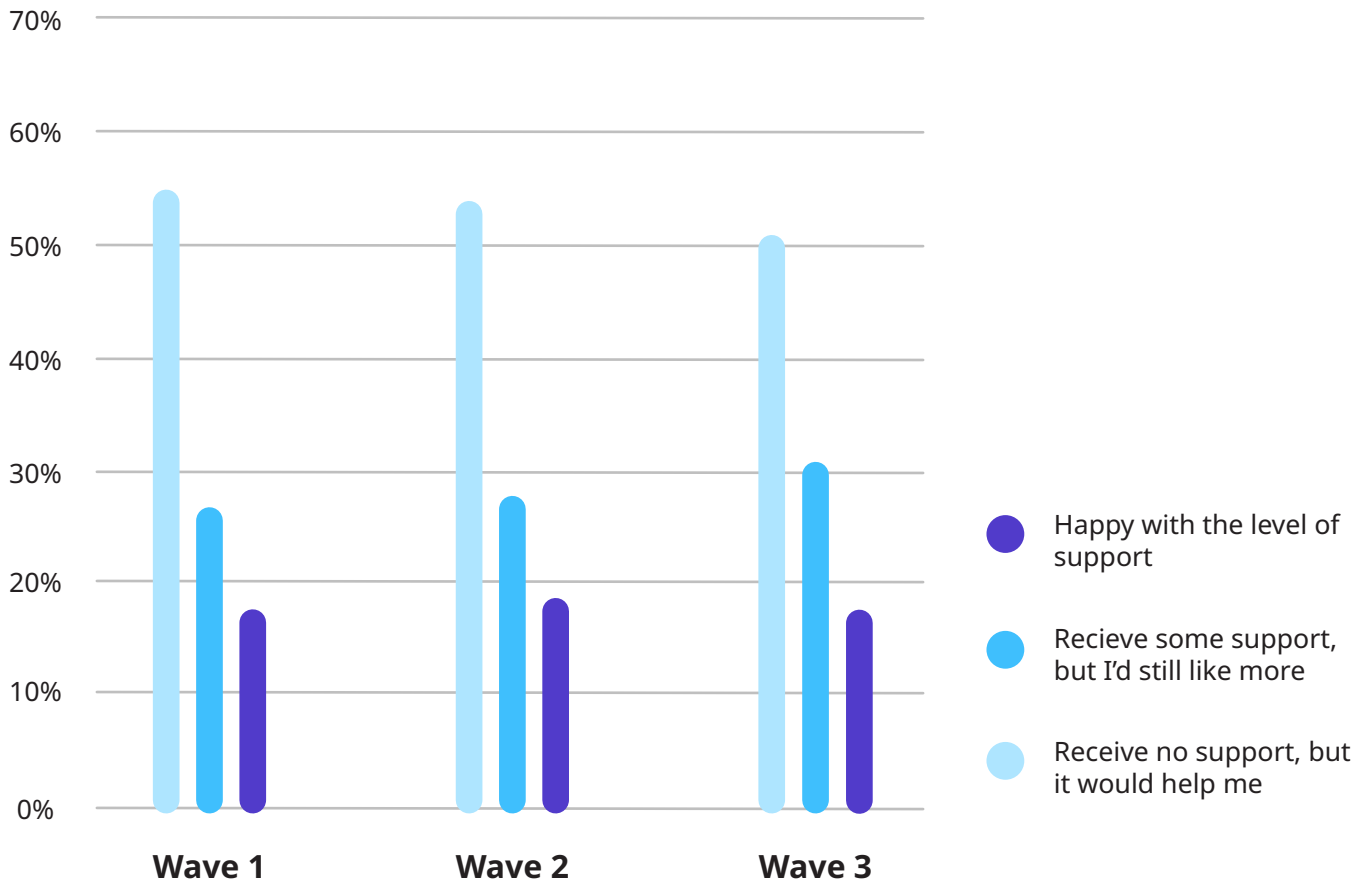
8.2 Mental health

When asked about mental health support, fewer people reported that the support they received met their needs. In wave 3, 51% (216) of respondents were either happy with the level of support they had (37% (157)), or did not feel that they needed any support (14% (59)). This is slightly lower than the figure in wave 2, in which 54% (964) of respondents

83. Homeless Link, (2022), Annual Review 2021: Support for Single Homeless People in England. Available at: https://homelesslink-1b54.kxcdn.com/media/documents/Homeless_Link_2021_Annual_Review_of_Single_Homelessness.pdf

were either happy with the support they received (37% (669)), or did not feel they needed any support (16% (295)). Chart 24 presents this data for all waves.

Chart 23: Respondents' views on the level of support received for mental health needs



When compared to physical health, there were more respondents who felt that they needed mental health support but were currently receiving none. The figure for people who reported that they currently received no mental health support, but that it would help them was 18% (75), compared to 11% (39) for physical health. Further suggesting that mental health support needs are not being met, 31% (132) of respondents in wave 3 told us that they currently accessed mental health support/ treatment, but were in need of more. The same trend around access to mental health support was found in Homeless Link's Annual Review 2021, where just 10% of accommodation providers reporting no trouble accessing mental health services for their clients.[84] Again this indicates that mental health services are more difficult to access than physical health services, at a difference of 34.4 percentage points.

84. Homeless Link, (2022), Annual Review 2021: Support for Single Homeless People in England. Available at: https://homelesslink-1b54.kxcdn.com/media/documents/Homeless_Link_2021_Annual_Review_of_Single_Homelessness.pdf

When we asked respondents whether there had been any time in the past 12 months that they needed an assessment or treatment for a mental health condition 37% (175) of people responded that there had been. When we compare this to the figure of 27% (125) for physical health, we can see again that mental health services appear more difficult to access to the extent needed by people experiencing homelessness. Given the extremely high prevalence of mental health diagnoses amongst this population, the high percentage of people who report self-medicating with drugs and alcohol, and the significance of mental health and attempted suicide/ self-harm as drivers of emergency service use, it is clear that we must do more to ensure that people experiencing homelessness get access to more and better mental health support and treatment that meets their needs.

8.3 Substance use

Everyone who responded that they had or were recovering from a drug problem was asked about the support that they received. In wave 3, 60% of respondents felt that they either did not need any support (25% (42)), or were happy with the support that they received (35% (59)).

Of those who wanted more support than they were receiving at the time of participating, 24% (40) of respondents received some support/ treatment but felt that they needed more and a further 17% (28) of respondents currently received no support/ treatment but felt that it would help them.

The HHNA asks those receiving treatment/ support for a substance use problem about what type of support they currently access. The most common forms of support accessed by respondents in wave 3 were community prescribing (50% (31)) and self-help groups (often called Mutual-aid) (48% (30)). Data for wave 1 are not available, the full results of this question for waves 2 and 3 are presented in table 20 below.

Table 20: Alcohol problem support/treatment accessed

	Wave 2		Wave 3	
Support/treatment	**Count**	**%**	**Count**	**%**
Self-help groups	134	39%	36	54%
Advice and information	145	43%	27	40%
Peer support	84	25%	21	31%
Counselling or psychological support	91	27%	13	19%
Attendance at day programmes, delivered in the community	66	19%	11	16%
Residential rehabilitation	27	8%	6	9%
Aftercare	29	9%	6	9%
Detox	35	10%	5	7%
Community prescribing	47	14%	5	7%
N	338		67	

The data presented through this section clearly shows that there is a gap in every instance between the support that people feel that they need and the support that they are able to access. This is most stark for people with a mental health condition, where 49% of respondents in wave 3 wanted more support than they currently had. We see the consequences of this lack of access to the level and kinds of healthcare needed in the high prevalence of self-medication and the high use of emergency healthcare services.

We need more information to understand exactly what additional support is needed and how it should be delivered to better meet the health needs of people who experience homelessness.

Chapter 9: The link between homelessness and ill health

For the first time in wave 3 we asked respondents with a diagnosed mental or physical health condition whether they received this diagnosis before or after they became homeless. Findings from this question are drawn from two audits (mental health data) and three audits (physical health data) and so should be considered as emerging findings only. In future reports we hope to further break down this data to explore experiences of specific mental and physical health conditions; for now we present the data for physical health as a whole and mental health as a whole.

Our findings suggest that slightly more people are diagnosed with a physical health problem after they experience homelessness. 56% (370) of respondents received a diagnosis after becoming homeless, compared to 44% (285) who received their diagnosis beforehand. This may speak to existing research about the negative health impacts of experiencing homelessness. We know, for example, that the physical environments in which people sleep can directly affect people's respiratory health.[85]

Interestingly, findings from mental health are quite different. Of those reporting a mental health condition, 72% (101) reported that this condition predated their experience of homelessness. This suggests that mental ill health may often be a trigger for homelessness, which can then be further exacerbated by the experience of homelessness. By contrast, our data suggests that physical health is slightly more likely to be a result of homelessness rather than a cause. In both cases, it is clear that many people first experience homelessness when they are already unwell. Systemic change is needed to ensure that people are provided with the support that they need to recover and remain well, rather than be left in circumstances known to worsen their health.

85. Groundwell, (2017), Room to breathe: A Peer-led health audit on the respiratory health of people experiencing homelessness. Available at: https://groundswell.org.uk/wp-content/uploads/2017/10/Groundswell-Room-to-Breathe-Full-Report.pdf

Chapter 10: Conclusion

Homelessness has a devastating impact on people's health and wellbeing. The findings set out in this report and captured from the Homeless Health Needs Audit demonstrate a stark narrative of health inequalities. Across all forms of health care needs, both physical and mental, as well as access to necessary support, people experiencing homelessness report poorer diagnoses and greater barriers to the healthcare needed than the general population.

Experiences of homelessness are both a cause and a result of poor physical and mental health. Over half of respondents reported being diagnosed with a physical health condition after they became homeless speaking to the negative impacts that experiences of homelessness cause. Chronic health conditions such as joint aches and problems with muscles and bones are the most commonly reported physical health need, and a reported consequence of rough sleeping and homelessness. In this context we cannot ignore homelessness as a health issue: it is a condition that results in poor physical health and it must be considered as we would any other public health concern.

Mental health conditions are much more likely to have predated experiences of homelessness, with nearly 3 in 4 respondents having had a mental health condition before becoming homeless. Homelessness exacerbates mental health needs but if it is not the primary cause then the importance of preventative healthcare is apparent. We cannot end homelessness if we are not tackling the underlying support needs that lead people to be at greater risk of losing their home.

The findings from the HHNA also highlights the barriers in access to timely and appropriate support that is leading people experiencing homelessness to access emergency services at a substantially higher rate than the general public. Overreliance on ambulances and A&E is not just costly to the health service but it also speaks to concerns that people experiencing homelessness are not able to access healthcare before their needs become an emergency.

From public health initiatives around smoking cessation or flu vaccines, to access to secondary healthcare services that don't leave people reliant on A&E, to support to prevent people from being discharged from hospital back to the streets, what is evident across the HHNA is that poor experiences and outcomes are universal across the health care system. We must understand why this is and address the systemic change needed.

The public health response to homelessness during the COVID-19 pandemic at both a national and local level demonstrated that when the system enables it significant progress can be made. It is vital that the relationship between health and social care, and homelessness services maintains and continues to grow.

National and local governments must work to understand why health inequalities for people experiencing homelessness are increasing and why services are still not able to meet their needs. This learning must be used to introduce the change needed to ensure that people are provided with the support that they need to recover and remain well, rather than be left in circumstances known to worsen their health.

Experiencing homelessness should not mean that someone is unable to access the healthcare they need. Nor should it mean we accept poorer health outcomes and growing health inequalities. Homelessness is a health issue and we must respond accordingly.

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Homeless Link

Homeless Health Needs Audit

For over a decade, organisations around the country have used the Homeless Health Needs Audit (HHNA) to help understand health inequalities faced by people experiencing homelessness in their area.

The HHNA is a tool for gathering local data about the physical and mental health needs of people experiencing homelessness and how they access services.

The HHNA toolkit gives you a framework you can use to bring together the right local partners and members of your areas Integrated Care System to plan and carry out the audit. It also gives guidance on using the data you gather to reduce health inequalities by informing service improvements and commissioning.

The HHNA is a proven approach that provides you with valuable local insights into the health and wellbeing of people experiencing homelessness.

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