The Unhealthy State of Homelessness 2025

Findings from the Homeless Health Needs Audit

Produced by

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Introduction

It is now well established that people experiencing homelessness face worse health and worse health outcomes than the general population. Lord Darzi, in his *Independent Investigation of the National Health Service in England*, identifies that whilst the NHS faces decreased capacity to support a population in deteriorating health in the context of 15 years of underfunding and the aftershocks of the pandemic,[1] the impact of this is much more acute for those who experience deep health inequalities. The report recognises that people experiencing homelessness are both more likely to be in poor health and less able to access the care that they need:

> "People facing homelessness do not receive the same level of care as those who have a safe place to call home. They experience stigma and discrimination as negative social attitudes in society are also present in the NHS. The result is that services are harder to access than they should be."[2]

His conclusion that "homelessness is a health catastrophe"[3] is a welcome acknowledgement of both the scale of the problem and the urgency with which it should be addressed. The government, in their 10-Year Plan, likewise acknowledges the "intolerable injustice" that people experiencing homelessness are "more likely to experience worse NHS access, worse outcomes and to die younger."[4]

The NHS 10-Year Plan includes changes that have potential to benefit people experiencing homelessness,[5] if they are implemented in a way that ensures that they reach and include them. Alongside these wider acknowledgements, we have seen a growing understanding of the interaction between homelessness and health, and of the subsequent need for services to provide suitable support.

1. Darzi, A. (2024). *Independent Investigation of the National Health Service in England.* https://assets.publishing.service.gov.uk/media/66f42ae630536cb92748271f/Lord-Darzi-Independent-Investigation-of-the-National-Health-Service-in-England-Updated-25-September.pdf
2. Ibid
3. Ibid
4. NHS England. (2025). *Fit for the Future: 10 Year Health Plan for England.* https://assets.publishing.service.gov.uk/media/6888a0b1a11f859994409147/fit-for-the-future-10-year-health-plan-for-england.pdf
5. See, for example: Pathway. (2025). *Pathway's response to the NHS Ten Year Plan*. https://www.pathway.org.uk/2025/07/03/pathways-response-to-the-nhs-10-year-plan/

In 2022, the National Institute for Health and Care Excellence (NICE) published guidelines on how to deliver integrated health and social care services for people experiencing homelessness (NG214). These aim to improve access to and engagement with health and social care, and to ensure care is coordinated across different services.[6] This has led to the development of a range of best practice examples, from innovations in rough sleeping data monitoring, to infectious disease outreach, to intermediate care services.[7] We have also seen an increase in activity and understanding in areas such as access to nutrition for people experiencing homelessness[8,9] and the early onset of frailty.[10]

Integrated Care Systems (ICSs) have also continued to develop within their remit to reduce health inequalities and act on the social determinants of health. Although the degree to which each ICS has focused on this varies, this report itself serves as an example of the commitment of multiple ICSs to understanding the health needs of people experiencing homelessness, in order to then provide services that meet identified needs.[11]

However, the context of this progress is a shocking increase in homelessness since the measures to end street homelessness during the COVID-19 pandemic were withdrawn. Since then, rates of homelessness have soared, with many measures in 2024 standing at, or close to, their highest level ever recorded: rough sleeping rose to 4,667 in 2024, just 2% below the highest number on record;[12] the number of people sleeping rough in London increased by 10% in 2024, reaching its highest ever rate;[13] local authority homelessness relief duties increased by 6% in 2023/24; and the number of households in temporary accommodation increased by 12%, to its highest level ever recorded.[14] Added to this, the Museum of Homelessness' Dying Homeless Project reported that in 2024 1,611 people died homeless, an increase of 9% from the previous year.[15]

This devastating increase in homelessness comes at a time when resources in the homelessness sector have also diminished,[16] and services report finding it increasingly challenging to access healthcare on behalf of those they support. For the first time in

6. NICE. (2022). *Integrated health and social care for people experiencing homelessness*, NICE Guideline: NG214. https://www.nice.org.uk/guidance/ng214
7. Homeless Health Consortium. (2025). *Delivering integrated health and social care for people experiencing homelessness*. https://homeless.org.uk/news/reducing-health-inequalities-for-people-experiencing-homelessness-through-integrated-services/
8. Style H, Vickerstaff V, Brown A. (2025). Nutrition Status of People Experiencing Homelessness Residing in Temporary Accommodation in London. J Hum Nutr Diet. 2025 Feb;38(1):e70024. doi: 10.1111/jhn.70024. PMID: 39925038; PMCID: PMC11808289.;
9. Homeless Link. (2025). *Access to food and nutrition for people experiencing homelessness and using substances: provision, challenges and opportunities for support in Tower Hamlets*. https://homelesslink-1b54.kxcdn.com/media/documents/Access_to_food_and_nutrition.pdf
10. Dawes, Jo et al., (2025). Prevalence of frailty and associated socioeconomic factors in people experiencing homelessness in England: cross-sectional secondary analysis of health needs survey data. *The Lancet Healthy Longevity*, Volume 6, Issue 8, 100745
11. Local Homeless Health Needs Audit, supported by Homeless Link. See: https://homeless.org.uk/what-we-do/research/health-needs-audit/
12. Ministry for Housing, Communities and Local Government. (2025). *Rough Sleeping Snapshot Autumn 2024*. https://www.gov.uk/government/statistics/rough-sleeping-snapshot-in-england-autumn-2024/rough-sleeping-snapshot-in-england-autumn-2024
13. CHAIN. *Rough sleeping in London: Annual data table 2024/25*. https://data.london.gov.uk/dataset/rough-sleeping-in-london-chain-reports-2n88x/
14. Ministry for Housing, Communities and Local Government. (2025). *Statutory homelessness live tables*. https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness
15. Museum of Homelessness. (2025). *The Dying Homeless Project: 2024 Findings*. https://static1.squarespace.com/static/623b05f9825aa34cda99921f/t/68e506c2bb1d910564a02b48/1759839938725/MoH_DHR2025.pdf
16. Homeless Link. (2025). *Breaking the Cycle: Moving from crisis to a country free from homelessness*. https://homelesslink-1b54.kxcdn.com/media/documents/Homeless_Link_Homeless_Strategy_Policy_Briefing_Breaking_the_Cycle.pdf

2024, Homeless Link's *Support to End Homelessness*[17] report, a longitudinal study into the homelessness sector, found that 100% of homelessness accommodation providers struggle to access mental health support for their clients; 61% face barriers accessing drug and alcohol services; and 58% face barriers accessing physical health support.[18]

Despite these challenges, there is clear opportunity in the growing examples of best practice, the improved understanding of the complex interaction between health and homelessness, and the government's firm acknowledgement of the need to tackle this issue. The government's upcoming homelessness strategy is an opportunity to provide an integrated cross-departmental strategy which enables good practice to grow, and that provides the framework and resources to tackle health and homelessness as the interlinked issues that they are.[19]

This research builds on the learning of our *2022 Unhealthy State of Homelessness* report.[20] In this report, we present new findings from Homeless Health Needs Audits (HHNA) undertaken between 2022 and 2025 which represent 727 individuals experiencing homelessness, situating them alongside the three previous waves of data collected through HHNAs since 2012. The data presented make clear that the health of people experiencing homelessness has worsened, in particular physical health, and that many people have been left to self-medicate for their mental health in the face of inadequate support. It also highlights the role health services have in preventing homelessness, with a clear identified pattern of people already experiencing ill health before becoming homeless.

Homelessness is a health issue: it is both caused by poor health and a cause of poor health. The findings from this report show the urgency with which this must be understood and addressed by both health, social care and the homelessness systems.

The HHNA still provides the only national dataset of its kind on this topic.[21] It 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.

17. Support to End Homelessness is a longitudinal study of the support available to single homeless people, which has been run by Homeless Link since 2014.
18. Homeless Link. (2025). *Support to End Homelessness 2024: A review of services addressing single homelessness in England*. https://homeless.org.uk/documents/1454/Support_to_End_Homelessness_2024.pdf
19. Homeless Link. (2025). *Breaking the Cycle: Moving from crisis to a country free from homelessness*. https://homelesslink-1b54.kxcdn.com/media/documents/Homeless_Link_Homeless_Strategy_Policy_Briefing_Breaking_the_Cycle.pdf
20. Homeless Link. (2022). *The Unhealthy State of Homelessness 2022: Findings from the Homeless Health Needs Audit*. https://homelesslink-1b54.kxcdn.com/media/documents/Homeless_Health_Needs_Audit_Report.pdf
21. For more information, please see: https://homeless.org.uk/what-we-do/research/health-needs-audit/

Key findings

Physical health

Throughout this section, we see worrying trends indicating a decline in the physical health of people experiencing homelessness. In the later chapters, data show that fewer people experiencing homelessness are receiving adequate support for their physical health. This trend is deeply concerning. As we look more closely at individual conditions and diagnoses, there is clear evidence that this decline is linked to the poor conditions faced by those experiencing homelessness.

- In wave 4, 81% (587) of respondents reported having at least one physical health condition. This figure marks a continuing decline in the physical health of people experiencing homelessness, with an increase of 8 percentage points in those reporting physical health conditions since wave 1 (wave 1: 73%; wave 2: 76; wave 4: 78%)
- 50% of respondents in wave 4 reported that they had a long-term illness, disability, or infirmity. This represents a decline compared to wave 3 and compares to 25% within the general population.
- In wave 4, 58% (423) of respondents had a physical health diagnosis.
- The most common diagnosed physical health condition was asthma (21% (142)), followed by chronic breathing problems including bronchitis, and emphysema, obstructive airways disease (19% (132)).19% of all physical health diagnoses made after an experience of homelessness were of a chronic breathing problem, making this the most common diagnosis after experience of homelessness, followed by liver problems at 15%. 'Dental/ teeth problems' are now the most commonly reported physical health condition, affecting 48% (339) of respondents, and representing a 12 percentage point increase from wave 3 (36% (187)). Physical health conditions are considered as distinct from diagnoses, and reflect ongoing physical health conditions and symptoms that can significantly impact quality of life
- Joint aches, problems with bones and muscles is the second most commonly reported physical health condition, affecting 47% (331) of respondents, and representing a 10 percentage point increase from wave 3 (37% (194)).
- Across all physical health conditions it was most common for respondents to be managing multiple physical health issues: 81% of those with any physical health condition/ diagnosis had at least 2 and 29% reported between 5 and 10 physical health conditions.

Taken together, the data suggest a picture of declining physical health amongst people experiencing homelessness in England. Data across waves show a steady deterioration whilst a closer look at the health conditions people are managing reveals sharp increases in

dental issues, in joint aches / problems with bones and muscles, as well as chronic breathing problems. We also see a clear impact of homelessness in the predominance of liver and respiratory health conditions diagnosed after experience of homelessness, and in the clear impact of homelessness on musculoskeletal health. These findings, considered alongside data showing high rates of substance use to manage mental health, and high prevalence of smoking and alcohol use, demonstrate how exclusion from healthcare services combined with exposure to multiple risks linked to the social determinants of health, can both create and compound poor health.

Cognitive health

HHNAs in wave 4 collected data on the cognitive health of respondents, with specific questions on ADHD/ ADD, autism, learning disability, and traumatic or acquired brain injury. These conditions represent a wide spectrum of symptoms, and, as with many conditions listed in this report, the experience of people with a diagnosis in any of these categories vary widely.

There is evidence that people with certain cognitive conditions, such as autism and learning disability are at increased risk of homelessness.[22,23] The findings here support this, revealing a substantial over-representation of people with autism and with learning disabilities,[24] whereas ADHD/ ADD rates are more closely aligned with those seen in the general population.

- In wave 4, 5% and 6% of respondents reported having an acquired brain injury (ABI) or traumatic brain injury (TBI) respectively. This represents a substantial overrepresentation compared to the general population, where an estimated 1.9% of people live with a disability as a consequence of a brain injury.
- 24% (166) of respondents reported having a learning disability.
- There is a high overrepresentation of autism amongst people experiencing homelessness, with 8% reporting a diagnosis compared to 3% of the general population.
- Conversely ADHD/ ADD rates amongst people experiencing homelessness are closer to those of the general population:16% compared to 14% in the general population.

This is important data: illuminating the prevalence of these conditions amongst people experiencing homelessness enables the development of targeted support, and targeted prevention solutions to those at greatest risk of experiencing homelessness.

22. Groundswell. (2022). *Learning Disabilities and Homelessness*. https://groundswell.org.uk/wp-content/uploads/2022/05/Learning-Disabilities-Toolkit-.pdf
23. Churchard, A., Ryder, M., Greenhill, A., & Mandy, W. (2018). The prevalence of autistic traits in a homeless population. *Autism*, 1362361318768484
24. It is important to note that some respondents to HHNAs may have identified themselves as having a learning disability when they in fact had a 'specific learning difficulty', for example dyslexia. This means that this figure should be interpreted with caution and is likely an overrepresentation of learning disability.

Mental health

In this section, we see a more mixed picture, indicating that while some progress has been made in tackling mental health amongst people experiencing homelessness, serious challenges remain. Poor mental health is still vastly overrepresented compared with the general population, and there is an increasing trend in self-medicating to manage symptoms, suggesting that too many people are not accessing the support they need.

- The number of people reporting a diagnosed mental health condition soared between wave 1 (45%) and wave 3 (82%). Wave 4 shows a stabilisation and a slight reduction, with 77% (560) of respondents reporting at least one mental health condition.
- Although this decrease is undoubtedly positive, comparison to the general population shows that people with diagnosed mental health conditions are still vastly overrepresented amongst those experiencing homelessness: 20.2% of adults in England have a diagnosed mental health condition, compared to 77% of people experiencing homelessness.[25]
- This decline in overall mental health diagnoses is driven largely by a decrease in diagnosed depression. Although still the most commonly reported mental health diagnosis, the number of people with depression dropped three percentage points in this wave of data, from 72% to 69%.
- The most commonly reported mental health conditions remain consistent between waves 3 and 4: depression and anxiety disorder are most prevalent, while dual diagnosis, PTSD, and personality disorders have seen the largest increases..
- The increase in people with a co-occurring mental health condition and drug/ alcohol use issue is of particular concern. This has seen the largest percentage point increase between waves 3 and 4 of HHNA data, with a 12 percentage point increase bringing the proportion of people with a dual diagnosis to 37% in wave 4, from 25% in wave 3.
- Almost half (49% (344)) of respondents reported self-medicating with drugs or alcohol to help them cope with their mental health. This is an increase from wave 3 (45% (211)).
- Rates of comorbidities are extremely high: among those with a mental health condition, only 15% (84) reported experiencing just one, while 85% had multiple. It was most common for people to report three (24% (135)) or two (23% (127)) mental health conditions.
- Of all reported mental health diagnoses, 67% predated the respondent's experience of homelessness. This trend holds across all conditions but is particularly pronounced for personality disorder, where 73% of diagnoses occurred prior to homelessness, and for depression, where 70% were made before homelessness.

25. NHS. (2025) *Adult Psychiatric Morbidity Survey 2023/4: Survey of Mental Health and Wellbeing, England*. https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey

- HHNA data also shows that 27% (193) of respondents had been admitted to hospital because of a mental health condition at some point in their past, indicating a high level of acute mental health need prior to homelessness.

Taken together, these findings indicate an ongoing pattern of poor mental health amongst people experiencing homelessness, including significant challenges in managing symptoms. Whilst there has been a small decline in reported diagnosed conditions, the increase in self-medication and dual diagnosis suggests worsening access to appropriate support. Findings of the prevalence of mental health need prior to becoming homeless only further substantiates the importance of mental health services in any meaningful consideration of homelessness prevention.

Drug and alcohol use

Findings in this section show an increase in daily use of alcohol and illicit drugs. Alongside the finding that there is an increase in the number of people self-medicating with drugs and alcohol to manage their mental health, this indicates that whilst many people's mental ill-health predates their experience of homelessness, homelessness can compound and increase the complexity of the situation. It is therefore vital that the acute need for services available to people experiencing homelessness is considered a core part of any inclusion health strategy and service development. Increased understanding of the interaction between mental health, substance misuse and homelessness should be used to establish better upstream preventative care.

- In wave 4, almost three quarters of respondents (72%, (510)) reported using drugs in the last 12 months. The figure is substantially higher than wave 3, where 55% (287) reported the same, and far higher than the general population estimate of 8.8% of people aged 16 to 59 years reporting using any drug in the last 12 months for the year ending March 2024.[26]
- 35% (145) of respondents reported using drugs almost every day.
- Cannabis is the most commonly used drug at 41% (292), followed by crack (27% (195)), cocaine (22% (159)) and heroin (20% (146)).
- 36% (238) of respondents reported having, or recovering from, a drug problem.
- 49% (131) of respondents were at high risk of exceeding the Chief Medical Officer's (CMO) low-risk drinking guidelines, this compares to 24% of the general population.
- 26% (173) of respondents had, or were in recovery from, an alcohol problem.

26. Office for National Statistics. (2024). *Drug misuse in England and Wales: year ending March 2024*. https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/drugmisuseinenglandandwales/yearendingmarch2024

The overall trends towards increased alcohol consumption and riskier drug use are concerning, particularly alongside the rise in self-medication. The increased prevalence of co-occurring drug use and mental health diagnosis highlights the interlinked nature of these issues and an area of heightened concern.

Use of healthcare services

This section first considers primary healthcare services, including GP and dental access and registration levels, before looking at use of acute health services and reasons for use. By comparing this data with general population figures, we can better understand whether and how people experiencing homelessness use and access services differently.

The data demonstrate that people experiencing homelessness continue to use emergency services at a higher rate than the general population, despite high levels of GP registration. Mental ill-health remains a key driver of emergency service use, alongside poor physical health and increased alcohol use, adding to the urgency of providing suitable, person-centred health and care for people experiencing homelessness.

- In wave 4, the majority of respondents were registered with a GP (89%, 626)). A further 28% (149) of respondents were registered with a specialist homeless healthcare provider.
- Despite initiatives to increase registration over the past 10 years, some respondents still face barriers: 7% (46) had been refused registration at a GP practice, and 3% (14) had been refused registration with a specialist homeless healthcare provider.
- Dental registration levels are much lower than GP registrations, with only 37% (247) of respondents reporting they were registered with a dentist in wave 4, compared to 53% (246) in wave 3. This is concerning given that dental / teeth problems are the most commonly reported physical health complaint, affecting 48% (339) of respondents.
- Just over half of respondents (52%, (350)) had used A&E services at least once in the past year, a slight increase from wave 4 (48%, (202)). This indicates that people experiencing homelessness use A&E four times more often than the general population.
- 15% of respondents had used A&E services more than three times in the last 12 months.
- Physical health was the primary reason for A&E presentations (28%, (106)), followed by issues relating to mental health and attempted suicide/self-harm (21%, (59)).
- 38% (254) of respondents had been admitted to hospital in the 12 months prior to completing a HHNA. Physical health problems and conditions were the most common reason for admission (35%, 60), followed by mental health (19%, 11)), and self-harm/ attempted suicide (11%, 19).
- The number of people being discharged onto the streets stands at the highest rate since data collection began. Nearly a third (32%, (77)) of respondents were discharged onto the

streets, and a further 18% (44) were discharged into accommodation that was not suitable for their needs.

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. Just over 4 in 10 (42%) respondents reported that they have not been asked whether they have an appropriate place to stay on discharge. However, asking the question alone does not make sufficient appropriate accommodation available; health and homelessness must be tackled together if we are to support people to recover and remain well in housing suitable for their needs.

Is more help needed?

This section compares the support that people felt they needed with what they actually received, highlighting potential gaps in service provision. The findings show the extent to which current services meet the needs of people experiencing homelessness and start to identify areas for learning and progress.

- Respondents who reported currently experiencing symptoms for a physical health condition were asked whether they were receiving support or treatment for any of their physical health needs. Just over half of respondents (54% (304)) were accessing help for a physical health condition.
- 51% (286) of those accessing support felt their needs were met through the support and treatment they were receiving, a decrease from 60% (214) in wave 3.
- 49% (276) of those with a physical health condition reported needing more help than they were currently receiving, and 20% reported receiving no support, up from 11% in wave 3.
- 35% (254) of respondents reported at least one occasion in the past 12 months when they needed medical treatment but did not receive it. 61% (321) of respondents experiencing symptoms of a mental health condition were receiving support or treatment.
- Of these, 32% (170) felt their needs were met, 29% (151) needed more help, and 21% (110) received no support despite needing it.
- The most common treatments respondents received were prescribed medication (61%), support from a specialist mental health worker (38%), and talking therapies (36%).
- 71% (163) of respondents who had or were recovering from a drug problem received support or treatment, yet 46% reported wanting more help.
- 64% (107) of respondents who had or were recovering from an alcohol problem received support or treatment, yet 49% wanting more help.

The data in this section show a consistent gap between the healthcare needed and what they

are actually able to access. This gap is most stark for those with mental health conditions, where 50% of respondents reported unmet needs. The gap has increased most for physical health, alongside substantial change in the prevalence and types of conditions people are managing. The consequences of this lack of access are evident in higher use of emergency healthcare services and the increased prevalence of self-medication to manage mental health.

Wellbeing, prevention and health resilience

The findings in this chapter are key to demonstrating some of the determinants of health inequalities. They show that people experiencing homelessness are not equally able to engage in preventative or protective health measures compared to the general population, compounding existing health inequalities.

- The HNNA asks respondents to rate their health at the time of responding, and compared to 12 months prior. These indicators reflect overall perceptions of health and perceived trends over time. Overall, 40% of respondents felt their health was 'very good' or good' at the time of completing the survey, while 31% reported it as 'very bad' or bad'.
- 35% of respondents reported that their health had improved over the past 12 months, 32% felt it was unchanged and 33% felt it had worsened.
- There are significant differences in perception of health based on current housing status: those living in hostels or supported accommodations were more likely to report improvements (41%) while 32% felt their health had stayed the same. Among those rough sleeping, 51% felt their health had worsened.
- The HHNA asked respondents whether they have been vaccinated against Hepatitis B and the flu. Vaccination rates were low: in wave 4, just 7% (46) of respondents were fully vaccinated against Hepatitis B, and 25% (129) had received a flu vaccination in the last year, up from 18% in wave 3.
- Women experiencing homelessness were far less likely than the general population to access cervical or breast cancer screening. Only 38% of those eligible had received a cervical smear, and 29% a breast screening, compared to 69% and 70% in the general population respectively.
- Smoking remains prevalent: 77% (551) of respondents reported smoking cigarettes, e-cigarettes, cigars or a pipe. This compares to 11.9% of adults in the general population.
- Of those who smoked, 36% (194) reported wanting to quit, yet 52% (100) reported that they had not been offered help to stop smoking.
- Nearly two thirds of respondents (65% (449)) reported that they were taking some form of prescribed medication.
- Food access is limited. 36% (239) of respondents reported eating only one meal per day,

40% (268) ate two meals, and just 20% (137) ate three or more meals per day.

- Different accommodation models and types have an impact on people's health outcomes, particularly access to food. Respondents sleeping in hostels or supported accommodation were more likely to consume two meals per day (43%, 163)) than those in emergency accommodation (31%, 4)) or their own tenancy (36%, 13)). Respondents in temporary accommodation, B&Bs, or sofa-surfing were more likely to eat three or more meals per day.

These findings collectively reveal poor access to both preventative population health interventions and general access to healthy choices known to increase health outcomes and improve physical and metal resilience. They make a clear case for population-level healthcare interventions to consider the specific needs of inclusion health groups like those experiencing homelessness.

How do health and homelessness interact?

This issue of the Unhealthy State of Homelessness builds on early findings from 2022, which indicated that mental ill-health is more likely to predate experiences of homelessness, whereas physical ill-health is more likely to occur afterwards. In wave 4, HHNAs asked respondents whether each physical health diagnosis was made (or in the case of physical health conditions, first occurred) before or after their experience of homelessness. Our data show that mental ill-health is highly prevalent before people experience homelessness, while physical health presents a more complex picture.

- Findings indicate that existing mental ill-health is very common amongst people who experience homelessness, with 67% of all reported mental health conditions being diagnosed prior to their experience of homelessness. This highlights a stark reality: many individuals are already facing mental health challenges before becoming homeless, placing them at even greater risk when confronted with the additional hardships of homelessness. While mental health diagnoses generally predate homelessness, there is some variation. Post-Traumatic Stress Disorder (PTSD) and dual diagnosis are relatively more likely to be diagnosed after homelessness.
- Overall, 58% (503) of physical health diagnoses were made before respondents became homeless. However, there is significant variation across diagnosed physical conditions, suggesting that whilst many individuals already have health issues prior to homelessness, homelessness itself creates additional health challenges.
- Diagnoses made after homelessness include 64% of Hepatitis C cases, 57% of liver problems, and 53% of chronic breathing conditions. These conditions reflect overlapping disadvantages. Increased prevalence of smoking and alcohol use, often linked to self-medication due to inadequate mental health support, likely contribute to these diagnoses after experiencing homelessness.

- Conversely 76% of those with a diagnosis of epilepsy, 75% with a neurological condition, 70% with HIV, and 63% with a TBI were all diagnosed prior to becoming homeless. This suggests that these populations may be at greater risk of homelessness and could be targeted for upstream prevention.

Taken together, these findings demonstrate that more often than not people are in poor health when they become homeless. Homelessness then exacerbates health problems, increasing the likelihood of liver and chronic breathing issues, PTSD, and dual diagnosis. It also contributes to the onset of physical health conditions related to poor living conditions, where recovery is dependent on good nutrition, hygiene, and rest. Again, the data show that people experiencing homelessness face greater health challenges than the general population and are disadvantaged in their ability to access the support and facilities needed for recovery.

Conclusion

We know that many of the social determinants of health are stacked against people experiencing homelessness, and our findings clearly show that poor health often precedes homelessness. 67% (1185) of all diagnosed mental health conditions were present before respondents' experience of homelessness, and 27% (193) had been admitted to hospital because of a mental health condition at some time. Additionally, 58% (503) of physical health diagnoses already existed when respondents became homeless. This makes clear that homelessness is not just a housing issue; it is a health issue, and preventing homelessness requires targeted interventions from the health and social care system.

Once someone does experience homelessness, the findings presented throughout this report clearly demonstrate that this further negatively impacts health. For example, chronic breathing problems and liver disease are more likely to be diagnosed after an individual experiences homelessness, and a significant number of mental health conditions, most notably PTSD and dual diagnosis, are also impacted. The added complexity as poor health builds is reflected in the high rates of multimorbidity seen in this group. 47% (345) of respondents have at least one mental health and physical health diagnosis; and 11% (81) of respondents reported that they have a drug problem together with both at least one mental health and at least one physical health diagnosis.

The current situation therefore presents a direct contradiction: as the complexity of managing poor health increases, access to healthcare becomes harder. Evidence shows rising rates of self-medication and emergency healthcare use, four times higher than the general population. Our findings make clear that the wider health system is currently failing to meet the needs of people experiencing homelessness, with life-saving cancer screenings reaching people experiencing homelessness at declining rates, and increasing numbers discharged from hospital to the street. The ultimate consequence of this is seen

in the devastating findings of the Museum of Homelessness, who reported the deaths of 1,611 individuals experiencing homelessness in 2024.

Homelessness is a health issue. The response therefore must sit upstream, and outside of traditional homelessness services and requires the involvement and investment of multiple partners across health and social care to effectively prevent homelessness wherever possible. It must also ensure that when homelessness does occur the experience is short-lived and, instead of creating a spiral into increasing and deteriorating poor health, provide rapid access to person-centred support across all areas of health and care.

We know that these improvements can be made; we see this in the many examples of good practices across health and homelessness services working in partnership across the country. This includes targeted inclusion health services increasing access to support, but also re-framed homelessness support models, such as Housing First, which integrates health interventions within housing. Health systems and services must be accountable for the delivery of these services alongside homelessness services. As the national government reinforces its commitment to an NHS that works better for everyone, and a cross-departmental homelessness strategy, we must see more invested by local and national government to recognise and address homelessness as a health issue, and commit to the shared accountability needed to take seriously, and reduce, the stark and unacceptable health inequalities caused by homelessness.

It is now well established that people experiencing homelessness face worse health and worse health outcomes than the general population. Lord Darzi, in his *Independent Investigation of the National Health Service in England*, identifies that whilst the NHS faces decreased capacity to support a population in deteriorating health in the context of 15 years of underfunding and the aftershocks of the pandemic,[27] the impact of this is much more acute for those who experience deep health inequalities. The report recognises that people experiencing homelessness are both more likely to be in poor health and less able to access the care that they need:

> "People facing homelessness do not receive the same level of care as those who have a safe place to call home. They experience stigma and discrimination as negative social attitudes in society are also present in the NHS. The result is that services are harder to access than they should be."[28]

His conclusion that "homelessness is a health catastrophe"[29] is a welcome acknowledgement of both the scale of the problem and the urgency with which it should be addressed. The government, in their 10-Year Plan, likewise acknowledges the "intolerable injustice" that people experiencing homelessness are "more likely to experience worse NHS access, worse outcomes and to die younger."[30]

The NHS 10-Year Plan includes changes that have potential to benefit people experiencing homelessness,[31] if they are implemented in a way that ensures that they reach and include them. Alongside these wider acknowledgements, we have seen a growing understanding of the interaction between homelessness and health, and of the subsequent need for services to provide suitable support.

In 2022, the National Institute for Health and Care Excellence (NICE) published guidelines on how to deliver integrated health and social care services for people experiencing

27. Darzi, A. (2024). *Independent Investigation of the National Health Service in England*. https://assets.publishing.service.gov.uk/media/66f42ae630536cb92748271f/Lord-Darzi-Independent-Investigation-of-the-National-Health-Service-in-England-Updated-25-September.pdf
28. Ibid
29. Ibid
30. NHS England. (2025). *Fit for the Future: 10 Year Health Plan for England*. https://assets.publishing.service.gov.uk/media/6888a0b1a11f859994409147/fit-for-the-future-10-year-health-plan-for-england.pdf
31. See, for example: Pathway. (2025). *Pathway's response to the NHS Ten Year Plan*. https://www.pathway.org.uk/2025/07/03/pathways-response-to-the-nhs-10-year-plan/

homelessness (NG214). These aim to improve access to and engagement with health and social care, and to ensure care is coordinated across different services.[32] This has led to the development of a range of best practice examples, from innovations in rough sleeping data monitoring, to infectious disease outreach, to intermediate care services.[33] We have also seen an increase in activity and understanding in areas such as access to nutrition for people experiencing homelessness[34,35] and the early onset of frailty.[36]

Integrated Care Systems (ICSs) have also continued to develop within their remit to reduce health inequalities and act on the social determinants of health. Although the degree to which each ICS has focused on this varies, this report itself serves as an example of the commitment of multiple ICSs to understanding the health needs of people experiencing homelessness, in order to then provide services that meet identified needs.[37]

However, the context of this progress is a shocking increase in homelessness since the measures to end street homelessness during the COVID-19 pandemic were withdrawn. Since then, rates of homelessness have soared, with many measures in 2024 standing at, or close to, their highest level ever recorded: rough sleeping rose to 4,667 in 2024, just 2% below the highest number on record;[38] the number of people sleeping rough in London increased by 10% in 2024, reaching its highest ever rate;[39] local authority homelessness relief duties increased by 6% in 2023/24; and the number of households in temporary accommodation increased by 12%, to its highest level ever recorded.[40] Added to this, the Museum of Homelessness' *Dying Homeless Project* reported that in 2024 1,611 people died homeless, an increase of 9% from the previous year.[41]

This devastating increase in homelessness comes at a time when resources in the homelessness sector have also diminished,[42] and services report finding it increasingly challenging to access healthcare on behalf of those they support. For the first time in 2024, Homeless Link's *Support to End Homelessness*[43] report, a longitudinal study into the homelessness sector, found that 100% of homelessness accommodation providers

32. NICE. (2022). *Integrated health and social care for people experiencing homelessness*, NICE Guideline: NG214. https://www.nice.org.uk/guidance/ng214
33. Homeless Health Consortium. (2025). *Delivering integrated health and social care for people experiencing homelessness*. https://homeless.org.uk/news/reducing-health-inequalities-for-people-experiencing-homelessness-through-integrated-services/
34. Style H, Vickerstaff V, Brown A. (2025). *Nutrition Status of People Experiencing Homelessness Residing in Temporary Accommodation in London*. J Hum Nutr Diet. 2025 Feb;38(1):e70024. doi: 10.1111/jhn.70024. PMID: 39925038; PMCID: PMC11808289.;
35. Homeless Link. (2025). *Access to food and nutrition for people experiencing homelessness and using substances: provision, challenges and opportunities for support in Tower Hamlets*. https://homelesslink-1b54.kxcdn.com/media/documents/Access_to_food_and_nutrition.pdf
36. Dawes, Jo et al., (2025). Prevalence of frailty and associated socioeconomic factors in people experiencing homelessness in England: cross-sectional secondary analysis of health needs survey data. *The Lancet Healthy Longevity*, Volume 6, Issue 8, 100745
37. Local Homeless Health Needs Audit, supported by Homeless Link. See: https://homeless.org.uk/what-we-do/research/health-needs-audit/
38. Ministry for Housing, Communities and Local Government. (2025). *Rough Sleeping Snapshot Autumn 2024*. https://www.gov.uk/government/statistics/rough-sleeping-snapshot-in-england-autumn-2024/rough-sleeping-snapshot-in-england-autumn-2024
39. CHAIN. *Rough sleeping in London: Annual data table 2024/25*. https://data.london.gov.uk/dataset/rough-sleeping-in-london-chain-reports-2n88x/
40. Ministry for Housing, Communities and Local Government. (2025). *Statutory homelessness live tables*. https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness
41. Museum of Homelessness. (2025). *The Dying Homeless Project: 2024 Findings*. https://static1.squarespace.com/static/623b05f9825aa34cda99921f/t/68e506c2bb1d910564a02b48/1759839938725/MoH_DHR2025.pdf
42. Homeless Link. (2025). *Breaking the Cycle: Moving from crisis to a country free from homelessness*. https://homelesslink-1b54.kxcdn.com/media/documents/Homeless_Link_Homeless_Strategy_Policy_Briefing_Breaking_the_Cycle.pdf
43. Support to End Homelessness is a longitudinal study of the support available to single homeless people, which has been run by Homeless Link since 2014.

services struggle to access mental health support for their clients; 61% face barriers accessing drug and alcohol services; and 58% face barriers accessing physical health support.[44]

Despite these challenges, there is clear opportunity in the growing examples of best practice, the improved understanding of the complex interaction between health and homelessness, and the government's firm acknowledgement of the need to tackle this issue. The government's upcoming homelessness strategy is an opportunity to provide an integrated cross-departmental strategy which enables good practice to grow, and that provides the framework and resources to tackle health and homelessness as the interlinked issues that they are.[45]

This research builds on the learning of our 2022 *Unhealthy State of Homelessness* report.[46] In this report, we present new findings from Homeless Health Needs Audits undertaken between 2022 and 2024 which represent 727 individuals experiencing homelessness, situating them alongside the three previous waves of data collected through HHNAs since 2012. The data presented make clear that the health of people experiencing homelessness has worsened, in particular physical health, and that many people have been left to self-medicate for their mental health in the face of inadequate support. It also highlights the role health services have in preventing homelessness, with a clear identified pattern of people already experiencing ill health before becoming homeless.

Homelessness is a health issue: it is both caused by poor health and a cause of poor health. The findings from this report show the urgency with which this must be understood and addressed by both health and social care and homelessness systems.

The HHNA still provides the only national dataset of its kind on this topic.[47] It 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.

44. Homeless Link. (2025). *Support to End Homelessness 2024: A review of services addressing single homelessness in England*. https://homeless.org.uk/documents/1454/Support_to_End_Homelessness_2024.pdf
45. Homeless Link. (2025). *Breaking the Cycle: Moving from crisis to a country free from homelessness*. https://homelesslink-1b54.kxcdn.com/media/documents/Homeless_Link_Homeless_Strategy_Policy_Briefing_Breaking_the_Cycle.pdf
46. Homeless Link. (2022). *The Unhealthy State of Homelessness 2022: Findings from the Homeless Health Needs Audit.* https://homelesslink-1b54.kxcdn.com/media/documents/Homeless_Health_Needs_Audit_Report.pdf
47. For more information, please see: https://homeless.org.uk/what-we-do/research/health-needs-audit/

Aims and objectives of the research

This research builds on the learning of our 2022 Unhealthy State of Homelessness report.[48] The 2022 report presented aggregated data from 31 new individual Homeless Health Needs Audits (HNNAs) completed between 2015 and 2021, representing a total of three waves of data, and demonstrated the stark health inequalities faced by people who experience homelessness. The HNNA still provides the only national dataset of its kind on homelessness and inclusion health.[49]

This report aims to expand 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 adds a fourth wave of data to this series, introducing 7 new Homeless Health Needs Audits undertaken between 2022-2025. These new HHNAs represent 14 individual local authority areas and the experiences and views of 727 individuals experiencing homelessness.

This report presents time series data in four groups: wave 1 (2012-2014), wave 2 (2015-2017), wave 3 (2018-2021) and wave 4 (2022-2025). 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 indicate the impact of particular changes to policy or practice.

Finally, through comparison with general population data, this research aims to improve and update our understanding of the extent of health inequalities faced by people experiencing homelessness and of how the types of and access to support needed may differ from the general population.

48. Homeless Link. (2022). *The Unhealthy State of Homelessness 2022: Findings from the Homeless Health Needs Audit.* https://homelesslink-1b54.kxcdn.com/media/documents/Homeless_Health_Needs_Audit_Report.pdf
49. For more information, please see: https://homeless.org.uk/what-we-do/research/health-needs-audit/

Methodology

Wave 4 data is drawn from aggregating data gathered through 7 individual Homeless Health Needs Audits, representing 14 local authority areas, completed between 2022-2025. This represents the experiences and views of 727 individuals experiencing homelessness.

Wave 4 is added to the existing waves 1-3 of data and presented here side by side in order to identify how health needs and access to care and support has changed over time. This section provides an overview of the wave 4 dataset, as well as an overview of data presented within waves 1-3.

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 are interviewer-led, take approximately 30 minutes to complete and are most often completed by support workers.

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 local partnerships and to guide local health commissioning.

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 and our research partners. With consent, data 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.

Wave 4 overview

Data for wave 4 was drawn from 7 Homeless Health Needs Audits, representing 14 local authority areas, undertaken between 2022 and 2025.

All audit questionnaires were completed by people currently experiencing homelessness, or who were being supported by homelessness services having very recently moved into a property.

There have been no substantial updates to the Homeless Health Needs Audit survey within wave 4. Instead, minor updates were made in response to intelligence from health and homelessness colleagues, including collecting data on brain injury, learning disability and neurodivergence.

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.

Waves 1-4 overview

Across all four waves, data is included from 57 individual Homeless Health Needs Audits, all of which were undertaken with the support of Homeless Link. This represents a total of 6,093 individual survey respondents.

An overview of this data is presented in Table 1 below.

Table 1: 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)	506	8
Wave 4 (2022-2025)	727	7

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'.[50] 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 four waves of data.

Limitations of the data

Aggregate HHNA data is not geographically representative for England. HHNAs are currently commissioned by local authorities or Integrated Care Systems and therefore there is a bias towards data being collected in those authorities who are both inclined to and have the funds available to complete a HHNA. Ability to deliver HHNAs in a targeted way to account for different geographies, and other socio-economic contexts would strengthen this dataset going forward.

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

This section outlines the housing status and background of respondents to the Homeless Health Needs Audit (HHNA). We present data on respondent demographics, where people were sleeping at the time of responding, their history of homelessness, and whether they have experienced life events known 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.

Age

The majority of respondents in both waves 3 and 4 were aged 25-54, at 70% (496) in wave 4 and 69% (339) in wave 3. Full breakdown of the age of the respondents is provided in Table 2 below.

Table 2: Respondents' age

	Wave 3		Wave 4	
Experience	**Count**	**%**	**Count**	**%**
15-17	1	<1%	6	1%
18-24	71	14%	78	11%
25-54	339	69%	496	70%
55-75	81	16%	126	18%
75+	1	<1%	3	<1%
N:	493		709	

Statutory data about people owed a prevention or relief duty by any English local authority in the financial year 2024/25 shows that 69% (288,670) of people owed a duty who were aged 25-54, closely matching our data.[51] There is more divergence in other age groups,

51. MHCLG. (2025). *Statutory homelessness live tables*. https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness

with young people aged 18-24 representing 17% (71,750) of people owed a duty in England during this time[52], compared to 11% (78) in our most recent data. 13% (54,460) of people owed a prevention or relief duty were aged 55+, compared to 18% in the wave 4 data.

Possible explanations include lower participation by youth-specific services or an older age profile among the 'static' homeless population (i.e., those not presenting to a local authority in the past year).

Ethnicity

The majority of respondents in wave 4 (2022-2025) were White (70%, 506)), with 10% (76) being Black, Black British, Caribbean or African, 8% (59) Asian/Asian British, and 8% (55) being Mixed/multiple ethnic groups.

Table 3: Ethnicity of respondents

	Wave 3		Wave 4		Population data: Census 2021
Ethnicity	**Count**	**%**	**Count**	**%**	
White	461	93%	506	70%	81.7%
Black, Black British, Caribbean or African	11	2%	76	10%	4%
Asian/ Asian British	6	1%	59	8%	9.3%
Mixed/ multiple ethnic groups	17	3%	55	8%	2.9%
Other	5	1%	30	4%	2.1%
N:	495		726		

Population data from Ethnic Group, England and Wales: Census 2021

Comparing this to the statutory data on people owed a homelessness prevention or relief duty in the financial year 2024/25 indicates an overrepresentation in our data of people whose ethnicity is White. 62% (259,400) of people identified their ethnicity as White in the statutory data, compared to 70% in the HNNA data. The statutory data also suggests that the wave 4 data just slightly underrepresents people whose ethnicity is Black/Black British, Caribbean or African – a figure which stands at 12% (49,300), and 10% (76) in our data. The HNNA wave 4 sample reflects the number of people who identify as Asian/Asian British in the statutory homelessness data, at 8% respectively in both datasets. There is a slight

52. MHCLG. (2025). *Statutory homelessness live tables*. https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness

overrepresentation of Mixed/multiple ethnic groups in the wave 4 data compared to the statutory data, which stands at 4% (15,290) compared to 8% (55) in our data.[53]

These differences likely reflect the locations in which the Homeless Health Needs Audits took place during 2022-2025. However, when comparing the statutory homelessness data to the population level estimates, we can see a clear overrepresentation of people who identify their ethnicity as Black, Black British, Caribbean or African approaching their local authority for homelessness assistance.

Gender

Respondents were asked to identify their gender. In wave 4, 76% (551) of respondents identified as male and 23% (164) as female. 2% (12) of respondents identified as transgender and a further 1% (7) identified as non-binary.

Table 4: Gender of respondents

	Wave 3		Wave 4	
Gender	**Count**	**%**	**Count**	**%**
Male	340	68%	551	76%
Female	153	30%	164	23%
Transgender	5	1%	12	2%
Non binary	3	1%	7	1%
Other	2	<1%	4	1%
N:	503		726	

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.[54,55] Likewise, women face specific health needs particularly around reproductive health, and maternity care.

53. Office for National Statistics. (2021). *Population estimates by ethnic group and religion, England and Wales: 2019*. https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/articles/populationestimatesbyethnicgroupandreligionenglandandwales/2019#ethnicity-in-england-and-wales
54. Bretherton J., and Pleace, N. (2018). *Women and Rough Sleeping: A critical review of current research and methodology, St Mungo's*. https://www.mungos.org/publication/women-and-rough-sleeping-a-critical-review/
55. Goundswell. (2020). *Women, homelessness and health: a peer research project*. https://groundswell.org.uk/wp-content/uploads/2020/02/Womens-Health-Research-Report.pdf

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.[56] It is because of the importance of capturing the differential experiences of this community that the HHNA asks respondents about their sexual orientation.

Table 5: Sexual orientation of respondents

	Wave 3		Wave 4	
Sexual orientation	**Count**	**%**	**Count**	**%**
Heterosexual or straight	423	89%	638	89%
Bisexual	21	4%	30	4%
Gay or lesbian	18	4%	26	4%
Pansexual	6	1%	2	<1%
Other	7	1%	3	<1%
N:	475		503	

Statutory data on homelessness records the sexual orientation of all those owed a homeless prevention or relief duty. In the financial year 2024/2025, 73% (306,530) of those owed a prevention or relief duty identified as heterosexual. 1% (6,050) of people owed a prevention or relief duty identified as gay/lesbian, 1% (4,200) identified as bisexual, and 1% (2,520) as 'other'. A further 23% (96,140) preferred not to say and 1% (2,710) was recorded as not known.[57]

It is difficult to meaningfully benchmark HHNA data against national data when as high as 24% of responses to local authority data is 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.

56. Akt. (2021). *The lgbtq+ youth homelessness report*. https://www.akt.org.uk/Handlers/Download.ashx?IDMF=59eae91c-ee80-4b6b-8ecb-158edfeeaccd
57. MHCLG. (2025). *Statutory homelessness live tables*. https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness

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.[58] 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.[59] As HHNA data is drawn from participating services in local areas some of the statutory provides services may only be accessible to those with recourse, it is possible that this data underrepresents non-UK nationals with restricted or undetermined eligibility.

Table 6 : Respondents' immigration status

	Wave 4	
Immigration status	**Count**	**%**
British Citizen	539	75%
EEA citizen with settled status	79	11%
Permanent residence/Indefinite leave to remain	36	5%
EEA citizen with pre-settled status	19	3%
Limited leave to remain (all other)	13	2%
Asylum Seeker	11	2%
Refugee	11	2%
Unknown	7	1%
Other	8	1%
N:	723	

58. Boobis, S., Jacob, R., and Sanders, B. (2019). *A Home For All: Understanding Migrant Homelessness in Great Britain*. London: Crisis. https://www.crisis.org.uk/media/241452/a_home_for_all_understanding_migrant_homelessness_in_great_britain_2019.pdf
59. 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

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 across waves 2 to 4 are presented in Table 7 below, and show that the majority of people were sleeping in a hostel or supported accommodation service. Findings for wave 1 are not available.

Table 7: Where are you currently sleeping?

	Wave 2		Wave 3		Wave 4	
Current sleep site	**Count**	**%**	**Count**	**%**	**Count**	**%**
In a hostel or supported accommodation	1295	58%	336	68%	412	57%
Rough sleeping	216	10%	32	6%	140	19%
In B&B or other temporary accommodation	116	5%	20	4%	48	7%
Housed - in own tenancy	227	10%	19	4%	39	5%
Sleeping on somebody’s sofa/ floor	163	7%	17	3%	33	5%
In emergency accommodation	145	6%	55	11%	14	2%
Vehicle or caravan on the side of the road or car park	0	0%	0	0%	9	1%
Housing First	-	-	-	-	7	1%
Squatting	12	1%	2	<1%	5	1%
In NASS accommodation	-	-	-	-	2	<1%
Other	54	2%	14	3%	14	2%
N:	2244		495		723	

The number of HHNA respondents rough sleeping increased by 77% between wave 3 and wave 4. Whilst the HNNA does not measure trends in the increase/decrease of forms of homelessness, it is interesting to consider respondents housing status within the wider context of national homelessness trends, including the dramatic increase in rough sleeping numbers. The 2024 rough sleeping snapshot found that 4,667 people were estimated to be sleeping rough on a given night, a 20% increase from 2023 and a

164% increase since 2010.[60] It is well known that rough sleeping has a detrimental and severe impact on people's health outcomes and their access to health services. Research from Crisis found that 70% of people sleeping rough had health issues caused by extreme weather conditions. The report also explored the impact of rough sleeping on loneliness, and the association between isolation and poor mental health and early mortality. The research found that just over 60% of people rough sleeping often feel isolated from others, compared to around 6% of the general population.[61]

There has also been an 18% decrease in the number of people currently sleeping in a hostel or supported accommodation service between wave 3 and wave 4. This is reflective of the barriers that people experiencing homelessness can face in accessing suitable housing and the contraction of the sector and available bed spaces. In Support to End Homelessness 2024, 88% of day centres cited waiting lists as the primary barrier for service users accessing accommodation services. The report also highlighted the long term trends in decreasing capacity within homelessness accommodation.[62]

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 4 the majority of respondents, 87% (633), had stayed at a homelessness accommodation service (including hostels, foyers and refuges). Around two thirds of respondents had slept rough (69%, (505)), sofa surfed (64%, 462)), and applied to the council as homeless (63%, (458)). The proportion of respondents who have stayed at a homelessness accommodation service and slept rough have increased from wave 3, whilst the proportion of respondents who have sofa surfed or applied to the council as homelessness has seen a slight decline. Data for wave 1 is not available. The full data is presented in Table 8 below.

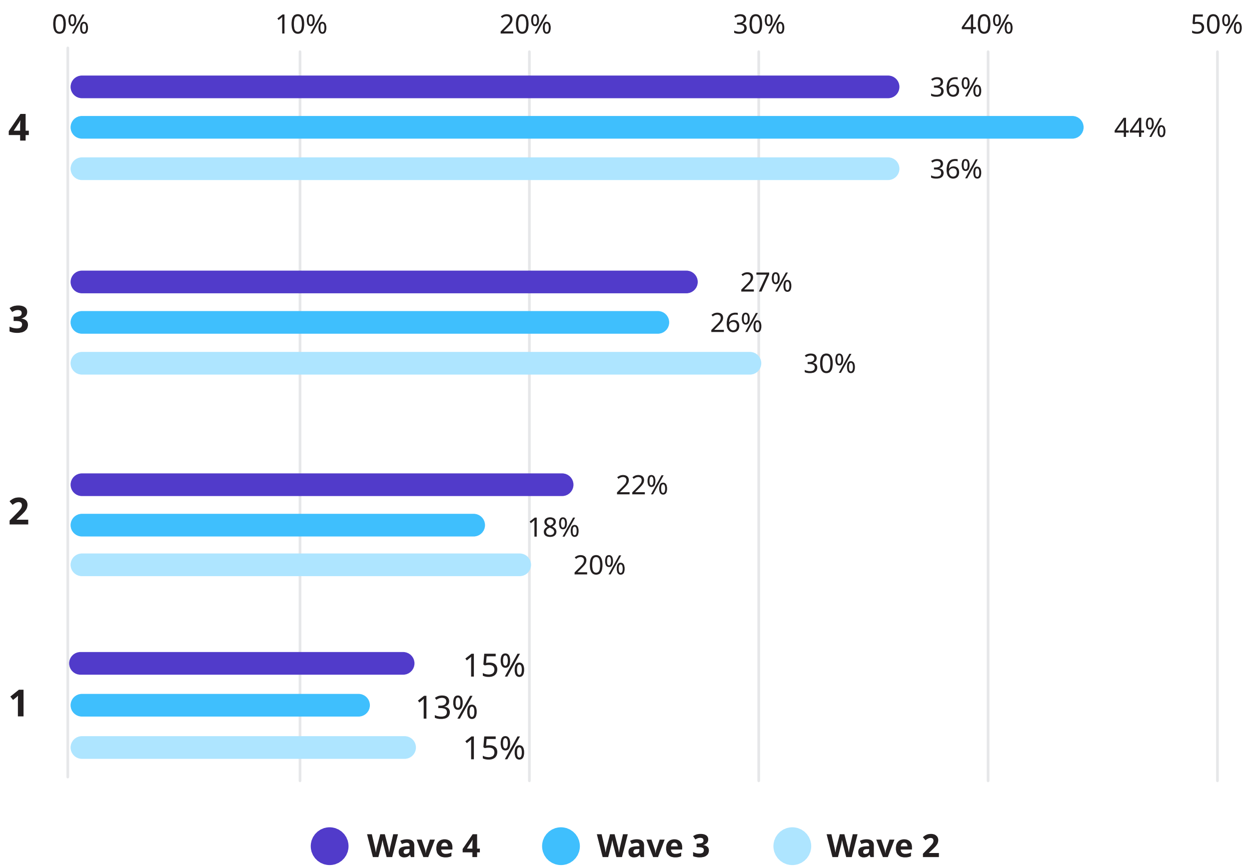
60. MHCLG. (2025). *Rough Sleeping Snapshot Autumn 2024*. https://www.gov.uk/government/statistics/rough-sleeping-snapshot-in-england-autumn-2024/rough-sleeping-snapshot-in-england-autumn-2024
61. Sutton-Hamiliton, C., and Sanders, B. (2023). *The experiences and impacts of sleeping rough*. Crisis. https://www.crisis.org.uk/media/gdrdmtyj/oneeyeopen_report.pdf
62. Homeless Link. (2025). *Support to End Homelessness 2024: A review of services addressing single homelessness in England*. https://homeless.org.uk/documents/1454/Support_to_End_Homelessness_2024.pdf

Table 8: Ever had any of the following experiences of homelessness

	Wave 2		Wave 3		Wave 4	
Experience	**Count**	**%**	**Count**	**%**	**Count**	**%**
Stayed at a hostel, foyer, refuge or any other type of homelessness service	1845	82%	434	85%	633	87%
Rough sleeping	1400	62%	339	66%	505	69%
Sofa surfed	1559	69%	353	69%	462	64%
Applied to the council as homeless	1449	65%	349	68%	458	63%
None	65	3%	15	3%	1	<1%
N:	2246		513		727	

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 indicates the transient nature of homelessness, and the fact that people transition through, and experience, many forms of homelessness. Someone who is street homelessness tonight may have been sleeping in a hostel for several weeks, and vice versa. These are important considerations when considering the particular health impacts of certain forms of homelessness, particularly rough sleeping, as based on the HHNA data over two thirds of people experiencing homelessness will have been exposed to those risks.

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, 36% (261) of respondents had experienced all four of these forms of homelessness in wave 4. This represents an 8% percentage point decrease from wave 3, in which 44% (215) of respondents had experienced all four forms of homelessness. 15% (108) of respondents in wave 4 had experienced only one of these forms of homelessness. Chart 1 below presents this data.



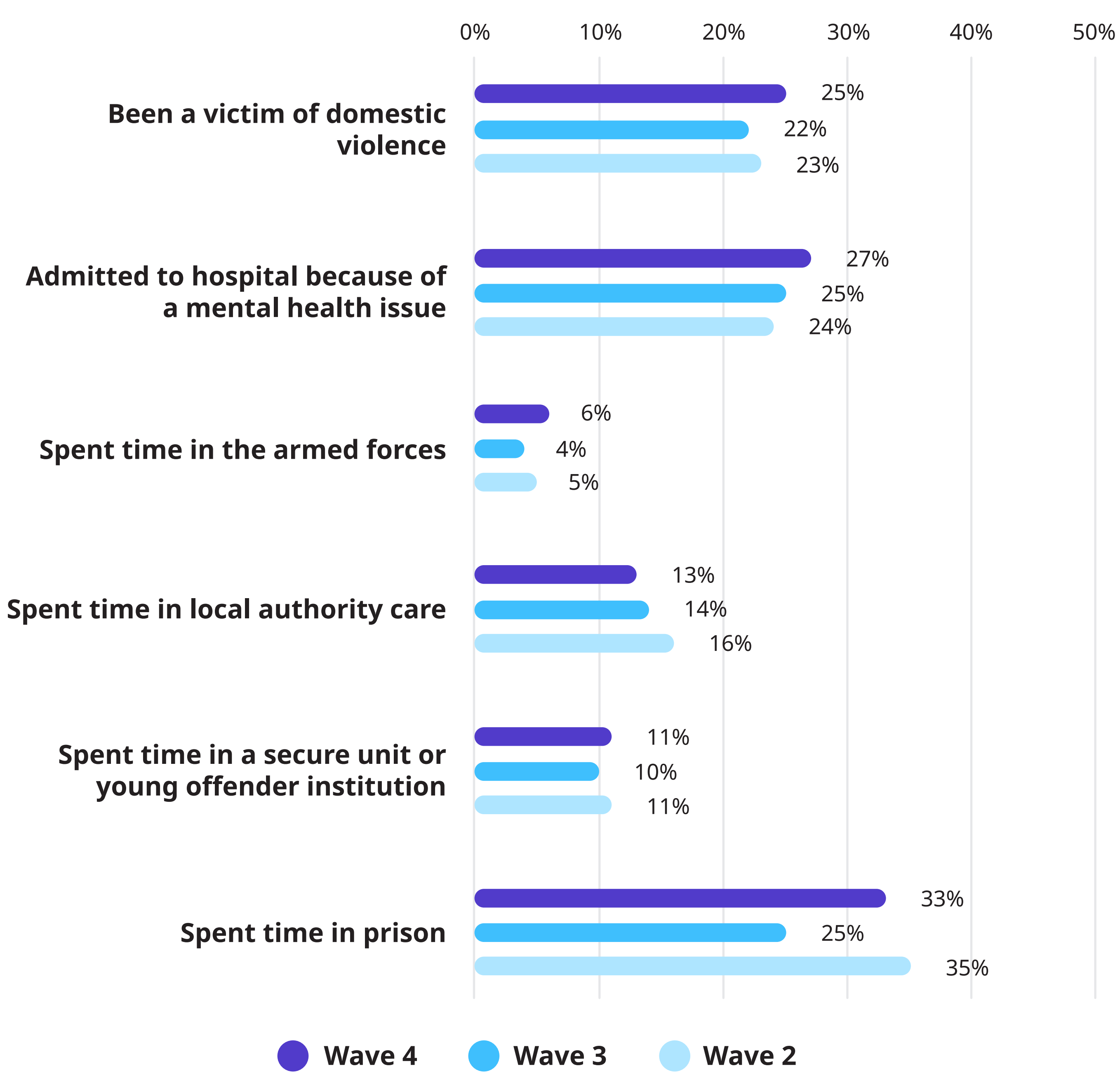
Homeless Health Needs Audit, Wave 2, N=2181; Wave 3, N=491; Wave 4. N=727

Life experiences associated with homelessness

Respondents were asked whether they had faced any of six different life experiences. These life experiences are over-represented amongst those experiencing homelessness; they indicate the multiple challenges that many people have faced through their lives and the associated trauma that many people carry.[63]

In wave 4, 66% of respondents had experienced at least one of these life experiences, and almost a third (32%) of respondents had faced more than one. Chart 2 presents the findings from waves 2-4, data for wave 1 is unavailable.

63. FEANTSA. (2017). *Recognising the link between trauma and homelessness*. https://www.feantsa.org/download/feantsa_traumaandhomelessness03073471219052946810738.pdf



Homeless Health Needs Audit, Wave 2, N=2271; Wave 3, N=635; Wave 4, N=727

Many of the associated risk factors and life experiences asked about have remained consistent across waves 3 and 4. The main change seen between the two waves is an 8% percentage point increase in the number of respondents having ever spent time in prison in wave 4 compared to wave 3. This has long been a challenge, with people at all stages of the criminal justice system facing significant barriers to maintaining and securing stable housing.

There has also been a 3% percentage point increase in the number of respondents who have previously been admitted to hospital because of a mental health issue. This increase, although small, is pertinent when considered alongside a range of measures which indicate that many people are struggling to access the support needed to manage their

mental health, as explored throughout this report. Available statutory data on people who applied to a local authority as homeless in 2024/25 shows that our sample has an overrepresentation of people who have ever spent time in prison, local authority care or in the armed forces, or been a victim of domestic abuse. This may reflect sample bias, or may indicate that these groups are less likely to approach their local authority for homeless assistance. Table 9 below presents this data in comparison with wave 4.

Table 9: Life experiences and risk factors

	Wave 4		Statutory homelessness figures
Life experience	**Count**	**%**	
Spent time in prison	240	33%	6%
Admitted to hospital because of a mental health issue	193	27%	-
Been a victim of domestic violence	182	25%	9%
Spent time in local authority care	95	13%	2%
Spent time in a secure unit or young offender institution	80	11%	-
Spent time in the armed forces	47	6%	1%
N:	727		

This chapter presents findings across five key areas: physical health, learning disability, neurodivergence, mental health, and drug and alcohol use. We report key health statistics across each of these areas, and where available present national data for comparison, to understand the extent of the health inequalities faced by people experiencing homelessness. In later sections of this report we go on to explore how people experiencing homelessness use healthcare services and the extent to which the available services meet the needs of people experiencing homelessness.

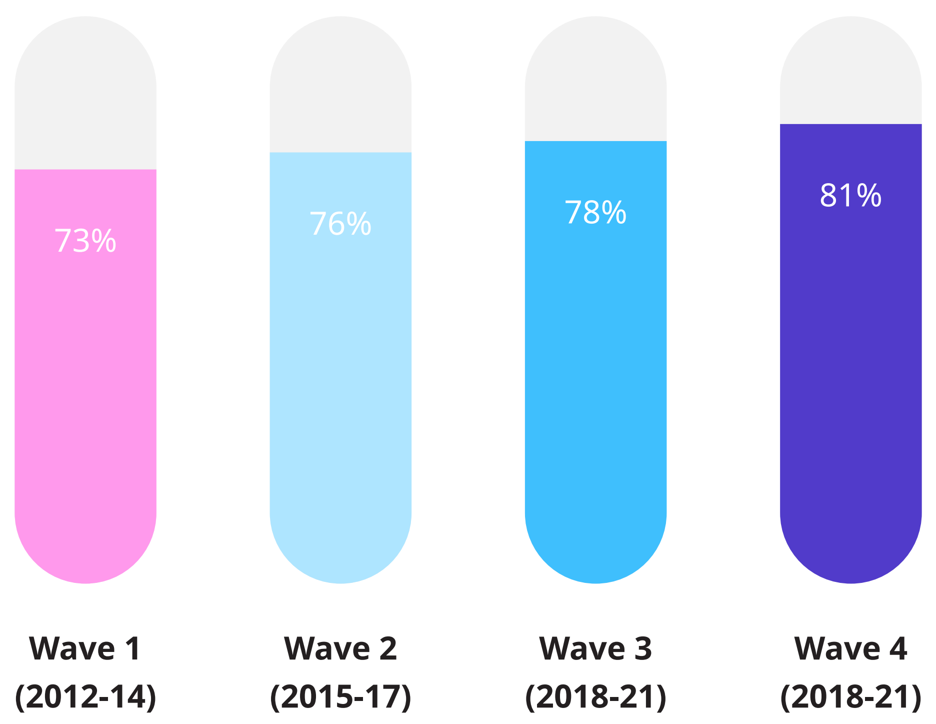
Physical health

This section presents findings related to the physical health of HHNA respondents. New to wave 4 of the USOH, physical conditions are categorised in two ways: physical health diagnoses and physical health conditions. Physical health conditions are presented as distinct from formally diagnosed conditions and illnesses, and include symptoms or conditions which significantly negatively impact a person's health and their quality of life, but which may not come with a diagnosis, such as joint aches/ problems with bones and muscles. The data presented here explores the prevalence of specific physical health diagnoses and physical health conditions, and how this has changed over time. We also explore trends in whether conditions occurred before or after an individuals' experience of homelessness, and the number of people managing comorbidities. Finally, we present rates of disability amongst HHNA respondents.

Overall physical health

Taking physical health diagnoses and conditions together in order to create a consistent dataset across waves, we see that in wave 4, 81% (587) of respondents reported having at least one physical health condition. This figure marks a continuing decline in the physical health of people experiencing homelessness, with an increase of 8 percentage points in those reporting physical health conditions since wave 1 (wave 1: 73%; wave 2: 76; wave 4: 78%). Chart 3 below presents the data from all four waves of HHNA data.

Chart 3: Respondents with a physical health condition and/ or diagnosis



Homeless Health Needs Audit, Wave 1, N=2590; Wave 2, N=1732, Wave 3, N=522; Wave 4, N=727

Throughout this section we see worrying trends indicating a decline in the physical health of people experiencing homelessness and in later chapters data shows that fewer people experiencing homelessness are receiving adequate support for their physical health. This trend is concerning, there is clear indication as we turn to look at individual conditions and diagnoses that this decline in health is related to the poor conditions faced by those experiencing homelessness.

Physical health diagnoses

In this section we report only those conditions which have an associated diagnosis. Other physical health conditions are explored in the section below.

In wave 4, 58% (423) of respondents had a physical health diagnosis. The most common diagnosed physical health condition was asthma (21% (142)), followed by chronic breathing problems including bronchitis, emphysema, obstructive airways disease (19% (132)). It is notable that respiratory conditions are the most common diagnosed condition amongst people experiencing homelessness, who are exposed to living conditions known to exacerbate poor respiratory health and who are much more likely to smoke tobacco and illicit substances, a known driving factor of poor respiratory health.[64]

64. Groundswell. (2016). *Room to Breathe: A Peer-led health audit on the respiratory of people experiencing homelessness*. https://groundswell.org.uk/wp-content/uploads/2017/10/Groundswell-Room-to-Breathe-Full-Report.pdf

The physical health conditions captured by the HHNA have developed over time, and in wave 4 were expanded to include both traumatic and acquired brain injury, and hearing loss. Table 10 presents data on the prevalence of physical health diagnoses across all four waves where this is possible, and otherwise presents data for all waves in which data are available.

Table 10: Frequency of physical health diagnoses

	Wave 1		Wave 2		Wave 3		Wave 4	
	Count	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**
Asthma	-	-	492	22%	125	24%	142	21%
Chronic breathing problems	-	-	298	13%	70	13%	132	19%
Heart problems	-	-	297	13%	68	13%	116	17%
Liver problems	296	14%	251	11%	57	11%	94	14%
Hearing loss	-	-	-	-	-	-	79	11%
Diabetes	116	6%	97	4%	29	6%	57	8%
Hepatitis C	-	-	169	7%	44	8%	47	7%
Epilepsy/seizures	126	6%	203	9%	25	5%	51	7%
Cancer	-	-	51	2%	20	4%	27	4%
HIV	-	-	21	1%	4	1%	10	2%
Tuberculosis (TB)	-	-	17	1%	4	1%	17	2%
Other	248	15%	186	8%	57	11%	39	8%
N:					522		727	

The most common physical health diagnoses remained constant between waves three and four, however within this prevalence rates have changed. In wave 4 we see an increased prevalence of chronic breathing problems, which have climbed six percentage points since wave 3 (19% (132)); and heart problems, the prevalence of which has increased by 4 percentage points since wave 3 (17% (166)).

Data on whether these conditions were diagnosed before or after the respondent's experience of homelessness shows that 19% of all physical health diagnoses made after an experience of homelessness were of a chronic breathing problem, making this the

most common diagnosis after experience of homelessness, followed by liver problems at 15%. These findings, considered alongside data presented here which show high rates of substance use to manage mental health, and high prevalence of smoking and alcohol use in this population, demonstrate how exclusion from healthcare services, together with facing multiple risks related to the social determinants of health, can both create and compound poor health.

Physical health conditions

New to this wave of data, we separate the physical health conditions that people experiencing homelessness are managing as distinct from diagnoses. These chronic physical health conditions can significantly impact quality of life and require daily management which is a particular challenge for people experiencing homelessness who may have limited access to hygiene facilities, limited nutrition, and inadequate sleeping arrangements.

In wave 4 we see that physical health in this category has seen a marked decline, with an increase in people reporting almost all physical health conditions that the HHNA asks about and bigger increases amongst those more commonly experienced.

Chart 4: Frequency of physical health conditions

	Wave 1	Wave 2	Wave 3	Wave 4
Urinary problems/infections/incontinence	13%	9%	12%	12%
Circulation problems/blood clots	14%	12%	13%	15%
Skin/wound infection or problems	18%	16%	18%	18%
Stomach problems, including ulcers	24%	15%	20%	19%
Fainting/blackouts	20%	18%	18%	22%
Problems with feet	24%	16%	18%	25%
Difficulty seeing/eye problems	29%	21%	22%	27%
Joint aches/problems with bones and muscles	46%	33%	37%	47%
Dental/teeth problems	36%	29%	36%	48%

Homeless Health Needs Audit, Wave 2, N=2270. Wave 3, N=522. Wave 4, Dental/teeth problems, N=705; Joint aches/problems with bones and muscles, N=700; Difficulty seeing/eye problems, N=689; Problems with feet, N=696; Fainting/blackouts, N=681; Stomach problems, N=681; Skin/wound infection or problems, N=676; Circulation problems/blood clots, N=677; Urinary problems/ infections/ incontinence, N=682.

For the first time in wave 4 dental/ teeth problems (48% (339)) is the most commonly reported condition. Joint aches/ problems with bones and muscles is the second most common condition at 47% (331), with both conditions reported at a higher rate in wave 4 when compared to wave 3. This decline in physical health is concerning. We explore this subject further in the section 'Is more help needed' where we present data on the sufficiency of support people are receiving for their physical health.

Table 11 presents the frequency of these physical health conditions across all 4 waves of data.

Table 11: Frequency of physical health conditions

	Wave 1		Wave 2		Wave 3		Wave 4	
	Count	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**
Dental/teeth problems	802	36%	657	29%	187	36%	339	48%
Joint aches/problems with bones and muscles	1046	46%	751	33%	194	37%	331	47%
Difficulty seeing/eye problems	628	29%	476	21%	114	22%	185	27%
Problems with feet	529	24%	352	16%	95	18%	176	25%
Fainting/blackouts	438	20%	417	18%	93	18%	152	22%
Stomach problems, including ulcers	514	24%	331	15%	104	20%	128	19%
Skin/wound infection or problems	395	18%	352	16%	92	18%	122	18%
Circulation problems/blood clots	305	14%	266	12%	67	13%	100	15%
Urinary problems/infections/ incontinence	276	13%	215	9%	61	12%	85	12%
Other							11	6%

Comorbidities

In this section, we consider both physical health diagnoses and other health conditions together. In wave 4, whilst 19% (109) of respondents who reported a physical health problem had one such condition, many more lived with comorbidities. This figure is almost unchanged from wave 3 (20%) and remains higher than the 24% of those with a physical health condition who were managing one such condition in wave 2. Across all waves of

data it is more common for respondents with a physical health condition to be managing comorbidities, with the number of people with one such condition declining.

In wave 4, 29% (119) of people with a physical health condition reported that they had between 5 and 10 such conditions. 21% (86) of respondents with a physical health condition reported two separate conditions, 15% (60) reported three such diagnoses, and 12% (50) reported four physical health conditions. Chart 5 below presents data on comorbidities for waves 2, 3 and 4. Data for wave 1 is not available.

Chart 5: Comorbidities amongst those with a physical health condition

	1	2	3	4	5-10	11+
Wave 2	24%	20%	15%	13%	24%	2%
Wave 3	20%	21%	15%	12%	23%	2%
Wave 4	19%	20%	14%	12%	33%	2%

Homeless Health Needs Audit, Wave 2, N=1732, Wave 3, N=408, Wave 4, N=587

The difficulty of managing numerous health conditions whilst experiencing homelessness cannot be understated. The challenges here are manifold: maintaining a diary of appointments with multiple specialists and attendance at various clinics and locations; the practical challenges of storage and administration of medications; and the ability to rest and to engage in behaviours which support symptom management. For many people experiencing homelessness, managing this is simply not possible: the health and care system must do more to adjust the support and care provided to people experiencing homelessness in order to reduce healthcare barriers.[65]

65. McNeill S., O'Donovan D., Hart N. (2022). Access to healthcare for people experiencing homelessness in the UK and Ireland: a scoping review. *BMC Health Services Research*.

Disability

In addition to being asked about specific health conditions, respondents were asked whether they had a disability. Our data shows that in wave 4 the number of respondents who consider themselves to have a disability has fallen, with half of people reporting this in wave 4 (50% (349)), compared to 63% (306) in wave 3.

The latest estimates from the Family Resources Survey (FRS) indicate that 6.8 million people in the UK had a disability in the 2023/24 financial year. This represents 25% of the total population,[66] a figure substantially lower than that reported by people experiencing homelessness. This highlights that despite a decline in disability rates in this wave of data, people experiencing homelessness are still twice as likely to have a disability than the general population – and due to homelessness, face many more challenges in managing this.[67]

Taken together, the data presented in this section suggests a picture of decreasing physical health amongst people experiencing homelessness in England. Data across waves shows a steady decline in overall physical health, whilst a closer look at the health conditions people are managing reveals a sharp increase in dental issues, in problems with joint aches/ problems with bones and muscles, and in chronic breathing problems. We see a clear impact of homelessness in the predominance of liver conditions and respiratory health conditions diagnosed after experience of homelessness and in the clear impact of homelessness on musculoskeletal health. People experiencing homelessness in England are twice as likely to have a disability than the general population, and many people are managing more than one physical health condition.

Homelessness is a health emergency and, whilst understanding of this is growing, without adequate housing and the support needed to keep it people experiencing homelessness in England remain in circumstances known both to worsen health and that manifestly make it more challenging to manage and attend appointments, to safely store and take medication, and to have consistent access to a clean, safe and hygienic place to rest and recover. We also see that people experiencing homelessness are more likely to come from populations already exposed to societal barriers, and health inequalities, before they become homeless.

We will go on to explore data which shows a decline in the number of people who report receiving the level of support that they need for their physical health in the section 'Is more help needed', and will explore people's reported ability to take measures that help support health resilience in the final section of this report.

66. Department for Work and Pensions. (2024). *Family Resources Survey: Financial year 2023 to 24*. https://www.gov.uk/government/statistics/family-resources-survey-financial-year-2023-to-2024/family-resources-survey-financial-year-2023-to-2024#disability-1

67. Stone, B., & Wertans, E. (2023). *Homelessness and Disability in the UK. Centre for Homelessness Impact*. https://cdn.prod.website-files.com/59f07e67422cdf0001904c14/645a76da097c6dad33fcc423_CHI-disabilities-homelessness23.pdf

Cognitive health

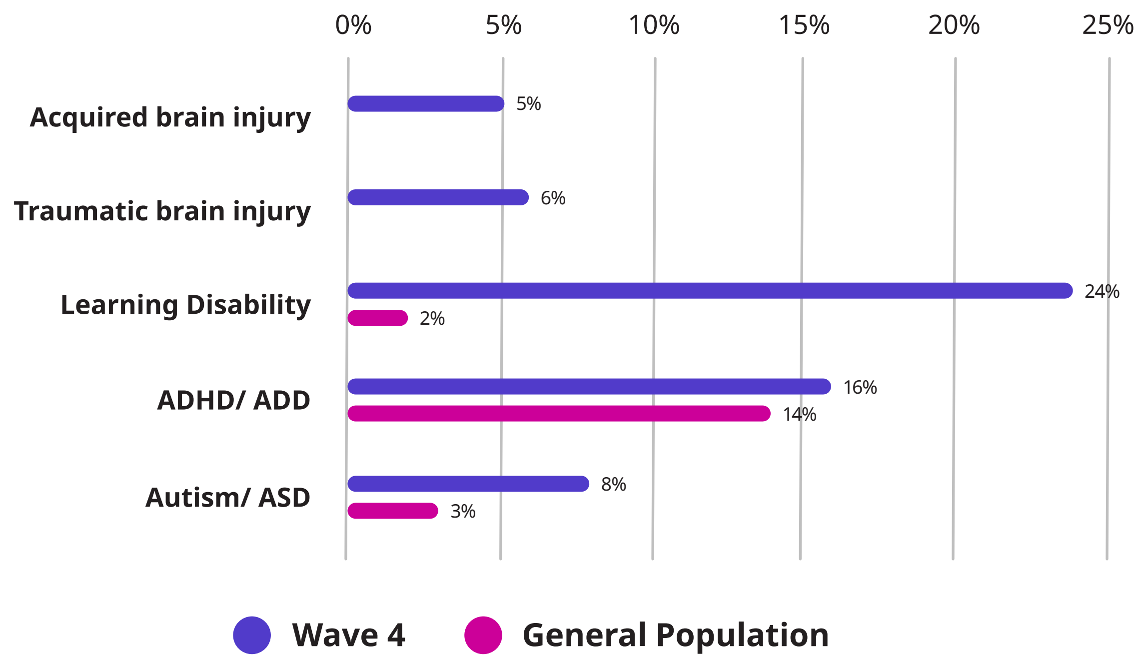
HHNAs in wave 4 collected data on the cognitive health of respondents, with specific questions on ADHD/ ADD, autism, learning disability, and traumatic and acquired brain injury. These conditions represent a wide spectrum of symptoms and, as with many of the conditions listed in this report, the experience of people with a diagnosis in any of these categories will vary widely. For example, some autistic adults live independently, some will need help with specific tasks, and others will require 24-hour specialist support. It can be hugely beneficial for services to know that someone has a cognitive condition in order to better understand and interpret behaviours, and, crucially, to ensure that individualised adjustments are made to support and to accommodation settings in order that people can access support and accommodation that is appropriate to them and supports their recovery.[68,69]

There is some evidence that people with some cognitive conditions, such as autism and learning disability are at increased risk of homelessness.[70,71] Findings here support this, revealing a substantial over-representation of people with autism and with learning disabilities,[72] whereas ADHD/ ADD rates are much more aligned with those seen across the general population. This is important data: illuminating the prevalence of these conditions amongst people experiencing homelessness enables the development of targeted support, and targeted prevention solutions to those at greatest risk of experiencing homelessness. Data on both acquired and traumatic brain injury refers to those with consequential symptoms related to their brain injury.

Whilst directly comparable data does not exist for the general population, an estimated 1.3 million people are living with a disability as consequence of either an ABI or TBI in the UK.[73] This represents 1.9% of the general population and therefore suggests that the HHNA supports previous studies in identifying that brain injury is overrepresented amongst people experiencing homelessness.[74] This is an area to consider both for preventative approaches, but also ensuring services are equipped to support people with brain injuries.

68. Homeless Link. *Autism and Homelessness Toolkit: Edition 2*. Available at: https://homelesslink-1b54.kxcdn.com/media/documents/Autism_and_Homelessness_Toolkit_Edition_2.pdf
69. Groundswell. (2022). *Learning Disabilities and Homelessness*. https://groundswell.org.uk/wp-content/uploads/2022/05/Learning-Disabilities-Toolkit-.pdf
70. Groundswell. (2022). *Learning Disabilities and Homelessness*. https://groundswell.org.uk/wp-content/uploads/2022/05/Learning-Disabilities-Toolkit-.pdf
71. Churchard, A., Ryder, M., Greenhill, A., & Mandy, W. (2018). *The prevalence of autistic traits in a homeless population*. Autism, 1362361318768484
72. It is important to note that some respondents to HHNAs may have identified themselves as having a learning disability when they in fact had a ‘specific learning difficulty’, for example dyslexia. This means that this figure should be interpreted with caution and is likely an overrepresentation of learning disability.
73. UKRI Medical Research Council. (2022). *Traumatic Brain Injury across the life course: priorities, challenges, and opportunities*. https://www.ukri.org/wp-content/uploads/2022/12/MRC-07122022-MRC-Traumatic-Brain-Injury-Workshop-report_June-2022.pdf
74. Stubbs JL, Thornton AE, Sevick JM, Silverberg ND, Barr AM, Honer WG, Panenka WJ. (2020). *Traumatic brain injury in homeless and marginally housed individuals: a systematic review and meta-analysis*. Lancet Public Health. 2020 Jan;5(1):e19-e32. doi: 10.1016/S2468-2667(19)30188-4. Epub 2019 Dec 2

Chart 6: Prevalence of cognitive conditions in HHNA respondents vs. general population



Homeless Health Needs Audit, Wave 4, Acquired brain injury, N=689; Traumatic brain injury, N=672; learning disability, N=690; ADHD/ ADD, N=681; autism/ASD, N=677. Gen pop autism data[75]; Gen pop ADHD/ ADD data[76]; Gen pop LD data[77]

It is interesting to note that the majority of diagnoses in this section had been made prior to an individual's experience of homelessness. In the context of the lengthy process of diagnosis and the much shorter length of time that homelessness organisations are often able to provide support, this does mean it is likely that these figures underrepresent the true number of people with a cognitive health condition experiencing homelessness.[78]

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 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 conditions diagnosed before versus after an individual's experience of homelessness. 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.

75. NHS. (2025). *GP Patient Survey 2025*. https://gp-patient.co.uk/latest-survey/results
76. NHS. (2025). *Adult Psychiatric Morbidity Survey 2023/4: Survey of Mental Health and Wellbeing, England*. https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey
77. NHS. (2025). *GP Patient Survey 2025*. https://gp-patient.co.uk/latest-survey/results
78. Stone, B., & Wertans, E. (2023). *Homelessness and Disability in the UK. Centre for Homelessness Impact*. https://cdn.prod.website-files.com/59f07e67422cdf0001904c14/645a76da097c6dad33fcc423_CHI-disabilities-homelessness23.pdf

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 are currently experiencing symptoms of this condition. Methodological changes mean that data for some mental health conditions are not available for previous waves of data, this is made clear where data are reported.

Mental health conditions

The number of people reporting a diagnosed mental health condition soared between wave 1 (45%) and wave 3 (82%). Wave 4 sees a stabilisation of this trend, and a slight reduction in the proportion of people with a mental health diagnosis, with 77% (560) respondents reporting at least one such condition. Although this decrease is undoubtedly positive, comparison to the general population shows that people with diagnosed mental health conditions are still vastly overrepresented amongst those experiencing homelessness – with a national rate of 20.2% across adults in England with a mental health diagnosis compared to 77% of people experiencing homelessness.[79]

Chart 7: Rates of mental health diagnosis

45%
77%
82%
77%

Wave 1 **Wave 2** **Wave 3** **Wave 4**

Homeless Health Needs Audit, Wave 1, N=1005, Wave 2, N=1797, Wave 3, N=487, Wave 4, N=727

When we break down this data to consider individual mental health conditions, we can see that this decline in overall mental health diagnoses is driven in majority by a decrease in the number of people with diagnosed depression. Although still the most commonly

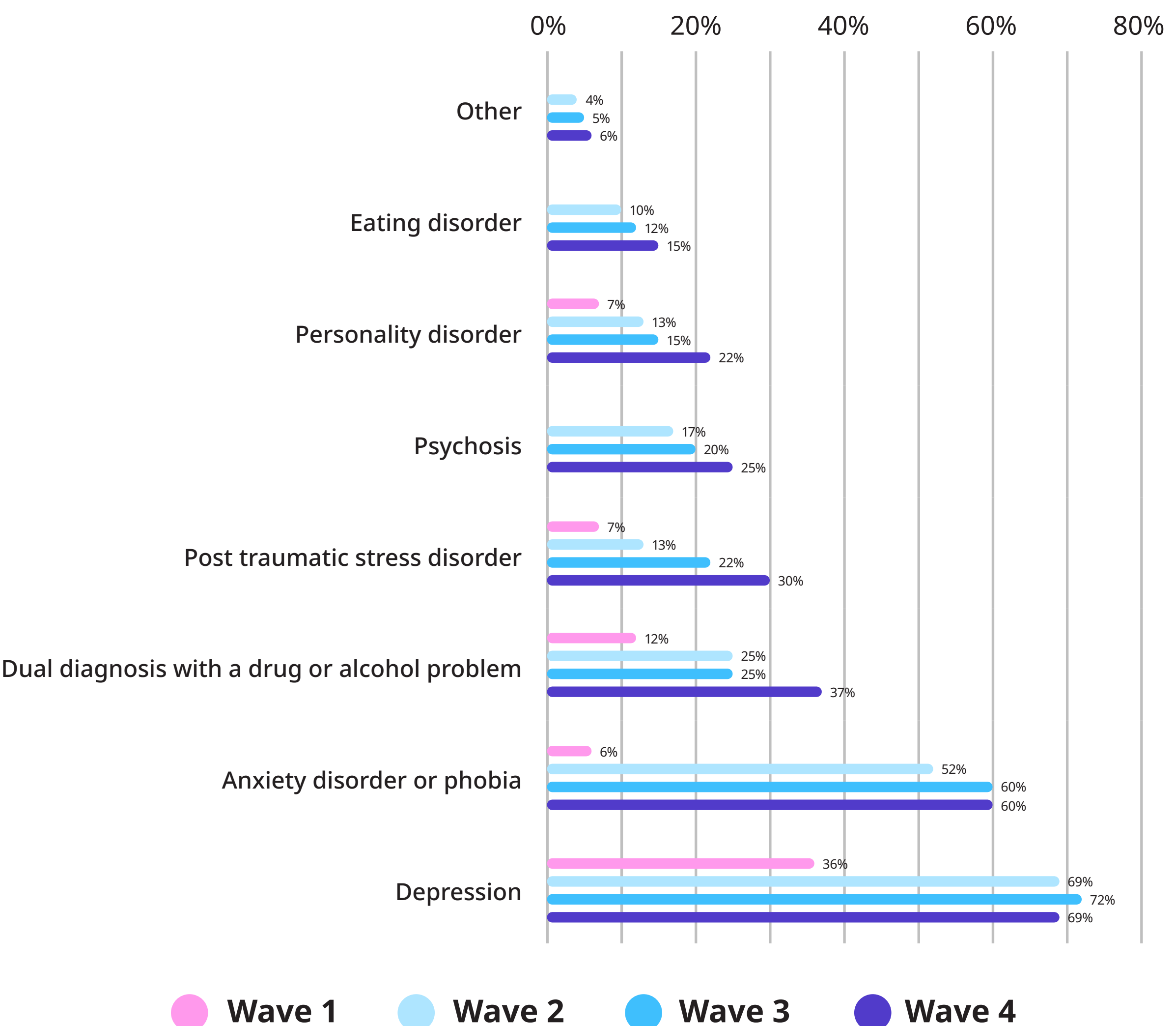
79. NHS. (2025) *Adult Psychiatric Morbidity Survey 2023/4: Survey of Mental Health and Wellbeing, England*. https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey

reported mental health diagnosis, the number of people with depression dropped three percentage points in this wave of data, from 72% to 69%. The most commonly reported mental health conditions remain constant between waves 3 and 4, with depression and anxiety disorder the most commonly reported conditions, and dual diagnosis, PTSD, and personality disorders seeing the biggest increases in rates of diagnosis. When we look at individual health conditions, we again see very stark health inequalities, with rates of depression at 69% amongst people experiencing homelessness in comparison to 3.8% across the general population[80], and rates of anxiety disorder/ phobia at 60% amongst respondents to a HHNA and 10% across the general population.[81]

The increase in people with a co-occurring mental health condition and drug/ alcohol use issue is of particular concern. This has seen the largest percentage point increase between waves 3 and 4 of HHNA data, with a 12 percentage point increase bringing the proportion of people with a dual diagnosis to 37% in wave 4. For people with a co-occurring mental health condition and drug/ alcohol use 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.[82,83] We go on to explore data relating to drug and alcohol use further below. Chart 8 presents data on mental health diagnoses from waves 1-4.

80. NHS. (2025). *Adult Psychiatric Morbidity Survey 2023/4: Survey of Mental Health and Wellbeing, England*. https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey
81. NHS. (2025). *Adult Psychiatric Morbidity Survey 2023/4: Survey of Mental Health and Wellbeing, England*. https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey
82. Staiger P. K., Thomas A C., Ricciardelli L A., Mccabe M P., Cross W., & Young G. (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.
83. E. Marcus, M. Brown, S. Stockton, & S. Pilling. (2016). *Coexisting severe mental illness and substance misuse: community health and social care services*. Review 2: Service user, family and carer, provider and commissioner views and experiences of health and social care services for people with a severe mental illness who also misuse substances, NICE. https://www.nice.org.uk/guidance/ng58/evidence/evidence-review-2-service-user-family-and-carer-provider-and-commissioner-views-and-experiences-of-health-and-social-care-services-for-people-with-a-severe-mental-illness-who-also-misuse-substances-pdf-2727941294

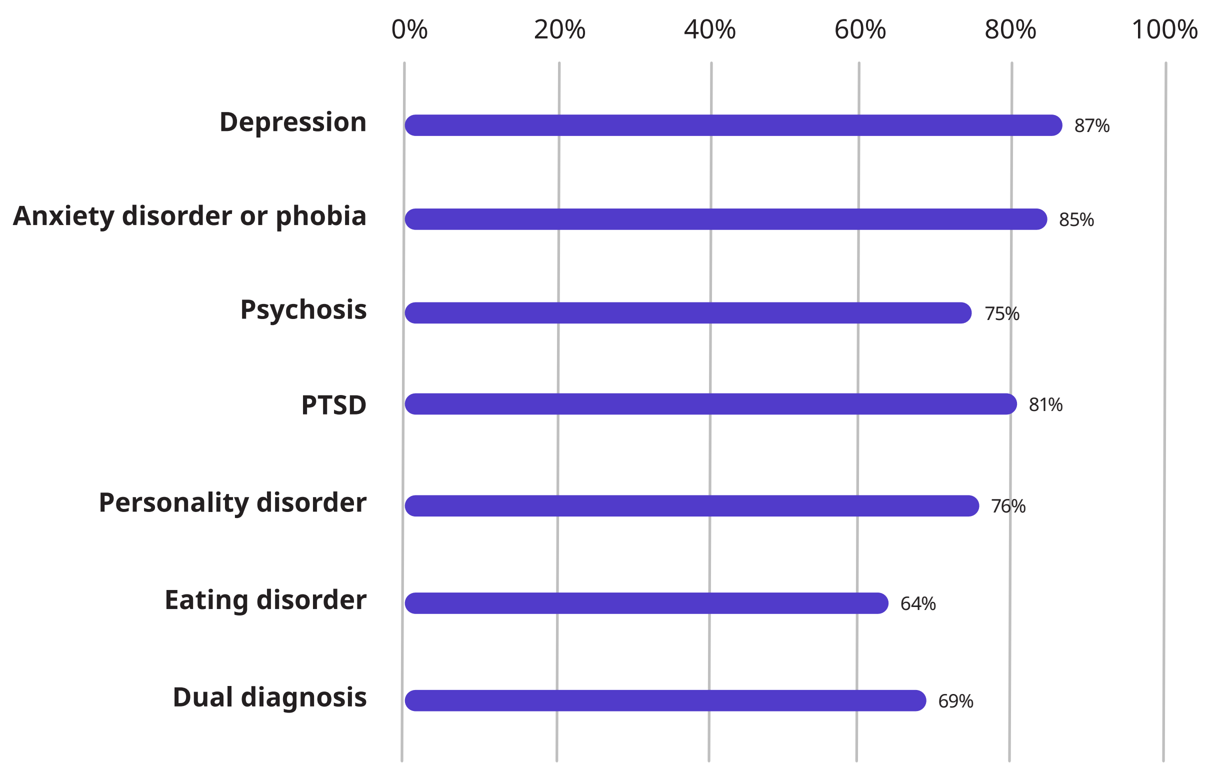
Chart 8: Frequency of mental health conditions



Homeless Health Needs Audit, Wave 1, Depression, N=793, Anxiety disorder or phobia, N=137; Dual diagnosis, N=278; PTSD, N=151; Personality disorder, N=166. Wave 2, N=2270. Wave 3, N=404. Wave 4, Depression, N=707; Anxiety disorder or phobia, N=699; Dual diagnosis, N=682; PTSD, N=663; Psychosis, N=680; Personality disorder, N=541; Eating disorder, N=680; Other, N=509.

New to this wave of data, we asked respondents if they are currently experiencing symptoms of their mental health condition. Findings indicate a sizeable variation in experience of managing a mental health condition, and a high proportion of people with active symptoms that require management.

Chart 9: Percentage of those with a mental health diagnosis who are currently experiencing symptoms



Homeless Health Needs Audit, Wave 4, Depression, N=359; Anxiety disorder or phobia, N=303; Psychosis, N=130; PTSD, N=145; Personality disorder, N=96; Eating disorder, N=73; Dual diagnosis, N=203

Comorbidities

It was very common for respondents to report having multiple diagnosed mental health conditions. Of those who reported having a mental health condition, just 15% (84) reported experiencing just one, with 85% experiencing mental health comorbidities. It was most common for people to report three (24% (135)) or two (23% (127)) mental health conditions. Data for on mental health comorbidities for waves 2, 3 and 4 are presented in Chart 10 below. Data are unavailable for wave 1.

Chart 10: Mental health comorbidities

	2	3	4	5	6+
Wave 2	30%	22%	14%	7%	4%
Wave 3	27%	24%	13%	9%	8%
Wave 4	22%	24%	19%	10%	9%

Homeless Health Needs Audit, Wave 2, N=1797; Wave 3, N=328; Wave 4, N=560

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, although some limited improvements have been felt, the support that respondents receive often falls short of what they need, with significant impact on both the individual 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 4 this has continued to rise, with 49% (344) of respondents indicating that they self-medicate in this way. This figure, together with an increase in rates of daily alcohol and drug consumption and an increase in the number of people with a dual diagnosis suggests an area of particular concern with a need for strategic and targeted support to ensure that people are able to access appropriate and much needed mental health and substance use support to avoid the onset of even poorer health outcomes for this group. Chart 11 below presents this data across all waves.

Chart 11: Use of self-medication to manage mental health

Wave 1	Wave 2	Wave 3	Wave 4
37%	47%	45%	49%

Homeless Health Needs Audit, Wave 1, N=2590; Wave 2, N=1929; Wave 3, N=464, Wave 4, N=699

Impact of homelessness on mental health

Comparing USOH data to national data reveals substantial inequalities of prevalence of mental health diagnoses: 69% of USOH respondents have depression, compared to 3.8% of the general population;[84] 60% of USOH respondents have anxiety disorder or phobia to

84. NHS. (2025). *Adult Psychiatric Morbidity Survey 2023/4: Survey of Mental Health and Wellbeing, England*. https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey

compared to 10% of the general population;[85] and 30% of USOH respondents have Post-Traumatic Stress Disorder compared to 5% of the general population.[86] Added to this, our data makes clear that many people experiencing homelessness were in poor mental health before they became homeless.

Of the mental health diagnoses reported by respondents, 67% predated their experience of homelessness. This trend held across all conditions, and is particularly stark for personality disorder, where 73% (87) of diagnoses were made before a person's experience of homelessness, and depression where 70% (342) of diagnoses were made before a person's experience of homelessness. HHNA data also shows that 27% (193) of respondents had been admitted to hospital because of a mental health condition at some point in their past, indicating a high rate of acute mental health need prior to experience of homelessness. Table 12 presents this data in full.

Table 12: Prevalence of mental health diagnoses before and after experience of homelessness

	Yes before		Yes after		N
Disability	**Count**	**%**	**Count**	**%**	
Depression	342	70%	145	30%	487
Anxiety disorder or phobia	280	67%	138	33%	418
Psychosis	120	70%	52	30%	172
PTSD	119	61%	77	39%	196
Personality disorder	87	73%	33	28%	120
Eating disorder	62	61%	39	39%	101
Dual diagnosis	158	62%	95	38%	253
Other	17	61%	11	39%	28
N:	1185		590		

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 the section 'Is more help needed', 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)

85. NHS. (2025). *Adult Psychiatric Morbidity Survey 2023/4: Survey of Mental Health and Wellbeing, England*. https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey

86. NHS. (2025). *Adult Psychiatric Morbidity Survey 2023/4: Survey of Mental Health and Wellbeing, England*. https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey

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.

Aligned to this, findings showing an increase in daily use of alcohol and illicit drugs, and an increase in the number of people self-medicating with drugs and alcohol to manage their mental health, indicates that whilst many people's mental ill-health predates their experience of homelessness, homelessness can then compound and increase the complexity of this situation. It is therefore vital that the acute need for services available to people experiencing homelessness is considered as a core part of any inclusion health strategy and service development; and that increased understanding of the interaction between mental health and homelessness is used to establish better upstream preventative care.

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 Chief Medical Officer's low risk drinking guidelines.[87]

Drug use

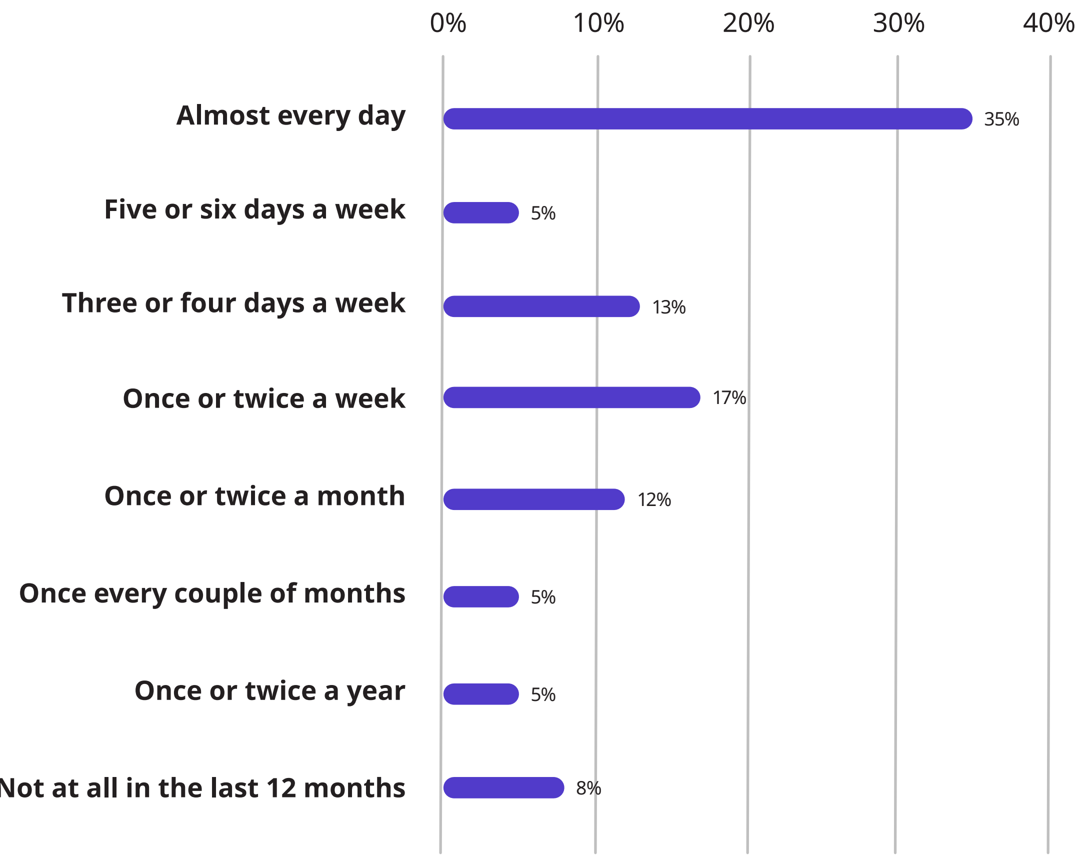
In our most recent wave of data (wave 4), almost three quarters of respondents (72%, (510)) reported that they had used drugs in the last 12 months. The figure is substantially higher than was found in wave 3, where 55% (287) reported the same and significantly higher than the general population estimate of 8.8% of people aged 16 to 59 years reporting using any drug in the last 12 months for the year ending March 2024.[88]

Adding to this concerning trend, new to this wave of data we asked respondents how often they used drugs. The most common response was 'almost every day' at 35% (145) of respondents and 53% (219) of respondents to this question reported that they used drugs at least three days a week. Full results of this question are presented in Chart 12 below.

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

88. Office for National Statistics. (2024). *Drug misuse in England and Wales: year ending March 2024*. https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/drugmisuseinenglandandwales/yearendingmarch2024

Chart 12: Frequency of drug use by those using any substances



Homeless Health Needs Audit, Wave 4, N=411

In wave 4, we collected data on several substances for the first time. We found that the most commonly used substances were Cannabis (41% (292)), Crack (27% (195)) and Cocaine (22% (159)). The full findings for this question are presented in Table 13 below.

Table 13: Frequency of substances used

Substance	Count	%
Cannabis	292	41%
Crack	195	27%
Cocaine	159	22%
Heroin	146	20%
Medication not prescribed for you	82	11%
Amphetamine	48	7%
MDMA/ Ecstasy	35	5%
Mephedrone	32	4%
Spice/ Mamba	31	4%
Ketamine	30	4%
Methamphetamine	24	3%
Fentanyl	21	3%
GHB/ GBL	9	1%
Other	12	2%
N:	720	

A comparison using only like-for-like data from waves 2-4 shows that whilst rates of use of specific drugs jumped between waves 2 and 3, they have remained relatively constant between waves 3 and 4. Table 14 below presents this data.

Table 14: Substance use in the past 12 months

	Wave 2		Wave 3		Wave 4	
Substance	**Count**	**%**	**Count**	**%**	**Count**	**%**
Cannabis/weed	971	43%	213	41%	292	41%
Crack	341	15%	126	24%	195	27%
Cocaine	389	17%	108	21%	159	22%
Heroin	366	16%	105	20%	146	20%
Amphetamines/speed	288	13%	42	8%	48	7%
N	2271		522		720	

It is important to note that whilst rates of crack and heroin have either increased slightly or remained constant, the risk of taking these substances has increased substantially as the UK has seen an increase in fentanyl and nitazenes. Fentanyl and nitazenes are potent synthetic opioids which can be added to heroin and other drugs without the user's knowledge and which are also sometimes openly sold as a heroin substitute. These opioids are many times stronger than heroin and carry an increased risk of fatal overdose.[89,90] In recognition of this, in April 2024 the government requested all Combating Drugs Partnerships to establish plans to manage the risk of synthetic opioids in their areas. A 2025 government report reviews these plans, outlining both the changing nature of risk around synthetic opioids and the importance of a 'sufficient local capacity for partners to deploy naloxone in a range of scenarios.'[91] It should be noted then, that whilst the rates of these substances has not significantly increased, the risk has. We also see 3% (21) of respondents reporting that they are knowingly taking fentanyl, a substance newly added for this wave of data collection.

Self-reported problematic drug use

In our most recent data 36% (238) of people reported that they have or are recovering from a drug problem. This has slightly decreased from wave 3, in which 38% (143) of respondents reported the same.

The overall trends seen here towards increased and riskier drug use is concerning, especially in the context of the finding that an increased number of people are using drugs or alcohol to cope with their mental health. This, together with an increased prevalence of co-occurring drug use and mental health diagnosis highlights the interlinked nature of mental health and substance use for many and indicates an area in which this issue of the Unhealthy State of Homelessness sees potential cause for increased concern.

Alcohol

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".[92] 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,

89. Office for Health Improvement and Disparities. (2024). *Deaths linked to potent synthetic opioids*. https://www.gov.uk/government/publications/deaths-linked-to-potent-synthetic-opioids
90. Change Grow Live. (2023). *Drugs contaminated with synthetic opioids: a collective message*. https://www.changegrowlive.org/news/drugs-contaminated-synthetic-opioids-collective-message
91. HM Government. (2025). *Local Preparedness for Synthetic Opioids in England: Findings and recommendations for Combating Drugs Partnerships.* https://assets.publishing.service.gov.uk/media/68596e78eaa6f6419fade65b/20250620_Local+Preparedness+for+Synthetic+Opioids+report_final_v.1.pdf
92. Department of Health. (2018). *UK Chief Medical Officers' Low Risk Drinking Guidelines*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/545937/UK_CMOs__report.pdf

respondents were identified who routinely consume more than 14 units of alcohol per week and analysis reveals a sharp increase in the number of respondents drinking at this level, to 49% (131) in wave 4 – an increase of 29 percentage points from the previous dataset at wave 3 and 28 percentage points higher than the estimated general population figure of 21%.[93] The variability in data across waves 2-4 suggests that perhaps alcohol use was underreported in wave 3, with wave 4 data more aligned to that seen in wave 2. We will require more years of data to fully understand this trend.

Chart 13: Alcohol consumption above low risk guidelines

	Wave 2	Wave 3	Wave 4
	31%	20%	49%

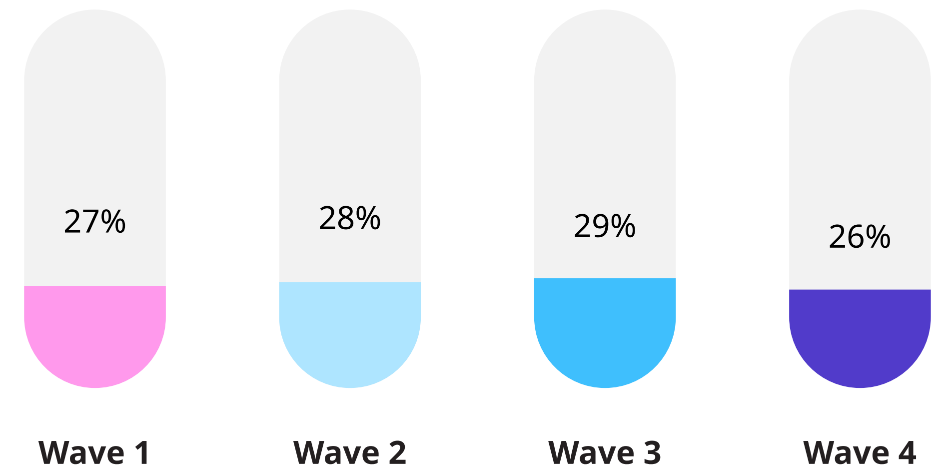
Homeless Health Needs Audit, Wave 2, N=2143; Wave 3, N=308; Wave 4, N=266

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. Although data in this category has remained fairly stable, it is interesting to note that wave 4 data does reverse the trend of an increasing number of people identifying themselves as having/ recovering from an alcohol problem, at 26% (173) compared to 29% (132) in wave 3. Chart 14 below presents data from all 4 waves.

93. NHS England. (2022). *Statistics on Alcohol, England 2021*. https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-alcohol

Chart 14: Respondents who have/are recovering from an alcohol problem



Homeless Health Needs Audit, Wave 1, N=2383, Wave 2, N=2071; Wave 3, N=455, Wave 4, N=677

The findings presented in this chapter overall indicate a concerning decline in health amongst people experiencing homelessness. Rates of all conditions reported are higher amongst people experiencing homelessness than the general population, we see that many people are already unwell when they become homeless and with then further impact of homelessness on worsening health. These findings, together with the increases seen in the number of people with a dual diagnosis and who are using substances to manage their mental health indicates an urgent need for inclusion health programmes to move faster to meet the needs of people experiencing homelessness, and a more overarching need to ensure that homelessness is prevented.

Use of healthcare services

This section looks at how people experiencing homelessness use healthcare services. We first look at primary healthcare services, including GP and dental access and registration levels. We then consider use of acute health services, presenting data on frequency and reasons for use. By comparing our data to general population figures we bring greater understanding of whether and how people experiencing homelessness use services differently to the general population.

Finally, this section presents data on the advice and information that respondents received while in hospital, and whether those discharged were placed in appropriate accommodation.

Primary healthcare

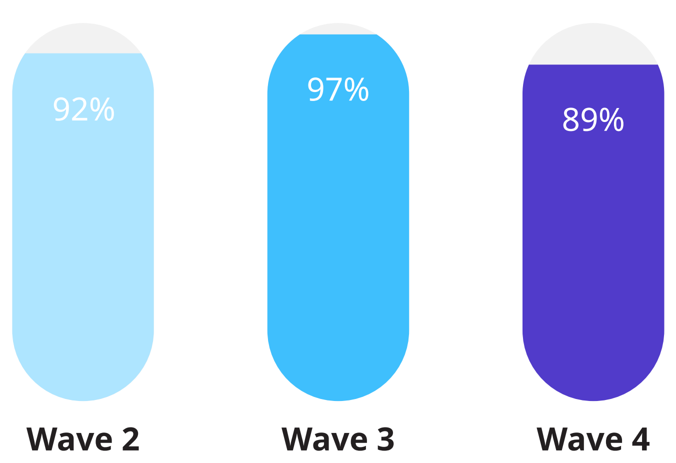
The previous chapter highlighted the increased prevalence of poor health amongst people experiencing homelessness. This only reinforces the vital importance of primary healthcare for people experiencing homelessness, who often have multiple healthcare needs which require support and coordination. GPs, dentists and homeless healthcare providers should be crucial anchors for people experiencing homelessness to manage and improve their health.

GP or specialist homeless healthcare service registration

In wave 4, data shows that the majority of respondents were registered at a GP (89%, 626)). A further 28% (149) of respondents were registered with a specialist homeless healthcare provider.

Respondents could report being registered at both a GP and a specialist homeless healthcare provider. When we consider respondents registered at either practice together, data shows that 89% of respondents were registered with a primary healthcare provider. This marks a notable decline from previous waves, a figure which stood at 97% (450) in wave 3 and 92% (2029) in wave 2. Given the decline in overall health amongst people experiencing homelessness and the continued challenges faced in accessing timely and appropriate healthcare, this finding is particularly concerning.

Chart 15: Proportion of respondents registered with a GP or specialist homeless healthcare service



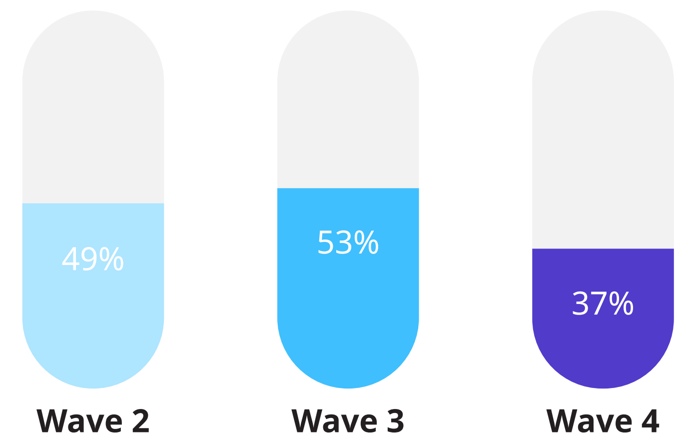
Homeless Health Needs Audit, Wave 2, N=2216, Wave 3, N=483, Wave 4, N=718

Despite initiatives to increase registration over the past 10 years, a small proportion of HNNA respondents still face refusal or other barriers.7% (46) of respondents had been refused registration at a GP practice, and 3% (14) had been refused registration with a specialist homeless healthcare provider. Some of the reasons for refusal included "not having ID" or "no proof of address". 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.[94] These findings therefore illustrate that, in some cases, people are still being erroneously refused access to GP care.

Dental registration

Dental registration levels are much lower than GP registration. In wave 4, only 37% (247) of respondents were registered with a dentist, compared to just over a half, (53%, 246)) in wave 3. This is particularly concerning given that dental / teeth problems were the most commonly reported physical health issue in wave 4, affecting 48% (339) of respondents.

Chart 16: Proportion of respondents registered with a dentist



Homeless Health Needs Audit, Wave 2, N=2150 ; Wave 3, N=461; Wave 4, N=667

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

In wave 4, 10% (68) of respondents had been refused registration at a dental practice, a level unchanged from wave 3. Among those refused, 68% cited dental practises not accepting new NHS patients as the primary reason. Other reasons included missed appointments and financial barriers to paying for treatment (e.g. unemployment, not in receipt of Universal Credit).

It is important to note that access to NHS dental services is challenging across England. Data from ONS found that in a 28 day period in 2024, 96.9% of those who did not have a dentist and who tried to access NHS dental care were unsuccessful.[95] Given this context, it is perhaps not surprising that vulnerable populations, such as people experiencing homelessness who often struggle to navigate services, find it extremely difficult to have their dental and oral health needs met.[96] Some organisations work to improve the accessibility of dental care for people experiencing homelessness, for example by bringing mobile clinical dental spaces to day centres; however, given the high prevalence of dental need amongst this population a more systemic response is clearly needed to increase access to vital treatment.

Acute healthcare

Historically, people experiencing homelessness use emergency services more often than the general population. This is partly due to a higher prevalence of poor health and partly because exclusion from primary care services often means that people do not always receive support before reaching crisis. This section explores respondents' use of ambulance and A&E services, as well as hospital admissions, within the 12 months prior to completing a HHNA.

A&E

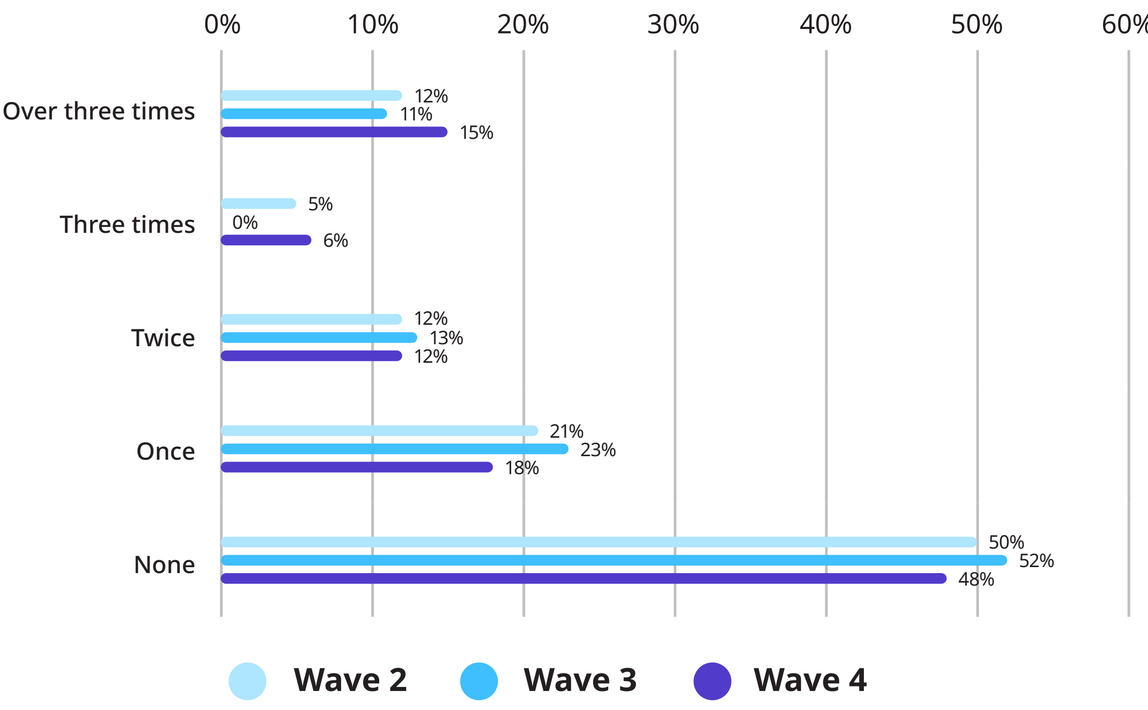
In wave 4, just over half of respondents (52%, 350)) had used A&E services at least once in the past year. This is a slight increase from wave 3, in which 48% (202) of respondents had used A&E at least once in the year prior to taking part in a HHNA.

The number of people using A&E increased more than 3 times from 11% in wave 3 to 15% (101) in wave 4. Similarly, those attending exactly three times rose from 0% in wave 3 to 6% (42) in wave 4. This increase in the number of A&E visits suggests that people are facing increased barriers to primary and secondary healthcare services, resulting in increased presentation at the point of crisis or emergency.

95. Office for National Statistics. (2024). *Experiences of NHS Healthcare Services in England*. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/datasets/experiencesofnhshealthcareservicesinengland

96. Homeless Link. (2023). *Inclusive Dentistry: Exploring ways to improve access to dental care for people experiencing homelessness*. https://homelesslink-1b54.kxcdn.com/media/documents/Inclusive_Dentistry_-_Improving_access_to_dental_care_for_people_experiencing__jPj0rTx.pdf

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



Homeless Health Needs Audit, Wave 2, N=2113; Wave 3, N=425; Wave 4, N=673

On average, people experiencing homelessness in wave 4 used A&E 1.2 times a year. This is a cautious estimate, as it assumes that everyone who responded 'over three times' used A&E services 4 times. According to NHS data, in 2023-24 there were 26.3 million attendances in Accident and Emergency.[97] This indicates an average of 0.3 attendances per person in the general population. Comparing these figures, people experiencing homelessness use A&E services on average four times more frequently 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 the Homeless Health section of this report. It is likely also driven by the gap between the support that people need and that which they receive, and the barriers faced in accessing primary or preventative health care services as explored further in the report.

The audit also asked respondents to identify the reason for their most recent attendance at A&E. In wave 4, the most common was a physical health problem or condition (38%, 106). This was followed by presentations relating to a mental health condition or problem (13%, 36), an accident (9%) and alcohol use (9%). Table 15 below presents the full list of reasons for A&E attendance.

The slight increase in presentations relating to alcohol use, from 7% (14) in wave 3 to 9% (24) in wave 4 reflects a potential impact of the concerning increase in the number of people drinking above the CMO's low-risk drinking guidelines (from 20% in wave 3 to 49% in wave 4).

97. NHS England. (2024). *Hospital Accident & Emergency Activity, 2023-24*. https://digital.nhs.uk/data-and-information/publications/statistical/hospital-accident--emergency-activity/2023-24

Table 15: Reason for last A&E attendance

	Wave 2		Wave 3		Wave 4	
Reason for use	**Count**	**%**	**Count**	**%**	**Count**	**%**
Relating to a physical health problem or condition	300	29%	63	32%	106	38%
Relating to a mental health problem or condition	130	13%	28	14%	36	13%
Accident	118	12%	20	10%	25	9%
Relating to alcohol use	76	7%	14	7%	24	9%
Self-harm/attempted suicide	105	10%	34	18%	23	8%
Other violent incident or assault	66	6%	14	7%	22	8%
Relating to drug use	74	7%	12	6%	16	6%
Domestic violence	35	3%	8	4%	6	2%
Relating to childbirth or pregnancy	11	1%	1	1%	6	2%
Other	107	10%	0	0%	16	6%
N:	1022		194		280	

These results again attest to the worsening physical health amongst people experiencing homelessness with a 6 percentage-point increase in the number of A&E presentations related to physical health compared to wave 3. This shows the urgent need to address physical health outcomes for this group and to expand access to timely and appropriate support.

Encouragingly, the number of respondents reporting A&E attendance due to self-harm/attempted suicide has fallen significantly in wave 4, from 18% (34) in wave 3 to 8% (23) in the latest data. The notable decline in presentations relating to mental health crises may suggest the early positive impact of inclusion health initiatives focused on mental health among people experiencing homelessness. Examples include multidisciplinary hospital and community teams working to bridge gaps across the healthcare system, helping to prevent unscheduled hospital presentations and episodes.[98]

98. Homeless Link. (2025). *Integrating the NICE Guidelines on Integrated Health and Social Care for People Experiencing Homelessness Examples of best practice*. https://homelesslink-1b54.kxcdn.com/media/documents/Integrated_health__social_care_best_practice_examples.pdf

Ambulance use

In wave 4, 36% (238) of respondents reported using an ambulance at least once in the 12 months prior to taking part in the HNNA. This represents a slight decrease from wave 3, when 38% (159) of respondents had used an ambulance in the previous year. In wave 4, it was most common for respondents to have used an ambulance once in the past year (18%, 120), while 8% (50) reported using an ambulance 2 or more times. Full data on frequency of ambulance use is presented in Chart 18 below.

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

0% 10% 20% 30% 40% 50% 60% 70%

Over three times: 8% 8% 8%

Three times: 3% 0% 3%

Twice: 8% 7% 7%

Once: 18% 23% 18%

No: 63% 62% 64%

Wave 2 Wave 3 Wave 4

Homeless Health Needs Audit, Wave 2, N=2083; Wave 3, N=159; Wave 4, N=666

As with A&E above, the most common reason for using an ambulance was a physical health problem/condition, accounting for 34% (63) of the most recent ambulance callouts. Mental health crises also remained a substantial driver of ambulance use, with 24% (44) of callouts relating either to self-harm/ attempted suicide, or relating to a mental health problem or condition. The proportion of ambulance use linked to alcohol has doubled in wave 4, rising from 6% (9) in wave 3 to 13% (23). This increase likely reflects the broader rise in alcohol consumption and self-medication with drugs and alcohol among people experiencing homelessness, as well as the ongoing barriers to accessing timely and appropriate support. Table 16 presents this data in full.

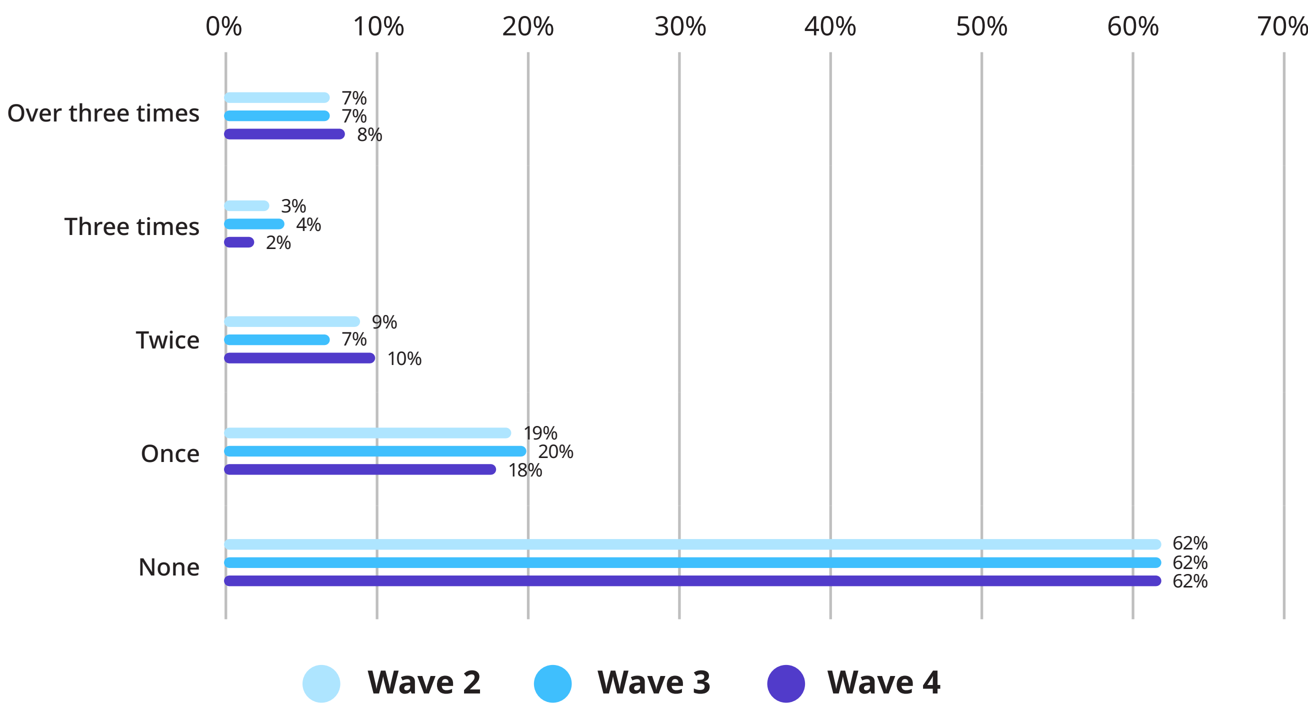
Table 16: Reason for most recent ambulance use

	Wave 2		Wave 3		Wave 4	
	Count	%	Count	%	Count	%
Relating to a physical health problem or condition	209	29%	55	38%	63	34%
Relating to a mental health problem or condition	92	13%	19	13%	24	13%
Relating to alcohol use	64	9%	9	6%	23	13%
Self-harm/attempted suicide	95	13%	21	14%	20	11%
Other violent incident or assault	46	6%	13	9%	17	9%
Accident	68	9%	7	5%	12	7%
Relating to drug use	57	8%	17	12%	12	7%
Domestic violence	18	2%	2	1%	5	3%
Relating to childbirth or pregnancy	8	1%	2	1%	1	1%
Other	67	9%	0	0%	6	3%
N:	724		145		183	

Hospital admissions

In wave 4, 38% (254) of respondents had been admitted to hospital in the 12 months before participating in a HHNA. This figure has held constant since wave 3 (38%, (167)). In the most recent data, it was most common for people to have been admitted once (18%, (118)), with a small group of respondents having been admitted over 3 times (8% (54)). Data on the number of hospital admissions for waves 3 and 4 can be found in Chart 19 below.

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



Homeless Health Needs Audit, Wave 2, N=2102; Wave 3, N= 440; Wave 4, N=674

Reasons for hospital admission in wave 4 follow a similar pattern to that observed throughout this chapter, with physical health problems/conditions the most common reason for people having been admitted to hospital (35%, (60)). Mental health is the second most common driver of hospital admission amongst this population (19%, (11)), followed by self-harm/attempted suicide (11%, (19)). This marks a slight uptick in the number of respondents being admitted due to a mental health crisis (including relating to a condition, or self-harm/attempted suicide) from 28% in wave 3 to 30% in wave 4, with a 4 percentage point increase in the number of admissions relating to a mental health problem or condition. Table 17 below shows the other reasons for hospital admission across waves 2 to 4.

Table 17: Reason for last hospital admittance

	Wave 2		Wave 3		Wave 4	
	Count	**%**	**Count**	**%**	**Count**	**%**
Relating to a physical health problem or condition	224	33%	53	37%	60	35%
Relating to a mental health problem or condition	108	16%	21	15%	32	19%
Self-harm/attempted suicide	83	12%	19	13%	19	11%
Other violent incident or assault	28	4%	11	8%	15	9%
Relating to alcohol use	52	8%	7	5%	14	8%
Relating to drug use	52	8%	9	6%	11	6%
Accident	49	7%	4	3%	7	4%
Domestic violence	16	2%	1	1%	5	3%
Relating to childbirth or pregnancy	14	2%	1	1%	2	1%
Other	51	8%	16	11%	6	3%
N:	677		142		171	

This data demonstrates that people experiencing homelessness continue to rely on emergency services at a higher rate than the general population, despite the high levels of GP registration. Mental ill-health remains a key driver of emergency service use, alongside a growing impact of poor physical health and increased alcohol use, adding to the urgency of providing suitable person-centred health and care for people experiencing homelessness.

Hospital discharge

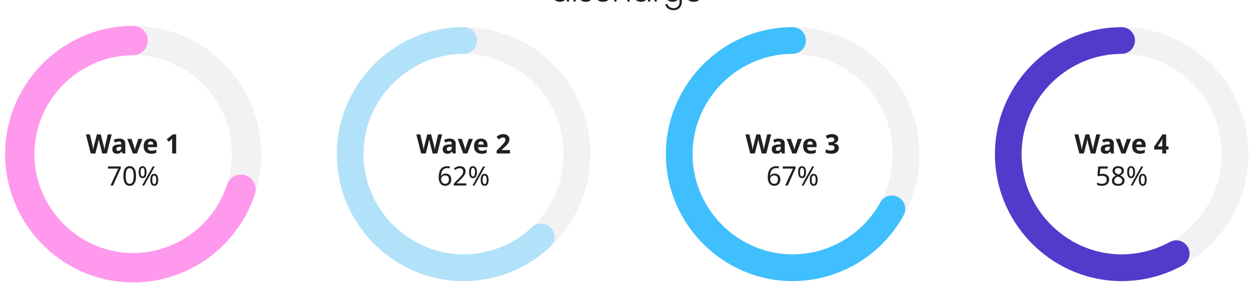
People who experience homelessness at the time of being admitted to hospital have a much higher chance of being readmitted to hospital in an emergency than the general population. A 2020 study, which matched patients experiencing homelessness to housed patients, found that this difference cannot be explained by an individual's health. It concludes that to address this disparity other factors, including housing, need to be tackled.[99] Therefore, we need to understand the extent to which people's housing situation and support around moving from hospital to suitable accommodation is considered.

99. Lewer D, Menezes D, Cornes M, et al. (2021). Hospital readmission among people experiencing homelessness in England: a cohort study of 2772 matched homeless and housed inpatients. *J Epidemiol Community Health*

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 2024/25, 7% (5,120) of referrals to the Local Authority were made by Hospital A&E, urgent care centres, or inpatient care.

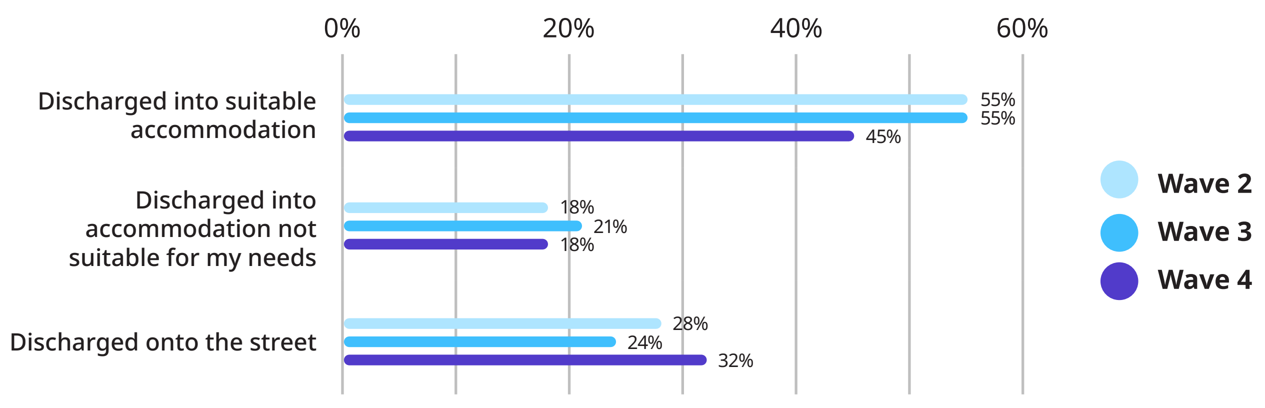
In wave 4, 58% (140) of respondents reported being asked by a staff member during their most recent hospital admission whether they had somewhere suitable to stay on discharge. This is a sharp decrease from wave 3, in which 67% (93) of respondents reported being asked the same. It also marks the lowest proportion recorded since data collection began, when 70% of respondents were asked whether they had somewhere suitable to stay upon discharge. Chart 20 displays this change over time.

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



Discharge outcomes present a deeply concerning picture, with the number of people being discharged onto the streets now at an all-time high. In wave 4, 32% (77) of respondents were discharged onto the streets, which represents an 8% percentage point increase since wave 3 (24%, 37)). Similarly, the number of people being discharged into suitable accommodation has fallen by 10% since wave 3, with 45% (106) of people in wave 4 being housed in accommodation suitable for their needs, compared to 55% (84) in wave 3.

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



Homeless Health Needs Audit, Wave 2, N=2102; Wave 3, N= 440; Wave 4, N=674

Being discharged onto the street exacerbates poor health (e.g. having to manage a wound or take new medication in an unsafe environment) and can increase the likelihood of hospital readmission.[100] Of those who responded, 20% (49) of respondents in wave 4 were readmitted to hospital within 30 days. This represents a decrease from 26% (40) in wave 3.

The findings suggest 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. Just over 4 in 10 (42%) 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; health and homelessness must be tackled together if we are to support people to recover and remain well in housing suitable for their needs.

100. Pathway. (2024). *Intermediate care for people experiencing homelessness: Cost-benefit analysis*. https://www.pathway.org.uk/resources/intermediate-care-for-people-experiencing-homelessness-cost-benefit-analysis/

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 by people experiencing homelessness compared to the general population.

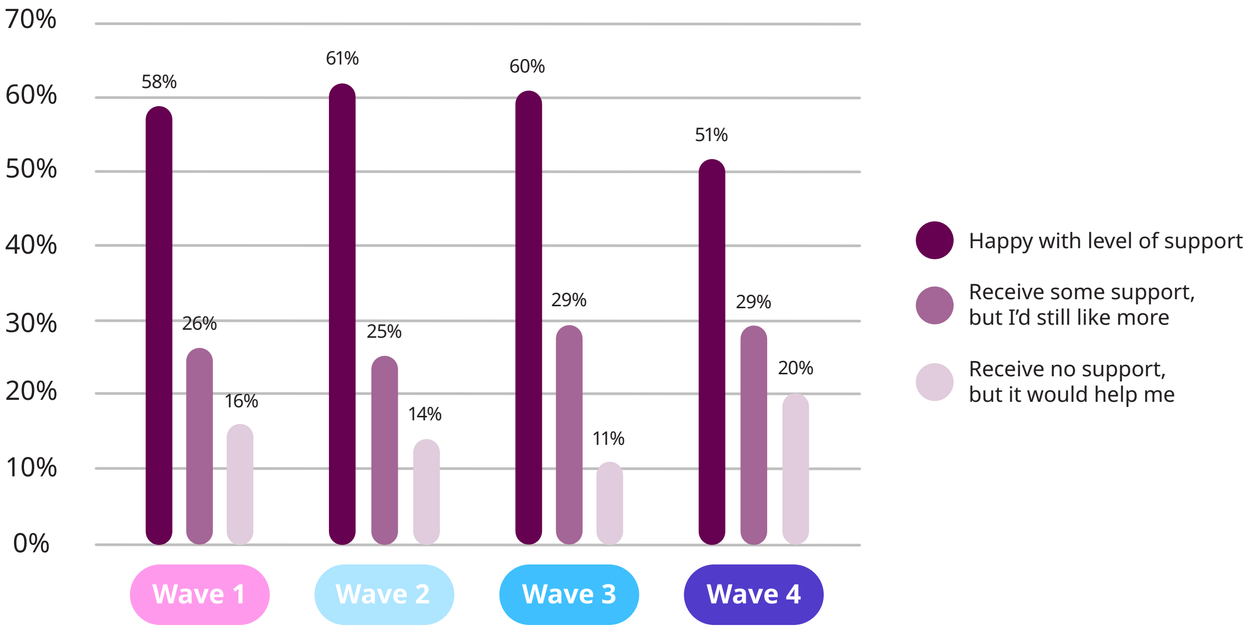
In this section, we come to look at the difference between the support that people felt they needed, versus that which they received. These findings demonstrate the degree to which current services meet the needs of people experiencing homelessness and starts to identify areas for learning and progress. In this section we take each area of health in turn, considering the extent to which respondents report that available services met their needs and expectations.

Physical health

Respondents who reported currently experiencing symptoms for a physical health condition were asked whether they were receiving support or treatment for any of their physical health needs. In wave 4, just over half of respondents (54% (304)) were accessing help for a physical health condition. 51% (286) of respondents felt their needs were met through the support and treatment they were receiving. Of this group, 25% (140) of respondents were receiving support which met their needs, and a further 26% (146) did not feel that they needed support or treatment. This marks a 9 percentage point decrease from wave 3, in which 60% (214) of people were happy the level of support they were receiving for their physical health.

Just under half of wave 4 respondents (49%, 276)) felt their current physical health needs were not being met. Of this group, 29% (164) were receiving some support or treatment, but required more help, and 20% (112) were not currently receiving support but reported that it would help them. Data from waves 1-4 is shown below in Chart 22.

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



Homeless Health Needs Audit, Wave 1, N=2383, Wave 2, N=2071; Wave 3, N=455, Wave 4, N=677

Added to this, 35% (254) of respondents in wave 4 indicated that there had been at least one occasion in the past 12 months when they had needed a medical examination or treatment for a physical health problem, but did not receive this. Some of the common reasons for not being able to access support when it was needed, included: being on a waiting list (19%, 36)) and not having an address (17%, 32)). Other reasons included difficulties in getting a GP appointment, and delays or cancellations during COVID-19. The full list of reasons can be found in Table 18 below.

Table 18: Reasons for not receiving a medical examination or treatment for a physical health problem

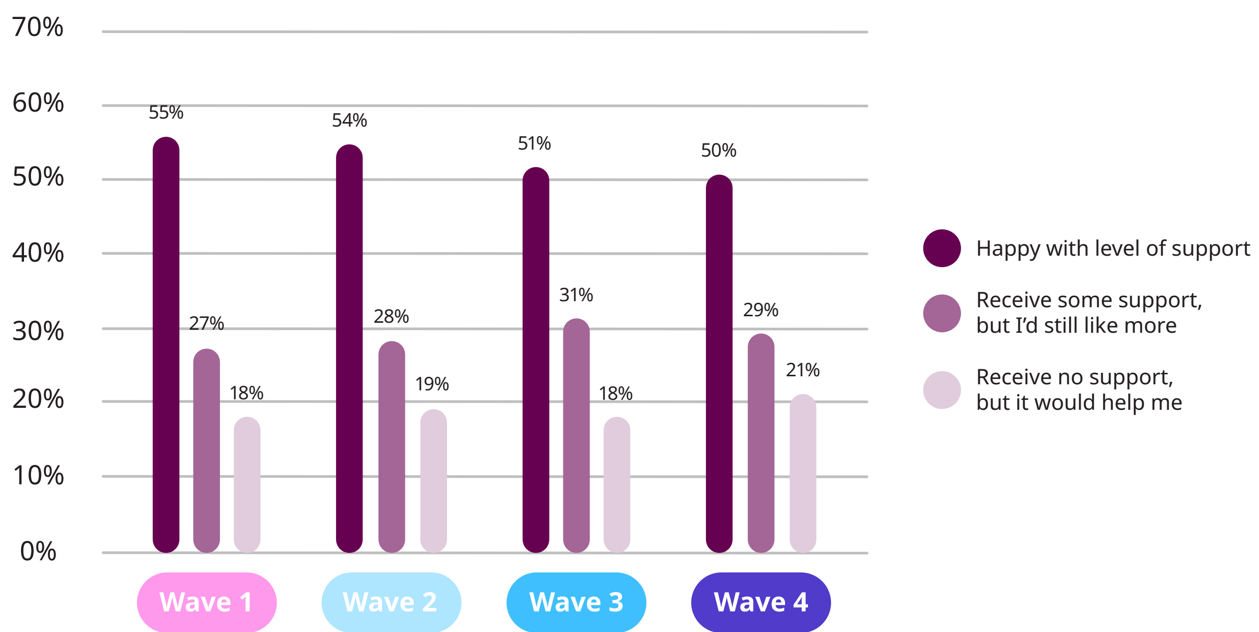
	Count	%
On a waiting list/ still waiting for an appointment	36	19%
Could not receive treatment because of no address	32	17%
Too far to travel / no means of transportation	22	12%
Concerns about judgement from staff	19	10%
Wanted to wait and see if problem got better on its own	18	9%
Was refused treatment/examination	17	9%
Concerns about seeking healthcare due to immigration status	4	2%
Other	42	22%
N:	190	

This data together indicates that many people who experience homelessness are not currently receiving sufficient support to meet their physical health needs. Findings from Support to End Homelessness 2024 found that 58% of homelessness accommodation providers experienced barriers in accessing physical health services for their clients. The most commonly cited reason was waiting lists (58%), followed by high thresholds (15%) and distance to travel to the appointment (7%), mirroring some of the findings above.[101]

Mental health

The HNNA asks respondents who report that they currently have symptoms of a mental health condition(s) whether they are receiving any support or treatment. In wave 4, 61% (321) of respondents received support or treatment for a mental health condition. 32% (170) of respondents reported that the support or treatment they received met their mental health needs, whilst a further 18% (93) felt that they did not any support or treatment.

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



Homeless Health Needs Audit, Wave 1, N=2383, Wave 2, N=2071; Wave 3, N=455, Wave 4, N=677

Half of respondents in wave 4 reported that their needs around support or treatment for their mental health were not being met. Nearly 3 in 10 respondents (29%, 151)) felt that despite receiving some level of support or treatment, they needed more help with their mental health; a further 21% (110) of respondents were not currently receiving support or treatment but felt that it would help them.

101. Homeless Link. (2025). *Support to End Homelessness: A review of services addressing single homelessness in England.* https://homelesslink-1b54.kxcdn.com/media/documents/Support_to_End_Homelessness_2024.pdf

Additionally, 34% (232) of respondents reported needing an assessment or treatment for a mental health condition but not receiving it. Findings from the most recent Support to End Homelessness report found that for accommodation providers, mental health support remains by far the most challenging type of support to access, with 100% of services stating they have a problem accessing mental health services.[102] This highlights a serious challenge.

The HNNA also asks respondents who are currently experiencing symptoms related to their mental health condition whether they are receiving support or treatment. The most common type of treatment respondents received was prescribed medication (61%), followed by support from a specialist mental health worker (38%) and talking therapies (36%). Table 19 below presents the range of support or treatment received.

Table 19: Support or treatment received for a mental health condition

	Wave 3		Wave 4	
Support / treatment	**Count**	**%**	**Count**	**%**
Medication that has been prescribed to me	183	64%	196	61%
Support from a specialist mental health worker	87	30%	122	38%
Talking therapies	97	34%	117	36%
A service that deals with my mental health and drug/alcohol use at the same time	53	18%	79	25%
Practical support that helps me with my day to day life	59	20%	60	19%
Peer support	59	20%	45	14%
Activities like arts, volunteering or sport	43	15%	35	11%
Training and activities to learn new skills / gain employment	34	12%	24	7%
Other	24	8%	11	3%
N:	288		321	

Given the continued 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.

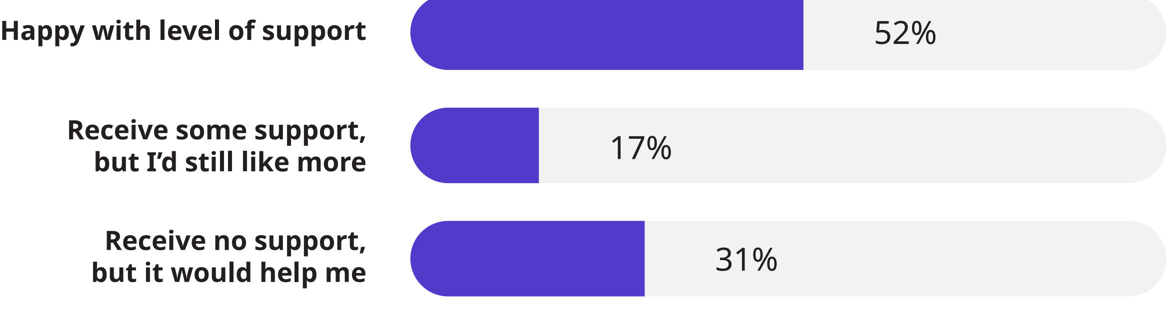
102. Homeless Link. (2025). *Support to End Homelessness: A review of services addressing single homelessness in England*. https://homelesslink-1b54.kxcdn.com/media/documents/Support_to_End_Homelessness_2024.pdf

Cognitive disability

The HNNA asks respondents who have reported that they have a diagnosed cognitive health condition whether they are receiving support or treatment. This question was asked of all respondents who reported that they had any of the following: a learning disability, autism and/or ADHD/ADD.

In wave 4, 36% (58) of respondents received support or treatment for these cognitive health conditions. Of those receiving treatment, 19% (31) of respondents felt the treatment or support met their needs, whilst a further 17% (27) felt that despite receiving treatment or support, they would benefit from more help. Nearly a third (31%, (51)) of respondents were not currently receiving treatment or support, but felt it would help, whilst 33% (54) of respondents did not feel they needed treatment or support relating to their cognitive health. Chart 24 below demonstrates respondents' satisfaction with the support and treatment received.

Chart 24: Respondents' views on the level of support received for cognitive health needs



Homeless Health Needs Audit, N=163

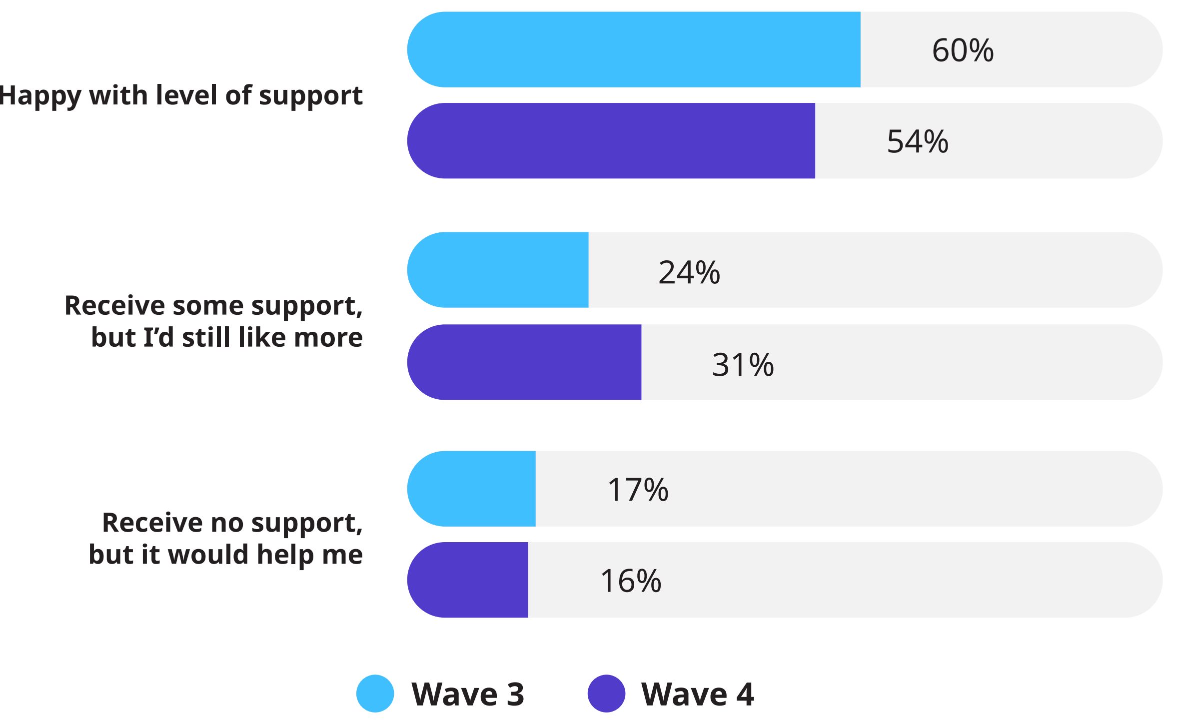
Substance use

Everyone who responded that they had or were recovering from a drug problem was asked about the support that they received. In wave 4, 71% (163) of respondents received support or treatment for their drug use. Of this group, 41% (93) were happy with the support or treatment they were receiving for their drug problem and a smaller group of respondents felt that they didn't need any support (13%, 30)). The proportion of respondents who felt happy in wave 4 with the support they received represents an uptick from wave 3, in which 35% (59) of respondents reported being satisfied.

Just over 3 in 10 respondents (31%, 70)) received support or treatment but felt that their support and treatment needs were not met, and 16% (36) received no support or treatment but felt that it would help them. This marks a 7 percentage point increase from

wave 3, in which 24% (40) of respondents received some support/treatment but felt that they needed more. Chart 25 below shows how satisfaction levels have changed over time.

Chart 25: Respondents' views on the level of support received for drug problem



Homeless Health Needs Audit, Wave 3, N=169; Wave 4, N=229

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 or treatment were: 1-1 support (62%), prescribed medication (55%) and group support (27%). The table below presents the full list of support and treatment received by those who reported that that they have or are recovering from a substance use problem.

Table 20: Support or treatment accessed for drug use

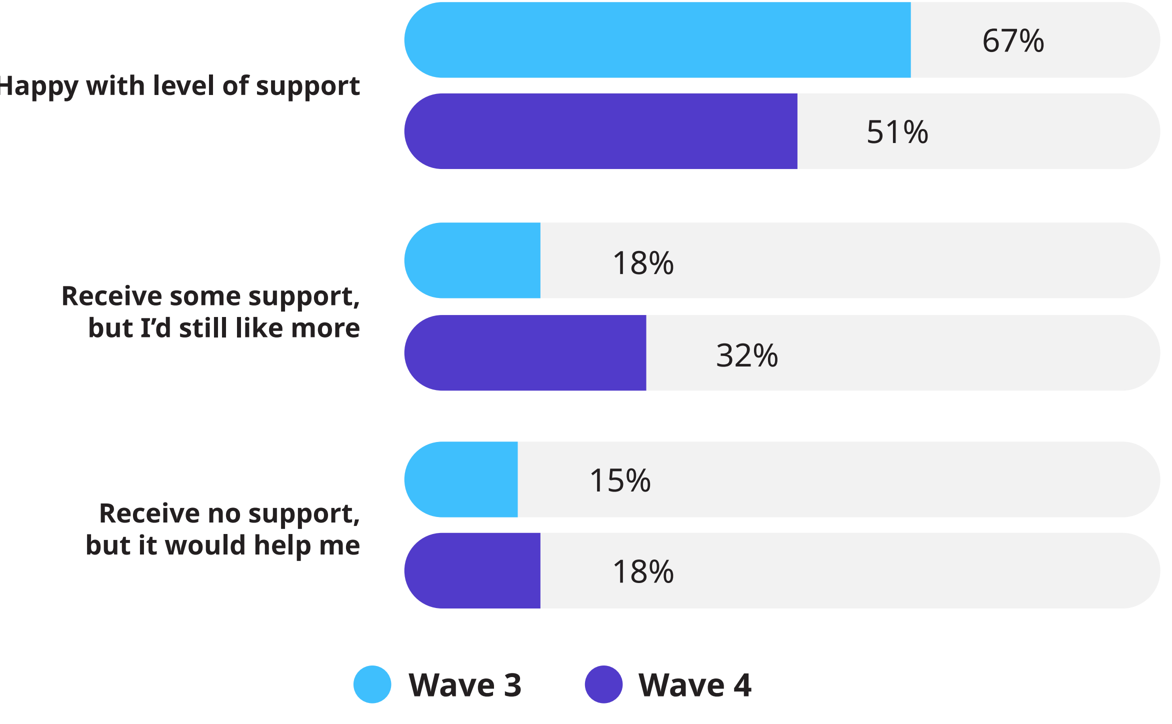
	Count	%
1-1 Support	102	62%
Prescribed medication	90	55%
Group support	44	27%
Support (such as counselling, psychology services and aftercare)	29	18%
Community detox / community rehab	16	10%
Needle exchange	15	9%
Mutal aid	13	8%
Other	12	7%
N:	164	

Respondents who reported that they had or were recovering from an alcohol problem was asked about the support that they received. A slightly smaller proportion of respondents were receiving support or treatment for problematic alcohol use (64%, 107)) compared to drug use. Of this group, 32% (54) felt that the treatment or support met their needs, whilst 32% (53) felt that they needed more support. A further 18% (30) of respondents stated that whilst not currently in receipt of support or treatment, it would help them.

The level of satisfaction with treatment and support in wave 4 has notably declined in comparison to wave 3. In the wave 3 cohort, 41% (47) of respondents felt alcohol support/ treatment met their needs, whilst 18% (20) felt they needed more support despite being in receipt of support/treatment. Chart 26 below shows this change over time.

The HHNA also asks those receiving treatment/ support for a alcohol problem about

Chart 26: Respondents' views on the level of support received for alcohol problem



Homeless Health Needs Audit, Wave 3, N=114; Wave 4, N=168

what type of support they currently access. Advice and information (from GPs, A&E department, etc) was the most common type of support accessed (39%). The landscape of support and treatment has changed quite significantly from wave 3 to wave 4. Access to mutual aid and peer support has declined, whilst more specialist interventions such as community prescribing, detox and psychological support have increased. The most recent Support to End Homelessness report found that 61% of accommodation providers faced barriers in accessing drug and alcohol support services.[103] This challenge in accessing drug and alcohol services may explain why the types of support or treatment accessed by

103. Homeless Link. (2025). *Support to End Homelessness: A review of services addressing single homelessness in England*. https://homelesslink-1b54.kxcdn.com/media/documents/Support_to_End_Homelessness_2024.pdf

respondents in wave 4 has changed. The table below shows the type of support accessed and how this has changed over time from wave 3.
The data presented throughout this section clearly shows a gap in every instance between

Table 21: Alcohol problem support/treatment accessed

	Wave 3		Wave 4	
	Count	**%**	**Count**	**%**
Advice and information (e.g. from GPs, A&E department)	27	40%	42	39%
Counselling or psychological support	13	19%	27	25%
Community prescribing	5	7%	23	21%
Mutual Aid e.g. Alcoholics Anonymous	36	54%	23	21%
Peer support	21	31%	20	19%
Attendance at day programmes, delivered in the community	11	16%	18	17%
Detox	5	7%	13	12%
Aftercare	6	9%	8	7%
Residential rehab	6	9%	3	3%
Other	-	-	18	17%
N:	338		107	

the health care and support that people feel that they need and the support that they are able to access. This gap is most stark for people with a mental health condition, where 50% of respondents in wave 4 felt that their needs were not met; it has increased the most in the case of physical health where we also see substantial change in the rate and kinds of conditions that people are managing. We see the consequences of this lack of access to the level and kinds of healthcare needed in increased use of emergency healthcare services, and in the increased prevalence of people self-medicating to manage their mental health.

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.

In this chapter we explore respondents' perception of their health and how this has changed over a 12 month period. We also evidence the disparity faced by those experiencing homelessness in accessing population-level preventative healthcare services, and present findings relating to the extent to which people experiencing homelessness are able to build health resilience through having equal opportunity to engage in behaviours that support their health.

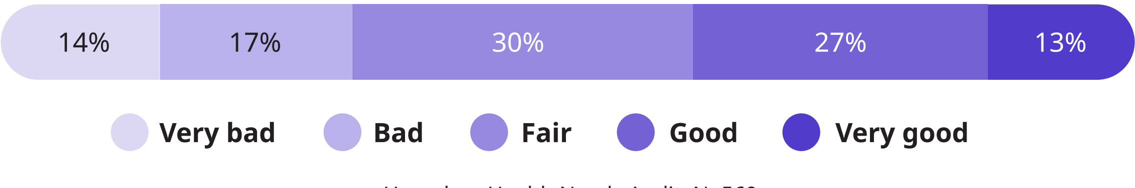
The findings in this chapter are key to demonstrating some of the determinants of health inequalities. They clearly express that people experiencing homelessness are not equally able to engage in preventative or protective health measures when compared to the general population, a situation which compounds existing health inequalities. The findings make a clear case for population-level healthcare interventions to consider the specific needs of inclusion health groups like those experiencing homelessness, in order that they are able to benefit everyone.

Wellbeing

Perception of health

The HNNA asks respondents to rate their health at the time of responding, and as compared to 12 months prior to completing the audit. These health indicators tell us how people feel their health is overall, and their perception of the trend of their health over time.

Chart 27: Respondent's perception of their health at time of completion



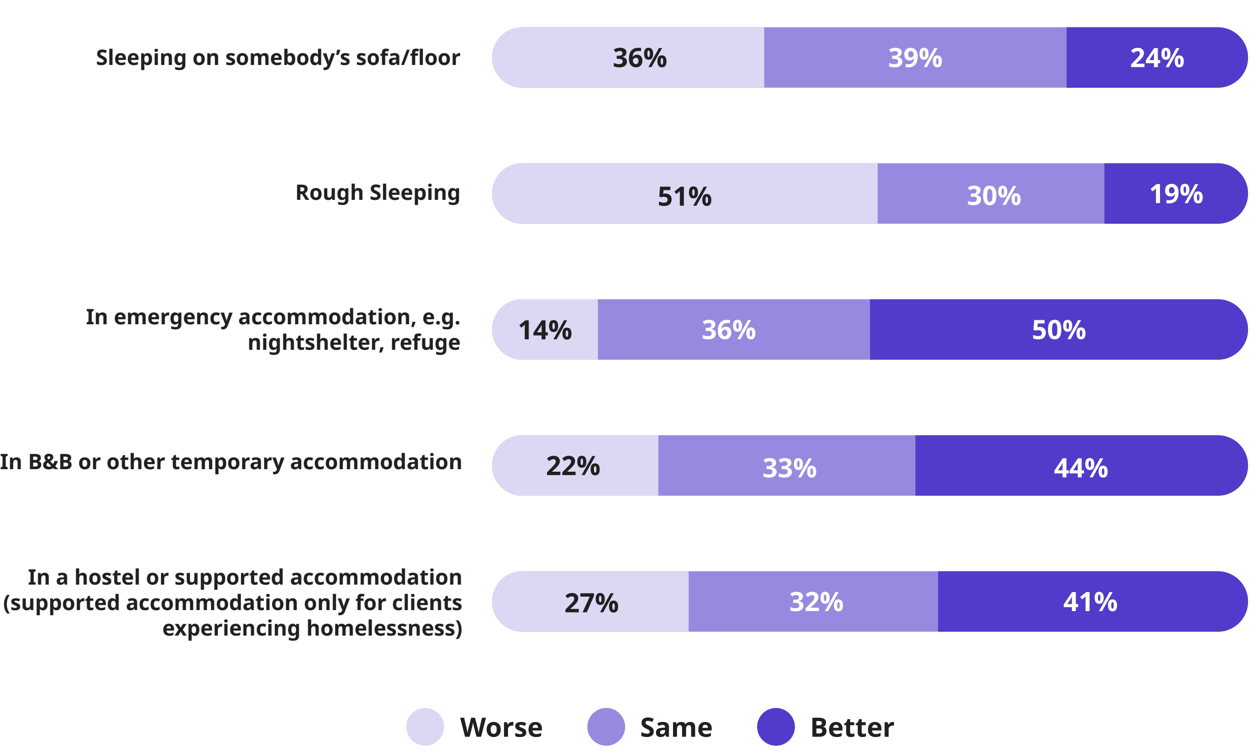
Homeless Health Needs Audit, N=569

4 in 10 respondents (40%, 223)) rated their health to be 'very good' or good' at the time of undertaking a HNNA. 17% (96) of respondents deemed their health to be 'bad' and a further 14% (78) felt their health was 'very bad'.

When asked to compare their health at the time of completion to 12 months ago, 35% (238) felt their health was better than 12 months ago, and a further 32% (221) felt their health was about the same. A third of respondents (33%, 229)) felt that their health was worse than 12 months ago.

When looking at the perceptions of how their health has changed, where a respondent was currently sleeping impacted the extent to which their health had got better or worse. Those living in a hostel or supported accommodation were more likely to report that their health had gotten better over the past 12 months (41%) and 32% felt it had stayed the same. Of those who were rough sleeping, 51% felt their health had got worse over the past 12 months, and a further 44% of those currently sleeping in a vehicle or caravan felt their health had also worsened.

Chart 28: Perception of change in health over 12 months by current sleeping situation



Homeless Health Needs Audit: In a hostel or supported accommodation, N=389; In a B&B or temporary accommodation, N=45; In emergency accommodation, N=14; Own tenancy/accommodation, N=38; Rough sleeping, N=131; Sleeping on somebody's sofa or floor, N=33.

These findings clearly indicate a relationship between health and different forms of homelessness. Demonstrating how those most extreme forms of homelessness such as rough sleeping and sofa surfing drive poorer health, compared with access to somewhere reliable to sleep which provides support and access to services which drives better overall perception of health.

Preventative healthcare

Vaccinations

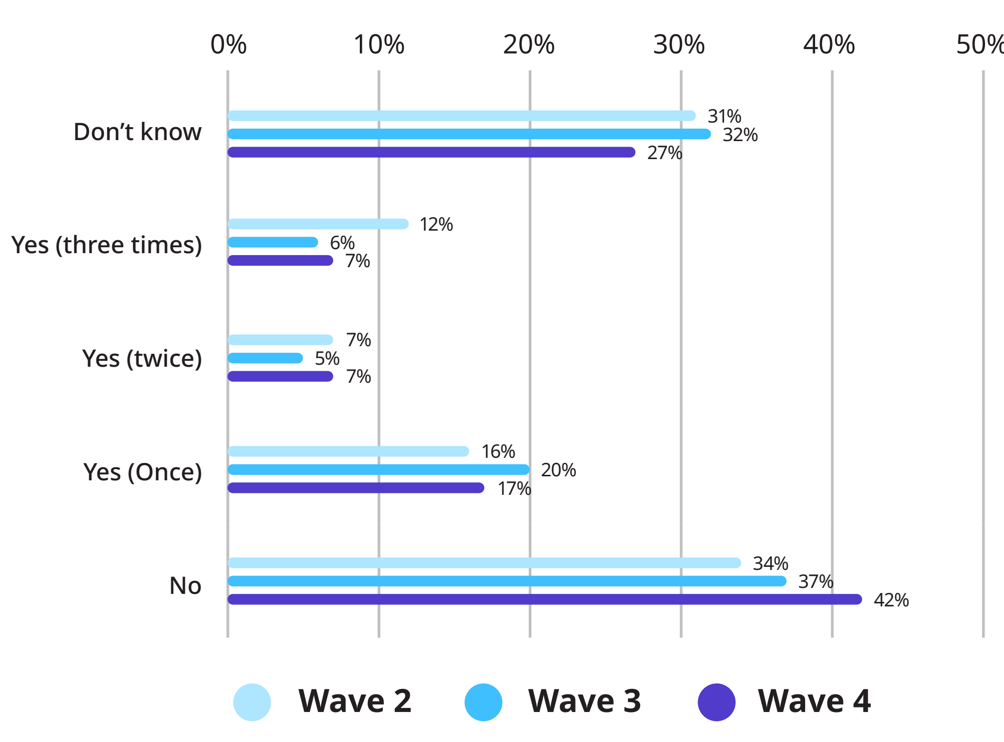
The Homeless Health Needs Audit asks respondents whether they have been vaccinated against Hepatitis B and the flu.

Hepatitis B

In wave 4, just 7% (46) of respondents were fully vaccinated against Hepatitis B, and a further 31% (207) had had at least one vaccination against Hepatitis B. A significant proportion of respondents had never had a vaccination against Hepatitis B (42% (283)) and 27% (185) did not know or remember.

This represents a very minor uptick in the proportion of people fully vaccinated compared to wave 3, where 6% (27) of respondents had had all three Hepatitis B vaccinations. However, the proportion of respondents who had never had a vaccination against Hepatitis B has increased since wave 3, with 37% reporting not having a vaccination. The results are presented in Chart 29 below.

Chart 29: Levels of vaccination against Hepatitis B



Homeless Health Needs Audit, Wave 2, N=2015; Wave 3, N=463; Wave 4, N=675

Flu vaccinations

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, 25% (129) of respondents had been vaccinated in the last year, a higher figure than reported in wave 3 (18% (52)). The full results for this question are presented in Table 22 below.

Table 22: Proportion of respondents who received a flu vaccine

	Wave 3		**Wave 4**	
	Count	**%**	**Count**	**%**
Never	156	53%	211	40%
Yes (more than a year ago)	45	15%	89	17%
Yes (in the last year)	52	18%	129	25%
Don’t know	43	15%	92	18%
N:	296		521	

Cancer screenings

Two questions explore whether people experiencing homelessness have attended routine, life saving, cancer screenings. Appointments for these routine screenings are sent by post to eligible individuals registered with a GP surgery, however, this system is flawed for people experiencing homelessness who may not have an address at which to receive a letter and for whom evidence shows forward planning of appointments can be very difficult. The data we report here does not capture the reasons that people do or do not attended screenings, but does indicate that current processes urgently need to be reconsidered to reverse a decline in cancer screening amongst people experiencing homelessness.

Breast screening

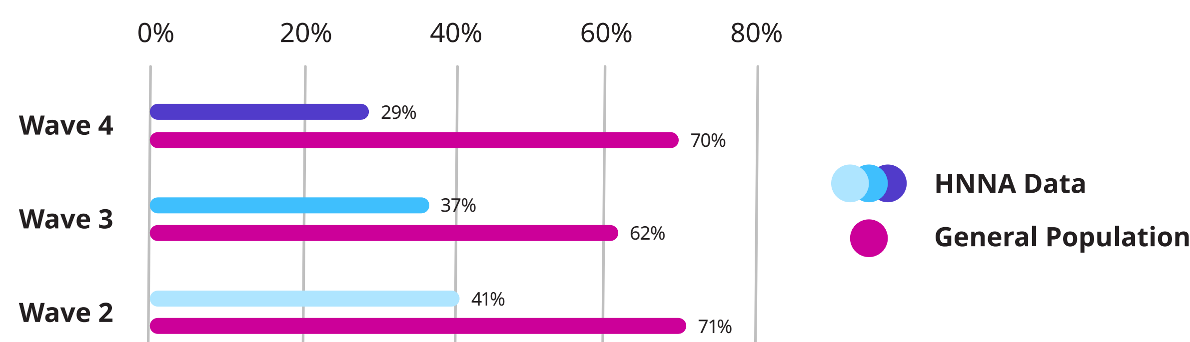
All females over the age of 50 are invited for breast screening by the NHS every three years between the ages of 50 and 71.[104] The HHNA asks all those eligible whether they have had a breast screening in the past 3 years. Some services exist to support women experiencing homelessness to access these screenings, and many go further than the NHS guidance on reducing inequalities in breast cancer screening.[105] These best practice services generally use a trauma-informed approach to individualise support, and work with local hospitals and GPs to agree amendments to their practice around screenings which increase inclusivity and therefore access.[106]

In wave 4, just 29% (10) of eligible females had had a breast screening. This indicates a downward trend in the proportion of women experiencing homelessness accessing this service: in wave 3, this figure stood at 37% (17) and in wave 2, 41% (30) females had had a breast screening.

According to NHS England, in 2023-24, 70% of women aged 50-71 took up their invitation for a breast screening. This represents just over a 5% percentage point increase on the previous year (64.5% in 2022-23).[107]

This suggests that access to the breast screening programme is becoming increasingly difficult for women experiencing homelessness, whilst access is being somewhat improved for the general population. Females who are homeless are therefore at an unfair disadvantage in not receiving the protective benefits of the breast screening programme. Chart 30 below presents wave 2 to 4 comparisons alongside the national level NHS data.

Chart 30: Breast screening uptake in HHNA population and general population



Homeless Health Needs Audit, Wave 2, N=73; Wave 3, N=46; Wave 4, N=34

104. Information on NHS breast screening is available at: https://www.nhs.uk/conditions/breast-screening-mammogram/when-youll-be-invited-and-whoshould-go/
105. NHS England. (2024). *Guidance: Breast Screening: Reducing Inequalities.* https://www.gov.uk/government/publications/breast-screening-identifying-and-reducing-inequalities/breast-screening-reducing-inequalities#homeless-women
106. See, for example Wildflowers outreach clinic in Peterborough - Drink and Drug News, (2024), A Place of Safety. Available at: https://www.drinkanddrugsnews.com/a-place-of-safety-wildflowers-outreach-clinic/
107. NHS England. (2025). *Breast Screening Programme, England, 2023-24.* https://digital.nhs.uk/data-and-information/publications/statistical/breast-screening-programme/england---2023-24

Cervical screening

All eligible individuals aged between 25 and 64 are invited for cervical screening by the NHS every 3 or 5 years, depending on age.[108] The HHNA asks all those in this age group who are eligible whether they have attended a cervical screening in the past 3 years.

38% (50) of eligible respondents in wave 4 had received cervical screening, compared to 54% (66) in wave 3, and 57% (183) in wave 2. 68.8% of eligible individuals in the general population aged 25 to 64 were screened between 2023-24.[109] This again clearly shows that access to and uptake of cervical screening among women experiencing homelessness is significantly lower than for those in the general population. Whilst the number of women in the general population being screened has steadily declined since wave 2, this rate of decline is much sharper among those experiencing homelessness. The chart below presents this data, alongside general population comparisons.

Chart 31: Cervical screening uptake HHNA population and general population

0% 20% 40% 60% 80%

Wave 4
38%
69%

Wave 3
54%
70%

Wave 2
57%
72%

HNNA Data
General Population

Homeless Health Needs Audit, Wave 3, N=122; Wave 4, N=131

There are numerous potential barriers to accessing these routine screenings for people experiencing homelessness. We know not all females experiencing homelessness will either have an address at which to receive their invitation, and some may not be registered with a GP service. Added to this, wider research tells us that it can be more difficult for people experiencing homelessness to attend advance booked appointments[110] and that in particular lack of access to hygiene facilities can be a barrier to accessing these intimate screenings. More work urgently needs to be done to reverse this trend to protect more women from the worst experiences of cancer.[111]

108. Information on NHS cervical screening is available at: https://www.nhs.uk/conditions/cervical-screening/when-youll-be-invited/

109. NHS England. (2024). *Cervical Screening Programme, England 2023-24.* https://digital.nhs.uk/data-and-information/publications/statistical/cervical-screening-annual/england-2023-24

110. McNeill S., O'Donovan D., Hart N. (2022). Access to healthcare for people experiencing homelessness in the UK and Ireland: a scoping review. *BMC Health Services Research*.

111. Schiffler T, Carmichael C, Smith L, Doñate-Martínez A, Alhambra-Borrás T, Varadé MR, Barrio Cortes J, Kouvari M, Karnaki P, Moudatsou M, Tabaki I, Gil-Salmeron A, Grabovac I.(2023). Access to cancer preventive care and program considerations for people experiencing homelessness across four European countries: an exploratory qualitative study. *EClinicalMedicine*. 2023 Jul 20;62:102095.

Health resilience

Smoking, nutrition, sexual health and access to medication are used as indicators of health resilience in the HNNA, including average consumption of food (including fruit and veg), and knowledge of where to seek sexual health advice. Being able to access nutritious food and take prescribed medication, for example, are fundamental in a maintaining a baseline of good health.

Sexual health

Evidence shows that people experiencing homelessness are at an increased risk of Sexually Transmitted Infections (STI), and that uptake and engagement with sexual health services can be lower among this population.[112] The HNNA asks respondents about seeking sexual health advice and where they would go to receive it.

Just over 7 in 10 (72%, 495)) respondents reported that they knew where to access advice about sexual health. When asked where they would go, the most common answer was a GP or nurse (56%, 260)), followed by a GUM/sexual health clinic (35%, 162)). Others suggested they may look for advice themselves online. The table below shows the full response.

Table 23: Where respondents would go to seek sexual health advice

	Count	%
GP or nurse	260	56%
GUM/sexual health clinic	162	35%
Homeless/housing staff	22	5%
Other	24	5%
N:	468	

Smoking and smoking cessation

Across those surveyed in wave 4, 77% (551) reported that they smoke cigarettes, e-cigarettes, cigars or a pipe. According to national data, 11.9% of adults aged 18 years or over are current smokers.[113] The difference in prevalence between those experiencing

112. Paisi, M., March-Mcdonald, J., Burns, L., Snelgrove-Clarke, E., Withers, L., & Shawe, J. (2020). Perceived barriers and facilitators to accessing and utilising sexual and reproductive healthcare for people who experience homelessness: a systematic review. *BMJ Sex Reprod Health*. 2021 Jul;47(3):211-220.

113. Office for National Statistics. (2024). *Adult smoking habits in the UK: 2023*. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/adultsmokinghabitsingreatbritain/2023

homelessness and the national population indicates a significant overrepresentation of smoking behaviours amongst those who experience homelessness.

The proportion of people experiencing homelessness who smoke is consistent throughout the research series.

Table 24: Proportion of respondents who smoke cigarettes, e-cigarettes, cigars or a pipe

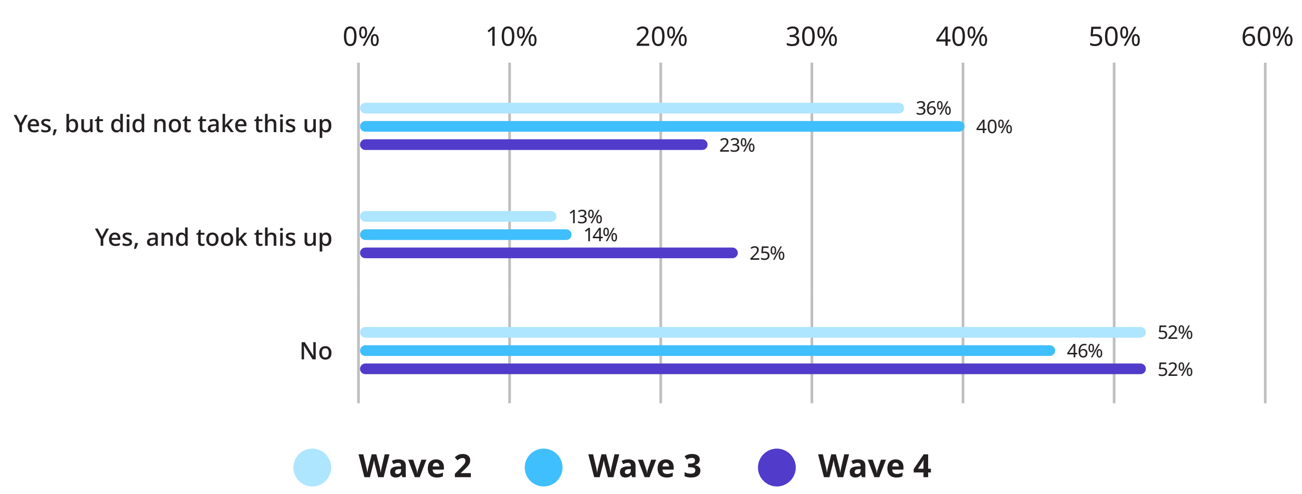
Wave 1 (2010-2014)	77%	2590
Wave 2 (2015-2017)	79%	1765
Wave 3 (2018-2021)	76%	378
Wave 4 (2022-2025)	77%	551

Smoking is known to cause poor health and to exacerbate existing health conditions. As evidenced in earlier chapters, respiratory conditions are very common among people experiencing homelessness, with asthma (21%) and chronic breathing problems (19%) the most prevalent physical health diagnoses reported. Moreover, 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.[114] 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, 36% (194) report that they would like to give up smoking altogether. This represents a 14% percentage decrease since wave 3, in which 50% (156) of respondents expressed wanting to stop smoking. The availability of smoking cessation advice appears to be varied, with 52% (100) of respondents who wanted to quit smoking stating that they had not been offered help to stop smoking. Of those who had been offered support, up-take was relatively low: 25% (49) had taken up support, and 23% (45) had not taken up the offer of support. Chart 32 presents this data below.

114. Groundswell. (2016). *Room to Breathe: A Peer-led health audit on the respiratory of people experiencing homelessness*. https://groundswell.org.uk/wp-content/uploads/2017/10/Groundswell-Room-to-Breathe-Full-Report.pdf

Chart 32: Proportion of respondents offered smoking cessation advice who want to stop smoking



Homeless Health Needs Audit, Wave 2, N=1348; Wave 3, N=329; Wave 4, N=194

This data reveals a large group of smokers who would like to give up, but are either being offered no support at all to do so, or are not being offered support that they are able to take up. This suggests that more needs to be done to increase awareness of smoking cessation support, and to consider how services might need to be tailored or amended to meet the needs of people experiencing homelessness.

Prescribed medication

The HNNA asks respondents whether they are currently taking any medication prescribed to them. In wave 4, almost two thirds of respondents (65% (449)) reported that they were taking some form of prescribed medication. This figure represents a 6 percentage point decrease from wave 3 (71%, 331)).

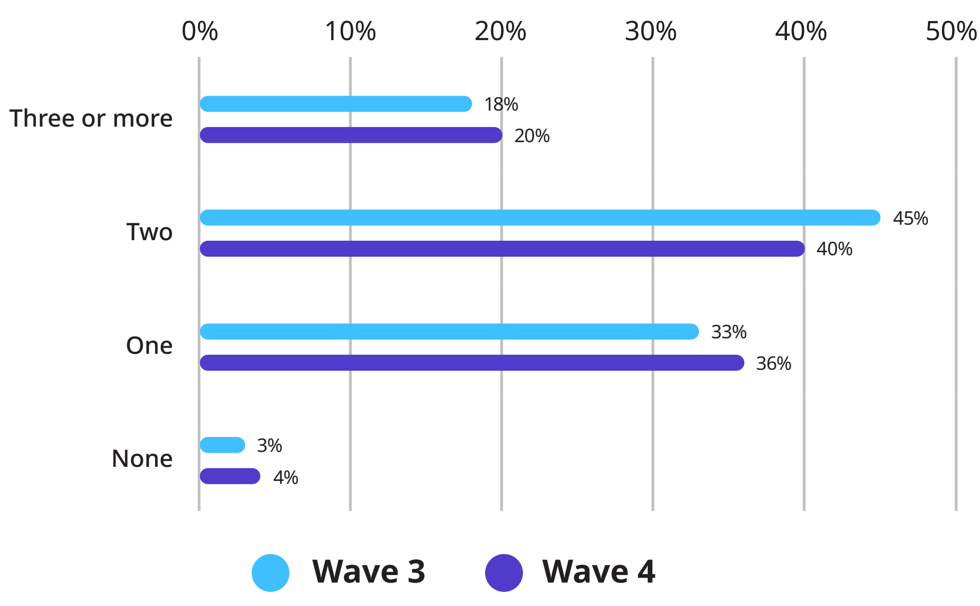
97% (430) of respondents said they were able to access their medication, with a minority (3%, 13)) not able to access prescribed medicines. Challenges with access included not being registered with a GP, the prescription being too far away to collect, “forgetting” and “not engaging” with services. It should be noted that people experiencing homelessness can also face challenges in storing and taking their medication,[115] such as with diabetes medication which needs to be kept at a certain temperature. These challenges, which can severely impact a person’s ability to take their medication, are not represented in this data and so it is important to note that this finding does not straightforwardly indicate ability to take medication as advised.

115. Homeless Link. (2025). *Access to food and nutrition for people experiencing homelessness and using substances: provision, challenges and opportunities for support in Tower Hamlets*. https://homelesslink-1b54.kxcdn.com/media/documents/Access_to_food_and_nutrition.pdf

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.[116]

In wave 4, just under 4 in 10 respondents (36%, (239)) reported on average only eating one meal a day and just 20% (137) reported that they eat three or more meals per day. 40% (268) of respondents stated that they eat an average of two meals a day. The number of people eating three meals per day has very slightly increased from 18% (85) in wave 3. The time series comparison can be seen in Chart 33 below.



Homeless Health Needs Audit, N=2015; Wave 3, N=463; Wave 4, N=675

Data from Trusell found that in 2024, 16% of UK households (14.1 million people) lived in food insecure households. This means that individuals experienced running out of food and were unable to purchase more, reducing the size of their meals or eating less, or going hungry.[117] The report also found that 41% of people referred to food banks had experienced some form of homelessness in the past year.[118] Whilst this data is not directly comparable with the data collected through the HNNA, and food insecurity is a stark and increasing issue in the wider population, it highlights the damaging impact of experiencing homelessness on food access and nutrition.

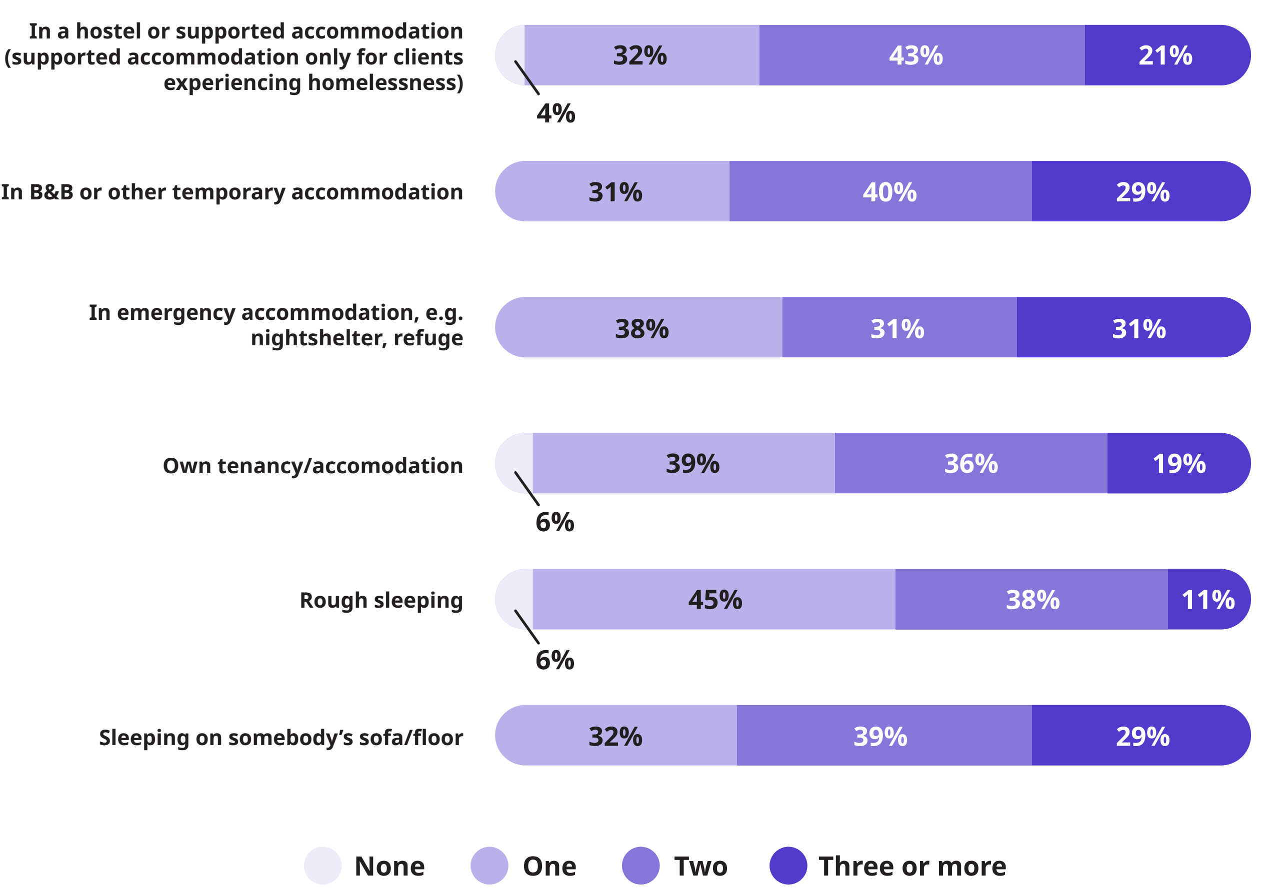
116. Department for Environment, Food & Rural Affairs. (2021). *National Food Strategy: Part Two*. https://assets.publishing.service.gov.uk/ government/uploads/system/uploads/attachment_data/file/1025825/national-food-strategy-the-plan.pdf

117. Trusell. (2025). *Hunger in the UK*. https://cms.trussell.org.uk/sites/default/files/2025-09/hunger_in_uk_sept25.pdf?_gl=1*tdlntu*_gcl_au*MjM1MzIzMDg4LjE3NTgxODk3NDI.

118. Trusell. (2025). *Hunger in the UK*. https://cms.trussell.org.uk/sites/default/files/2025-09/hunger_in_uk_sept25.pdf?_gl=1*tdlntu*_gcl_au*MjM1MzIzMDg4LjE3NTgxODk3NDI.

Different accommodation models and types have an impact on people's health outcomes, particularly access to food. Respondents sleeping in a hostel or supported accommodation were more likely to consume two meals a day (43%, 163)), compared to those in emergency accommodation (31%, 4)), and those in their own tenancy/accommodation (36%, 13)). However, those staying in emergency accommodation, B&B or other temporary accommodation, or sleeping on somebody's sofa/floor were more likely to consume three or more deals a day on average. This suggests that food access and provision varies significantly by housing situation.

Chart 34: Average number of meals eaten per day by current sleeping situation



Homeless Health Needs Audit: In a hostel or supported accommodation, N=389; In a B&B or temporary accommodation, N=45; In emergency accommodation, N=14; Own tenancy/accommodation, N=38; Rough sleeping, N=131; Sleeping on somebody's sofa or floor, N=33.

Further indicating the challenge that people experiencing homelessness face in eating well, 68% (325) of respondents ate one or fewer portions of fruit or very per day. Just 3% (21) of respondents ate the recommended 5 or more portions of fruit or veg per day. Figures for the national average from the Department of Health and Social Care indicate that in 2023/24 31.3% of adults met the 5 a day consumption recommendation.[119] Table 25 below presents the full results of this question for waves 3 and 4.

119. Department of Health and Social Care. *Public health profiles*. Available at: https://fingertips.phe.org.uk/search/fruit#page/4/gid/1/pat/159/par/K02000001/ati/15/are/E92000001/iid/93982/age/164/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1

Table 25: Average number of portions of fruit and vegetables eaten per day

	Wave 3		Wave 4	
	Count	**%**	**Count**	**%**
Less than 1	187	41%	169	25%
One portion	114	25%	156	23%
Two portions	61	13%	138	20%
Three portions	54	12%	47	7%
Four portions	22	5%	12	2%
Five portions or more	17	4%	21	3%
N:	455		676	

How do health and homelessness interact?

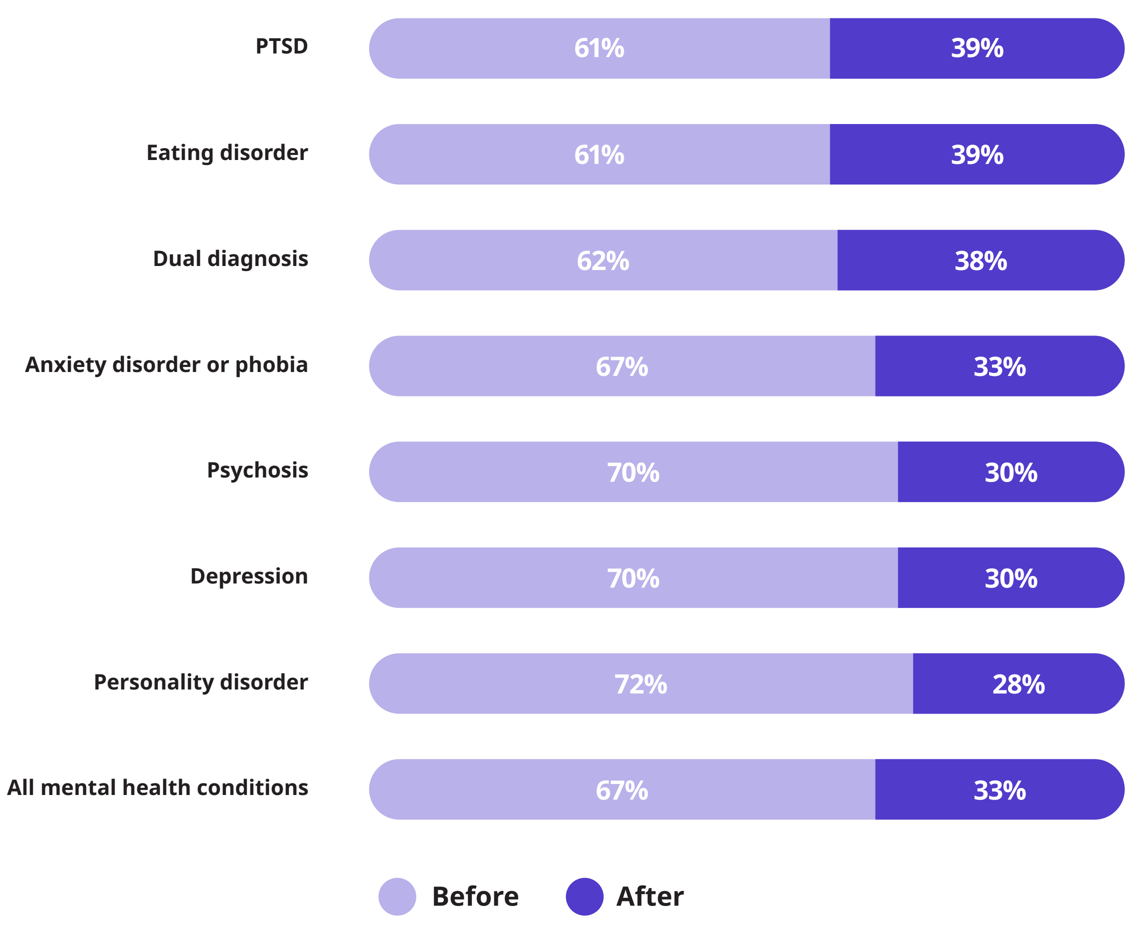
This issue of the Unhealthy State of Homelessness builds on early findings presented in 2022, which indicated that mental ill-health is more likely to predate experience of homelessness; whereas physical ill-health is more likely to occur after experiencing homelessness. HHNAs in wave 4 asked respondents whether each physical health diagnosis was made (or in the case of physical health conditions, first occurred) before or after their experience of homelessness. Our data shows that mental ill-health is very common before people experience homelessness, with a more complex picture emerging around physical health. Within physical health we see the impact of homelessness in the rising prevalence of some conditions after experience of homelessness, whilst other conditions are more commonly diagnosed before experience of homelessness. These data help us understand where targeted prevention efforts are both most needed and can be most effective in reducing and preventing homelessness.

Mental health and homelessness

Findings indicate that existing mental ill-health is very common amongst people who experience homelessness, with 67% of all mental health conditions reported by respondents being diagnosed before their experience of homelessness. This finding is stark: it clearly shows how commonly people who experience homelessness are already facing mental ill-health before being put in a situation which only provides further challenges.

The trend of mental health diagnoses being made prior to experience of homelessness holds across all conditions that the HHNA asks about, however there is some variation within this. In particular, post traumatic stress disorder and dual diagnosis of a mental health condition and drug and alcohol use, are relatively more likely to be diagnosed after experience of homelessness. The full findings showing rates of diagnosis for each condition before versus after experience of homelessness are presented in Chart 35 below.

Chart 35: Whether mental health diagnoses were made before or after experience of homelessness

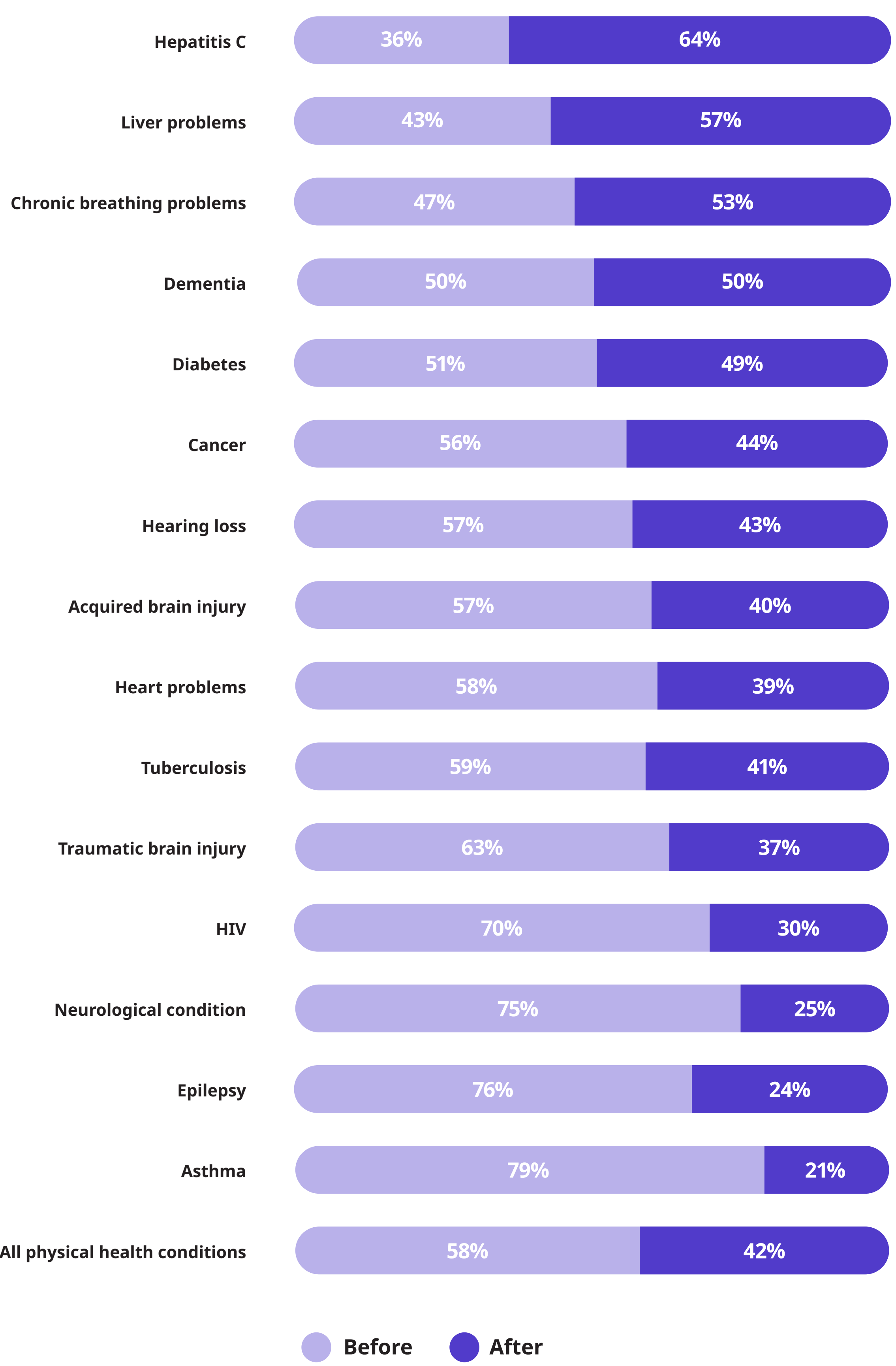


Homeless Health Needs Audit, Wave 4, N=1185 (people could report multiple mental health diagnoses)

Physical health and homelessness

Findings around the impact of homelessness on physical health present a more complex picture. Taken as a whole, physical health diagnoses were more commonly made before experience of homelessness, with 58% (503) of physical health diagnoses reported predating respondents' experience of homelessness. However, as can be seen in Chart 36 below, there are sizeable variations between diagnosed physical conditions, suggesting that whilst many people are already in ill-health when they become homeless, the impact of homelessness creates additional health challenges.

Chart 36: Whether physical health diagnoses were made before or after experience of homelessness

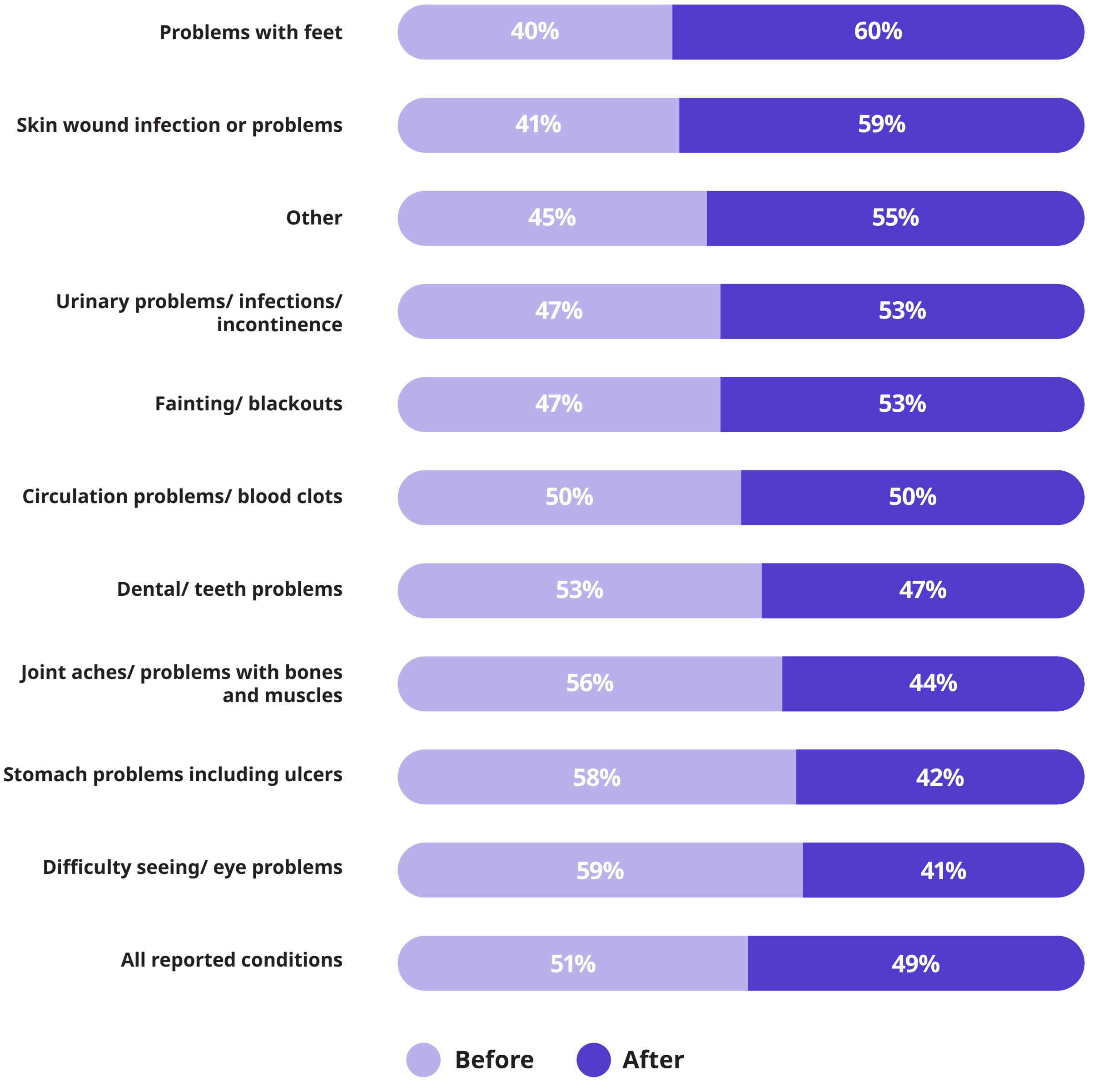


Homeless Health Needs Audit, Wave 4, N=874 (people could report multiple physical health diagnoses)

It is notable that the conditions most likely to be diagnosed after experience of homelessness indicate a high degree of overlapping disadvantage. Increased prevalence of smoking and alcohol use in this population, which in themselves are related to high rates of self-medication due to inadequate mental health support, are very likely a factor in the diagnosis of liver problems, Hepatitis C and chronic breathing problems after an individual experiences homelessness.

When we turn to consider physical health conditions, rather than specified diagnoses, there again appears to be greater impact of homelessness for some conditions than others. However, when taken together there is an almost even split between conditions occurring before (51% (836)) versus after (49% (793)) experience of homelessness. Chart 37 presents these findings below.

Chart 37: Whether physical health conditions occurred before or after experience of homelessness



Homeless Health Needs Audit, Wave 4, N=1629 (people could report multiple physical health diagnoses)

When we consider the breakdown of conditions, again clear impact of homelessness is evident. The onset of these conditions may be impacted by exposure to poor living conditions and lack of personal safety; they are then exacerbated by lack of regular access to hygiene facilities, inadequate nutrition and an overwhelming lack of ability to simply allow the body to rest and to recover.

Taken together, the findings in this chapter demonstrate that more often than not people are in poor health when they become homeless. We see within the data some clear indications of homelessness then further negatively impacting on health, with multiple additional risk factors leading to an increase in diagnoses of liver problems and of chronic breathing problems, and of PTSD and dual diagnosis. We also see indications of the impact that homelessness has on the onset of physical health conditions that result from poor living conditions, with recovery supported by good nutrition, regular access to hygiene facilities, and rest. Again we see that whilst people experiencing homelessness face far greater health challenges than the general population, they are at a disadvantage in their ability to access the support and facilities needed to recover.

We know that many of the social determinants of health are stacked against people experiencing homelessness, and our findings clearly show that poor health often precedes homelessness. 67% (1185) of all diagnosed mental health conditions were present before respondents' experience of homelessness, and 27% (193) had been admitted to hospital because of a mental health condition at some time. Additionally, 58% (503) of physical health diagnoses already existed when respondents became homeless. This makes clear that homelessness is not just a housing issue; it is a health issue, and preventing homelessness requires targeted interventions from the health and social care system.

Once someone does experience homelessness, the findings presented throughout this report clearly demonstrate that this further negatively impacts health. For example, chronic breathing problems and liver disease are more likely to be diagnosed after an individual experiences homelessness, and a significant number of mental health conditions, most notably PTSD and dual diagnosis, are also impacted. The added complexity as poor health builds is reflected in the high rates of multimorbidity seen in this group. 47% (345) of respondents have at least one mental health and physical health diagnosis; and 11% (81) of respondents reported that they have a drug problem together with both at least one mental health and at least one physical health diagnosis.

The current situation therefore presents a direct contradiction: as the complexity of managing poor health increases, access to healthcare becomes harder. Evidence shows rising rates of self-medication and emergency healthcare use, four times higher than the general population. Our findings make clear that the wider health system is currently failing to meet the needs of people experiencing homelessness, with life-saving cancer screenings reaching people experiencing homelessness at declining rates, and increasing numbers discharged from hospital to the street. The ultimate consequence of this is seen in the devastating findings of the Museum of Homelessness, who reported the deaths of 1,611 individuals experiencing homelessness in 2024.

Homelessness is a health issue. The response therefore must sit upstream, and outside of traditional homelessness services and requires the involvement and investment of multiple partners across health and social care to effectively prevent homelessness wherever possible. It must also ensure that when homelessness does occur the experience is short-lived and, instead of creating a spiral into increasing and deteriorating poor health, provide rapid access to person-centred support across all areas of health and care.

We know that these improvements can be made; we see this in the many examples of good practices across health and homelessness services working in partnership across the country. This includes both targeted inclusion health services increasing access to support, but also re-framed homelessness support models, such as Housing First, which integrates health interventions within housing. Health systems and services must be accountable to the delivery of these services alongside homelessness services. As the national government reinforces its commitment to an NHS that works better for everyone, and a cross-departmental homelessness strategy, we must see more invested by local and national government to recognise and address homelessness as a health issue, and commit to the shared accountability needed to take seriously, and reduce, the stark and unacceptable health inequalities caused by homelessness.

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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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