2019 HOMELESSNESS JSNA

PUBLIC HEALTH, SWINDON BOROUGH COUNCIL

Executive summary

1. Introduction

- A JSNA helps us to understand:
    - What we know about the current health and wellbeing needs of local people
    - How their needs are currently being met
    - What we think their future needs are likely to be; and
    - How their needs can be best met in the future.

- We want to understand Swindon's changing population, what is going on in Swindon and what makes a difference to people's health and wellbeing so that we can plan for the future. The Swindon Health and Wellbeing Board oversees the development of JSNA's, and any resulting recommendations.

- This is the first homelessness JSNA, and one of the main aims is to inform the development of the Homelessness Strategy. Other aims of the JSNA are to:
    - provide an up-to-date overview of homelessness in the Swindon population
    - provide a baseline of what data is available to assess the need in Swindon, highlighting subgroups of interest, where there is unmet need, or a need for better data
    - assess support service provision for children and adults and identify gaps in provision
    - present information gained from engagement with homeless support service users and providers
    - identify effective interventions for homelessness from the literature
    - make recommendations for service provision to inform the commissioning process
    - facilitate effective working relationships between stakeholders
    - take an asset-based approach to homelessness, and make recommendations that are relevant to the needs of this group.

2. Homelessness – causes and impacts

- Homelessness means not having a home. A home is a place that provides security, and links to a community and support network. It needs to be decent and affordable. Under the law, even if someone has a roof over their head they can still be homeless. This is because they may not have the right to stay where they live or their home may be unsuitable to live in. People living in unsuitable accommodation, or sofa surfing are often referred to as the hidden homeless.

- Reasons people become homeless are complicated and involve societal structures (such as the economy, access to jobs and low cost housing), changing circumstances (such as relationship breakdown or leaving an institution), as well as personal factors (such as mental health issues, age, and substance dependency).

- Homelessness is associated with poor outcomes for the individual and for society.

3. National and local policy

- Homelessness has increased nationally, with a 28% increase in the numbers of homeless people nationally documented between 2011 and 2016.

- The government has a Rough Sleeping Strategy which sets out a vision to halve rough sleeping by 2022, and end it by 2027. Resources have been allocated for tackling homelessness

- New legislation, the Homeless Reduction Act (2017) means everyone is now entitled to support from local authorities if they are at risk of, or experiencing, homelessness. It also means other public services must refer people at risk of homelessness to local authorities under the Duty to Refer.

- In Swindon, a Rough Sleeping Strategy has been released this year, and work is ongoing to bring together the organisations that support homeless individuals. This includes a Rough Sleeper Panel, and Homeless and Healthcare network. Funding has been put into multiple interventions to relieve homelessness, especially rough sleeping.

4. Population - who is affected?

a. Numbers of people affected

- It is challenging to accurately estimate numbers of people who are at risk of, or experiencing, homelessness. Much of homelessness is “hidden”, rather than rough sleeping.

- The rough sleeper counts in Swindon show numbers have risen from 2010 to 2017, and then reduced from 2017 to 2018. For identifying clear trends the numbers are small, and these changes are within the margin of error for such counts. National research shows that for every 2 people rough sleeping, there are an estimated 98 who are in shelters, temporary accommodation, bed and breakfasts or other precarious accommodation. So the rough sleeper counts likely represent the minority of people experiencing homelessness in Swindon.

- Statutory homelessness means those who have approached the council and been accepted into a duty due to being at risk of, or experiencing, homelessness. In the first 6 months since the Homeless Reduction Act (2017) came into force, 527 households were assessed, and 291 (55%) were accepted into a duty. Of these, 80 were threatened with homelessness, and 211 were homeless.

b. Population profile

- The most common reasons for statutory homelessness in Swindon are family and friends no longer willing or able to accommodate, non-violent relationship breakdown, loss of rental accommodation and violence.

- Most people approaching the council in 2018 were either in private rental accommodation or living with friends or family.

- 70% of households in temporary accommodation in 2018 in Swindon included children. The great majority were in private rental or local authority/housing association stock, minimising the number required to stay in B&B or hostel/refuge type accommodation.

c. Vulnerable groups and groups of interest

- The following groups are of particular focus in the JSNA, as the evidence shows they are more at risk of homelessness, or the complications of experiencing homelessness:
    - Single adults
    - Children and young people
    - Care leavers
    - People with mental health problems
    - People with experience of substance misuse
    - Victims of domestic abuse
    - People with offending histories
    - Asylum seekers and former asylum seekers
    - People with previous experience of homelessness
    - Sex workers
    - LGBT+ individuals
    - People with learning disabilities or difficulties
    - People from black and minority ethnic (BME) communities
    - Veterans of the Armed Forces

- Factors such as being a care leaver, experiencing domestic abuse and having previous experience of homelessness are recorded in statutory assessments. Some of these personal factors are not well-recorded in our current data systems, and some groups such as veterans of the armed forces are only present in very small numbers in Swindon's homeless population. Data collection is an area for development so we can understand more fully the local profile of homelessness, as well as making sure our services meet the needs of the local people.

- There is a lot of co-ordinated work between different services to support some of these groups, such as victims of domestic abuse, and care leavers. This is reflected in the finding that over 90% of Swindon's care leavers were in suitable accommodation in 2018/19. Other groups, including asylum seekers, and those with experience of the prison system, would benefit from closer partnership working and clear referral pathways between the council and relevant organisations.

d. Mental health and substance misuse

- The associations between mental health, substance misuse and homelessness are well recognised. There is strong evidence that both poor mental health and substance misuse are drivers of homelessness, as well as complications of being homeless, and a barrier to engaging with services.

i. Mental health

- National data shows that up to 80% of people with experience of homelessness report some form of mental health issue. In England, suicide was the second most common cause of death for homeless people in 2017, causing 13% of deaths.

- In Swindon, the Threshold health audit found that the proportions of homeless people in Swindon self-reporting depression, anxiety, post-traumatic stress, personality disorder, and schizophrenia were higher than general population levels, in all cases.

- In 2017 there were no deaths due to suicide recorded for homeless people in Swindon.

- Mental health service provision for people with experience of homelessness has been identified as an area of unmet need, and data from Great Western Hospital shows that poisoning and psychiatric conditions account for over 30% of attendances for homeless individuals at A&E.

- To address this unmet need, all housing officers who work with homeless people have been offered mental health first aid training and Connect 5, and work is ongoing to identify how best to provide specialist care in this area.

- This area needs to be a focus for all working with homeless people, as well as considering how we provide opportunities for people at risk of homelessness to engage in positive activities to promote good mental health.

ii. Substance misuse

- National literature shows substance misuse is common across the spectrum of homelessness, and the most common cause of death in homeless people in 2017.

- Compared to England figures, Swindon has a low number (2.4 per 100,000) of deaths due to substance misuse, and this has reduced in the last 7 years.

- In Swindon, 4.5% of households accepted into a homelessness duty with the council reported drug dependency, and 6.5% reported alcohol dependency, however national literature and a local health survey of homeless people shows that substance misuse is likely to be more common than this.

- Data from the substance misuse service shows that since 2014/15 the proportions of new adult clients with a housing problem has been rising, with a trend for more people to be categorised as having an “urgent” housing issue.

- The majority of adults with a housing problem are opiate users.

- Turning Point (the adult substance misuse service) has a dedicated housing worker, however this service only supports the minority of people with substance misuse and housing issues.

- Young people with substance misuse issues are seen and treated in much smaller numbers in Swindon. Very small numbers were identified as having housing

problems, more common were other social vulnerabilities that are recognised risk factors for homelessness later in life.

- Overall, substance misuse needs strong partnership working between substance misuse services and other support services, and this is a continued focus for those working in Swindon.

e. Offenders and prison releases

- The national evidence shows there are complex links between homelessness and offending. At crisis point, prison represents a way off the streets. Homelessness can also be associated with a number of illegal activities, including the risk of being recruited by county lines offenders. Effectively supporting and rehabilitating offenders improves individual outcomes, and has wider benefits for society.

- Statutory data shows that about 1 in 10 people in the South West who are accepted as being at risk of, or experiencing homelessness, have an offending history.

- Most prison releases to the Swindon area are from HMP Bullingdon and HMP Eastwood Park.

- Swindon data for May 2018 – April 2019 shows that only 45% individuals sentenced more than 10 times came out of prison to settled accommodation, compared to 83% of those sentenced up to 10 times. This paints a picture of a revolving door between prison and homelessness.

- Additional resources have recently been allocated to the community rehabilitation company to build on the support pathways for those being released from prison to the Swindon area. This is in line with the national Through the Gates strategy.

f. Complex needs

- When poor mental health, substance misuse and significant social issues such as homelessness or time in prison coincide, this is known as complex needs.

- The exact numbers of people who would fit the definition of complex needs in Swindon is not known.

- Those working frontline in homeless support services describe the challenges of engaging with people with complex needs. Intensive support is often needed, for prolonged periods.

g. Health Inequalities

- In England the average age of death for homeless men is 47 years, and for women is 43 years. This compares to 77 years for the general population.

- National research shows homeless people are more likely than the general population to die from conditions relating to alcohol, drugs, suicide, HIV and hepatitis, lung conditions, heart attacks and falls. It is difficult to maintain a healthy lifestyle whilst homeless, and mainstream health services can struggle to meet the needs of this population.

- The recent Threshold Health Survey found that 38% of homeless people in Swindon who responded to the survey reported physical conditions that were not adequately treated, and low proportions reported accessing preventative care including screening tests and vaccinations.

5. What services do people use?

a. NHS

- Nationally, the annual costs of unscheduled healthcare for homeless patients is eight times that of the housed population. This is contributed to by multiple disconnected points of crisis management, and the use of A&E as emergency accommodation.

- Data from the Great Western Hospital (GWH) shows that in 2018, 128 homeless people presented to A&E, meaning that proportionally homeless people are likely to be high users of acute services in Swindon.

- Most admissions of homeless people to the GWH were for less than 2 nights, and the destination of these individuals from hospital is generally unknown. Work is ongoing to build the referral pathways between the hospital and housing services.

- 35% of homeless people attending A&E in 2018 were registered at the Carfax Medical Centre, with 25% having no known GP. At the end of 2018/19 the Carfax Medical Centre had 65 individuals registered with them who self-identified as homeless. This means approximately 120 homeless people in Swindon are likely either registered at other practices or are unregistered.

- National data shows that homeless people are at increased risk of poor outcomes in the following areas:
    - Dental care
    - Health improvement (smoking cessation and screening)
    - Sexual health
    - End of life care
    - Infectious diseases
    - Wound care
    - Mental health

- Homeless health checks for physical and mental health are in development, and need to consider the issues raised above. Commissioners should consider a specialist homeless healthcare service, or ensuring mainstream services are adequately adapted. The sexual health outreach model of care is an example of good practice.

b. Other services and community assets

- Accommodation-based support and floating support is commissioned by Swindon Borough Council, including supported housing for a range of needs.

- Swindon Borough Council spends just under £1.4m per year on supported housing schemes for the single homeless. This is mainly Direct Access hostels, as well as move on accommodation.

- There is a gap in provision for emergency accommodation locally, with Booth House often only available for 3 nights, and Bed and Breakfasts representing a costly temporary option.

- The Council has worked with the Government's Rough Sleeping Initiative and its delivery partners to co-produce a range of funded interventions to meet the needs of rough sleepers in the area.

    - A dedicated rough sleeping project co-ordinator
    - Temporary Winter Housing Provision between November – March 2019
    - 3 Housing First assertive outreach workers
    - 14 units of supported Housing First accommodation.
    - Specialist mental health training for frontline staff
    - Additional floating support to prevent loss of tenancies in the private rented sector
    - Establish a Day Centre 'one stop shop' to co-ordinate and integrate services in one location

- Due to the success of those interventions the Council have been awarded a further £255,125 for 2019/20 to continue delivering these services for a full 12 months.

- There are a many other homeless support services in Swindon, both commissioned and purely voluntary. These provide accommodation-based support, food and provisions, outreach support, and support to engage with SBC and other services such as mental health and substance misuse. Work is ongoing to better co-ordinate the efforts of the different organisations.

c. Evidence of effectiveness and cost effectiveness

- Tackling homelessness and addressing its causes is a long-term project that needs to draw on partners and organisations from across the public sector. National reviews of the evidence conclude that no single intervention will prevent or relieve all cases of homelessness. The following are features of effective interventions:

    - Early intervention
    - Integrated working
    - Interventionist approaches, including assertive outreach
    - Recognising heterogeneity of homelessness housing and support needs in local homeless populations and individuals
    - Be housing-led – offering swift access to settled housing including the use of Housing First

- A single person sleeping rough for 12 months in the UK costs approximately £20,128. It is not always less costly to prevent homelessness, however Crisis (2016) conclude that prevention of homelessness would have been cost-saving in 65% of cases, compared to a year of homelessness. Savings are largely from reductions in use of NHS, drug and alcohol, mental health and the criminal justice system. This makes the case for adequate funding of preventative and enhanced evidence-based interventions, such as Housing First.

6. What does the future look like?

- There is a level of uncertainty around the future of house prices and the wider economy. However, more certain is that population growth will continue and the shortfall in affordable accommodation is predicted to worsen.

- Research shows that, nationally, homelessness is predicted to rise, with particular increases seen in rough sleeping and those in unsuitable temporary accommodation.

- Homelessness is affected by factors outside local control, however evidence shows local homelessness prevention schemes have a strong positive potential to reduce levels.

- Legislative changes such as the Homelessness Reduction Act (2017) have significant impacts on homelessness services inside and outside local authorities. The government is currently reviewing other legislation such as the Vagrancy Act (1824), and has announced plans to end Section 21 “no fault” evictions from private rental properties. These changes have the potential to further impact on the profile of homelessness locally.

7. What do local people think?

a. Ways of involving people

This JSNA was informed by engagement work undertaken by Swindon CCG and Threshold around understanding the health needs of homeless people in Swindon. We also interviewed 20 people with experience of homelessness (including rough sleeping, living in supported accommodation and Housing First) to better understand the issues facing homeless people in Swindon.

b. Key issues raised

- Homelessness is not a single story, and there are many reasons behind it. Anyone can be at risk of homelessness if their personal or social circumstances deteriorate. Descriptions of time in prison, poor mental and physical health, and substance misuse were common, but not universal.

- Most people approach the council for support at crisis point. Barriers to approaching the council earlier included the stigma attached to homelessness, and a lack of awareness of council services.

- Journeys through homelessness are complex, often involving cycling between rough sleeping and temporary or emergency accommodation.

- Rough sleeping is difficult and dangerous for a person’s mental and physical health. A few choose to rough sleep, but most do not.

- Positive experiences that helped resolve homelessness included support workers, addressing mental health and/or substance misuse issues, and social support networks.

- Long term goals for homeless people centred on wanting stability in accommodation, employment, relationships and their physical health.

8. Conclusions

- Homelessness is complex, multi-faceted and associated with poor outcomes for individuals and society.

- We cannot be certain of the numbers affected in Swindon, but it is likely that rough sleeping, along with the hidden homeless increased from 2010 to 2017 consistent with the national picture. A reduction in counts of people rough sleeping has occurred from 2017 to 2018, although this is within the margins of error for such counts.

- Factors are identified that drive homelessness, as well as resulting from being homeless. This includes substance misuse, poor mental or physical health, and time in prison.

- There are many positive interventions, and examples of partnership work around homelessness in Swindon, some of which could be expanded or replicated to support different vulnerable groups. The recommendations aim to build on our strengths, and highlight any gaps. The full list of recommendations are given at the end of this document, the overarching recommendations are shown below:

    - To build the local strategic approach to homelessness, informed by the findings of this JSNA, and to continue developing the Swindon Homelessness Strategy.

    - To ensure an ongoing upstream approach to homelessness, with a focus on prevention.

    - To ensure that assistance for those finding themselves homeless or at risk of homelessness is quick, practical and tailored to individual needs.

    - To recognise that reducing homelessness requires inter-organisation collaboration and a shared commitment, particularly for vulnerable groups such as victims of domestic abuse, care leavers, refugees and asylum seekers and sex workers.

    - Homelessness can be linked with mental health and substance misuse issues. To support people with complex needs we should continue to build links between these services to enable effective referrals and interventions.

    - To ensure that local data is available to understand the local homelessness profile, and future demand. Providers of support services should use this data to gain a better understanding of the needs of the wide variety of groups experiencing homelessness, the impact of the Homelessness Reduction Act (2017) and the Duty to Refer.

- Other themes for successful interventions include co-ordination and collaboration between services, outreach, and intensive support that considers the multiple needs of an individual or family.

Abbreviations

APMS	Adult Psychiatric Morbidity Survey
ASEP	Adult Sexual Exploitation Partnership
CASSR	Council with Adult Social Services Responsibility
CMHT	Community mental health team
CCG	Clinical Commissioning Group
DWP	Department of Work and Pensions
GP	General Practitioner
GWH	Great Western Hospital
JSNA	Joint Strategic Needs Assessment
ILR	Indefinite Leave to Remain
LGBT+	Lesbian, Gay, Bisexual, Transgender/Transsexual Plus
LSOA	Lower Super Output Area
MECC	Making Every Contact Count
MHCLG	Ministry of Housing, Communities and Local Government
NDTMS	National Drug and Treatment Monitoring Service
NFA	No Fixed Abode
NHS	National Health Service
ONS	Office of National Statistics
PHE	Public Health England
PHOF	Public Health Outcomes Framework
SBC	Swindon Borough Council
SWEP	Severe Weather Emergency Protocol
UASC	Unaccompanied Asylum Seeking Child

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Chapter 1 Introduction

1.1 Joint Strategic Needs Assessment: considerations for homelessness

Health needs assessment is a systematic method of identifying unmet health needs of a population, with the goal of informing the planning and commissioning of health, well-being and social care services within the local authority area. The overall goals of health needs assessments are to improve health and reduce health inequalities.

A Joint Strategic Needs Assessment (JSNA) is a type of health needs assessment that is commonly co-produced by a number of partners with a focus on longer-term strategic issues. Each Health and Wellbeing Board has a statutory obligation to produce an annual JSNA which must describe the current and future health, wellbeing and social care needs of the local population. In Swindon, an overall JSNA Summary is produced each year, alongside of which a programme of thematic 'deep-dive' JSNAs on specific topics or population groups is carried out, of which the present report is part.

The Homeless Code of Guidance for Local Authorities makes clear the need for collaboration between housing and other partners within, and external to, the local authority (MHCLG, 2018). Section 1(1) of the 2002 Homelessness Act gives housing authorities the power to carry out a homelessness review for their district and formulate and publish a homelessness strategy based on the results of the review. Each local authority also has a legal duty under the Health & Social Care Act 2012 to take such steps as it considers appropriate for improving the health of the people in its area. This includes people experiencing homelessness or at risk of homelessness.

The main aim of this JSNA is to form the basis for the Homelessness Strategy which will be written later this year. As the first homelessness JSNA for Swindon, it also has the following objectives:

- To provide an up-to-date epidemiological overview of homelessness in the Swindon population
- To provide a baseline of what data is available to assess the need in Swindon, highlighting subgroups of interest, where there is unmet need, or a need for better data.
- To assess support service provision for children and adults and identify gaps in provision
- To present information gained from engagement with homeless support service users and providers
- To identify effective interventions for homelessness from the literature
- To make recommendations for service provision to inform the commissioning process
- To facilitate effective working relationships between stakeholders
- To take an asset-based approach to homelessness, and make recommendations that are relevant to the needs of this group

1.2 Definitions in homelessness

The following definitions are referred to in this JSNA (Shelter, 2006, Homeless Link, 2019):

Homelessness means not having a home. A home is a place that provides security, and links to a community and support network. It needs to be decent and affordable. Under the law, even if someone has a roof over their head they can still be homeless. This is because they may not have the right to stay where they live or their home may be unsuitable to live in.

Rough sleeping is defined by the Government as 'people sleeping, or bedded down, in the open air (such as on the streets, or in doorways, parks or bus shelters); people in buildings or other places not designed for habitation (such as barns, sheds, car parks, cars, derelict boats, stations, or 'bashes').

Street homelessness is a much wider term than rough sleeping, taking into account the street lifestyles of some people who may not actually sleep on the streets. Street homeless people are those who routinely find themselves on the streets during the day with nowhere to go at night. Some will end up sleeping outside, or in a derelict or other building not designed for human habitation, perhaps for long periods. Others will sleep at a friend's for a very short time, or stay in a hostel, night-shelter or squat, or spend nights in prison or hospital.

Hidden homelessness means people who become homeless but are not identified in official figures. This includes people who become homeless but find a temporary solution by staying with family members or friends, living in squats or other insecure accommodation.

Priority need is a term used historically to assess for vulnerability by councils in considering homelessness applications. "When homeless, is significantly less able to fend for themselves than an ordinary person if made homeless, so that injury or detriment to them will result, when a less vulnerable ordinary person would be able to cope without harmful effect."

1.3 Structure of the 2019 Homelessness JSNA

The JSNA will review the background to homelessness including the national trends, and the policy context. The place-based and population-based contributors will be considered for Swindon. Homelessness in Swindon will then be explored as a general issue. This will be followed by subgroups of the population known to be at increased risk of homelessness. Service user views and the lived experience of homelessness in Swindon will then be discussed, followed by a review of the evidence of best practice and models of homelessness support and prevention in other areas. Finally, projections and forecasts will be considered before conclusions and recommendations are made.

Chapter 2 Background

2.1 Homelessness

Homelessness is a pressing issue nationally. It is multi-faceted, and associated with profound negative outcomes for affected individuals, as well as being costly to society. The latest rough sleeper counts found that more than 4,500 people in England are sleeping rough (MHCLG, 2018). The scale of the issue is far larger than this, however, once we consider those in temporary accommodation, and the hidden homeless. Table 1 is from Bramley's (2017) report for Crisis, and models the changes seen across the spectrum of homelessness in England.

Core homelessness in England	2011	2016	% change
Rough Sleepers	5,000	8,000	37.5%
Car, tent, pub, transport	5,000	8,000	37.5%
Squatting (in unlicensed, non-residential buildings)	6,800	11,000	38.2%
Hostels, refuges, and night/winter shelters	44,200	39,000	-13.3%
Unsuitable Temporary Accommodation	7,000	17,000	58.8%
Sofa Surfers	35,000	60,000	41.7%
Total (medium)	**103,000**	**143,000**	**28.0%**
Total (med) as % of household	0.45%	0.62%	27.4%
Total (Low)	74,300	81,000	8.3%
Total (High)	125,400	176,000	28.8%

Table 1. Core homelessness in England from 2011-2016.

Data Source: Bramley, 2017.

Homelessness is a complex economic, social and biomedical entity. Reasons people become homeless involve societal structures (such as the economy, access to jobs and low cost housing), changing circumstances (such as relationship breakdown or leaving an institution), as well as personal factors (such as mental health issues, age, and substance dependency). Recent literature acknowledges that structural factors create the conditions within which homelessness occurs, and people with certain personal factors are more vulnerable to these adverse social and economic trends (MHCLG, 2019a). The strongest structural drivers are identified as poverty, availability and affordability of housing, and the range of prevention measures employed (Bramley, 2017).

Hood and Waters (2017) report that national changes to the tax and benefit system including freezing benefit rates, cuts to child tax credit and the continued roll-out of the universal credit changes have significant potential to reduce the income of low-income working age households, particularly those with children. A recent LGiU (2019) homelessness commission report states further that housing benefits have not kept pace with local market rates, and is also critical of central governments' approach to meeting housing demand. In almost all areas of Great Britain, only a 20% of private rental accommodation is affordable within Local Housing Allowance rates (Basran, 2019). The universal credit system has been reported to exacerbate the problems, with late payments and reduced amounts making it difficult to find stable, long term accommodation, particularly for those seeking private rentals (LGiU, 2019).

Crisis' Homeless Monitor 2017 states: "the causation of homelessness is complex, with no single 'trigger' that is either 'necessary' or 'sufficient' for it to occur". In summary, combinations of modifiable and fixed risk factors interconnect in various and unpredictable ways, and lead to a heightened risk of homelessness for an individual or family. This makes prevention of homelessness crucial, yet challenging, and means that it is not always possible to prevent homelessness.

2.2 Impacts of homelessness

Homelessness is associated with poor outcomes for the individual and for society:

- The average age of death for homeless men (dying on the streets or in homeless accommodation), is 47 years, and for women 43 years of age. This compared to 77 years for the general population, 74 years for men and 80 years for women (Crisis, 2012).
- Just over one third of deaths in homeless people were attributable to drugs and alcohol. This means homeless people have seven to nine times the chance of dying from alcohol-related diseases, and 20 times the chance of dying from drugs (Crisis, 2012).
- The risk of death is also elevated for cardiovascular disease, chronic lung disease, HIV and hepatitis (Crisis, 2012)
- Homeless people are also more likely to have mental health issues, experience substance misuse, and are unlikely to be in employment (Homeless Link, 2019).

These risks are significant for the individuals concerned, and resource-intensive for the health and social care systems as well as the wider economy.

Rough sleeping as a sub-category of homelessness has the most extreme negative impacts for individuals, the community, and the economy. Community concerns relating to rough sleeping include fear of crime, anti-social behaviour and begging. However, the risk of poor outcomes for individuals and families extends across the spectrum of homelessness, and applies to a range of issues, from poor mental health, to tuberculosis infection or substance misuse.

Homelessness also has implications for wider communities. It can be associated with some kinds of anti-social behaviour, including begging and street drinking. The Vagrancy Act (1824) allows prosecution of those with a street life style. Numbers of offences in the UK are shown in Figure 1 below. This Act is contentious, and currently being reviewed, as criminalising homelessness is not desirable, whilst the wider community must be protected.

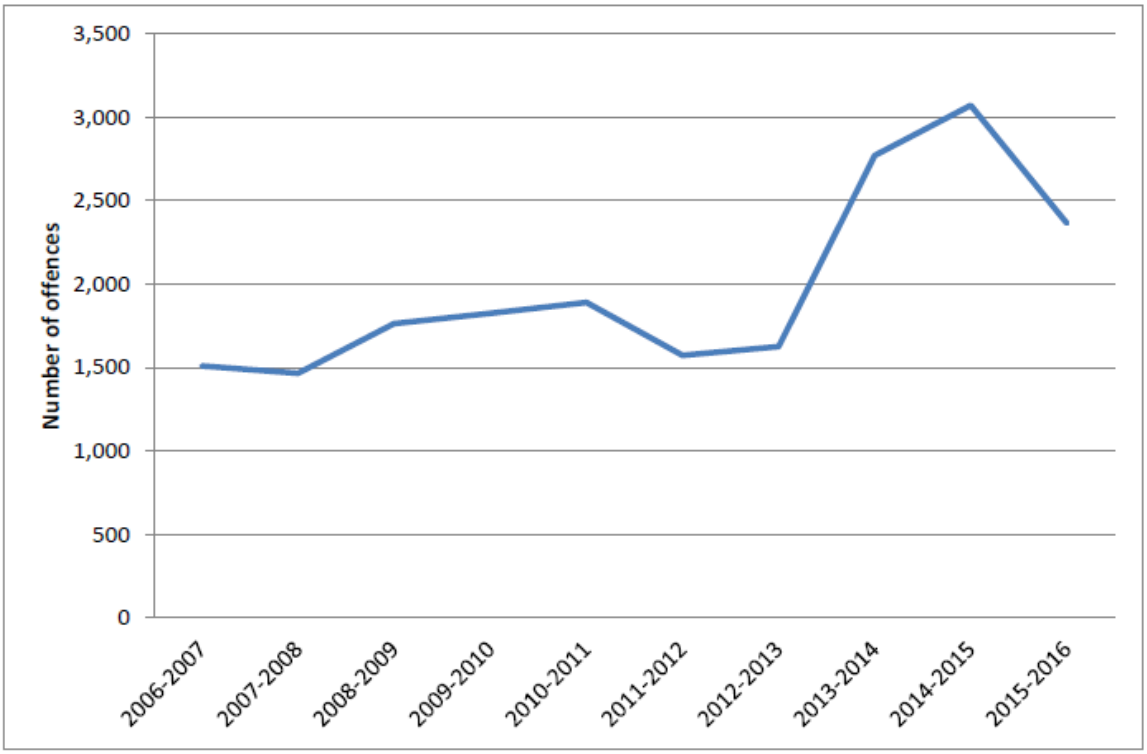


Figure 1. Number of offences under the Vagrancy Act 1824, section 3, which reached a hearing in the UK from 2006/7 – 2015/16.

Source: Crown Prosecution Service, Freedom of Information Release, 6.7.2016.

2.3 Homelessness Policy Context

The government has an ongoing Rough Sleeping Strategy (MHCLG, 2018c) which sets out a vision to halve rough sleeping by 2022, and end it by 2027. This is supported by a commitment of £100 million for 2018-2020. The strategy recognises that there is a shortage of secure, affordable housing, including social housing, and commits to addressing this shortage. Alongside this, the response to rough sleeping is three-pronged, and described as prevention, intervention and recovery. It is emphasised that central and local government are key, but that many parts of society need to come together to support rough sleepers, or those at risk of rough sleeping.

In April 2018 the Homelessness Reduction Act 2017 came into force. The major changes brought in by the Act are:

- change to the definition of a person who is threatened with homelessness – now 'threatened' if it is likely that they will become homeless within 56 days (was 28 days)
- if an applicant was found to be threatened with homelessness and therefore eligible for assistance, the local authority must take 'reasonable steps' to help them avoid becoming homeless – the prevention duty would continue for 56 days or earlier/ longer in some circumstances
- local authorities will now be required to provide free information and advice on preventing homelessness, securing accommodation if homeless, the rights of people who are homeless or threatened with homelessness and any help that is available for those who are homeless or likely to become homeless, including how to access it
- local authorities will need to ensure that services are designed to meet the needs of those at increased risk of becoming homeless such as care leavers, those leaving prison, those leaving the armed forces, victims of domestic abuse, those leaving hospital and those with mental health problems
- where an eligible applicant is homeless or at risk of becoming homeless, local authorities will have a duty to carry out an assessment and agree the actions to be taken through the development of a personalised plan of action. This must be done irrespective of their priority need status
- local authorities must take 'reasonable steps' to help all eligible applicants secure accommodation for at least 6 months – the relief duty would continue for 56 days or earlier in certain circumstances
- there is a requirement on all applicants to cooperate with local authority attempts to comply with their duties. Local authorities can serve notice on an applicant that it considers has 'deliberately and unreasonably refused' to cooperate
- A new 'duty to refer' - public services will need to notify a local authority if they come into contact with someone they think may be homeless or at risk of becoming homeless.

It is recognised nationally that housing affordability and availability are under pressure, and increasing proportions of households live in rented accommodation. The government is taking action to improve security for those in rental accommodation, including ending Section 21 evictions – so called "no fault" evictions. These are identified as a cause of family

homelessness, and the objective is to create a market where open-ended tenancies are the norm (MHCLG, 2019c).

Whilst it is well-documented that homelessness is rising, during the last decade there have been reductions in funding available to local authorities to tackle the issue. Figure 2 below shows the changes in expenditure during the last 10 years particularly affect the single homeless (WPI Economics 2019). Concerns have also been raised by some local authorities that the new legislation could potentially divert further funding from prevention to crisis management activities, as there are increased numbers who are owed a duty (WPI Economics, 2019).

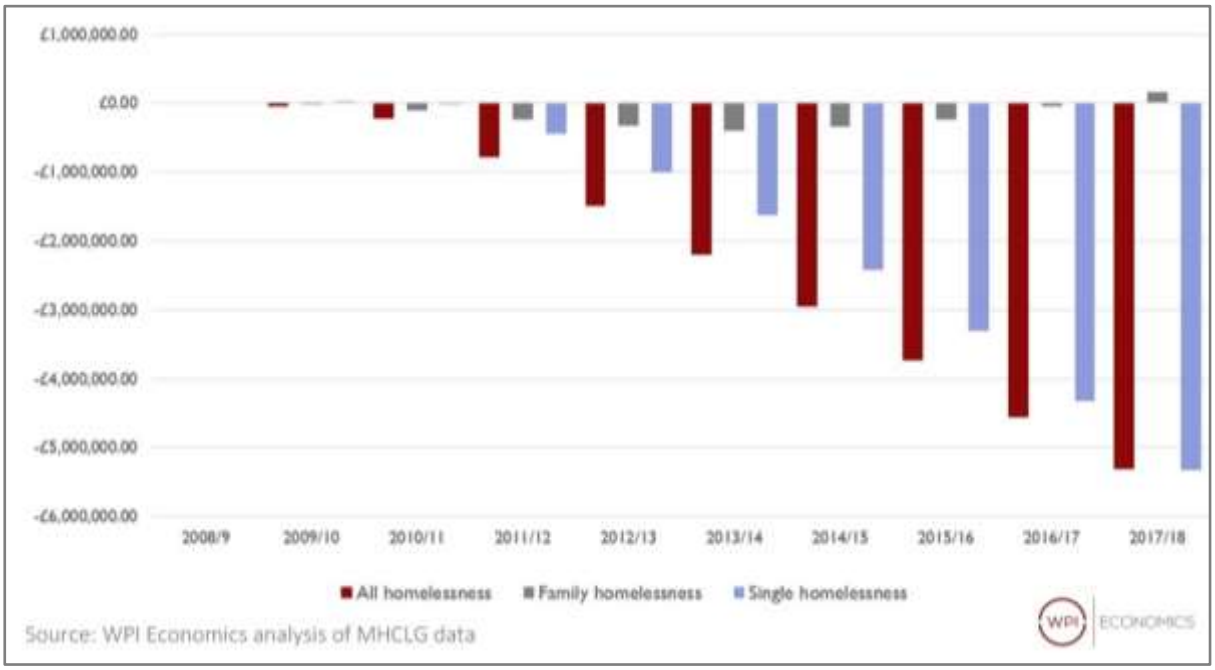


Figure 2. Cumulative change in expenditure on homelessness since 2008/9 (2017/2018 prices).

Data source: WPI Economics 2019, using MHCLG data.

This includes advice and support to households who are, or are at risk of homelessness, providing temporary accommodation, and measures to help people stay in their homes, whether housing-related support or discretionary housing payments.

The authors of the WPI Economics report interviewed local authority staff and service providers from across England. The themes that arose were of reductions to low and medium-level support services, so that support is increasingly only available when someone reaches crisis point. There are the additional costs for service providers when more complex cases arise. Specific figures for the South West of England show that there has been a 73% reduction in spending on single homeless people, a 10% reduction in spending on homeless families, and an overall 57% reduction in spending on homelessness activities in the last decade (WPI Economics 2019). The financial commitment accompanying the Rough Sleeping Strategy (MHCLG, 2018c) is needed to address this.

Discussions between the authors of the WPI Economics report and local authorities identified other factors driving the level of need. These include:

- Lack of availability of social housing: resulting in a need to seek accommodation in the private rental sector

- Welfare reform: Local Housing Allowance has been frozen since 2016 as rents have risen. Delays in Universal Credit were also regularly mentioned.
- Reduced availability of non-crisis mental health and substance misuse treatment
- The use of short custodial sentences

Clearly homeless is complex, and cannot be ignored as an issue. There is national and local recognition of the importance of addressing homelessness, and understanding the local drivers and profiles of those at risk.

2.4 Swindon: Population, Housing and Economic determinants

Swindon's population

For an in-depth population profile please refer to the Swindon Joint Strategic Needs Assessment (JSNA, 2018/19).

- The 2018 mid-year ONS estimate for Swindon residents is 221,996.
- At the time of the 2011 census the average (mean) age of residents was 38.1 years, and 90.7% of residents identified as English/Welsh/Scottish/Northern Irish/British. (NOMIS, 2019).
- The 2016 mid-year projections for the Swindon Borough Council (SBC) area are that Swindon's resident population will increase by 11% between 2018 and 2028, and a further 7% by 2038. The largest increases in population will be in the 65 plus age group (JSNA, 2018/19).
- There are 132 Lower Layer Super Output Areas (LSOAs) in the Swindon Unitary Authority (UA) area. According to the Index of Multiple Deprivation (IMD), 19 of the 132 (14%) LSOAs in the Swindon UA area are in the most deprived 20% nationally. In the most deprived areas of Swindon, men live on average 14 years less in good health and women 12 years less than those in the least deprived areas.
- According to the End Poverty Coalition, 13.5% of children in Swindon are considered in poverty before housing costs are considered, or 22.2% if these are included (JSNA 2018/19).

Table 2 below summaries some of indicators for Swindon that describe the inequalities and social determinants of health, some of the most relevant areas to homelessness are explored in more detail below.

Category of determinant	Indicator	Swindon figure *(England figure if applicable)*	Year
Deprivation & inequality	IMD rank *(Range: 1-152, 1=most deprived)*	113	2015
	Proportion of lower-layer super output areas (LSOAs)[1] in most deprived decile nationally	6.1%	2015
	Rank of proportion of LSOAs in most deprived decile nationally *(Range: 1-152, 1=most deprived)*	86	2015

	Proportion of the population living in the most deprived 30% of LSOAs nationally (weighted by deprivation percentile)	14.6%	2015
	Rank of proportion of the population living in the most deprived 30% of LSOAs nationally *(Range: 1-152, 1=most deprived)*	90	2015
	Life expectancy gap (males) between most and least deprived LSOA deciles	5.9 years *(9.4 years)*	2015-17
	Life expectancy gap (females) between most and least deprived LSOA deciles	5.3 years *(7.4 years)*	2015-17
Financial insecurity	Number of people who are income-deprived[2]	26,335	2015
	Rank on number of people who are income deprived *(Range: 1-152, 1=most deprived)*	120	2015
Education & lifelong learning	Rank on education, skills and training deprivation *(Range: 1-152, 1=most deprived)*	53	2015
	Proportion of the population aged 16-64 with no qualifications	5.6% *(7.7%)*	2017
Employment	Number of people who are employment-deprived[3]	12,683	2015
	Rank on number of people who are employment-deprived *(Range: 1-152, 1=most deprived)*	122	2015
	Long-term unemployment rate per 1,000 working age population	2.1 *(3.5)*	2017
	Proportion of the population claiming out-of-work benefits as of Oct. 2018	2.3% *(2.3%)*	2018

	Gap in employment rate for those in contact with secondary mental health services and the overall employment rate	64.4 percentage points *(67.4%)*	2016/17
Crime, safety & violence	Rank on crime *(Range: 1-152, 1=most deprived)*	82	2015
	Rate of violent offences per 1,000 population in Swindon	24.5 *(23.7)*	2017/18

Table 2. Wider determinants of health and inequality in Swindon.

[1]Small areas containing on average 1,500 residents

[2]Income-deprived is defined as being on a low income and in receipt of benefits and tax credits.

[3]Employment-deprived is defined as being involuntarily excluded from the labour market due to unemployment, sickness or disability or caring responsibilities.

Sources: English Indices of Deprivation 2015, Public Health England, Official Labour Market Statistics

Being in a relationship is associated with a lower risk of homelessness (Bramley and Fitzpatrick, 2018). At the 2011 census, 48.9% of adults (>16 years) in Swindon were married or in a civil partnership. 61.4% of adults (>16 years) were recorded as living in a couple (co-habiting, married or in a civil partnership), meaning 64,273 (38.6%) were not living in a couple (NOMIS, 2019).

Employment and unemployment (Jan 2018-Dec 2018)				
	Swindon (numbers)	**Swindon (%)**	**South West (%)**	**Great Britain (%)**
All people				
Economically active†	117,400	82.5	81.3	78.5
In employment†	112,600	79.2	78.7	75.1
Employees†	100,600	71.0	66.1	64.3
Self-employed†	11,800	8.0	12.3	10.6
Unemployed (model-based)§	4,500	3.8	3.1	4.2
Males				
Economically active†	62,800	86.7	84.8	83.3
In employment†	61,100	84.3	82.2	79.7
Employees†	53,000	73.4	66.1	65.3
Self-employed†	8,000	10.9	16.0	14.1
Unemployed§	1,800	2.8	2.9	4.2
Females				
Economically active†	54,500	78.3	77.8	73.7
In employment†	51,500	73.8	75.2	70.6
Employees†	47,600	68.6	66.2	63.2
Self-employed†	3,800	5.0	8.7	7.1
Unemployed§	3,000	5.5	3.3	4.1
Source: ONS annual population survey † - numbers are for those aged 16 and over, % are for those aged 16-64 § - numbers and % are for those aged 16 and over. % is a proportion of economically active				

Table 3. Employment and unemployment in Swindon.

Data Source: NOMIS. 2019.

Whilst Table 4 shows that the proportions of unemployed in Swindon are below national figures for all people, and for men, they are above national and regional figures for women. A more in-depth analysis of patterns of employment for Swindon shows that proportionally in Swindon more people are employed in social group 8-9 occupations than in group 1-3 occupations, compared to regional and national figures. This means fewer professional occupations, and more processing plant and machine operatives (see Table 5). This is relevant with changes to the manufacturing industry, where, for instance, Honda plan to close their factory with predicted job losses numbering more than 3,000. SBC are currently working on reducing the impacts from this on Swindon residents.

Employment by occupation (Jan 2018-Dec 2018)				
	Swindon (numbers)	**Swindon (%)**	**South West (%)**	**Great Britain (%)**
Soc 2010 major group 1-3	45,900	41.1	45.2	46.4
Soc 2010 major group 4-5	24,200	21.7	21.1	20.2
Soc 2010 major group 6-7	16,500	14.8	16.4	16.5
Soc 2010 major group 8-9	25,100	22.4	17.2	16.8
8 Process plant & machine operatives	12,500	11.1	6.2	6.3

Table 4. Numbers and proportions of individuals in Swindon, South West and England in different occupational groups.

Source: NOMIS 2019. ONS annual population survey Numbers and % are for those of 16+, % is a proportion of all persons in employment

Housing in Swindon

In the year ending September 2018, there was wide variation in the median house price sales for LSOAs within Swindon, ranging from £142,000 to £400,500 (ONS, 2018). Figure 3 shows the trend in property prices to earnings ratios in Swindon over the last two decades. Swindon has experienced the same trends as England, with owning a house becoming progressively less affordable, and property ownership associated with more borrowing. Houses in Swindon now cost on average around 7 times the average full time salary, this is comparable to the average for England and Wales of 7.8 times the average full time salary.

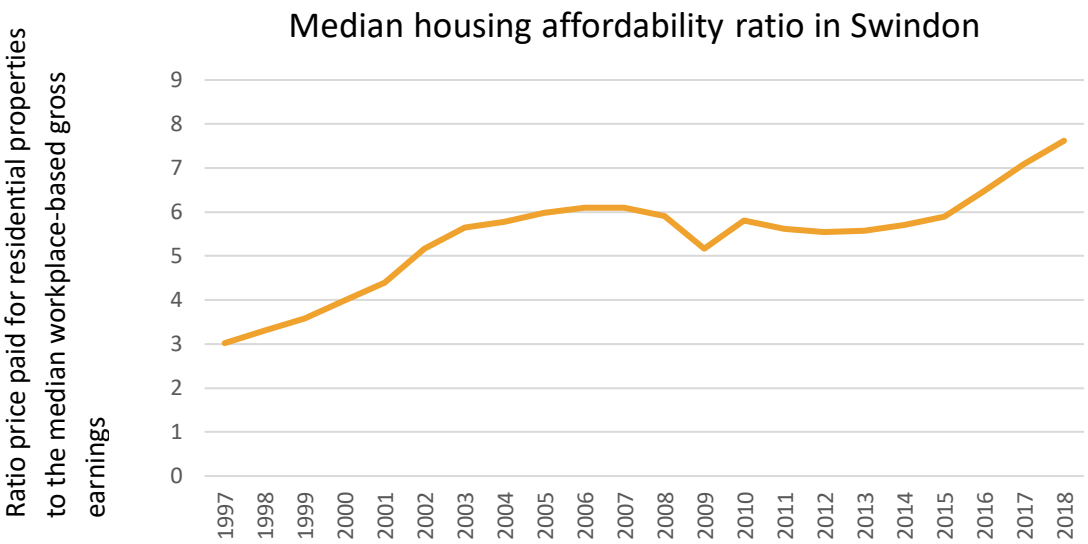


Figure 3. Median housing affordability ratio in Swindon.

Median housing affordability ratio refers to the ratio of median price paid for residential property to the median workplace-based gross annual earnings for full-time workers.

Data source: ONS, 2018.

Using population estimates, it is projected that from 2012-37, Swindon will grow by 1,190 households per annum (ORS, 2017). Considering migration trends, it is predicted that Swindon will grow by 1,334 households per annum, (1,377 dwellings per annum) (ORS, 2017). Rising house prices and incomes are associated with the number of acceptances for priority needs, looking at local authority data from 1993-2008. A 1% increase in house price was associated with a 0.18% increase in the proportion of households that are homeless, and household incomes as well as personal factors such as age and gender also feed into risk of homelessness (MHCLG, 2019b).

Figure 4 shows trends for property repossessions in England and Wales. Nationally, whilst fewer mortgaged homes are being repossessed, higher numbers of rental properties continue to be repossessed following court orders. In Swindon, in the first quarter of 2016, 89 properties were returned by court order to social and private landlords, compared to 16 properties to mortgage lenders, consistent with the picture for England and Wales (MOJ, 2018).

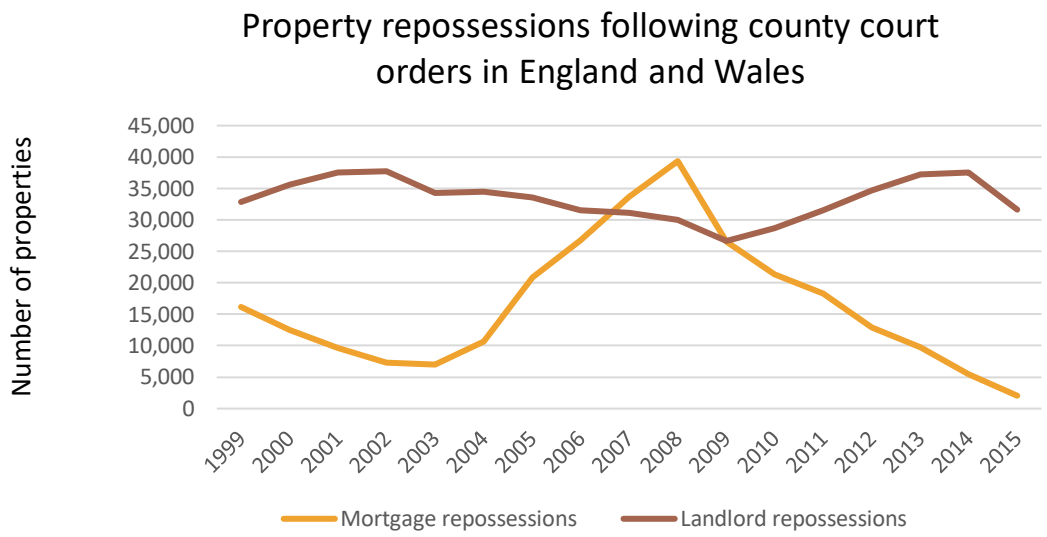
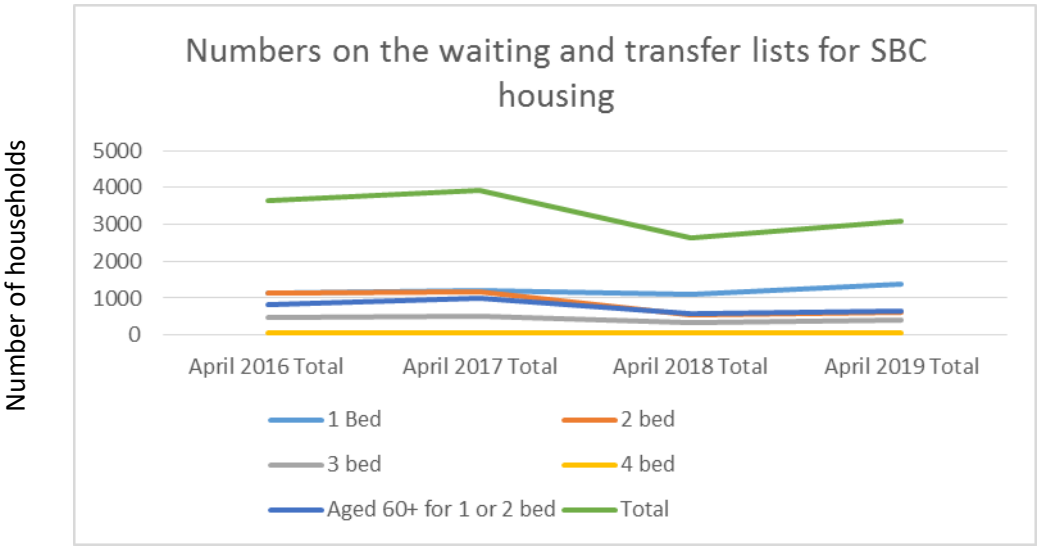


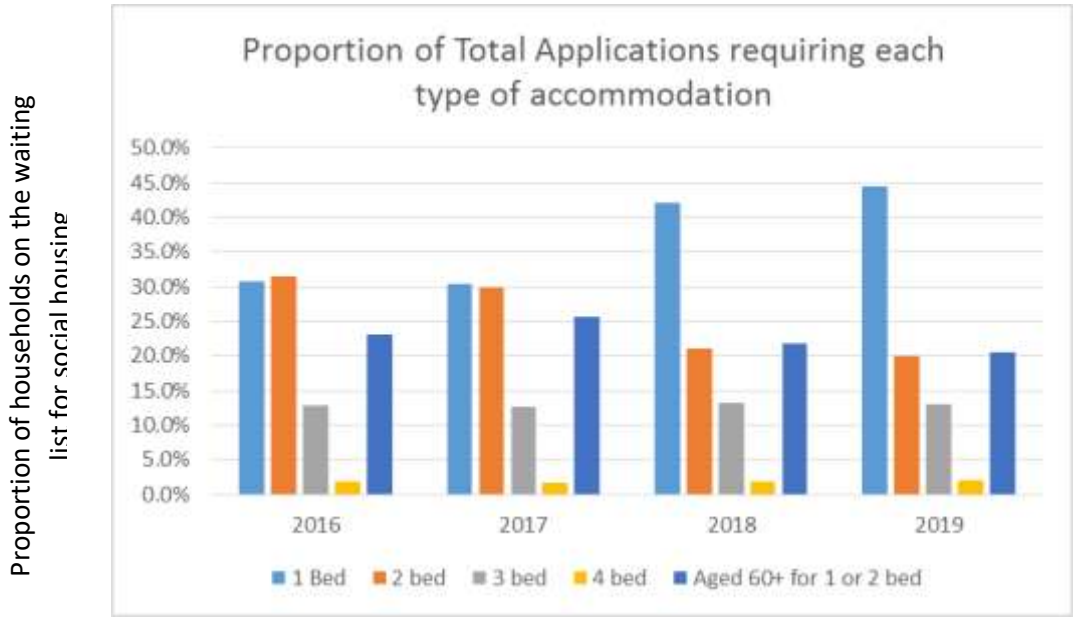
Figure 4. Property repossessions following county court orders in England and Wales.

Data source: MoJ 2018.

Social Housing Demand in Swindon

Homebid statistics for those waiting for, and needing transfer within, social housing in Swindon are shown below in Figures 5-6. The total numbers of households on the waiting list, and on the transfer list have fallen between 2016 and 2019. However, in the last 4 years need for single bed accommodation has risen, both in absolute numbers and proportionally. Whilst the numbers on the waiting list for single room accommodation have fluctuated, proportionally this has increased from 30.8% to 50.3% of the waiting list. This represents a need amongst single people and couples.





Figures 5 and 6. Total numbers and proportions of applications for social housing accepted onto the Homebid system in SBC.

Data is taken from the final quarter of each financial year. Numbers of applications is for households. Data source: SBC Housing.

Table 5 below shows the trends in those households on the waiting list for social housing. Applicants are assigned to Band A or B, with Band A applicants having the highest level of housing need.

Main findings are:

- In 2019 2.8% of households on the waiting list were in Band A, compared to 9.5% of applicants in 2016.
- There has also been a reduction in absolute numbers of Band A households as people have been successfully housed.
- Many of the Band B applicants are already housed by SBC, but awaiting another property with a different number of rooms for instance.

Data time point	Parameter	1 Bed	2 bed	3-4 bed	Aged 60+ for 1 or 2 bed	**Total in Band**
April 2019	Band A	37	7	7	15	**66**
	Band B	1227	428	228	390	**2,263**
	Total	**1264**	**435**	**225**	**405**	**2329**
	% of Total applications	**54.3%**	**18.7%**	**9.6%**	**17.4%**	**100.0%**
April 2018	Band A	34	13	5	9	**61**
	Band B	965	404	206	353	**1,928**
	Total	**999**	**417**	**211**	**362**	**1,989**
	% of Total applications	**50.2%**	**21.0%**	**10.7**	**18.2%**	**100.0%**
April 2017	Band A	33	10	14	10	**67**
	Band B	1,001	939	320	670	**2,930**
	Total	**1034**	**949**	**334**	**680**	**2997**
	% of Total applications	**34.5%**	**31.7%**	**11.1%**	**22.7%**	**100.0%**
April 2016	Band A	149	37	33	127	**346**
	Band B	975	1110	503	713	**3301**
	Total	**1124**	**1147**	**536**	**840**	**3647**
	% of Total applications	**30.8%**	**31.5%**	**14.7%**	**23.0%**	**100.0%**

Table 5. Applicants on the waiting list for social housing in Swindon.

Data taken from the final quarter of each financial year. Data Source: Homebid system, SBC.

Social Housing Provision in Swindon

	Waiting List	**Social Housing Provision**	**Bedsit**	**1 bed**	**2 bed**	**3 bed**	**4 bed**	**Total**
2017/18	2997	SBC	16	265	124	78	7	490
		HA	7	141	128	53	17	346
		Total	**23**	**406**	**252**	**131**	**24**	**836**
2018/19	1989	SBC	32	361	280	166	19	858
		HA	4	172	99	48	19	342
		Total	**36**	**533**	**379**	**214**	**38**	**1200**

Table 6. Social Housing provision by SBC (Swindon Borough Council) or HA (Housing Association) in the financial years ending 2017/18 and 2018/19.

Waiting list figures are the numbers of households on the waiting list at the start of those financial years and will not include new applications received during that year. Data source: Homebid system, SBC.

Table 6 above shows that:

- There was a 43.5% increase in the number of properties allocated between 2017/18 and 2018/19, with all of the increase from SBC properties.
- The properties allocated in 2017/18 represent 27.9% of the waiting list at the start of the year (disregarding new applications that year), whilst in 2018/19 properties were allocated that represented 60.3% of the initial waiting list.
- 70% of the increase in properties allocated is accounted for by one and two bed properties.

It is challenging to interpret these figures with only two years of data and change in legislation during the last few years including the Homelessness Reduction Act 2017 and the Under Occupancy Charge, all of which could affect demand for different properties. These figures will need to be monitored over the coming years to identify trends in demand and provision.

Benefits and Housing payments

The numbers of housing benefits claimants in Swindon and Great Britain are shown in Figure 7. Broadly, the trend in Swindon has mirrored the national trend, with a downturn in the number of claimants since 2010-2013. It is difficult to know if this reflects need, demand, or restrictions on benefits. In May 2018, of the 9,242 housing benefit claimants in Swindon, 7,242 (78.4%) were in the social rental sector, and 2,003 (21.7%) in the private rental sector.

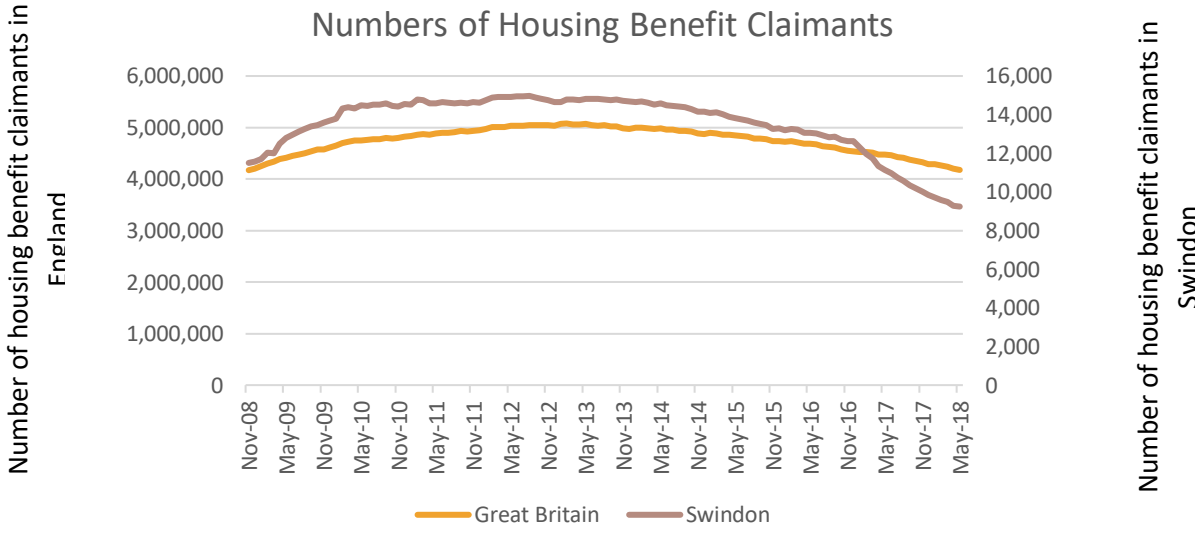


Figure 7. Numbers of housing benefit claimants in Great Britain and Swindon.

Data source: DWP Housing Benefit Caseload Statistics

Discretionary Housing Payments are awards that can be made by local authorities to Housing Benefit or Universal Credit (housing cost) claimants who are experiencing financial difficulty with housing costs. This aims to support those affected by key changes such as the introduction of the benefit cap, the removal of the spare room subsidy and the local housing allowance (LHA) reforms. The majority of local authorities in 2017/18 spent less than or equal to their central government allowance (DWP, 2018). These figures can be a proxy for impact of the changes to the benefits system, which anecdotally, multiple service users and front line staff in homelessness services reported as detrimental to homelessness in Swindon. As seen in Table 8, central government has increased the allocation to local

authorities for this purpose. It appears that in 2017/18 benefit caps and LHA reforms were the biggest drivers of need in this area, consistent with local opinion.

Time Period	Total spend Benefit cap (£)	Total spend LHA reforms (£)	Total spend Combination of reforms (£)	Total spend Other (non welfare reform) (£)	Total spend (£)	Total allocation (£)
Apr-Sept 2018	60,676	50,208	6041	4,663	**190,820***	492,420
2017/18	149,499	158,839	0	24,167	**490,750**	507,168
2016/17	77,846	106,880	0	42,990	**434,254**	343,221
2015/16	18,443	15,244	0	106,294	**444,982**	279,467

Table 8. Discretionary Housing Payments by Swindon Borough Council, with associated reasons for expenditure.

*Note an underspend due to 6 months of accounts available only

Data source: DWP, 2019.

Discretionary housing payments were used for the following reasons:

- To help secure and move to alternative accommodation e.g. rent deposit
- To help with short term rental costs while the claimant secures and moves to alternative accommodation
- To help with short term rental costs while the claimant seeks employment
- To help with on-going rental costs for a disabled person in adapted accommodation
- To help with on-going rental costs for a foster carer
- To help with on-going rental costs for any other reason

2.5 Summary

- Homelessness means not having a home. A home is a place that provides security, and links to a community and support network. It needs to be decent and affordable. Under the law, even if someone has a roof over their head they can still be homeless. This is because they may not have the right to stay where they live or their home may be unsuitable to live in.

- Reasons people become homeless are complicated and involve societal structures (such as benefits changes, the economy, access to jobs and low cost housing), changing circumstances (such as relationship breakdown or leaving an institution), as well as personal factors (such as mental health issues, age, and substance misuse).

- Trends in reducing housing affordability and numbers of housing benefit claimants in Swindon, alongside continued population growth are consistent with the picture for England.

- Homelessness is associated with poor outcomes for the individual and for society. It is a pressing issue nationally, with a 28% increase in the numbers of homeless people in England documented between 2011 and 2016.

- The government has a Rough Sleeping Strategy which sets out a vision to halve rough sleeping by 2022, and end it by 2027. New legislation, the Homeless Reduction Act (2017) means everyone is entitled to support from local authorities if they are at risk of, or experiencing, homelessness. It also means other public services must refer people at risk of homelessness to local authorities, called the Duty to Refer.

Chapter 3 Homelessness in Swindon

This section of the JSNA assesses levels of homelessness in Swindon and maps out the services being provided. It is challenging to accurately estimate numbers of people who are at risk of, or experiencing, homelessness, in any locality. This is the case whether only rough sleepers, or the broader spectrum of homeless people are considered. For this reason, the issue will be considered from different angles, including those who approach the council, those who sleep rough, the hidden homeless, and those who use homeless support services.

3.1 Statutory Homelessness

One method of identifying homelessness is through recording those who approach the council for support, and the results of statutory homelessness assessments. The process is as follows:

- Any individual, couple or family at risk of, or experiencing, homelessness can approach SBC for support.
- Firstly, they would work with the housing team to go through a statutory assessment of whether they are owed a duty under the Homelessness Reduction Act (2017).
- If they are owed a duty, then the SBC housing team would assess what input is needed, and the degree of urgency for action.
- A prevention duty is owed to those at risk of homelessness in the next 56 days, and a relief duty to those experiencing homelessness.
- Actions under a statutory duty might include finding emergency accommodation for that night, providing support in sustaining a tenancy, or accessing social housing.
- If individuals are owed a duty, their vulnerabilities are considered, as this determines whether they have a “priority need”, and the actions that are taken.

Although all people at risk of, or experiencing, homelessness are entitled to support from SBC, not everyone in this situation approaches the council. Barriers may include:

- lack of awareness of the support available,
- poor mental health,
- substance misuse,
- preconceptions of the support available,
- violent relationships,
- lack of identification documents, and
- fears around illegal behaviours.

People often also seek support from networks of family and friends, and can then become part of the hidden homeless. These behaviours are explored more fully in the “Service user views/consultation” section.

Given the changes to the legislation and who is owed a duty, the numbers, and patterns seen in those who are currently experiencing, or at risk of, homelessness could be expected to change from the time of the new Homelessness Reduction Act (2017) in 2018. In addition the central government data system has changed with introduction of the Act, so that some variables are not comparable. Table 9 shows the only data available since introduction of the Homelessness Reduction Act, for April to June 2018, alongside reasons for homelessness. The MHCLG report that there have been issues with missing or incomplete returns from some local authorities to the H-CLIC system. The quality of the data should improve with embedding of the system. A further issue is that H-CLIC submits data centrally on a case by case basis, with no facility for local collection of datasets. This is being addressed nationally for the future, but does limit what is available for the JSNA.

Statutory homelessness in Swindon

Much of the data presented in this JSNA is for those accepted as homeless; yet there are consistently more applications than acceptances. Between 2010 and 2018, on average (mean) 36% of applications, in Swindon, were accepted (range 26 - 46%) as being owed a duty. The latest figures in 2017/18 from before the Homeless Reduction Act, represented the smallest proportion accepted (26%). Data from April to December 2018, as shown in Table 9 shows that since the new Act the proportion of applications accepted as owed a duty has increased.

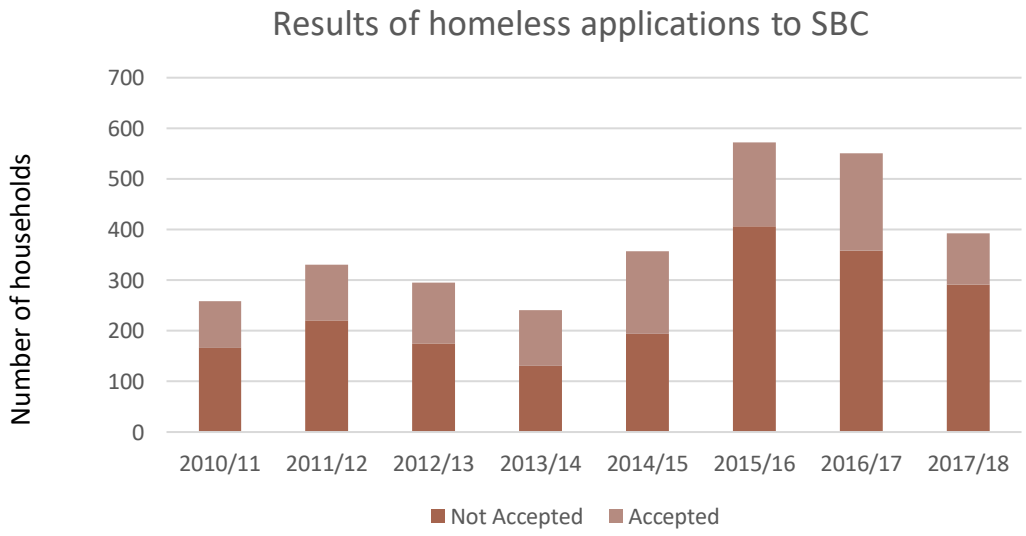


Figure 8. Number of statutory homeless applications and acceptances to SBC.

Data from the p1E system, preceding the introduction of the H-CLIC database and the Homeless Reduction Act.

As seen in Table 9, since the Homelessness Reduction Act (2017):

- 527 statutory assessments were carried out in Swindon, of which 291 (55.2%) were owed either a prevention or relief duty (April – Dec 2018).
- In the first quarter, 22 households were prevented from becoming homeless (42% of those accepted into a prevention duty).
- 155 households were accepted into a relief duty (36% assessments), and 71 of these households (46%) had their homelessness relieved, with new accommodation found for them.

- The most common reason for statutory homelessness, for over a third of cases, was loss of rented accommodation due to termination of assured shorthold tenancies

Initial decision of homelessness duty owed to households April-Dec 2018

	Initial decisions of homelessness duty owed		Threatened with homelessness - Prevention duty owed		Prevention duty owed due to service of Section 21 notice		Relief Duty Owed		Total number of households sessed
	Total	**%**	**n**	**%**	**n**	**%**	**n**	**%**	Total
ENGLAND	189,760	91.4%	105,230	55.5%	13,830	7.3%	84,530	44.5%	207,650
South West	17,630	90.1%	10,280	58.3%	1,430	8.1%	7,350	41.7%	19,560
Swindon	291	55.2%	80	27.5%	9	3.1%	211	72.5%	527

Reason for loss of last settled home for those owed a prevention or relief duty April-June 2018

	Total	Family and friends no longer willing or able to accommodate		Non -violent relationship breakdown with partner		Violent relationship breakdown with partner or associated persons		Loss of rented or tied accommodation due to: Termination of assured shorthold tenancy		Loss of rented or tied accommodation due to: Reasons other than termination of assured shorthold tenancy[1]		Other reasons[2]	
	n	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	
ENGLAND	58,660	13,090	22.3 %	4,130	7.0%	4,540	7.7%	14,150	24.1%	3,390	5.8%	19,360	33.0%
South West	5,240	860	16.4 %	440	8.4%	390	7.4%	1,490	28.4%	380	7.3%	1,680	32.1%
Swindon	144	25	17.4 %	14	9.7%	13	9.0%	53	36.8%	12	8.3%	27	18.8%

Table 9. Homelessness duties owed to households, and the reason for loss of last settled home for those owed a prevention or relief duty (April-June 2018).

Data source: MHCLG Homelessness Statistical Tables

1. Excluding rent arrears for assured shorthold tenancy which is included in category loss of rented accommodation due to termination of assured shorthold tenancy.

2. Other reasons include: racially motivated violence or harassment, non-racially motivated / other motivated violence or harassment, Left institution or LA care, Left HM forces, Required to leave accommodation provided by Home Office as asylum support, mortgage arrears (repossession or other loss of home), rent arrears on local authority or other public sector, Registered Provider or private sector dwellings, Fire or flood / other emergency, property disrepair. %: % initial decisions duty owed of those who were assessed, and % owed duties of those accepted into any kind of duty.

Note timescales for data reporting are different for Initial Decisions and Reasons for loss of accommodation due to data available from MHCLG.

Although the data is for less than a year, it does appear that numbers owed a duty have increased with the new HRA, as 291 were accepted into a prevention or relief duty in three quarters of 2018/19, compared to 191 for a whole financial year 2016/17. Numbers accepted into a duty will need to be closely monitored as more data becomes available.

The reasons for homelessness identified prior to the Homeless Reduction Act in those households who had approached the council and been accepted as homeless are shown in Table 10. Unfortunately it isn't straightforward to compare the reasons for homelessness from before and after the Homeless Reduction Act, due to different ways the data is categorised. Broadly, the distribution of reasons for homelessness are similar, especially when it is considered that some variation is expected due to the small numbers in some of the categories. Consistent with English trends in repossessions of properties by landlords, terminations of rental agreements have increased proportionally as a cause of homelessness. The majority of individuals are homeless due to terminations of an Assured Shorthold Tenancy (AST) or relatives and friends no longer accommodating them. The evidence base supports that terminations of AST are an increasing cause of homelessness (MHCLG, 2019a). Nationally, 7.3% are owed a prevention duty due to a valid Section 21 notice (no fault eviction from private rental property). This is of interest as there is potential for this legislation to change, offering greater protection to tenants.

Reason for homelessness	**Number of individuals 2014-2017**	**%**
Termination AST	190	36.6%
Relatives or friends no longer willing or able to accommodate	110	21.2%
Non-violent relationship breakdown	24	4.6%
Violence (relationship or other)	73	14.1%
Rent or mortgage arrears	18	3.5%
Left NASS	12	2.3%
Left institution	28	5.4%
Other	64	12.3%
Total	**519**	**100.0%**

Table 10. Reasons for homelessness amongst households accepted as homeless by Swindon Borough council

AST: Assured Shorthold Tenancy; NASS: National Asylum Support Service; Rent arrears: includes Local authority, Registered Social Landlords and private sector. Numbers have been combined for some categories due to numbers <5 limiting the ability to report data. Data source: p1E system, Swindon Council.

Reason for homelessness	**2014/15**		**2015/16**		**2016/17**	
Termination AST	50	30.7%	58	35.2%	82	42.9%

Table 11. Trends in Termination of Assured Shorthold Tenancy (AST) as a reason for homelessness amongst households accepted as homeless by Swindon Borough Council.

Data source: p1E system, Swindon Council.

The trend in Swindon is reflective of the England picture, as shown in Figure 9. Ending of assured shorthold tenancies is increasingly common as a reason for homelessness. This is

a driver for the review of legislation being undertaken nationally around private rentals, and explains why supporting landlords and tenants to maintain stable tenancies is a local priority.

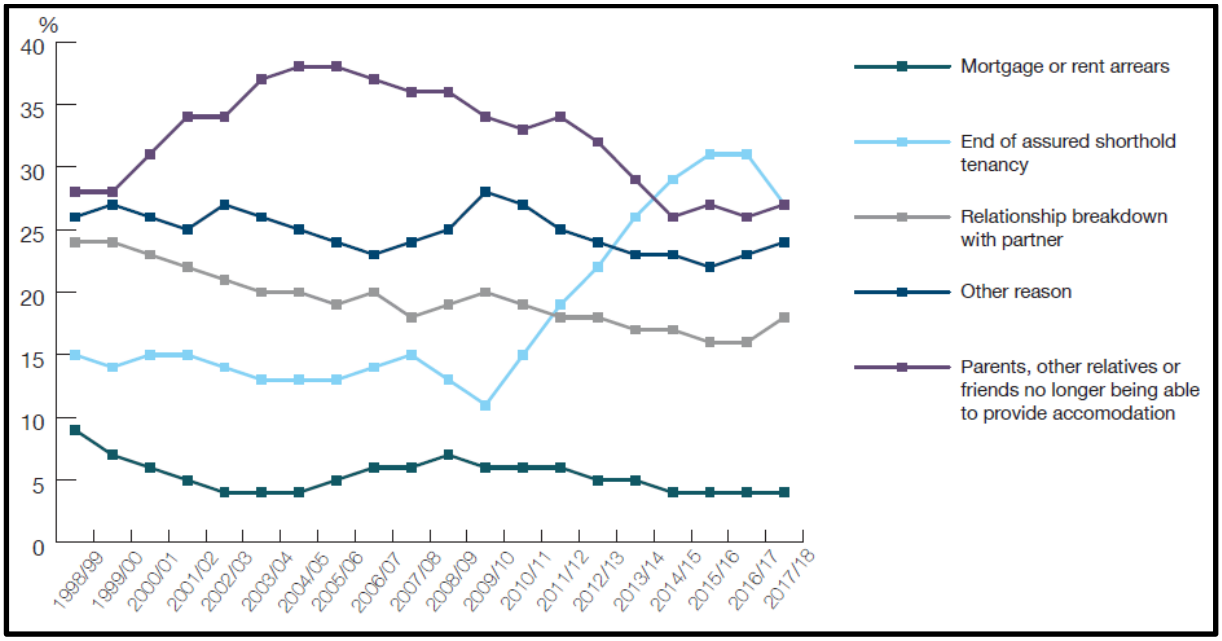


Figure 9. Reasons for statutory homelessness in England 1998-2018.

Data Source: p1E system, extracted from LGiU (2019) report. Figures represent proportions of households accepted into a homelessness duty.

Duty to Refer

The following public authorities are now subject to the duty to refer in England (MHCLG, 2018a):

- Prisons
- Young offender institutions
- Secure training centres
- Secure colleges
- Youth offending teams
- Probations services
- Jobcentres in England
- Social services
- Emergency departments
- Urgent treatment centres
- Hospitals providing inpatient care
- Secretary of State for defence in relation to members of the armed forces

This requires the public authority to identify and refer a service user who is homeless or threatened with homelessness within 56 days to a local housing authority.

There is no data available for Swindon, but Table 12 shows the first quarter of data regionally and for England .The minority of households accepted into a duty are referred under the Duty to Refer. This proportion would be expected to increase as the Duty to Refer becomes embedded, and referral pathways clearer.

	ENGLAND	% duty owed	South West	% duty owed
Total households owed a duty	61,410	-	5,990	-
Total households referred to a local authority	4,850	7.9%	590	9.8%
Households referred under the Duty to Refer	2,750	4.5%	310	5.2%
Adult Secure Estate (prison)	280	0.5%	40	0.7%
Youth Secure Estate	10	0.0%	0	0.0%
National Probation Service	430	0.7%	50	0.8%
Community Rehabilitation Company	90	0.1%	10	0.2%
Hospital A&E, Urgent Treatment Centres or in-patient care	280	0.5%	40	0.7%
Mental Health in-patient care	90	0.1%	10	0.2%
Jobcentre Plus	520	0.8%	60	1.0%
Adult Social Services	190	0.3%	20	0.3%
Children's Social Services	270	0.4%	30	0.5%
Nil Recourse Team[2]	20	0.0%	0	0.0%
Secretary of State for defence in relation to members of the armed forces	0	0.0%	0	0.0%
Other / not known[1]	570	0.9%	50	0.8%
Households referred by an agency (not subject to the Duty to Refer)	1,880	3.1%	260	4.3%
Households referred by another local authority	210	0.3%	20	0.3%

Table 12. Duty to refer housing referrals to local authorities in England and the South West, October – December 2018.

Data source: MHCLG, 2019.

Accommodation status at time of application

Figure 10 shows the accommodation status at the time of application where a prevention or relief duty was accepted (April-Jun 2018). In this period 34% of households in Swindon were in private rental accommodation, with 29% living with friends or family. Both are comparable with England and regional averages.

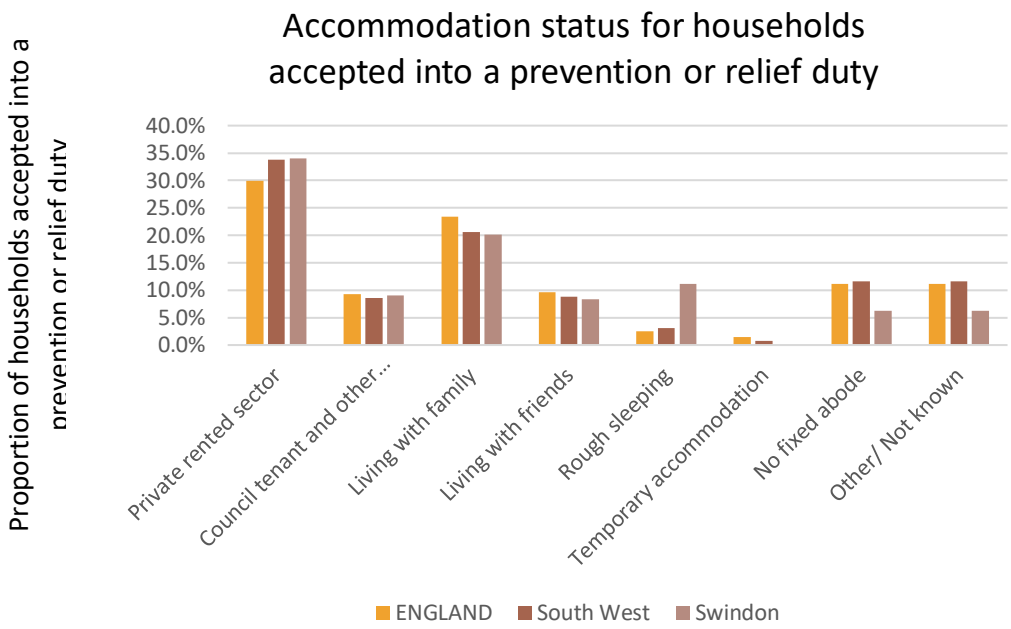


Figure 10. Statutory homelessness and accommodation status at the time of application in Swindon, April-June 2018.

Council tenant and other: Council tenant, registered provider tenant and social rented supported housing or hostel. Data source: MHCLG.

Outcomes for those owed a duty

Being assessed as being owed a statutory homelessness duty is only significant if it leads to action to resolve the risk or homelessness (LGiU, 2019).

Prevention duty outcomes:

- In Swindon the prevention duty ended for 16 households from April-June 2018 with accommodation secured for 6/+ months in 11 (64%) cases. The new H-CLIC system has had initial data recording issues, so this proportion may not be reliable, and further data is needed.
- In England, the most common prevention activity (24% of cases) undertaken by LA's resulting in a duty ending with secure accommodation, was to directly secure accommodation for that household. Other prevention activities included helping to secure accommodation found by an applicant, with or without financial payment, providing supported housing, negotiation/mediation work with family, friends or landlords and owners, and financial payments to reduce rent or mortgage arrears, as well as the provision of information alone (data source: MHCLG).

Relief duty outcomes:

- Outcomes for households where a relief duty ended April-June 2018 are summarised in Figure 11, with a total of 46 households in Swindon included.
- Although this is a small sample, for a short period, Swindon figures for proportions secured accommodation for at least 6 months are higher than regional and national reported numbers. Over 80% went into accommodation.

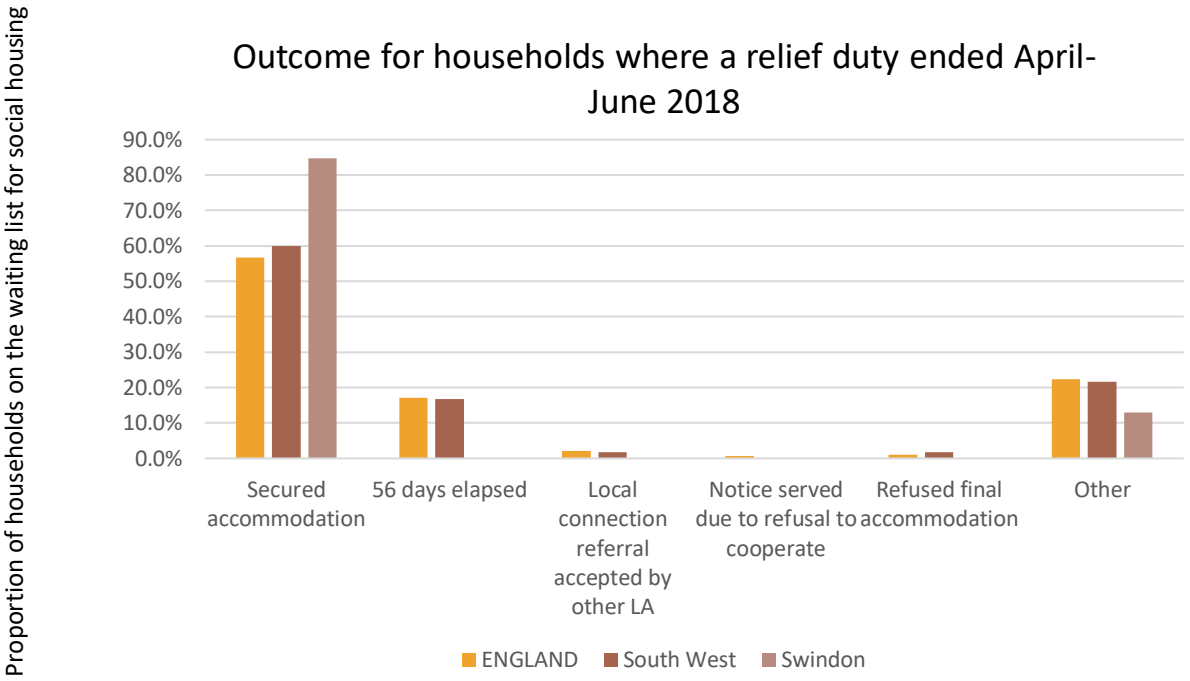


Figure 11. Outcomes for households where a relief duty ended in Swindon, April-June 2018.

Secured accommodation: secured for at least 6 months. Other: contact lost. Data source: MHCLG.

Temporary accommodation

Where people are housed is a determinant of the wider outcomes for that individual or family, with evidence to support the benefits of more stable housing (Mackie et al, 2017). In 2018, 3.12 per 1,000 households in Swindon were in temporary accommodation. In all cases, between 2008 and 2018 if a duty was owed, accommodation was secured by the end of the year. Comparatively, for 2017/18 Swindon had very similar rates of households in temporary accommodation to England, although rates appeared higher than for CIPFA neighbours (see Table 13).

Area	Count	Rate per 1000 households	95% Lower CI	95% Upper CI
England	79,880	3.4	3.4	3.4
CIPFA Neighbours	2,587	1.6	-	-
Swindon	338	3.6	3.2	4.0

Table 13. Households accepted as homeless in England, Swindon and Swindon's CIPFA neighbours and in temporary accommodation 2017/18.

Data source: MHCLG.

Figure 12 shows significant declines in numbers of households in Swindon in temporary accommodation since 2003-2006, however if we focus in on trends since 2013, (see Figure 13), there has been an upwards trend in the last 5 years. Numbers have declined in the last year. Whilst it may represent meeting a rising demand, temporary accommodation is not a settled option, and there is an emphasis on moving individuals and families into more permanent options

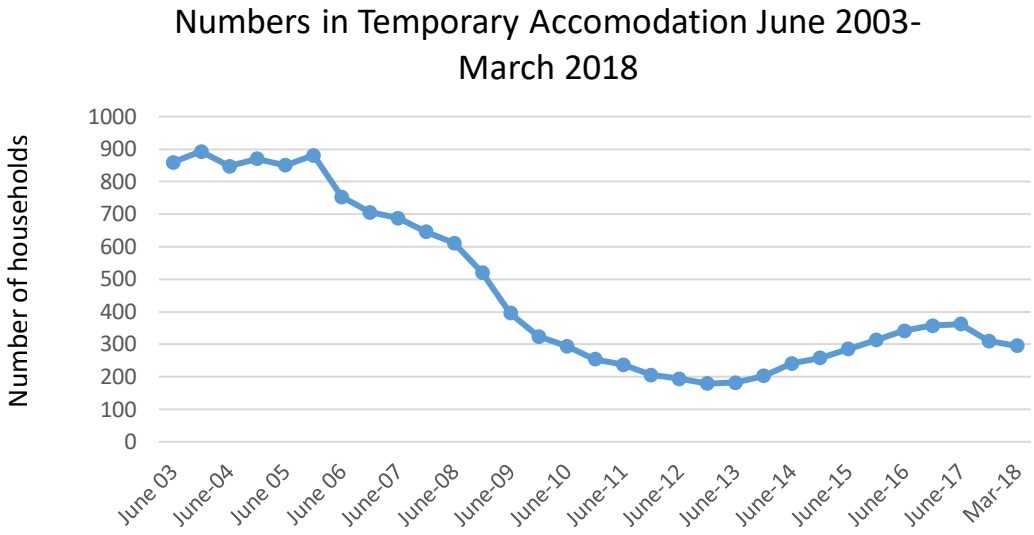


Figure 12. Numbers of households in temporary accommodation (provided by SBC) between June 2003 and March 2018.

Temporary accommodation included all forms of accommodation, including Bed and Breakfasts. Data source: MHCLG, 2019.

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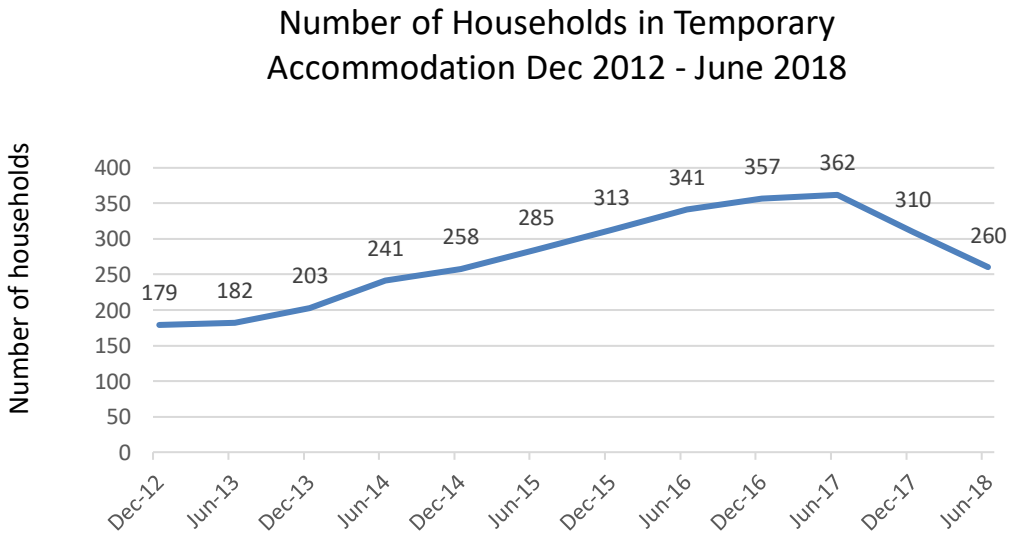


Figure 13. Number of households in temporary accommodation provided by SBC, December 2012-June 2018.

Temporary accommodation included all forms of accommodation, including Bed and Breakfasts Data source: MHCLG, 2019.

Types of temporary accommodation include Bed and Breakfast, Hostels, Local Authority (LA) or Housing Association (HA) Stock, Private Sector leases (by LA or HA), and other types of accommodation (including private landlord). From 2008-2018 there has been an increase in private sector leases, and a reduction in Bed and Breakfast and other types of accommodation. In 2017/18, in Swindon, 64% of temporary accommodation was private sector leased (by LA or HA), and 35% was LA/HA stock (MHCLG, 2019).

3.2 Rough sleeping

Levels of rough sleeping are hard to accurately assess. Statutory counts are done in November of each year and reported to MHCLG, with additional counts done discretionally by local authorities. Rough sleeping counts and estimates are single night snapshots of the number of people sleeping rough in local authority areas. It records only those people seen, or thought to be, sleeping rough on a single "typical" night. Sleeping rough includes people sleeping, or who are about to bed down in open air locations and other places including tents, cars and makeshift shelters. There are practical difficulties in counting the number of people sleeping rough including finding everyone who is sleeping rough, and figures may also vary from a "typical" night due to associated factors such as availability of night shelters, the weather and the time of the assessment. For these reasons, and because the numbers are small when interpreting changes, it is important to consider the margins of uncertainty around rough sleeper counts.

Rates for rough sleeping are shown in Figure 14, and rough sleeper counts since 2016 are shown in Table 14.

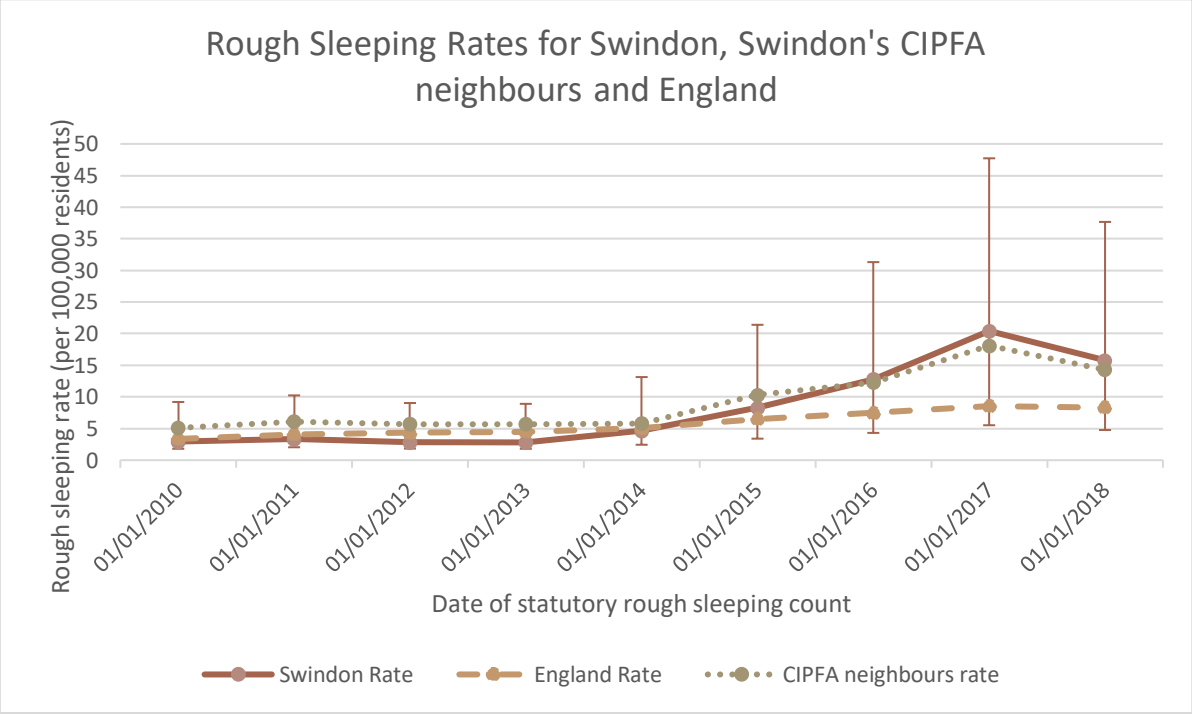


Figure 14. Rough sleeping rates (numbers of rough sleepers per 100,000 residents) for Swindon, England and Swindon's CIPFA neighbours.

Annual November statutory counts were used to calculate rates. CIPFA neighbours: Warrington, Bury, Bedford, Peterborough and Milton Keynes. 95% confidence intervals are included for the Swindon rate.

Data source: SBC rough sleeper counts, Rough Sleeper Live Tables for Local Authorities in England.

Date	Rough Sleeper count
30/11/2016	28

30/11/2017	45
30/09/2018	25
30/11/2018	35
31/01/2019	18
31/03/2019	19
31/05/2019	24
30/07/2019	15
30/09/2019	24

Table 14. Rough sleeper counts for Swindon, November 2016-September 2019.

Data source: SBC rough sleeper counts (statutory and non-statutory)

- Swindon trends for rough sleeping rates follow closely our CIPFA neighbours, meaning those local authorities with the most similar profiles. The rise from 2010 to 2017 is consistent with the national evidence for homelessness (Bramley, 2017).
- This has been followed by a 21% reduction from 2017 to 2018, although for Swindon this is within the margins of uncertainty (95% confidence interval), reductions in this period have also been observed in the South West and England total counts. The 2018 rough sleeping rate for Swindon is 3.8 per 10,000 households.
- Anecdotally, those in front line services feel the peak in 2017 was representative of the situation on the streets at that time. Interventions such as Housing First are cited as drivers of the reduction from the 2017 to the 2018 statutory count.

Characteristics and causes of rough sleeping

Demographics from the statutory rough sleeper counts show that:

- In Swindon, from 2016-18, of 108 rough sleepers 89.8% were male. This is generally consistent with national and regional estimates (Rough Sleeper Statistics, 2018).
- In Swindon, 14.8% of rough sleepers in 2016-18 were non-UK nationals. 75% of the non-UK national individuals identified in the 2018 Swindon count were EU nationals. Comparatively, in England data in the same period, 29% of rough sleepers were non-UK nationals. Proportions of rough sleepers who were non-UK nationals varied widely nationally.
- In Swindon, no rough sleepers under 18 years of age were identified in the Swindon statutory counts, with 15 individuals (13.9%) aged 18-25. The proportion of rough sleepers aged 18-25 in England was 7% for this period.

Causes of rough sleeping are complex. Figure 15 shows the reasons for rough sleeping identified by rough sleepers in Swindon in the recent Threshold health audit (Threshold, 2018).

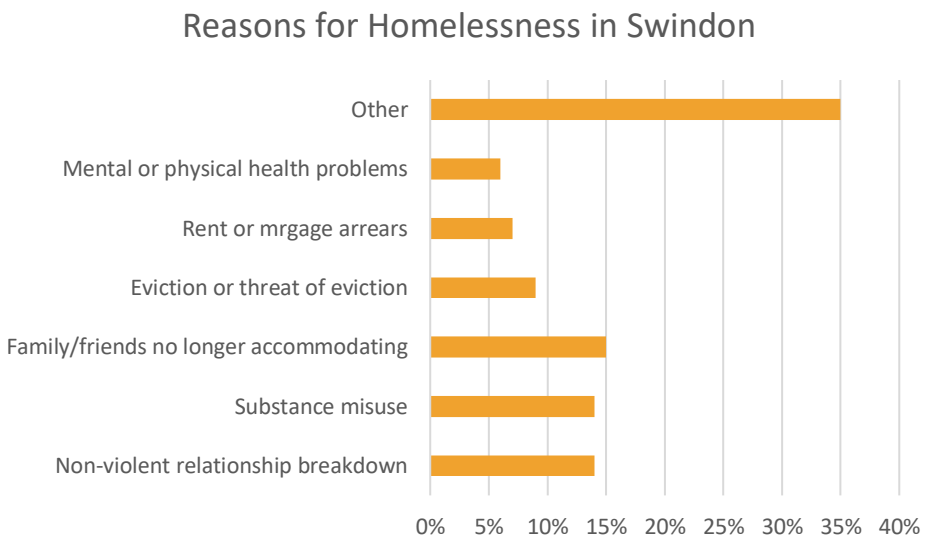


Figure 15. Reasons for rough sleeping amongst homeless people in Swindon who responded to the Threshold Health Needs Audit.

Source THL & Partners Homeless Health Audit – 2019

In addition to the reasons identified by SBC in Table 9, drugs and alcohol and physical and mental health are highlighted by rough sleepers as primary drivers for their homelessness. Although the data demonstrates that rough sleeping commonly occurs with co-existing substance misuse issues and mental health issues, separating out causation and association is difficult. There may be factors in a person's life, such as addiction or adverse childhood experiences, which are primary drivers of all the other issues, but in many cases it will be difficult to identify one single causative factor. Additionally, a trigger for an episode of homelessness can be different to the underlying network of causative factors that put an individual at risk of homelessness.

SBC has an established a Rough Sleepers Panel that forms the basis of a co-ordinated response to support individuals Rough Sleeping. Attendees include Swindon Council, substance misuse services, mental health services, probation, and local voluntary and homelessness support organisations. Individual cases of known rough sleepers are reviewed, with information sharing between partners and development of individual case plans.

Figure 16 presents data from one of the 2018 rough sleeper panels. Of the 48 individuals discussed, most had been rough sleeping for less than 3 months, or more than 12 months.

Figure 16. Duration of rough sleeping for individuals discussed at the Swindon Rough Sleeper Panel.

Defined as spending less than 3 months consecutively in settled accommodation between periods of rough sleeping. Data source: Rough Sleeper Reduction Strategy 2019.

In order to plan and deliver solutions the Rough Sleeper Panel provides evidence where there are four main categories of rough sleeping.

	Category	Description
1.	Lifestyle	Where factors such as alcohol and substance misuse means individuals are unwilling and/or unable to engage with appropriate agencies.
2.	Intermittent	Individuals who by day appear to be sleeping rough, but do have access to shelter via family, friends or own tenancy etc. during the night.
3.	Revolving Door	Those who have slept rough in the last 12 months and have returned to the streets after a period of accommodation, such as assured shorthold tenancies, licences and supported accommodation.
4.	Begging	The street homeless who may have accommodation options

Table 15. Categories of Rough Sleeping identified in the Rough Sleeper Panel in Swindon

Data Source: SBC, 2019.

Analysing the Rough Sleeper Panel discussions demonstrates that most of the Rough Sleepers in Swindon fall into Lifestyle and Revolving Door (SBC, 2019).

Under the Severe Weather Emergency Protocol (SWEP), rough sleepers are offered emergency accommodation by local authorities when severe weather is forecast. In the winter 2018/19 in Swindon:

- 56 people were supported under SWEP
- 15 people moved on from SWEP into more stable accommodation
- 18 people were identified who were not previously known to SBC services

The Temporary Winter Housing Provision was set up to offer a safe and comfortable environment for an identified group of street homeless, who due to their needs, found it difficult to engage with existing outreach services. 20 rough sleepers were identified for the provision, although not all completed it.

3.3 Hidden Homelessness

Hidden homelessness is not just a risk factor for rough sleeping, but has many negative associations including insecurity, poor living conditions, criminalisation, exploitation, risk to personal safety, and poor mental and physical health (Crisis, 2011). The nature of the issue means that exact numbers of people experiencing, or at risk of, hidden homelessness are not available. The data below aims to give a picture of hidden homelessness nationally and locally.

National research

The Just Life Foundation reported in 2018 on hidden homelessness nationally (Just Life, 2018). The authors aimed to identify those living in unsupported temporary accommodation (UTA) in England. UTA is private, short-stay accommodation in which households do not have permanent residency status and limited access to local authority support to find settled accommodation. It includes Bed & Breakfasts (B&Bs), short-stay Houses of Multiple Occupancy (HMOs), private hostels, emergency accommodation and guesthouses. Those in UTA are not always identified as homeless, although residents will not have access to safe, secure and settled housing, and often fit the legal definition for homelessness. There is evidence that many individuals cycle between UTA and rough sleeping (Rose, Maciver and Davies, 2016).

- The authors identified households claiming housing benefits from B&Bs from 2010/11-2015/16, as most UTA residents are in B&Bs.
- According to government figures, the average official quarterly B&B placements for 2015/16 by local authorities was 5,870; however, the authors estimate that nationally, the likely B&B population in 2015/16 was upwards of 51,500.
- The authors suggest that the introduction of Universal Credit may be associated with the 25% reduction in self-placements in B&Bs seen between 2010/11-2015/16, as payments to B&B landlords are limited. In this period, rough sleeping has increased nationally, raising concerns that Universal Credit may be driving some of this increase (Just Life, 2018).

Local data

- In the South West, 1 in 1,973 residents were claiming housing benefits and living in B&B accommodation; this was the highest proportion of any region nationally. Little association was found between housing affordability and LA B&B population, whereas in more deprived areas (measured by the Index of Multiple Deprivation (IMD)) there appeared to be higher numbers living in B&Bs (Rose, Maciver and Davies, 2016).
- In Swindon, the rough sleeper count was 35 in November 2018. LGiU (2019) report that for every 2 people rough sleeping, there are an estimated 98 who are in shelters, temporary accommodation, bed and breakfasts or other precarious accommodation. So rough sleeper counts likely represent the minority of people experiencing homelessness in Swindon.
- The Census provides detailed information about households and housing in the local area. This includes information about concealed families (i.e. couples or lone parents living with another household) and sharing households (i.e. more than one household

living in the same dwelling). These households lack the sole use of basic facilities (e.g. a bathroom or kitchen) and have to share these with their "host" household (in the case of concealed families) or with other households (for those sharing). Although there may be preference to sharing a household, this can also be involuntary due to affordability constraints.

- "Concealed families" are those where a family is living in a household with other adults who are not directly part of that family. This may be by choice, or necessity. The number of concealed families in Swindon and Wiltshire increased from 1,473 to 2,424 over the 10-year period 2001-11, an increase of 951 families (64%) (ORS, 2017). Within these families, there was substantial growth amongst those aged under 35 (in line with national trends). In the same period there was also 24% growth in multi-adult households, particularly in the private rental sector where 67% growth was seen (ORS, 2017). These families and individuals are not necessarily part of the "hidden homeless", but these trends may describe pressure on the housing system and reflect trends in affordability.

In summary, the nature of the hidden homeless is that we cannot definitively know how many fall into this category in Swindon. However, the links to rough sleeping are clear, and hidden homelessness is associated with negative outcomes. It is important that individuals and families are aware of the services and support available from SBC, and engagement with support is facilitated.

3.4 Housing Support and Homelessness Services

There are numerous registered charities and community groups in Swindon which provide services that aim to support the homeless. Some are commissioned by SBC to provide support, which may include accommodation or outreach workers. Others are grass roots movements organised by one or more individual. Support services are also commissioned by SBC around those with specific accommodation needs.

Commissioned Support Services

The services in Table 16 are commissioned by SBC to provide accommodation-based support (ABS) and/or floating support (FS) under the banner of supported housing.

From March 2018-April 2019:

- 335 referrals were received by SBC for supported housing, of which 286 (85%) were new referrals.
- 262 people left supported housing in this time, of whom 73% had a positive outcome
- 81 individuals were referred 3 or more times to supported housing, and work is ongoing about how best to join up services for these individuals.

SBC spends just under £1.4m every year on supported housing schemes for the single homeless. This is mainly in the form of Direct Access hostels but also other 'move on' accommodation. The hostels have a strong ethos of support and many successes, but find it difficult to engage with individuals with complex needs due to the level of support they are able to offer, and often the regime required to run a busy hostel in a safe and supportive way for the majority of residents. Some rough sleepers will choose not to be housed in such a way due to the terms of engagement with the facility and also, importantly, to keep a distance from former associates that have caused their condition to deteriorate on previous occasions. See the engagement section (page 108) of this report for more detail. Under the

Council's statutory duty to accommodate, often the only option available is specialist Bed and Breakfast accommodation at an average cost of £60 per night. With Booth House often only available for 3 nights, and Bed and Breakfasts representing a costly temporary option, Swindon therefore has a gap in provision for emergency accommodation.

Provider	Broad activity	Service name	Type of Support	Capacity	New Referrals	Service users 2018/19
The Riverside Group	Learning Disabilities	Booker House	ABS	14	<5	14
Stonewater	Learning Disabilities	Bow Court	ABS	23	<5	23
The Salvation Army	Homeless	Windrush	ABS	3	<5	<10
SBC	Homeless	Baileys Farm House	ABS	12	10	18
SBC	Homeless	Underwood House	ABS	21	16	32
The Salvation Army	Homeless	Booth House Floating Support	FS	80	27	46
SBC	Homeless	Evelyn House	ABS	16	<10	23
SBC	Homeless	Adult Floating Support	FS	117	54	84
SBC	Homeless	St Ives Court	ABS	38	53	66
Home Group	Homeless	Bridge Service	ABS	8	14	20
Sanctuary	Homeless	Culvery Court	ABS	20	35	25
The Salvation Army	Homeless	Booth House	ABS	50	93	100
SBC	Homeless	Temporary Winter Housing Provision	ABS	12	12	12
Stonewater	Mental Health	Hazelmead House	ABS	16	20	25
Home Group	Mental Health	ABS for Mental Health with Low Need	ABS	30	13	28
Stonewater	Young People	ABS for Young People with High Need	ABS	71	49	93
The Riverside Group	Young People	ABS for Young Parents	ABS	19	<10	28
The Riverside Group	Young People	Young People Floating Support	FS	50	29	45

Table 16. Supported housing commissioned by SBC, with capacity and numbers of referrals in 2018/19.

ABS: Accommodation-based support. FS: Floating Support. Floating support involves support for an individual around their needs. Data Source: SBC.

The numbers of new referrals may not give a good estimate of service use as service users may need supported accommodation for a prolonged period. In addition some homelessness accommodation-based support is provided by the voluntary sector without SBC funding. The main instance is the emergency accommodation provided by Booth House. The Salvation Army report Booth House provided accommodation-based support to individuals on 446 occasions, including emergency accommodation and resettlement

accommodation. This includes 29 individuals seeking support on multiple occasions. SBC do not commission the emergency accommodation, so these numbers don't feature in Table 16, and the data in Table 16 is therefore not a complete estimate of need. The Booth House model of emergency accommodation is short term, limited to a 3 night stay in general, with no assurance of the following night. Although the alternative may be rough sleeping, the stress associated with this model of relief accommodation consistently was raised by service users during the engagement.

Rough Sleeper Initiative

The Council has worked with the Government's Rough Sleeping Initiative and its delivery partners to co-produce a range of funded interventions to meet the needs of rough sleepers in the area. SBC were awarded £194,000 for 2018-19 to fund the following services:

- A dedicated rough sleeping project co-ordinator – raising the prominence of initiatives to end rough sleeping and ensuring delivery of the programme.
- Temporary Winter Housing Provision between November – March 2019
- 3 assertive outreach Housing First workers, focused on engagement, enabling reconnection and access to sustainable, supported accommodation.
- 14 units of supported Housing First accommodation.
- Specialist mental health training aimed at better equipping staff to work with and identify those most vulnerable and at immediate risk.
- Additional floating support to prevent loss of tenancies in the private rented sector.
- Establish a Day Centre 'one stop shop' to co-ordinate and integrate services in one location

Due to the success of those interventions the Council have been awarded a further £255,125 for 2019/20 to continue delivering these services for a full 12 months (SBC, 2019).

Housing First

Housing First is of particular interest as an evidence-based model of housing and support, increasingly implemented internationally (Mackie et al, 2017). There are a number of underlying principles that separate Housing First from other forms of more traditional housing. These include:

- Housing First provides rapid access to settled, independent housing, often using ordinary private rented or social rented housing.
- Access to housing is not conditional, i.e. someone using Housing First does not have to be assessed as 'housing ready' before housing is offered
- Housing, treatment and support are separated, i.e. someone using Housing First is not required to show treatment compliance, or changes in behaviour, once they are housed
- Support is provided using an intensive floating service, which visits people using Housing First at home, or at agreed venues, and provides case management, practical and emotional support. Caseloads per worker vary by service, but will typically be between three to eight individual service users at any one point.

There is an emphasis on ensuring that the possibility of positive change in someone's life is clearly conveyed, without any requirements being set in relation to behavioural or other changes, often referred to as a recovery orientation in *Housing First* services.

In October 2018-March 2019, 15 individuals were accepted onto the Housing First scheme (SBC, 2019). With an estimated success rate of 80% (Mackie et al, 2017), this would be expected to result in 12 individuals moving into settled accommodation in the longer term.

Voluntary Sector Support Services

There are a multitude of other homeless support services in Swindon. These provide accommodation-based support, food and provisions, outreach support, and support to engage with SBC and other services such as mental health and substance misuse. These include:

- Big Breakfast Plus
- Filling Station
- Threshold Housing Link
- Swindon Caring Hearts
- Swindon Alternative Angels
- Bridge Services – Home Group
- Swindon Night Shelter

Table 17 shows data obtained from some of these support services that aim to either support or relieve rough sleeping. This is presented to illustrate the level of support being provided. Individuals accessing these services are not always rough sleeping. The services below do not offer accommodation-based support, so these individuals may be accessing SBC housing support for homelessness alongside the interventions described below. Some services such as Big Breakfast Plus are open access, whilst others, such as Swindon Caring Hearts have some terms of engagement that mean services are targeted to those who are rough sleeping, or at risk of rough sleeping. Nonetheless, users of these services are likely to include rough sleepers, hidden homeless, those at risk of homelessness, and a minority of other individuals not at risk of homelessness.

Organisation	Nature of support	Individuals supported	Time period
Big Breakfast Plus	Breakfast 7 days a week, support to access services, location for outreach work	607 individuals (mean 40/month) 7,330 breakfasts (mean 16 per day)	Oct 2017-Dec 2018
Filling Station	Food and provisions 1 night/week, alongside wider support and engagement	Mean 40 individuals per night	Apr 2018 – Jan 2019
Swindon Caring Hearts	Food and provisions street outreach 3 nights/week	Mean 32 individuals per night	Feb 2019 - Apr 2019

Table 17. Service provision from Swindon-based homeless support charities and groups.

Data provided by the organisations named above.

Anecdotally, opportunities for development for some of the community groups were raised by multiple individuals working in established Swindon support services for the homeless. These points were summarised as:

- Duplication of work
- How funds are raised and used
- Engagement and co-ordination with other organisations providing homeless services
- Adherence to regulations, and consideration of service users' vulnerabilities
- Enablement

Enablement is a nuanced issue, where there is a balance of providing people with the necessary support needed to survive on the streets, whilst not removing the motivation to engage with other services and move towards a more stable housing situation. It also refers to providing support beyond that which is deemed "essential", and to those who may have other sources of support, or who use the support for purposes other than it is intended. There are grey areas within this, and it can be difficult to separate enablement from support.

HOSTS (Homeless Organisations Standing Together in Swindon) is a group of over 180 individuals and organisations formed about 25 years ago. They function to promote connection within, and outside, the voluntary sector. It promotes sharing of best practice, and members are encouraged to sign up to the Rough Sleepers Charter which centres on the objective of getting people off the street. This network has the potential to reduce the above issues, as well as promoting efficiency and effectiveness of the voluntary sector, and how it works with other organisations like SBC.

3.5 Summary and recommendations

- It is challenging to accurately estimate numbers of people who are at risk of, or experiencing, homelessness. Much is hidden, especially considering those squatting, sleeping in unsuitable temporary accommodation, or sofa surfing.

- Statutory homelessness means those who have approached the council and been accepted into a duty due to being at risk of, or experiencing, homelessness. In the first 6 months since the new legislation was introduced in 2018, in Swindon 527 households were assessed, and 291 (55%) were accepted into a duty. Of these, 80 were threatened with homelessness, and 211 were homeless.

- Rates of rough sleeping in Swindon rose between 2010-2017, and are subsequently reducing, although this is within the margins of uncertainty. The rough sleeping rate for Swindon is 3.8 per 10,000 households. 90% are males, and 15% are non-UK nationals. Reasons for rough sleeping are complex.

- National research shows that for every 2 people rough sleeping, there are an estimated 98 who are in shelters, temporary accommodation, bed and breakfasts or other precarious accommodation. So rough sleeper counts likely represent the minority of people experiencing homelessness in Swindon.

- The most common reasons for statutory homelessness in Swindon in 2018 were family and friends no longer willing or able to accommodate, non-violent relationship breakdown, loss of rental accommodation and violence.

- There are a variety of commissioned support services in Swindon for homelessness and rough sleeping, as well as others with specific accommodation needs. These

work alongside the voluntary sector, which has a significant role in supporting homeless people in Swindon. Work is ongoing to improve the co-ordination of different organisations and improve the overall effectiveness of support for homeless people in Swindon.

Chapter 4 Characteristics of Homeless People in Swindon

4.1 Support needs in Homelessness

Reasons for homelessness cannot fully describe an individuals' vulnerabilities, and Figure 17 shows the associated support needs for those owed a prevention or relief duty nationally since the Homeless Reduction Act (2017) applied. This highlights some of the factors associated with homelessness, beyond the economic drivers. Notably, poor mental and physical health are common support needs, along with the presence of domestic abuse. The support needs not already considered above are explored in more detail below, alongside the demographic profile of homelessness.

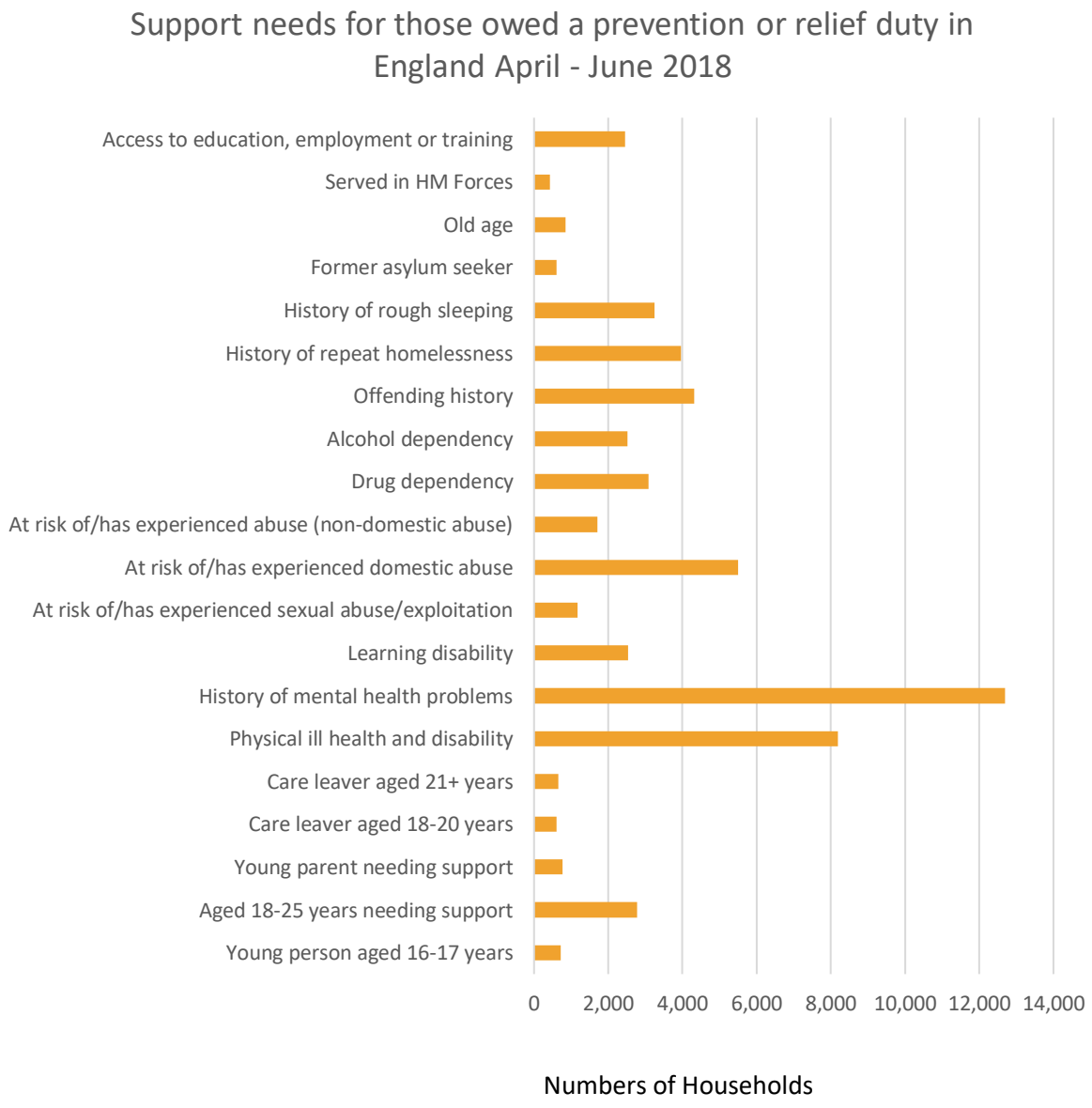


Figure 17. Statutory homelessness and support needs of main applicant and household members in England, April-June 2018.

Data is taken from a total of 40,110 individuals identified as having support needs. Data source: MHCLG Homelessness Tables.

4.2 Ethnicity

Proportionally, individuals from a Black and Minority Ethnic (BME) community are found in higher numbers in homeless populations than the general population (Bramley and Fitzpatrick, 2018). Shelter (2004) highlighted particular rises in homelessness rates amongst black African/Caribbean households and Indian/Pakistani/Bangladeshi households.

In England:

- 62% of homeless households in 2016/17 were White, and this has reduced from 74% in 2006/7.
- Increases in proportions of homeless households from Asian ethnic groups, and Black ethnic groups were seen in the same period.
- There is wide regional variation in the demographics of homeless populations.

In Swindon:

- In 2017/18, 71% of households who were accepted into a statutory duty were white, however ethnicity was unknown in 20% of cases.
- In the 2011 census, 15.4% of people (32,128) in the general population were from a BME group (ONS, 2011). This had increased from 8.5% in 2001.
- With the level of uncertainty described, we cannot make conclusions about the ethnicity of those experiencing homelessness in Swindon, and this area would benefit from review.

4.3 Gender and sexuality

Consistently, statistics show the majority of rough sleepers are males (Rough sleeper statistics, 2018). However, women are more likely to avoid sleeping rough in the open and, therefore, the rough sleeping statistics do not provide the full picture (Homeless Link, 2017a). Many women also end up living in a range of hidden and marginalised situations, putting them at risk of violence and abuse, often complicated by substance misuse. The issue is compounded by many homelessness services' design and delivery being dominated by the experience of male rough sleepers. Even for those that are able to access accommodation based services, nationally only 11 per cent of accommodation projects are able to offer women only provision within their service. Meanwhile 28% of service users in accommodation projects are women, and 24% using day centres are women.

In Swindon:

- 57% of people in supported accommodation are male, and 43% are female.
- The limited range of emergency options for females at risk of rough sleeping was raised by support staff and the female service users the author of the JSNA spoke to during the stakeholder and service user engagement.

Good practice in supporting women experiencing homeless includes (Homeless Link, 2014):

- Providing women-only spaces for support
- Staff training to enable gendered responses
- Psychologically informed services which respond to trauma
- Partnership working to address multiple support needs
- Client involvement
- Supporting women with children

The Nelson Trust supports vulnerable women in Swindon. In the financial year 2018/19 they received 270 referrals. Women who are referred are assessed on 9 pathways:

- Accommodation
- Skills and employment
- Health
- Drugs and alcohol
- Benefit and debt
- Children families and relationships
- Attitudes, thinking and behaviour
- Experience of abuse, rape or domestic violence
- Sex work

In 2018/19, 41 (15.2% of the 270 referrals) had an accommodation need, of whom 18 (6.7%) were homeless. However, the other pathway areas relate to women's overall vulnerability and many are known to increase risk of homelessness. If women have needs across four or more of these areas they are referred to the change team. In total 134 referrals (49.6%) met the change team referral criteria, highlighting the vulnerability of the population of Swindon's women that the Nelson Trust supports. The Nelson Trust has links with SBC housing, probation, mental health and substance misuse services, and allow these other services to engage with this group in a safe environment tailored to women's' needs. Consistent with the Homeless Link (2014) evidence, this is an example of good practice in Swindon.

There are also national concerns around homelessness support for people identifying as LGBT+. Shelter (2019) and the Albert Kennedy Trust (2014) report that for LGBT+ individuals there are commonly different contributory factors around homelessness, and a more limited range of appropriate accommodation solutions (AKT, 2014; Shelter, 2019). LGBT+ identifying young people are over-represented within youth homeless populations, and once homeless are more likely to experience discrimination, exploitation, violence and substance misuse (AKT, 2014).

Nationally, the top 5 issues identified by homeless LGBT+ young people are (AKT, 2014):

- Family rejection
- Mental health issues
- Alcohol abuse
- Homophobic bullying
- Sexual exploitation

Sexuality is not identified in the statutory reporting system. Considering Shelter's (2019) assertion that LGBT+ people may not wish to disclose their sexuality or gender when seeking accommodation, the proportions of people in Swindon with a housing need who identify as LGBT+ may be higher. Sexuality is recorded for those referred to supported housing schemes commissioned by SBC. In 2018/19 77.5% of people referred were heterosexual, however most of the remaining people preferred not to say. This is therefore also not a good source of information on housing need for people identifying as LGBT+.

4.4 Single homeless persons and couples who are homeless

In the homelessness literature “single homelessness” refers to single adults and adult couples without children. Crisis estimate that around 200,000 single people experience homelessness each year in England. From 2016-17, 19,460 people who made a homelessness application in England were found to not be in priority need by their Local Authority, and the majority of them were likely to be single homeless adults, or adult couples. A lack of priority need means individuals were less likely to be provided with accommodation. This represents 17% of the total number of households making a homelessness application (Homeless Link, 2017). With the change in legislation, all homeless people are entitled to support from the council, although the priority needs still determine how likely people are to be given accommodation by SBC. Across the South West there are 3,629 bed spaces for single adults, 155 projects and 20 day centres (Homeless Link, 2017). Most of the support provided by the voluntary sector in Swindon is for adults without children, likely due to the factors described around priority need.

Table 18 shows the applications and acceptances for a homelessness statutory duty with SBC, compared to the regional and national picture. In Swindon, similar proportions of single adults apply to the council.

	England	**South West**	**Swindon**
Total applications for a duty	207,650	19,560	527
Total acceptances into a duty	189,760	17,630	291
Single Adults Owed a Duty	**112,300**	**10,520**	**266**
% Applications	54.10%	53.80%	50.50%
% Acceptances	59.20%	59.70%	NA
Couples/multiple adults without dependent children Owed a duty	**11,670**	**1,290**	**21**
% Applications	5.6%	6.6%	4.0%
% Acceptances	6.1%	7.3%	7.2%

Table 18. Applications and acceptances into a homelessness duty in Swindon, for adults without dependent children, April-December 2018.

NA: Not available. Data source: MHCLG, 2019

There is strong evidence that relationship breakdown, mental health issues and substance misuse cause single homelessness. There is also moderate evidence for leaving prison or the armed forces, unemployment, poverty and lack of affordable housing as drivers (MHCLG, 2019b). In a national study of single homeless people (Crisis, 2016), the following were identified as important in preventing homelessness:

- Support to retain or access housing
- Support for mental health and substance misuse Also important is
- Support to access education and training, and
- Welfare support.

As the study is from before the Homelessness Reduction Act, it is hoped that the new duty will enable SBC to support single people at risk in the ways that are identified as most likely to prevent or relieve homelessness.

4.5 Homeless Families

Homelessness legislation means children should never sleep rough. There are, however, large numbers of families in temporary accommodation. Shelter estimate for 2018 there are 123,130 homeless children in England, equating to 1 in 96 children. This is a 62% national rise over 5 years, and a 41% regional rise. These experiences increase the risk of mental health issues and poor educational attainment (Shelter, 2018). Data for Swindon are not presented as there was likely a data collection or reporting issue, meaning results are invalid and require review prospectively.

	England	**South West**
Applications	207,650	19,560
Acceptances	189,760	17,630
Households with children	**65,230**	**12,030**
% Applications	31.4%	61.5%
% Acceptances	34.4%	68.2%
Single Parent with Dependent Children	**49,020**	**10,520**
% Applications	23.6%	53.8%
% Acceptances	25.8%	59.7%
Couple with dependent children	**14,390**	**1,390**
% Applications	6.9%	7.1%
% Acceptances	7.6%	7.9%
Three or more adults with dependent children	**1,820**	**120**
% Applications	0.9%	0.6%
% Acceptances	1.0%	0.7%

Table 19. Statutory homelessness for households with dependent children, April-December 2018.

Data source: MHCLG, 2019.

In the first quarter (April-June 2018) subsequent to the Homelessness Reduction Act (2017), 70.4% of households in Temporary Accommodation in Swindon included children. This population needs particular support, with a focus on preventing family homelessness and minimising the time spent in temporary accommodation. In this period the great majority were in private rental or local authority/housing association stock, minimising the number required to stay in B&B or hostel/refuge type accommodation.

Area	**Number of households (000s)**	**Total number of households in TA per (000s) households**	**Total number of households in TA**	**Total number of households in TA with children**	**% households in TA with children**	**Total number of children in TA**

ENGLAND	23,464	3.51	82,310	61,480	74.7%	123,630
South West	2,402	1.07	2,570	1,560	60.7%	3,170
Swindon	94	2.77	260	183	70.4%	258

Table 20. Numbers of households in Temporary Accommodation, including numbers of children.

Data from April-June 2018, source MHCLG. TA: Temporary Accommodation. Data for Swindon not available subsequent to June 2018. 1. 2014-based household projections for 2017.

Shelter report a rising number of working families are homeless and in temporary accommodation. 33,300 families are in this situation in England, up from 19,300 in 2013 (Shelter, 2018a). Causative factors include rising private rental costs, housing benefit caps and a shortage of social housing.

4.6 Youth homelessness

Here, young people are defined as those aged 16-24 years. Compared to other age groups, young people are more than three times as likely to have experienced homelessness in the last five years (Watts et al, 2015). Young people (up to age 24) with experiences of homelessness are a vulnerable group and continue to make up approximately half of the people accessing homelessness services in England (Homeless Link, 2017). Government statistics likely underestimate the scale of youth homelessness, and young people are more likely to sofa surf than to rough sleep (LGiU, 2019). Young people who have experiences of the care system, are from BME groups and identify as LGBTQ+ face higher risks of homelessness (Homeless Link, 2018).

Drivers of youth homeless (Homeless Link, 2018) include:

- Family relationship breakdown
- Structural factors including overcrowding, financial hardship, unemployment rates and welfare benefit restrictions
- Delayed payments under Universal Credit impacting on young people's ability to access and sustain accommodation.

Since the Homelessness Reduction Act, data shows that the minority of successful applications accepted as owed a duty were for younger people, with slightly higher proportions in the South West. Swindon appears to have more 18-25 year olds proportionally applying to the council for statutory assessment, although the numbers are small from the short time period in which data is available, and this will require monitoring.

	England	**South West**	**Swindon**
Applications	**207,650**	**19,560**	**527**
Acceptances	**189,760**	**17,630**	**291**
% applications	91.4%	90.1%	55.2%
16-17 yrs	**2,140**	**340**	**10**

% applications	1.0%	1.7%	1.9%
% acceptances	1.1%	1.9%	3.4%
18-25 years	**7,850**	**1,000**	**67**
% applications	3.8%	5.1%	12.7%
% acceptances	4.1%	5.7%	23.0%
young parent	**2,070**	**270**	**NA**
% applications	1.0%	1.4%	*
% acceptances	1.1%	1.5%	*

Table 21. Statutory Youth homelessness, April-Dec 2018.

Statutory assessments for households accepted into a prevention or relief duty. Data source: MHCLG, 2019.
NA: Not available due to suppression of small numbers. *: not reported due to small numbers, but comparable to England and South West proportions.

The term non-statutory youth homelessness is often used to refer to young people supported by various temporary accommodation services. There is no official register for these individuals, but of the homelessness services listed on the Homeless England database showed that 44% of young people supported by accommodation projects were between the ages of 16 and 24 in 2018 (Homeless Link, 2018). In Swindon, the numbers of Young People referred to Accommodation-Based Support services is shown in the "Housing Support and Homelessness Support" section of the JSNA. Notably, young people also use general adult services, so these numbers are an underestimate of need.

4.7 Repeat Homelessness

As discussed above, cycling through homelessness is consistently identified as an issue locally in the Rough Sleeper Panel. The proportions in England and the South West of those assessed as owed a prevention or relief duty with a history of homelessness are shown in Table 22.

	Applications	**Acceptances**	**History of repeat homelessness***	**% applications**	**% acceptances**	**History of Rough sleeping***	**% applications**	**% acceptances**
England	207,650	189,760	11,890	5.7%	6.3%	9,850	4.7%	5.2%
South West	19,560	17,630	1,600	8.2%	9.1%	1,370	7.0%	7.8%
Swindon	527	291	9	1.7%	3.1%	9	1.7%	3.1%

Table 22. Statutory homelessness for households with a history of repeat homelessness or rough sleeping, April-December 2018

* Data are for acceptances only. Data Source: MHCLG.

From Table 22 it appears that in Swindon a lower proportion of applications are from those with a history of homelessness or rough sleeping than regionally, or nationally. However, this may be a recording issue with the new data collection systems, recognised by MHCLG as being under development since their introduction in 2018. This should be an area for focus, to understand homelessness locally, and to identify points for intervention and prevention.

Repeat homelessness is a focus in the Rough Sleeping Strategy (MHCLG, 2018c). The government identify a need to understand who hostel type accommodation works for, and where it is more likely to lead to movement back to the streets. An emphasis on breaking the cycles of rough sleeping, temporary accommodation and unsuitable accommodation will improve outcomes for individuals and reduce resources spent on individuals experiencing repeated crises. The rough sleeper panel is a good forum for identifying those at risk of repeated homelessness and bringing support services together to intervene.

There are other points for intervention, including the prison and healthcare systems, which as discussed below in the JSNA need to be utilised in a Making Every contact Count (MECC) approach from all organisations who work with homeless people. This means service workers making the most of even brief encounters with people to assess and intervene, (even briefly), around issues such as substance misuse, mental health and housing. The approach is applicable as these individuals are known to have multiple interactions with services, but these interactions can be brief and focussed around crisis management. For people with complex needs, the engagement process can also be problematic, and multiple offers of engagement, using a MECC model, may be beneficial.

4.8 Summary and recommendations

- Age, gender, ethnicity and sexuality are all factors in vulnerability to homelessness and its consequences. These personal features may also influence an individual's support needs
- Children are particularly vulnerable to the consequences of homelessness. 70% of households in temporary accommodation in 2018 in Swindon included children. The great majority were in private rental or local authority/housing association stock, minimising the number required to stay in B&B or hostel/refuge type accommodation
- Most data for Swindon on the profile of homelessness is from statutory SBC assessments. Since the Homelessness Reduction Act (2017) came into force the central data collection system has changed and there have been some quality issues with the initial reports
- Local data collection and analysis is needed to understand the local homelessness profile, trends and future demand. SBC and other providers of support services should use this data to gain a better understanding of the needs of the wide variety of different groups experiencing homelessness, the impact of the Homelessness Reduction Act (2017) and the Duty to Refer
- People often cycle through homelessness, between rough sleeping and different accommodation options. Points of contact with these people are an opportunity for engagement and intervention.

Chapter 5 Mental Health

5.1 Mental Health and Homelessness

The association between mental health and homelessness is well-recognised. Poor mental health is a driver of homelessness, as well as a complication of homelessness, and a barrier to engaging with services to manage homelessness. There is strong evidence that poor mental health is a cause of single homelessness, and it is also implicated in rough sleeping and family homelessness. It does not just directly contribute to an individual's vulnerability to homelessness but may also cause relationship breakdown (violent and non-violent) and financial difficulties, some of the most common causes of homelessness (MHCLG, 2019b). Similarly, poverty has a strong causal effect on mental health (Bramley and Fitzpatrick 2018), creating negative reinforcement between poor mental health and homelessness for many (MHCLG, 2019b).

Homeless Link found in a survey of 2,590 people with experience of homelessness that 80% reported some form of mental health issue, and that 45% had been diagnosed with a mental health issue (Homeless Link, 2014a). In comparison, 27.4% of the general population are diagnosed with a common mental disorder in their lifetime (APMS, 2016). ONS (2018b) reported that in 2017, suicide was the second most common cause of death in homeless people in England, causing 13% of deaths.

In Swindon, it is estimated that around 29,820 people in Swindon have a diagnosed or undiagnosed common mental disorder (CMD), and 14,208 have a severe CMD warranting treatment (NHS Digital, 2016). For further detail on the profile of mental health in Swindon, please refer to the recent Mental Health JSNA (2018/19).

5.2 Mental Health and Homelessness in Swindon

Pooled results from 27 health needs audits completed across England with homeless people (Homeless Link, 2019) are presented below, alongside results from national Adult Psychiatric Morbidity Survey (APMS). In the Swindon Threshold Health Audit (2019), 85 homeless people answered questions about their mental and physical health. This is a relatively small sample, and mental health conditions were self-reported. Comparatively the APMS uses validated assessment screening tools, and conditions such as Schizophrenia are categorised differently in their report. For these reasons, Threshold results may not be representative of the homeless population in Swindon, or easily comparable to national results.

In summary:

- The proportion of homeless people experiencing mental health conditions in Swindon and nationally, are higher than general population estimates
- Methods of identifying people with mental health disorders differ between the national surveys and the local Threshold survey. This may bias the results towards higher Swindon prevalence figures, however generally the national evidence base does show that mental disorders are more common in the homeless population.

Mental health condition	Period for prevalence	Reported national Prevalence in homeless people	General Population prevalence
Depression	Last 12 months	12%	10.9%
	Lifetime	34%	27.8%
Anxiety	Last 12 months	-	18%
	Lifetime	-	-
Dual diagnosis	Last 12 months	5%	-
	Lifetime	13%	-
Post-traumatic stress disorder	Last 12 months	3%	4.4%
	Lifetime	7%	-
Personality Disorder	Last 12 months	3%	-
	Lifetime	7%	13.7%
Schizophrenia	Last 12 months	2%	-
	Lifetime	6%	0.7%
Bipolar disorder	Last 12 months	2%	-
	Lifetime	5%	2%

Table 23. Reported prevalence of mental health conditions amongst homeless people in England, compared to the general population.

National estimates for the homeless population in England are from a Homeless Link survey of 2,590 people with experience of homelessness, with general population estimates where available. Swindon estimates are from the Threshold Health Audit of 85 people with experience of homelessness, with diagnoses of mental health conditions in the last month. Dual Diagnosis: substance misuse and mental health issues. National estimates for general population prevalence are from the APMS 2014 survey, and include self-reported cases for depression, personality disorder, schizophrenia and bipolar disorder, but otherwise only include professionally diagnosed cases. Homeless Link, 2014a, NHS Digital, 2016.

Mental health condition	Period for prevalence	Reported prevalence in homeless people in Swindon
Depression	Last 12 months	49.4%
	Lifetime	78.8%
Anxiety	Last 12 months	34.1%
	Lifetime	56.5%
Dual diagnosis	Last 12 months	16.5%
	Lifetime	33.0%
Post-traumatic stress disorder	Last 12 months	14.1%
	Lifetime	24.7%
Personality Disorder	Last 12 months	11.8%
	Lifetime	17.7%
Psychotic disorder	Last 12 months	8.2%*
	Lifetime	21.1%*

Table 24. Self-reported prevalence of mental health conditions amongst homeless people in Swindon.
Estimates are from the Threshold Health Audit of 85 people with experience of homelessness, with diagnoses of mental health conditions in the last month. Dual Diagnosis: substance misuse and mental health issues. Psychotic disorder: diagnosis of either schizophrenia or bipolar disorder. Note these figures may not be representative of the wider homeless population in Swindon. Threshold Link, 2019.

In England (Homeless Link, 2014a), 12% reported a diagnosed mental health condition alongside substance misuse. However, 41% of all participants reported using drugs or alcohol to cope with their mental health issues, which shows the "high cost of being unable to access the right support" (Homeless Link, 2014a).

In Swindon:

- 13.5% of households assessed as homeless were recorded as having a mental health need. The proportions are lower than regional and national figures (see Table 25). Poor mental health is frequently under-diagnosed, self-managed, or not reported, therefore these numbers are likely to be an under-estimate of mental health needs amongst applicants.
- If the Homeless Link (2014a) findings above apply to the Swindon population, amongst the 291 households accepted into a homelessness duty in April-December 2018, 194 would be expected to have some kind of mental health issue, and 92 would be expected to have a diagnosed mental health issue. Given that the estimates are at household level, the numbers of individuals affected would be higher.
- There were no recorded deaths in homeless people due to suicide in 2017 (ONS, 2018b).
- In 2017/18, 74% (70.3-77.4% 95% CI) of adults receiving secondary mental health services and living independently were living in stable and appropriate accommodation (NHS Digital, 2019). This is higher than South West (62% (61.1-62.9%)) and England figures (57% (56.7-57.3%)).

	Applications	Acceptances	Mental health need*	% applications	% acceptances
England	207,650	189,760	40,140	19.3%	21.2%
South West	19,560	17,630	5,000	25.6%	28.4%
Swindon	527	291	39	7.4%	13.4%

Table 25. Statutory homelessness for households with a history of mental health problems, April-December 2018.

*Acceptances with a mental health need. Data source: MHCLG, 2019

5.3 Mental Health Service Provision

Currently, community mental health teams (CMHT) work through the primary care liaison team, with a single point of access system for referrals. They work with Homeless support services such as Booth House, and other services that homeless people may be accessing, including Turning Point (community substance misuse service providers) and local GP practices. Referrals can come to the community mental health teams from any source, including housing services at SBC, and the team works flexibly to accommodate homeless

people, seeing referrals in Booth House, Turning Point, Sandalwood Court or other locations in the community as required. Those with more severe and enduring mental health issues are cared for by the recovery service at Chatsworth House, and allocated a care co-ordinator.

Currently the Voluntary Sector Commissioning team commissions the following four voluntary sector providers of services;

- Cruse: a bereavement care service for people having difficulty coping with bereavement which provides support through one-to-one sessions, group sessions and over the phone.

- Twigs: a community gardens project for people with mental health problems.

- Mind: a national charity providing advice and support to people with mental health problems. The five ways to wellbeing underpin many of the services offered by Swindon Mind, which include one-to-one counselling for self-harm, a physical activity intervention, one-to-one employment support, one-to-one and group wellbeing support, and transitions services for both adults and children being discharged from mental health services,

- Phoenix: an independent social enterprise which supports people with mental health problems to access training and employment opportunities.

These services are for the general Swindon population, including for homeless people.

5.4 Gaps in Provision in Swindon

Anecdotally, those working in homeless support services felt that mental health was an area of unmet need. They felt that many of their clients have poor mental health, but are not deemed unwell enough for mental health input until a crisis occurs. Consistent with this, the Swindon Threshold Health Audit (2019) found that 41.2% of homeless people questioned identified as having a mental health treatment or assessment need in the last 12 months which was not addressed. More details are given in the “Health and Healthcare Services” section of the JSNA; this demonstrates that homeless people are commonly using the Acute Trust for mental health needs, and that poisoning and psychiatric conditions together make up over 30% of attendances for homeless individuals. Reducing hospital admissions for self-harm is a core aim of the CMHT, and a history of self-harm is reported in 14.8% of homeless people admitted to GWH.

Evidence shows that providing mental health care to homeless people is a specialist area benefiting from focussed activity, additional training and adequate experience (Pathway, 2018a). In the 2019 Mental Health JSNA the following vulnerable groups were identified as requiring targeting in service development as a priority, based on current limited provision for them:

- Young people, particularly women, aged 16-24
- Young and middle-aged men (in relation to suicide)
- **The prison population and offenders**
- **Homeless people**
- **Refugees, asylum seekers and stateless person**

- **People with debt problems**

(Mental Health JSNA, 2018/2019.)

Whilst homeless people are clearly identified, the other groups in bold are also known to be over-represented in the homeless population. Given the contribution of poor mental health to homelessness, under-provision of specific services for these risk groups could potentially exacerbate the risk of becoming homeless. Funding has been received to provide specialist homeless mental health care. With the needs highlighted above, and the time it can take to engage with this population and make progress, work is ongoing to identify how best to meet this need.

Frontline service staff reported finding basic training in mental health and the mental health assessment and treatment system useful in assessing homeless peoples' needs and working with mental health teams. Staff training could be an area for development in all organisations working face to face with homeless populations, and form part of the trauma-informed approach. According to the substance misuse and mental health services administration, a trauma-informed organisation does the following:

- Realises with widespread impact of trauma and understand the potential paths for recovery
- Recognises the signs and symptoms of trauma in clients, families, staff and others involved in the system
- Responds by fully integrating knowledge about trauma into policies, procedures and practices
- Seeks to actively resist re-traumatization

5.5 Promotion of Good Mental Health and Wellbeing

It is important that all the population have the opportunity to engage in positive activities to promote good mental health. The Foresight Mental Wellbeing and Capital project (Government Office for Science, 2008, pg. 61) found that,

> "people with a low level of wellbeing, even if they do not have a mental disorder, function far less well and have poorer health and life expectancy. This latter group is unlikely to come to the attention of specialist mental health services, but constitutes a large part of the population who are neither flourishing nor disordered, yet could benefit greatly from having access to interventions to improve their wellbeing. They are frequently seen in GP surgeries, primary care settings, social work departments and many other front-line public services."

Conceivably everyone who has experience of homelessness is at risk of a "low level of wellbeing". Positive mental health interventions include:

- Physical activity
- Access to green space
- Arts-based interventions

(Mental Health JSNA, 2019)

There are free mainstream opportunities in the above categories in Swindon that homeless people can use, however homelessness can be a personal barrier to taking positive action to promote one's own health, as well as a structural barrier to access if an address or identification are needed for instance. One Festival of Homeless Arts is a national example

of good practice, which uses an asset-based approach to allow people with experience of homelessness to develop and enjoy skills in the Arts. The appreciation of the Arts as a core human need is recognised in other areas in their homelessness strategies (Manchester City Council, 2018).

5.6 Summary and recommendations

- Poor mental health is a significant issue in the homeless population in Swindon
- The evidence shows that treating mental health issues in homeless people is a specialist area, and it has been identified as an area of unmet need in Swindon
- Recognition of mental health issues and collaboration between mental health and other support services is key to addressing this issue
- Mental health needs (including suicide prevention) must be considered in the homeless population in Swindon. Specialist mental health workers within homelessness, and CMHT outreach into homeless settings would benefit those with mental house and housing issues
- A positive approach to mental health in Swindon's homeless populations should make available evidence-based interventions to homeless people to promote good mental health

Chapter 6 Substance Misuse

6.1 Substance Misuse and Homelessness

Substance misuse is recognised as a driver and a complication of, and a barrier to resolution of homelessness (MHCLG, 2019a). In England, 912 individuals with experience of homelessness answered questions around substance misuse; 39% of audit participants said they take drugs or are recovering from a drug problem, and 36% had taken drugs in the month prior to the audit (Homeless Link, 2014a). This compares to 5% of the general population in that same time period. In addition 27% of respondents to the Homeless Link survey reported a current or previous alcohol problem.

Substance type	Reported prevalence of use
Cannabis	64%
Prescription drugs	29%
Heroin	27%
Benzodiazepines	18%
Amphetamines	17%

Table 26. Reported substance misuse by drug type in homeless people in England.

Percentages represent proportions of those who reported substance misuse. Data source: the Homeless Link (2014a) survey, of 912 individuals with experience of homelessness.

Substance misuse is a cause of premature mortality amongst rough sleepers and the wider homeless (Crisis, 2012). In 2017, over half of all deaths of homeless people in England were due to poisoning (ONS, 2018b). Deaths can occur directly due to overdose, but also because of the other physical risks that substance misuse exposes people to. Substance misuse amongst people with experience of homelessness has negative effects on the

general population too, including implications for infectious disease control, physical risks of drug paraphernalia and associations with criminal activity.

The prevalence of substance misuse also varies by kind of accommodation, and whether drugs or alcohol are considered. Substance misuse remains common across the spectrum of homelessness, including those who are the hidden homeless and those who are in supported or private accommodation.

Type of Accommodation	Prevalence of illicit drug use	Prevalence of alcohol misuse
Squatting	60.0%	23.5%
Rough sleeping	53.4%	38.5%
Sofa surfing	39.8%	25.3%
Supported accommodation	36.8%	23.3%
Private accommodation	32.5%	17.1%
Emergency accommodation	24.8%	21.3%
Other temporary accommodation	22.9%	16.7%

Table 27. Prevalence of illicit drug use and alcohol misuse by accommodation status of people with experience of homelessness in England.

Data source: England Homeless Link (2014a) survey. For drug use n=1828, for alcohol misuse n=1864.

Nationally, in 2017/18, 8% of adults starting treatment for substance misuse were identified as having urgent housing issues, usually no fixed abode. A further 11% had some other form of current housing problem, such as sofa surfing, or staying in a short term hostel (NDTMS, 2019).

6.2 Substance Misuse in Swindon

In Swindon, substance misuse and alcohol community services are commissioned by SBC and provided by the independent provider Turning Point for adults, and by an in-house SBC service U Turn for children and young people. The numbers in treatment during the period February 2017 to February 2019 for all providers are shown in Table 28. In England, deaths related to drug misuse are at their highest level (4.3 per 100,000) since comparable records began in 1993 (Statistics on Drug Misuse, 2018). Comparatively, Swindon has a lower rate of 2.4 per 100,000 and has seen a reduction since 2012/14.

More detailed profiling of the substance misuse issues in Swindon are shown in the Substance Misuse JSNA (2017).

Month	Feb 2017-Jan 2018		Feb 2018-Jan 2019	
	Number	%	Number	%
Opiate (n)	575	58.1	620	60.5
Non-opiate only (n)	67	6.7	72	7.0
Non-opiate and Alcohol (n)	66	6.7	77	7.5
Alcohol only (n)	282	28.5	256	25.0
Total	990	100	1025	100

Table 28. Number of clients for all providers of substance misuse and alcohol services in Swindon, 2017-2019.

Data source: national drug treatment and monitoring service (NDTMS, 2019).

Trends for the last decade in destinations of clients from the treatment programmes in Swindon are shown in Figure 18. The proportion of clients have successfully completed treatment appears to be reducing in the last 6 years from a peak in 2013/14, with increasing numbers dropping out of treatment. During this period there has been a change in service provider, and this transition period may explain some of this trend.

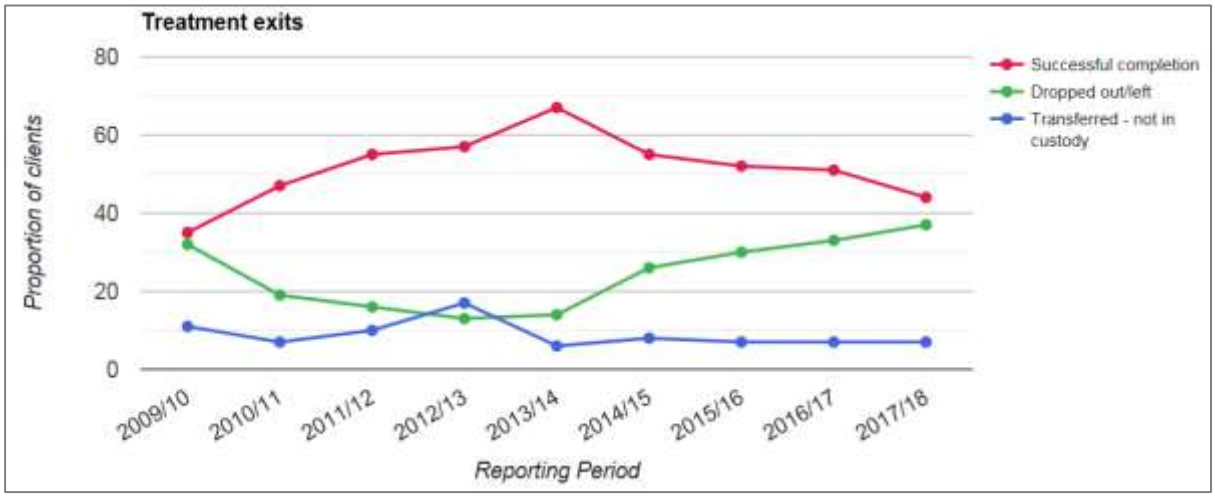


Figure 18. Treatment exits from substance misuse services in Swindon.

Data source: NDTMS.

6.3 Substance Misuse and Homelessness in Swindon

The data for statutory homelessness assessments in Table 28 shows that locally and nationally, those with substance misuse issues represent a minority of individuals applying to local authorities for homelessness support. Under-reporting of substance misuse conditions to local authorities is likely, and the figures in Table 29 only give the reported proportions across the spectrum of homelessness.

	Applications	Acceptances	Drug dep.*	% applications	% acceptances	Alcohol dep.*	% applications	% acceptances
England	207,650	189,760	10,020	4.8%	5.3%	7,800	3.8%	4.1%
South West	19,560	17,630	1,270	6.5%	7.2%	1,130	5.8%	6.4%
Swindon	527	291	13	2.5%	4.5%	19	3.6%	6.5%

Table 29. Statutory homelessness for households with an alcohol or drug dependency (Dep.) issue, April-December 2018.

* Data are for acceptances. Data source: MHCLG, 2019.

The numbers of adults starting treatment in Swindon with a self-reported housing issue are shown in Table 29. It is not known what proportion of these people presented to the council and were assessed as homeless.

Housing Situation	2009 /10	2010/ 11	2011 /12	2012 /13	2013 /14	2014 /15	2015 /16	2016 /17	2017 /18
No problem	302	366	394	458	377	424	324	310	233
Any Housing problem	65	73	55	82	57	121	124	114	73
Non-urgent Housing Problem	44	48	35	59	38	90	72	57	21
Urgent Housing Problem	21	25	20	23	19	31	52	57	52

Table 30. Numbers of new adult clients in Swindon starting substance misuse treatment with a housing problem.

Data source: NDTMS.

A small number of clients were coded as other and these figures have been suppressed as they were commonly less than 5. Totals are therefore not reported

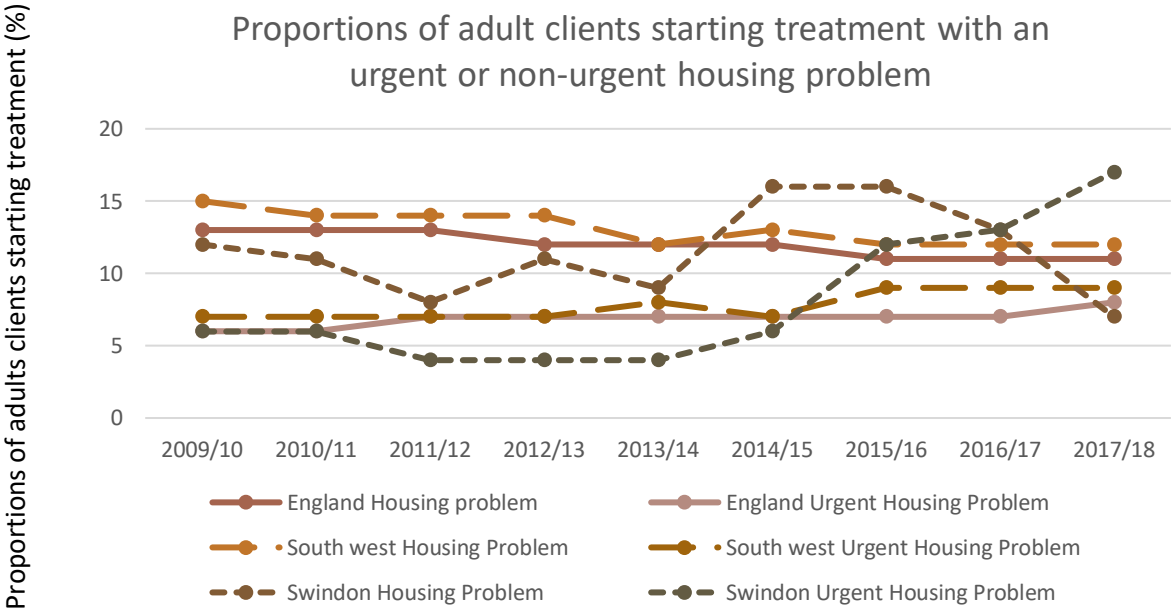


Figure 19. Proportions of new adult clients with a housing problem for Swindon, the South West and England.

Clients were starting treatment for any kind of substance misuse (opioid/alcohol/non-opioid). Data Source: NDTMS.

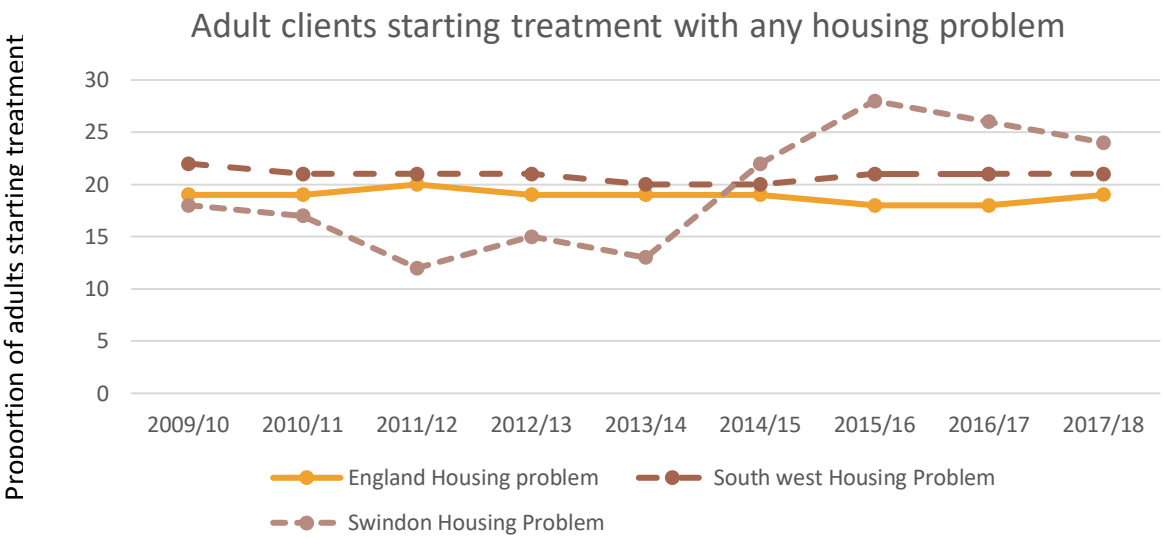


Figure 20. Proportion of new adult clients with any kind of housing issue in Swindon, the South West and England.

Adults were starting treatment for any kind of substance misuse (opioid/alcohol/non-opioid). Data source: NDTMS

A summary of the trends in Swindon, seen in Table 31 and Figures 19 and 20 are:

- Numbers of new clients with any housing problem increased in 2014-2017, peaking at 124 in 2016/17. This represented 28% of new adult clients. The reason for this increase is unclear.
- The latest figures for 2017/18 show that 73 clients had a housing problem (urgent or non-urgent), representing 24% of clients.
- Numbers (and proportions) of people in substance misuse treatment with an urgent housing problem have increased in the last 4 years, whilst numbers (and proportions) with a non-urgent housing problem have reduced. In 2009/10 5.7% (95% CI 3.3-8.1%) had an urgent housing issue, compared to 17.0% (95% CI 12.8-21.2%) in 2017/18.
- The trends for the South West and England have been less variable over the last 10 years, and this may be due to larger numbers.
- It's not clear if trends in housing need, and differences identified above represent a coding difference or a changing pattern in the Swindon clients' housing needs.

Type of Substance Misuse

Figure 21 shows numbers of new clients in Swindon by the type of substance misuse issue. It can be seen that more clients are seen for either alcohol or opiate misuse, than for non-opiate drug misuse. The number of opiate users appears broadly stable over the last decade, whilst the number of alcohol users has varied more widely and has fallen below the number of opiate users for the first time in 2017/18. Figure 22 shows trends for the last 10 years for type of substance misuse within those with housing problems.

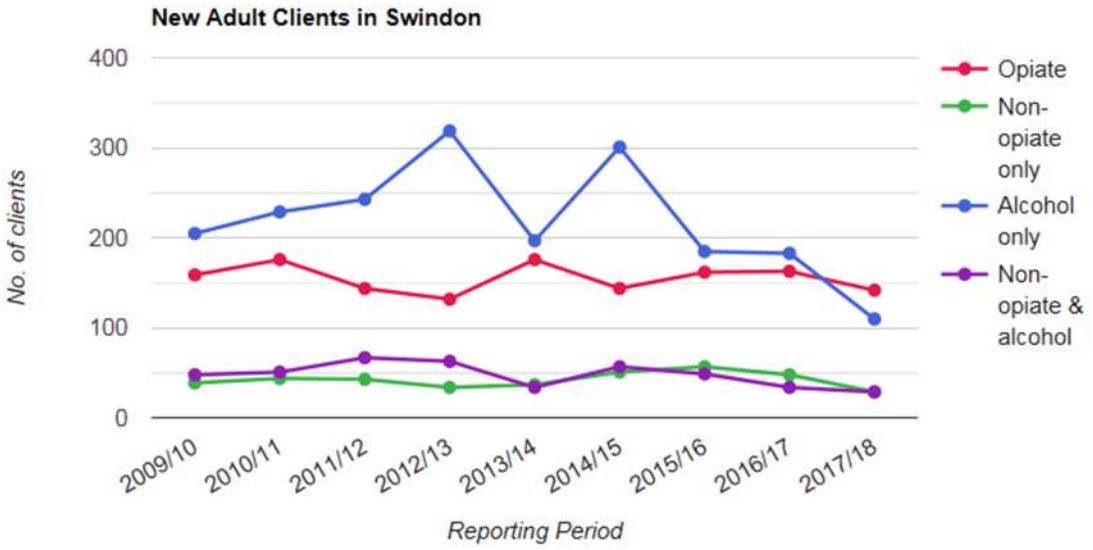


Figure 21. New Adult clients in Swindon by type of substance misuse issue.

Data source: NDTMS

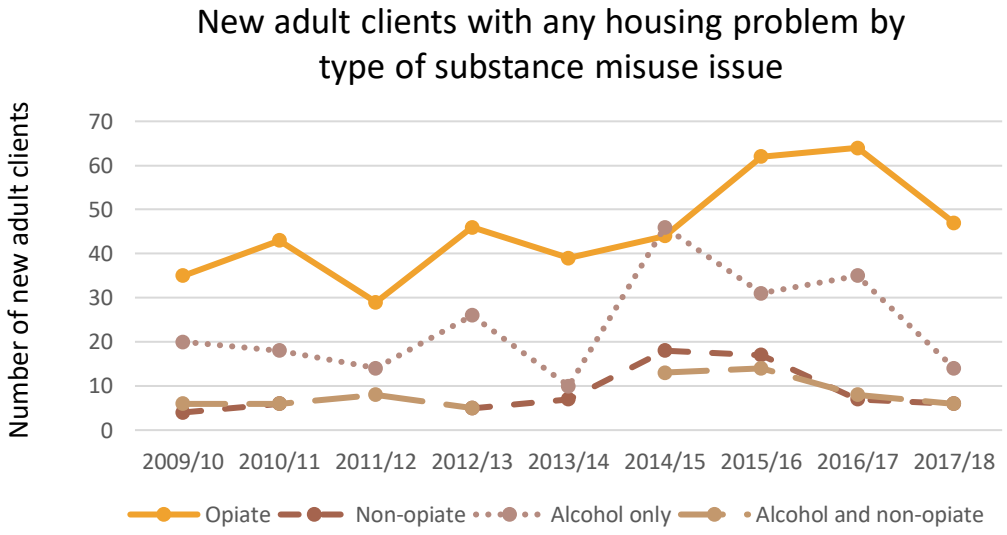


Figure 22. Numbers of new adult clients in Swindon with any housing problem by type of substance misuse issue.

Note some numbers were less than 5, and have therefore been suppressed. Data source: NDTMS.

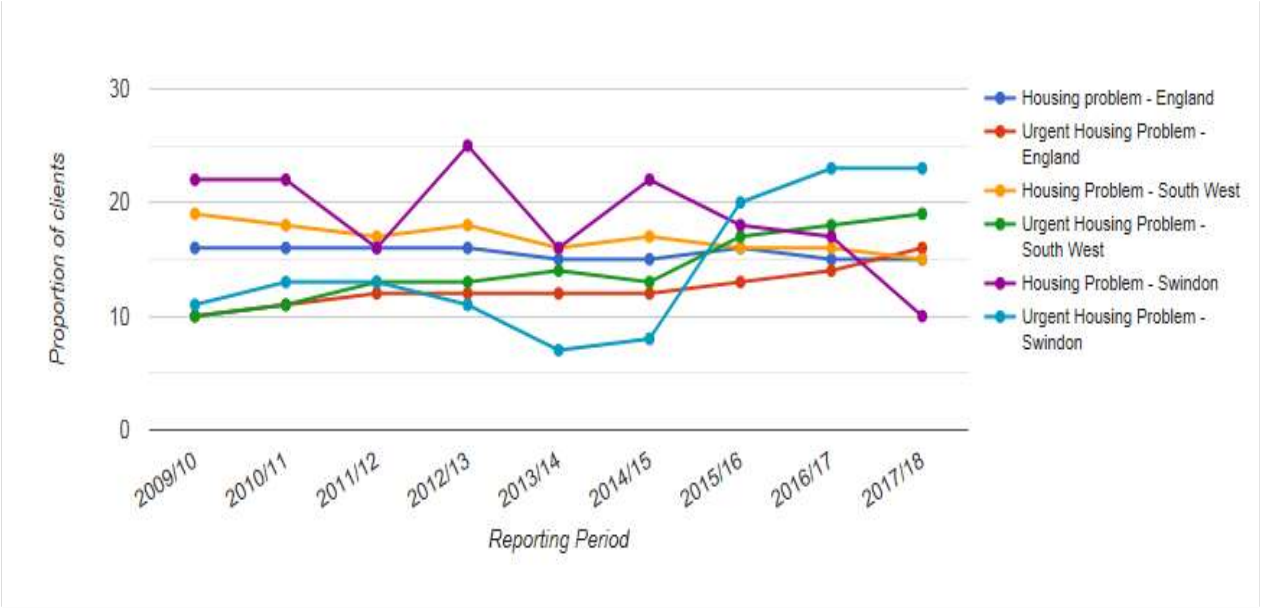
Interpretation of the trends:

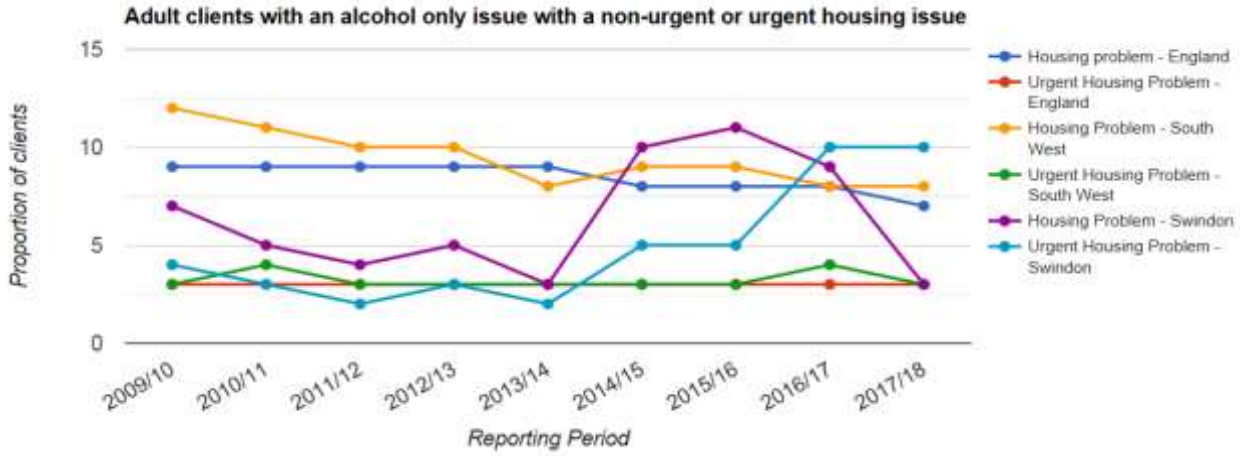
- Clients with opiate misuse: in Swindon, the South West and England absolute numbers with any housing problem, particularly with an urgent housing problem have increased over the last 10 years, although proportionally housing problems in opiate misusers remain stable. This suggests a rising problem with opiate misuse nationally.
- Clients with alcohol misuse: in Swindon, increasing proportions have an urgent housing problem, and there has been an overall increase in absolute numbers with any housing issue (data not shown, source NDTMS). This has not been seen

regionally or in England, and will need to be monitored. It may be a coding issue, or a real increase. Cause and effect between alcohol misuse and homelessness cannot be determined from these data.

- Clients with non-opiate, and non-opiate + alcohol misuse: smaller numbers mean variation is more likely due to chance, however it appears proportions with a non-urgent or urgent housing issue are around the England and South West averages.

Adult clients with an opiate issue with a non-urgent or urgent housing issue





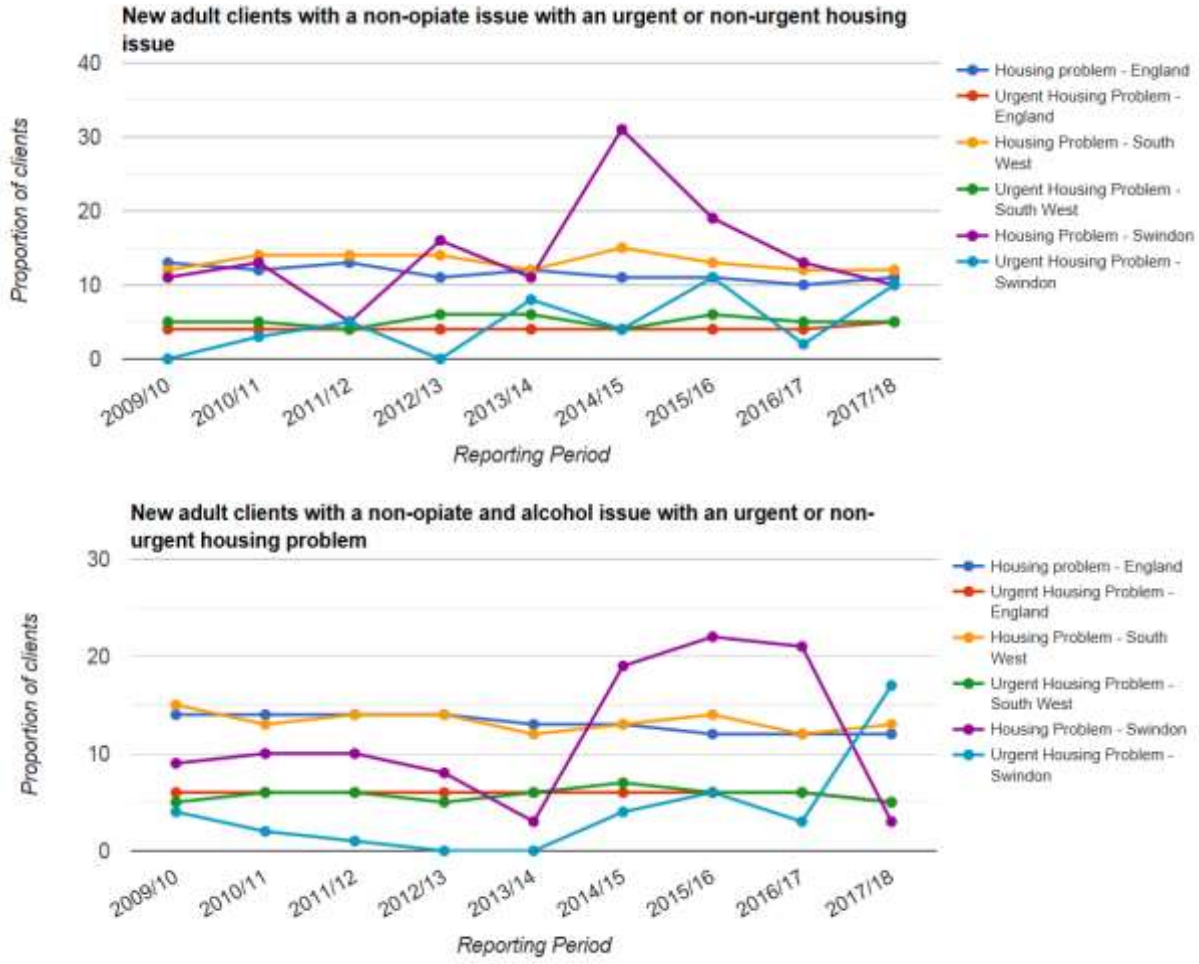


Figure 23. Proportion of adult clients with separate substance misuse issues who have an urgent or non-urgent housing problem, for Swindon, the South West and England.

Data source: NDTMS.

Nationally, it is reported that the highest levels of housing problems are seen in opiate users who also report novel psychoactive substance misuse (NDTMS 2019). In this cohort 59% reported a housing need in 2017/18, compared to 31% for opiate clients overall. Turning Point do not find that novel psychoactive substances are commonly used by those using substance misuse services in Swindon.

Although the focus of the substance misuse services is alcohol and drug use, they influence health in other ways. For instance, all clients are required to have a registered GP to engage in treatment. Turning Point also offers blood borne virus screening as part of the treatment offer. Latest reports show in December 2018-March 2019 over 90% of clients were offered testing for Hepatitis B, C and HIV. However, only 6% of those eligible for Hepatitis B vaccination have completed a course. As will be discussed, these are known health risks for the homeless population, and must be a continued focus for those accessing substance misuse services.

6.5 Experience of Turning Point

Experience of Turning Point was generally good in their last service user survey, and over 85% described Turning Point as “welcoming and inviting,” (IMPACT, 2019a). Anecdotal concerns around substance misuse services in Swindon from those interacting with homeless people in frontline services include:

- the need for better inter-agency working,
- waiting times for appointments, and
- availability of prescriptions over weekends and bank holidays.

Forums such as the Homeless and Healthcare network and the Rough Sleeper Panel are intended to facilitate such inter-agency collaboration. Issues raised by people with experience of homelessness during the engagement exercise carried out for this JSNA included the costs of calling Turning Point, and the restriction of support programmes to group therapy. The general service users who answered the survey (IMPACT, 2019a) found that availability of appointments was good, and that waiting times were not an issue.

Data from the NDTMS on waiting times is shown in Table 31. Here, it is clear that the performance of the adult substance misuse services starting treatment within three weeks has been consistently good for the last 6 years. A three week wait may be considered a long time by service users, and nationally the average waiting time is less than one week (Drug Commissioning Support Pack 2018/19). Turning Point report prioritising low waiting times for all clients.

Waiting Times	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Under 3 Weeks (%)	92	88	97	98	100	99	100	100	100

Table 31. Waiting times from referral for treatment to treatment availability in substance misuse services in Swindon.

Data source: NDTMS.

Turning Point has a dedicated housing worker. Housing is identified by them as a factor determining “recovery capital” of their clients, alongside education, social and family support. Between December 2018-March 2019, 8 clients accessed in house housing support from Turning Point. With between 73 and 124 clients starting treatment per year self-reporting a housing problem, this service appears under-utilised, although clients may prefer to seek support elsewhere.

Please refer to the service user engagement section for more detail on experiences around substance misuse in homeless people in Swindon.

6.6 Young people

Smaller numbers of young people are seen and treated by U Turn. Referrals sources in 2018/19 included:

- Youth engagement service
- Youth offending team
- Universal education
- Parents
- Mental health services
- Primary healthcare services
- Great Western Hospital
- Children’s services

- Alternative education

Numbers are not given as they are too small to be reported. However, it should be noted that the substance misuse profiles differ from adults in treatment, with many more young people in treatment for cannabis, and much less exposure to alcohol and opioids such as heroin.

	Swindon Apr-Dec 2018	England Apr-Dec 2018
Wider vulnerabilities	**(%)**	**(%)**
Looked After Child or Child in Need	18%	21%
Domestic Abuse	11%	21%
Mental health treatment need	65%	32%
Self-harm	30%	17%
NEET	24%	16%
Child Protection Plan	15%	8%
Anti-social behaviour / criminal act	28%	31%
Affected by others' substance misuse	20%	22%
Other	15%	17%
Total new presentations	100%	100%

Table 32. Wider vulnerabilities in children and young people under treatment with drug and alcohol services in Swindon, April-December 2018.

Other: child in need, sexual exploitation, housing problems, parental status or pregnant. Data source: National drug monitoring and treatment services. Young people executive summary (NDTMS, 2019a).

The data in Table 32 describes the wider vulnerabilities in children and young people using the U Turn service, with national comparison. Small numbers are identified as having housing problems. More common are the occurrence of other vulnerabilities such as being a looked after child, experiencing domestic abuse or sexual exploitation, and having mental health needs. Whilst homelessness is a more common issue for adults with substance misuse issues, many of the young people using U turn will have experience of Adverse Childhood Experiences (ACEs) which are a known risk factor for homelessness and poor outcomes later in life (MHCLG, 2019a). To this end, proactive engagement with this population is important to prevent homelessness amongst a high risk group.

6.7 Summary and recommendations

- Substance misuse is a driver of homelessness, as well as a cause of premature mortality amongst homeless people nationally.
- In Swindon, 11% of households accepted as homeless with SBC in 2018 had drug or alcohol dependency issues. 24% of those starting treatment in 2017/18 with adult substance misuse services reported a housing issue.
- In Swindon, there has been a rise in the numbers of new adult clients to substance misuse services with a housing problem, particularly amongst opiate users.
- There should be an emphasis on engaging with, and supporting completion of treatment, for adults and children with substance misuse and housing issues in Swindon
- Homeless support services and substance misuse services need to work together to support those with substance misuse issues into treatment, this may include writing

personal support plans, criteria for support with individuals, continued treatment in transitioning between prison and the community.

Chapter 7 Complex needs

7.1 Understanding complex needs

Complex needs is a phrase often used but rarely exactly defined. In the UK it is generally used to refer to those with needs that cross biopsychosocial divisions, including mental health, substance misuse, and significant social issues such as time in prison or experience of homelessness.

The WPI Economics report (2019) states that a consistent theme from local authorities and providers is that when people do access housing services, they do so with greater or more complex needs than previously. It is suggested that this is partly due to a reduction in lower-level support services, so that people with additional needs don't get support until their housing situation deteriorates and they are eligible for statutory housing support or are sleeping rough. Increased needs necessitate increased treatment intensity and/or duration, with associated costs.

7.2 Complex needs in Swindon

The LankellyChase Foundation undertook a study to provide a statistical profile of a key manifestation of 'severe and multiple disadvantage' (SMD) in England. In this report, SMD is a shorthand term used to signify the problems faced by adults involved in the homelessness, substance misuse and criminal justice systems in England, with poverty an almost universal, and mental ill-health a common, complicating factor (LankellyChase, 2015).

Findings for England are:

- over 250,000 people have contact with at least two out of three of homelessness, substance misuse and/or criminal justice systems,
- at least 58,000 people have contact with all three,
- 80% of people affected by this form of SMD are men, predominantly white, aged 25-44, with long-term histories of economic and social marginalisation, and in most cases childhood trauma.

Figure 25 gives the numbers estimated for Swindon in the three domains of SMD. This uses data from 2010/11 from multiple services for socially excluded groups of adults, offender assessment systems, ministry of justice statistics, NDTMS data and the multiple exclusion homelessness survey. This work has not been repeated since.

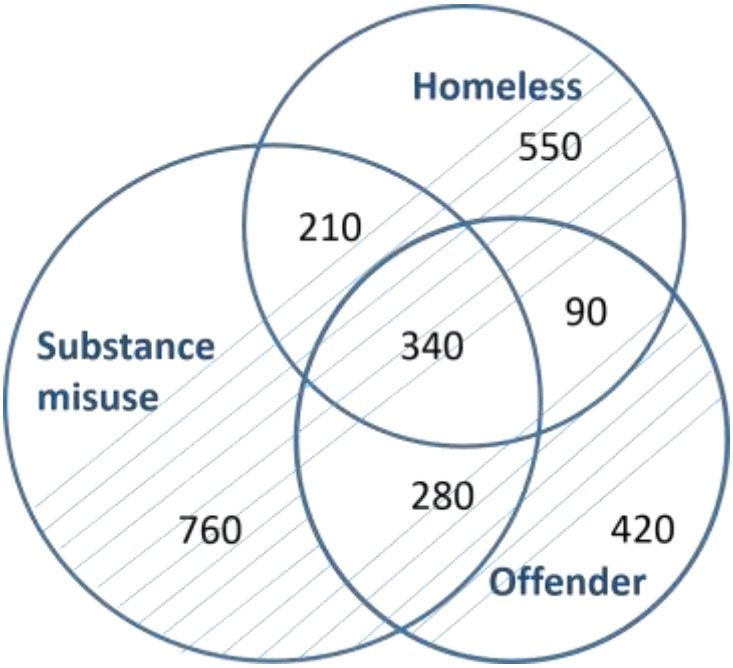


Figure 24. Numbers of individuals in overlapping SMD domains in Swindon, 2010/11.

Data source: Lankelly Chase, 2015. Hatched areas represent those with mental health issues estimated within the different domains.

Using data from the substance misuse services gives more up to date information, although doesn't allow consideration of how these difference domains overlap, as seen in Figure 24.

In England:

- 41% of new adult clients for substance misuse self-identified as having a mental health treatment need in 2017/18 (NDTMS, 2019).
- The proportion of clients with a mental health treatment need was highest for non-opiate and alcohol users (47%), whilst the absolute numbers were highest for alcohol only and opiate users.

In Swindon:

- Turning Point reported that 223 of 843 (26%) clients in the period April 2018-December 2018 were listed as dual diagnosis (having a severe, persistent mental health problem).
- In 2017/2018, 24% of new adult clients to Turning Point had a housing problem. If this proportion applies to those who also have a mental health treatment need (388 people), this results in an estimated 93 people (10% of the total numbers starting treatment in 2017/18) with complex needs. However, true prevalence of complex needs amongst the homeless of Swindon is likely to be higher, because:
  - it is possible that the presence of complex needs increases the risk of homelessness
  - mental health issues are under-diagnosed, and may be a barrier to engagement with substance misuse services.
  - those in the prison system are unlikely to be counted in the numbers above.

The Homeless Outcomes Star is used widely by homeless support services (Triangle, 2017), but is variably used in other services like mental health. This is a tool to facilitate objective assessment of an individuals' needs and goals, and could be used in communication

between services to create common understanding of objectives and progress. The Star is completed with an individual and should be used to track progress. It assesses the following different areas:

- Motivation and taking responsibility
- Self-care and living skills
- Managing money and administration
- Social networks and relationships
- Drug and alcohol misuse
- Physical health
- Emotional and mental health
- Meaningful use of time
- Managing tenancy and accommodation
- Offending

Anecdotally, those working frontline in homeless support services describe consistently the challenges in engaging with people with complex needs. Intensive support is often needed, with repeated offers of support rather than a single window to engage. Engagement is also often gradual and relies on a slow building of trust and relationships.

7.3 Summary and Recommendations

- Complex needs means having mental health, substance misuse, and significant social issues such as time in prison or experience of homelessness
- The exact numbers in Swindon are difficult to estimate, but data from 2010/11 suggests it is common for people experiencing homelessness to have other needs including mental health, substance misuse and time in prison
- Strong collaboration between substance misuse services, mental health services, probation and housing is needed to support those with complex needs
- Intensive support over longer periods may be required for homeless people with complex needs than for homeless people without substance misuse or mental health issues
- To facilitate collaboration between substance misuse services, mental health services, probation and housing, commitment to attendance at the CCG Homeless and Healthcare network or the Rough Sleeper Panel could be considered contractually

Chapter 8 Other vulnerable groups and support needs

In this chapter other vulnerable groups will be considered. These have been selected, as the evidence shows they are more at risk of homelessness, or the complications of experiencing homelessness. The groups considered here are:

- People with learning difficulties and disabilities
- Victims of domestic abuse
- Care leavers
- Asylum seekers and refugees
- Veterans of the Armed Forces
- Victims of modern slavery

- Sex workers
- People exploited by County Lines activity

8.1 Learning disabilities and difficulties

There is national evidence that people with learning disabilities are over-represented in the homeless population, however this is often not diagnosed or recorded (Oakes, 2008). Numbers have not been presented for Swindon as they are too small to be reported, but represented fewer than 1% of applications. The Swindon Threshold Health Audit (2019) found that 14 of 85 (16.5%) of homeless people in Swindon who responded to the survey reported having a learning difficulty or disability. Therefore, it seems that people with learning disabilities or difficulties are either not approaching the council for statutory assistance, this is not identified or not recorded by SBC.

	Applications	Acceptances	Learning Disability*	% applications	% acceptances
England	207,650	189,760	7,670	3.7%	4.0%
South West	19,560	17,630	1,070	5.5%	6.1%

Table 33. Statutory homelessness for households with a learning disability identified, April 2018-Dec 2018.

*data are for acceptances. Data Source: MHCLG, 2019.

It is also known that people with learning disabilities and difficulties are over-represented in prisons, (Mental health, 2019). Wiltshire Police, in reviewing modern slavery in Wiltshire and Swindon, raise learning disabilities as an individual vulnerability that can predispose people to exploitation (Wiltshire Police, 2018). These issues may all increase the risk of homelessness and poor outcomes for this group.

8.2 Domestic abuse

Violent relationship breakdown is a recognised cause of homelessness (MHCLG, 2019), and this group have particular vulnerabilities that need to be considered when supporting their housing needs. Further, domestic abuse can mask a housing need if people stay in these relationships.

For a more in-depth profiling of the domestic abuse (DA) issue in Swindon please see the JSNA (Domestic Abuse JSNA, 2018). The national prevalence rate is 5.9%, for women it is reported to affect 7.5% of the population, and 4.3% of males.

	Applications	Acceptances	Domestic abuse risk/experience*	% applications	% acceptances
England	207,650	189,760	17,330	8.3%	9.1%
South West	19,560	17,630	2,140	10.9%	12.1%
Swindon	527	291	23	4.4%	7.9%

Table 34. Statutory homelessness for households at risk of, or with experience of domestic abuse, April-Dec 2018.

* Data for acceptances. Data source: MHCLG, 2018.

As seen in Table 34, potential domestic abuse was identified in 7.9% of successful applications to SBC in the first three quarters since the Homelessness Reduction Act (2017). From the numbers referred to community support in Swindon in Table 35 below, it seems a minority of DA victims seek statutory homelessness support.

Swindon Women's Aid (SWA) is commissioned by SBC to provide the Swindon Domestic Abuse Support Service (SDASS). The numbers and details of domestic abuse referrals for the first three quarters of 2018/19 to SWA are detailed in Table 35. Some data has been suppressed as numbers were less than 5. Sources of referrals included the police, children's services, self-referral, SWA, mental health services, Great Western Hospital, GP, probation, drug and alcohol services. There were a small number of referrals to mental health services and drug and alcohol services from SWA in 2018/19 (fewer than 5 per quarter).

Support includes a refuge which provides accommodation for victims and their children if needed. The outcomes for women leaving the refuge include to have returned to their partners, returned home with no partner, moved out of the area, moved to family or friends, moved to private rental or social housing accommodation or were evicted. Numbers for most categories were small so could not be reported. 22 of 61 women leaving the refuge (36%) moved on to social housing or private rental accommodation (numbers not able to be reported separately). Cases referred to SDASS are discussed at the MARAC (Multi-agency risk assessment committee).

Area	**Measurement**	**Quarters 1-3 2018/9 (1/4 -31/12)**	
		Numbers	**% total referrals**
Referrals	Number of referrals to Women's Refuge	104 in total 65 accepted support	100% 63%
	Number of referrals to Community Support (CS)	744 in total 305 accepted support	100% 43%
	Number of dependent children with referral	425 in total	NA NA
	Number of repeat referrals	Refuge: 35 CS: 223	34% 30%
	High Risk Referral	Refuge: 39 CS: 54	38% 18%
	Average length of time abuse has been ongoing*	Refuge: 72-84 months CS: 55-63 months	NA NA
Starters with SDASS	Number of children taken into the Women's Refuge	188	NA
	Number who are NEET	Refuge: 43 CS: 194	66% 64%
	Number referred to MARAC	Refuge: 40 CS: 33	62% 11%
Supported by SDASS	Number of overall victims supported	Refuge: 122 CS: 305	NA NA
Leavers	Number of people leaving the Women's Refuge	61	NA
	Average length of stay for those leaving the Refuge*	2.2-4.1 months	NA
	Number of those leaving support registered with GP	Refuge: 41 CS: 160	67% NA
	Number of those leaving support who are NEET	Refuge: 35 CS: 100	57% NA
	The average scores*/responses to the OASIS Empowerment Exit	Refuge: 70-100% CS: 84-100%	NA NA

	form with reduced risk or improvement made.		

Table 35. Numbers for referrals and support provided by Swindon Domestic Abuse Support Services (SDASS) for quarters 1-3 of 2018/19.

*Averages are reported as ranges as means were only available for quarterly totals, and numbers per quarter were not available so an overall mean could not be calculated. CS: Community Support. NEET: Not in education, employment or training. Data Source: Swindon Women's Aid Domestic Abuse Service Performance Matrix. 2018/19.

The themes from the data above and the domestic abuse JSNA are:

- DA is usually longstanding before a referral is made to services,
- Referrals are most likely to come from the police.
- Children are often involved in a setting where domestic abuse is taking place, and it is a common reason for referral to children's services.
- A co-ordinated community response to domestic abuse is required, and is a priority in Swindon, with examples of good practice such as the MARAC.
- There is a need for better data sharing between organisations working with DA perpetrators and victims
- Swindon needs development of provision for victims and perpetrators with complex needs

The refuge generally operates near to capacity, and women (and children) generally stay for 2.2-4.1 months before moving on to a variety of settings, including back to their partner. Social housing and private rental accommodation are used in a minority of cases. The OASIS Empowerment Exit form is used to assess for reduced risk on leaving the refuge or support services, and consistently shows improved results on exiting support services. Nonetheless, repeated referrals for the same individual are common. 34% of refuge referrals were repeat referrals, and repeat refuge referrals tended to be higher risk than those to community services. It is common that women needing support from SWA are not in education, employment or training, a further factor that may be associated with them requiring support from the SWA services, rather than using a social network or their own resources to seek alternative accommodation.

8.3 Care leavers

Young people with experience of the care system face a higher risk of homelessness (Homeless Link, 2018). The Children (Leaving Care) Act 2000 and the Children and Young Person's Act 2008 give care leavers the rights the support they need to do well when living independently. Care leavers must be appointed a personal advisor, and have an assessment of their needs which will feed into a Care Plan (16 and 17 year olds) and Pathway Plan (from 16 years for transitioning to leaving care). Local Authorities are directed to develop "Staying Put" policies aimed at allowing care leavers aged 18+ to stay at their foster carers' homes. Social services are responsible for finding somewhere suitable for the care leaver to live, and for providing financial support. Duties vary, but extend across Eligible and Relevant Children, Former Relevant Children, Qualifying Children, and Young People on a secure remand. Suitable accommodation does not include B and B's, which can only be used in short-term emergencies (Coram Voice). Not being in education, employment or training (NEET) is the most common support need identified amongst young people using homeless accommodation (Homeless Link, 2018).

Numbers of care leavers accessing statutory homelessness support in England and the South West are shown below. Numbers are too small for Swindon to be reported, although proportions are similar to the national levels.

	Applications	Acceptances	Care leavers*	% applications	% acceptances
England	207,650	189,760	4,020	1.9%	2.1%
South West	19,560	17,630	570	2.9%	3.2%
Swindon	527	291	NA	-	-

Table 36. Statutory homelessness for households including one or more care leavers, April-December 2018.

Care leavers: aged 18-20 and 21+ grouped together due to small numbers in Swindon area. *data are for acceptances into a prevention or relief duty. Data source: MHCLG, 2019.

In Swindon:

- Of those accessing the commissioned services in Swindon referred to in "Housing Support and Homelessness Services", 15% of referrals from 2016-2019 were recorded as having experience of the care system.
- Between January 2018 and March 2019, there were an average of 260 care leavers registered with SBC. On average over this period, 58% of the care leavers were male.
- An average of 81 care leavers per month (31% of all care leavers), were eligible for, and linked with a personal assistant (SBC Children's Services Summary Scorecard).
- Around 40% of care leavers are not in education or training, comparable to England and Swindon's statistical neighbours' data (see Figure 25).
- Based on data from those in contact with their personal advisors, there has been an upward trend in Care Leavers in suitable accommodation, to 90.3% (95% CI 86.7-93.9%) in 2018/19, above the averages for England (84%) and Swindon's statistical neighbours (82.7%).
- SBC now have a young person Housing Panel that young people approaching 17.5 years will be presented at to ensure that the planning for post-18 accommodation is more timely and robust.
- SBC have appointed a Personal Advisor (PA) who works across both the Housing and the Leaving Care Team with the specific role of prevention of homelessness by providing additional targeted support to those young people who are most at risk.
- SBC have appointed a new Children's Commissioner who has been working with existing local providers to improve the quality of the offer to our care leavers as well as engaging with new providers to widen choice
- SBC have increased the number of Care Leavers Staying Put with their foster families

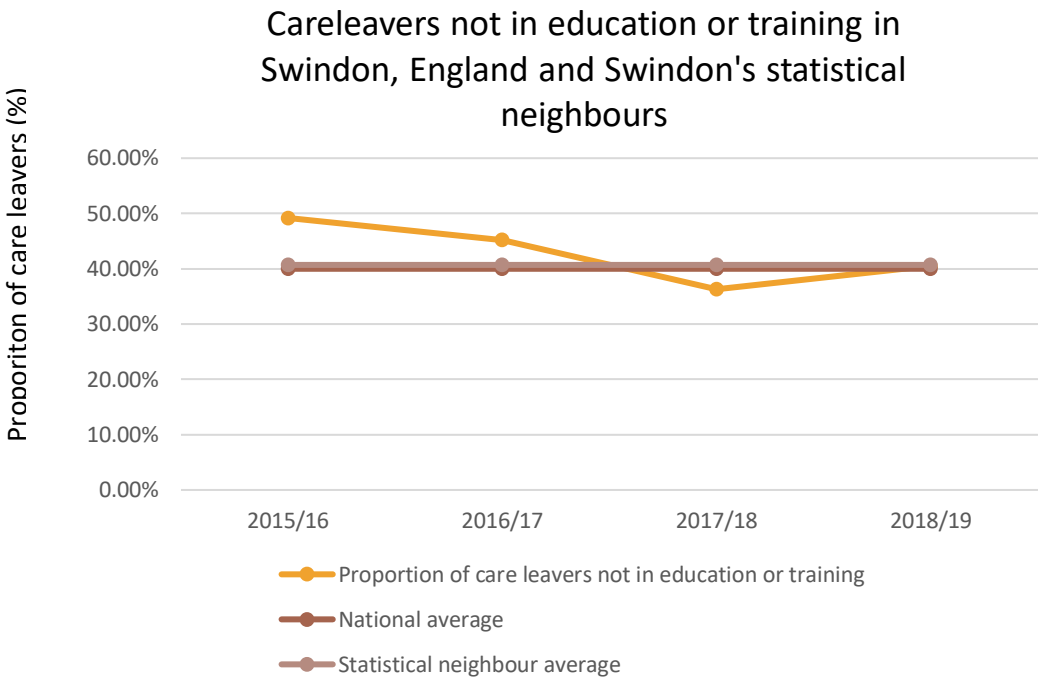


Figure 25. Proportion of care leavers registered with Swindon Borough Council not in education or training.

Data source: SBC Children's Services

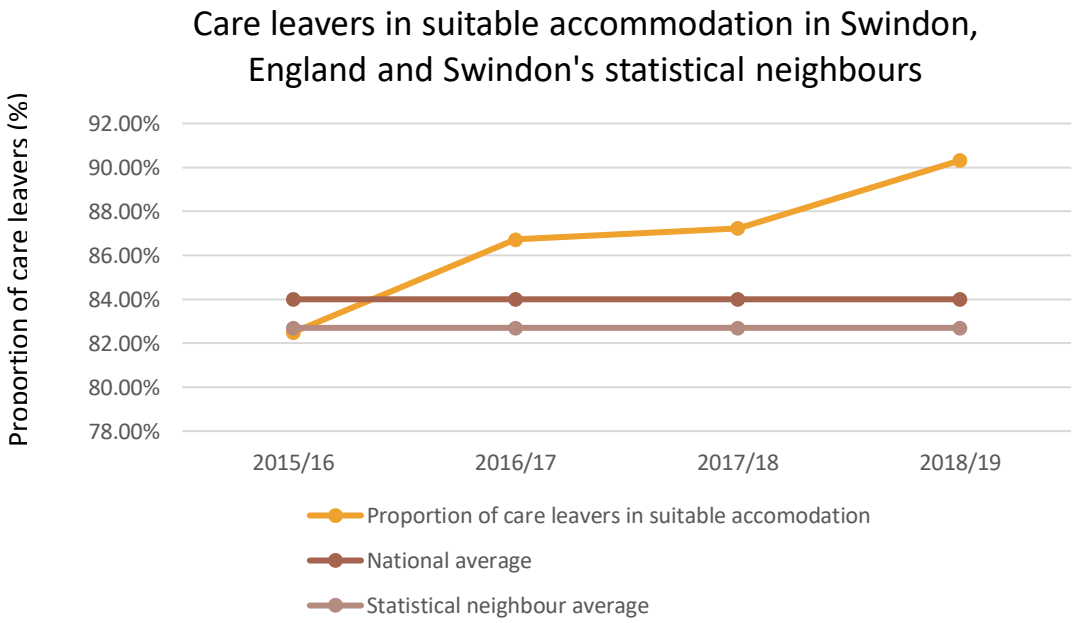


Figure 26. Proportion of care leavers registered with Swindon Borough Council in suitable accommodation.

Data source: SBC Children's Services

Some of the emergency accommodation provided to Care Leavers in Swindon would be assessed as "unsuitable", (such as Booth House and Culvery court), as it is homeless accommodation. However, the young person would be supported with a pathway to move on

from this accommodation if they choose to engage. It is recognised that there needs to be more choice of accommodation for young people within Swindon.

8.4 Asylum Seekers and Refugees

Swindon is a dispersal town for asylum seekers and refugees, meaning there is a support service in Swindon for new arrivals run by the National Asylum Support Service (NASS). There are many dispersal towns in England. NASS provides support, accommodation and financial help for asylum seekers whilst their claim is being considered by the Immigration & Nationality Directorate (IND). When given Indefinite Leave to Remain (ILR), individuals must then leave NASS accommodation, and may need to seek housing through SBC. The Harbour Project supports this process (see below). As seen in Table 37, Swindon has small numbers of applicants accepted into a prevention or relief duty who are in NASS accommodation.

	Applications	Acceptances	NASS accommodation when accepted into a duty*	% applications	% acceptances
England	207,650	189,760	2,380	1.1%	1.3%
South West	19,560	17,630	80	0.4%	0.5%
Swindon	527	291	6	1.1%	2.1%

Table 37. Statutory homeless for households in NASS accommodation, April-December 2018.

*data are for acceptances. Data source: MHCLG, 2019.

The Swindon Harbour Project supports asylum seekers and refugees with housing needs, as well as a range of other activities such as English lessons and support to register with a GP. Their data shows that 208 individuals applied for ILR in 2018/19, of which 92 (44%) were successful. Figure 27 demonstrates that a substantial proportion of these individuals have housing needs. Historically the absence of a priority need for single men in particular has contributed to the need for the City of Sanctuary Temporary Accommodation, as they would not otherwise have qualified for accommodation from SBC. Only 12 individuals were assessed as being owed a housing duty from April 2014-March 2017 due to leaving NASS, and 6 individuals owed a statutory duty from April-December 2018 (figures are not available for the whole of 2018/19 for comparison with the Harbour Project data). However, it is probable that there is unmet need in this population.

Asylum seekers and refugees often do not speak English and may have other vulnerabilities that increase the difficulty of navigating the system and raise the risk of rough sleeping. Anecdotally, The Harbour Project report an increase in the numbers of families seeking ILR in Swindon, as well as family reunions for those who have a ILR.

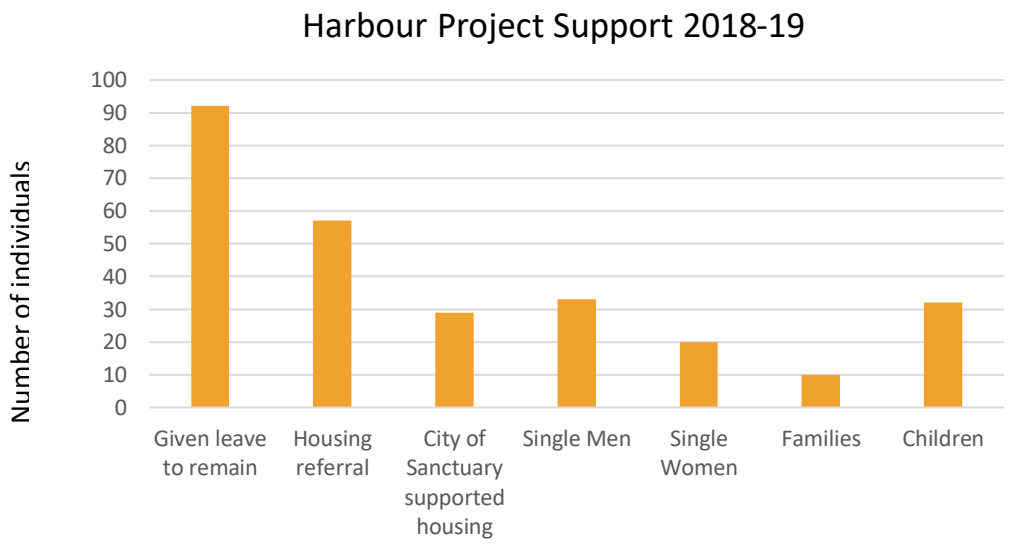


Figure 27. Individuals supported by the Harbour Project 2018/19.

Numbers are only from those individuals given Indefinite Leave to Remain (ILR) in the UK. Housing referral: individuals supported to make a housing referral to SBC.

The individuals who are not given ILR have no recourse to public funds. The Harbour Project report many of these individuals will leave Swindon, or rely on social networks to provide accommodation, potentially becoming part of the hidden homeless. Discussions with frontline homeless support staff repeatedly revealed concerns that there are an increasing number of individuals in Swindon with no recourse to public funds who are regularly sleeping rough. They include asylum seekers, but also those from the EU with no employment. The Harbour Project report being aware of 28 individuals between April 2018 and March 2019 who were without recourse to public funds, and therefore homeless. The Swindon Threshold Housing Audit (2019) found that 10.6% of homeless individuals spoken to did not have recourse to public funds, and a further 14.1% did not know if they were entitled. Currently, SBC has an offer to reconnect these individuals to a place where they previously had a connection, but this situation should be monitored and more input considered.

8.5 Unaccompanied Asylum Seeking Children

The numbers of Unaccompanied Asylum Seeking Children (UASC) that SBC had registered during the period 2015/16 to 2018/19 are relatively small, but appear to have increased slightly in this period. UASCs can require a high level of involvement from children's services as these individuals may have high levels of need, and the objectives are to transition them out of children's services into stable accommodation, education and/or employment.

If asylum seekers do not have ILR, they may become invisible to public services. Efforts to remain in contact focus on UASCs. Regular follow ups are made by SBC with the Home Office, and the personal assistants will continue to attempt to contact individuals, but this is a difficult situation. Again, this group may have vulnerabilities, and with no recourse to public funds, rough sleeping and exploitation are risks.

8.6 Armed Forces Leavers

The Armed Forces Covenant is a promise from the nation that those who serve or have served in the armed forces, and their families, are treated fairly (MoD, 2018). HM Forces veterans are identified in the housing application system, as it represents a support need. There are no Armed Forces bases in Swindon, although there are a number in neighbouring counties. The armed forces provide resettlement training on leaving the service, but extensive support is generally limited to those who have been in service for at least six years. Mentoring services are in place for more general use, and accommodation is one of the factors considered for those leaving the forces.

As shown in Table 38, veterans make a small minority of housing applications nationally, although proportionally there are more applications in the South West, perhaps consistent with the bases for the forces located in this region. No veterans were recorded as being accepted into a homelessness duty in SBC between April and December 2018. Numbers in Swindon are likely to remain small, for geographical reasons detailed above.

	Applications	Acceptances	Time in HM Forces*	% applications	% acceptances
England	207,650	189,760	1,330	0.6%	0.7%
South West	19,560	17,630	210	1.1%	1.2%
Swindon	527	291	0	0.0%	0.0%

Table 38. Statutory homelessness for households with a history of time in HM Forces, April - December 2018.

*data for acceptances. Data Source: MHCLG, 2018.

In Swindon and Wiltshire:

- The voluntary organisations British Legion, RAF Association and SSAFA support current and previous members of the armed forces, and their families. They do not have accommodation, but do support veterans in applying for accommodation, benefits and in the transition into housing, including accessing funds and resources.
- These charities also provide in reach into prisons for veterans, and work with probation. Those working in the sector report veterans can be reluctant to accept help, and also to identify as a veteran if they are in prison.

8.7 Victims of Modern Slavery

Modern slavery captures a range of types of exploitation. Homelessness is one of the vulnerabilities that traffickers target to exploit victims, alongside substance misuse, family breakdown and financial difficulties, all of which are also strongly associated with risk of homelessness. Additionally the exploitation may mask a housing need. Wiltshire police report a 52% increase in the number of crime offences relating to slavery in Swindon and Wiltshire from 2016/17 to 2017/18.

In Swindon:

- There were 308 intelligence submissions, occurrences and logs relating to slavery November 2017-November 2018.
- The minority of these events lead to prosecution.

- The most prevalent exploitation types identified are sexual exploitation, forced criminality, specifically theft and shoplifting, and forced labour.
- The most vulnerable individuals appear to be juvenile Romanians, but limited information is available in relation to the details of individual's exploitation.
- There is work ongoing in Wiltshire police to record, understand and address the motives and vulnerabilities involved in exploitation (Wiltshire Police, 2018).

8.8 Sex workers

Precarious or unfit housing is a cause of people resorting to sex work. Sex work, like domestic abuse, can also mask an accommodation need as individuals resort to transactional sex, or use sex work to fund accommodation. Nationally, Crisis report that nationally, 20% of women and 3% of men who were homeless had resorted to sex work to pay for temporary accommodation. In their survey, when faced with sleeping rough, 28% of women and 14% of men had spent the night or formed an unwanted sexual partnership with someone to obtain a roof over their head for the night (Crisis, 2011). Stable housing is regarded as a key factor in enabling women to complete drug treatment and/or exit prostitution successfully (Crisis, 2004). The most marginalised sex workers – those who are trans, roma or undocumented migrants are more at risk of homelessness (Feantsa, 2018). Sex workers often have links to dangerous drug networks, and involvement in County Lines activity.

Sex work is concentrated within urban centres, and Swindon has 76% of the intelligence reports to the police out of the combined Swindon and Wiltshire Police Force area (Wiltshire Police, 2018).

In Swindon:

- Sex workers known to be active in the area are identified by the Adult Sexual Exploitation Partnership (ASEP) panels.
- Most individuals referred to the ASEP work on street, although this may demonstrate under-reporting of off street occurrences rather than the true picture.
- In July 2017 there were 33 sex workers listed for Swindon on the ASEP panel, with 41% not born in Swindon.
- "Displaced" individuals are identified by the police as particularly vulnerable to exploitation. The two main groups of displaced individuals are runaway teenagers and immigrants.

The Nelson Trust provides community support for women and their families, including sex workers. From April 2018-March 2019, they received 270 referrals, of which 22 referrals (including self-referrals) were for sex workers. 16 (73%) had a housing problem, of whom 9 (41%) were of no fixed abode. Out of all 270 referrals 41 (15.2%) had a housing issue. This highlights that for the cohort of female sex workers in Swindon, accommodation is a significant need. The hidden nature of both sex work and homelessness means these numbers will likely only be the minority of individuals where these issues co-exist.

The sexual health team have developed an innovative outreach model using a mobile van clinic to reach street sex workers for sexual health checks, contraception and cervical screening.

8.9 County Lines

The county lines offending model involves gangs and organised criminal networks moving drugs into supply areas within the UK and using dedicated mobile phone lines. Exploitation is intrinsic to the business model. Victims of exploitation in county lines activity are often vulnerable, and the National Crime Agency recognises homeless shelters as one of the key locations for recruitment (NCA, 2019).

In Swindon, there are established links between sex workers and dangerous drug networks. Although small compared to the scale of the national issue, this is an area being closely monitored by Wiltshire Police, with established collaborative working on identifying and managing county lines-related activity (Wiltshire Police, 2018).

8.10 Summary and recommendations

- The groups described are at higher risk of homelessness, and also a range of other health and social issues
- The voluntary sector are often the main source of support for these groups
- A co-ordinated response is needed to identify and address the support needs of these groups. This is being done well in some areas, such as care leavers and victims of domestic abuse. Other groups such as asylum seekers and refugees would benefit from closer partnership working and clearer referral pathways between housing and relevant support organisations (here The Harbour Project)
- SBC and other organisations, including the voluntary sector, should consider how best to support those with No Recourse To Public Funds
- Organisations, including the voluntary sector, working within homelessness should work collaboratively to support those with No Recourse To Public Funds
- For some vulnerable groups, relatively small numbers are seen, or little local data available on the link with homelessness. This includes armed forces leavers, sex workers and those with learning disabilities or difficulties. Better case-level data collection would add to the local assessment of needs for these groups

Chapter 9 Offenders and prison releases

9.1 Homelessness and Offending

There are complex links between homelessness and reoffending, where each can be a cause and a result of the other (Homeless Link, 2011). At crisis point, it represents a way off the streets. In a national survey of single homeless people, 28% reported committing a crime in the hope of being taken into custody for the night (Crisis, 2011). Effectively supporting and rehabilitating individuals, including secure accommodation, improves individual outcomes and has wider benefits for society. Homelessness is often associated with vulnerabilities that can open an individual to exploitation. There are links to county lines activity, and homeless shelters are recognised recruiting grounds for county lines offenders (NCA, 2019).

Re-offending risk is associated with non-modifiable factors, including number and type of offences, and life experiences. Other factors (such as substance misuse, poor educational

attainment, unemployment and homelessness) correlate with a raised likelihood of reoffending, but they are not static. Instead, they can be influenced (MoJ, 2014) and therefore present a chance to reduce the likelihood of reoffending.

9.2 Homelessness and Offending in Swindon

In Swindon, between May 2017 and May 2019, 1,701 charges were brought by Wiltshire Police to individuals with an address of No Fixed Abode or a temporary address (incorporating a range of locations from probation addresses, refuges, shelters or foster homes). However, homeless people are also at higher risk of being victims of crime than the general population. In this same period individuals were charged with 101 offences where the victim was of No Fixed Abode, or at a Temporary Address (data source: Wiltshire Police).

Table 39 shows that about 1 in 10 people in the South West who are accepted into a prevention or relief duty for homelessness have an offending history, demonstrating the link between homelessness and experience of probation services or prison. The statutory figures may be underestimates of need, as the Swindon Threshold Housing Audit (2019) found that 38% of participants in their health audit had been in prison, and 15.8% had spent time in a secure unit of a young offender's institute.

	Total applications	Offending history	%
England	58,660	4,320	7.4%
South West	5,240	520	9.9%

Table 39. Statutory homelessness for households with individual (s) with an offending history, April-June 2018.

Data source: MHCLG, 2019.

9.3 People being released from prison

As part of the *Transforming Rehabilitation* strategy, aiming to reduce reoffending rates, offenders are to be given continuous support "through the prison gates" to the community. Community Rehabilitation Companies (CRCs) are tasked with helping prisoners find accommodation, and providing support around finances, education and employment for those being released from short term sentences (less than 12 months), (HMI Probation, 2016). Individuals should be seen in prison by a probation officer prior to release, and issues such as housing and benefits considered and planned for. The resettlement process aims to assess the needs of prisoners, starting within 72 hours of incarceration, leading to a planned release where the probation team support the individual with accommodation, finances, education and training.

Data from BGSW (Bristol, Gloucestershire, Somerset and Wiltshire) Probation Services shows that between May 2018 and April 2019, for Swindon:

- 206 individuals were released from prison into the Swindon local authority area. The average sentence length was 24 months (some of this is spent outside prison as this includes the custody and the licence period).
- 85% of prison releases were males.

- Most male releases were from HMP Bullingdon (129 total, 73% males), and most female releases from HMP Eastwood Park (26 total, 89% females).
- Other prisons that release small numbers to the Swindon area include:
    - HMP Portland
    - HMP High Down
    - HMP Channings Wood
    - HMP Guys Marsh
    - Currently, the Through the Gate Service is provided by the Swindon and Wiltshire CRC. Bridge Services provides accommodation specifically for prison releases.
- Only 8% of releases to the Swindon area were for people with no previous offending history.
- 37.4% of individuals had a negative housing outcome on release. This is likely an underestimate as probation services report clients will commonly list friends or family as settled accommodation, but this option often breaks down on release from prison.
- Men appeared more at risk of homelessness, with 39% recorded as experiencing a negative accommodation outcome, compared to 27% of women.
- When people had been sentenced more times, they had a higher likelihood of a negative housing outcome on release from prison: 55% (95% CI 45.7-64.3%) of those sentenced more than 10 times, compared to 17% (95% CI 9.4-24.6%) of those sentenced up to 10 times. This paints a picture of a revolving door between prison and homelessness for many.

Housing outcomes		Number of time the individual has received sentencing					
		1-5	6-10	11-20	21/+	**Total**	**% Total**
Negative housing outcome		8	8	21	40	**77**	**37.4 %**
Positive Housing Outcome	Friends/family settled	34	17	6	21	**78**	**37.9 %**
	Other accommodation	15	13	9	14	**51**	**24.8 %**
Positive outcome total		49	30	15	35	**129**	**62.6 %**
Total Releases		**57**	**38**	**36**	**75**	**206**	**100%**
% positive		**86.0%**	**78.9%**	**41.7%**	**46.7%**	**62.6 %**	**-**

Table 39. Housing outcomes for service Users managed by BGSW Probation Services released into Swindon local authority area May 18-Apr 19.

Negative housing outcome includes homeless (rough sleeping and other self-reported homelessness) and other negative outcomes: awaiting assessment, immigration detention and short term assessment. Other positive outcomes: approved premises, BASS (Bail accommodation and support service) accommodation, private rental, social rental, household owner, supported housing. Data source: BGSW and DDC Probation Services.

9.4 Substance misuse

Probation services work closely with many homeless individuals, and supporting engagement with substance misuse services and housing service is part of that work.

- Turning Point (adult substance misuse service provider) reported 15 individuals who had entered the county within the last 6 months from prison were in treatment during the period December 2018 to March 2019 (Turning Point Contract Review).
- In Swindon, data from the NDTMS shows that following release from prison in 2017/18, 44.8% of people with a substance misuse need successfully engaged in a community treatment programme within 3 weeks (PHOF, 2019). Here, Swindon performs significantly better than the England average of 32.1%, and its CIPFA neighbours average of 38.6%.

9.5 Addressing the link between homelessness and offending

The new Duty To Refer applies to prisons, but CRC support to prisoners extends beyond this. In a study of four prisons, over two thirds of prisoners on short term sentences were identified as needing some kind of support with accommodation (HMI Probation, 2016). Availability of accommodation and lack of a priority need were identified as barriers to obtaining stable accommodation, but as shown below in Figure 28, CRCs were instrumental in finding new accommodation for a substantial proportion of prisoners on short term sentences. This shows the potential impact the CRC in Swindon could have with prison releases to Swindon, as anecdotally front line homeless support staff and people with experience of homelessness report it is common to be released to the streets with no forward planning around accommodation, and to present to a hostel or the council in crisis.

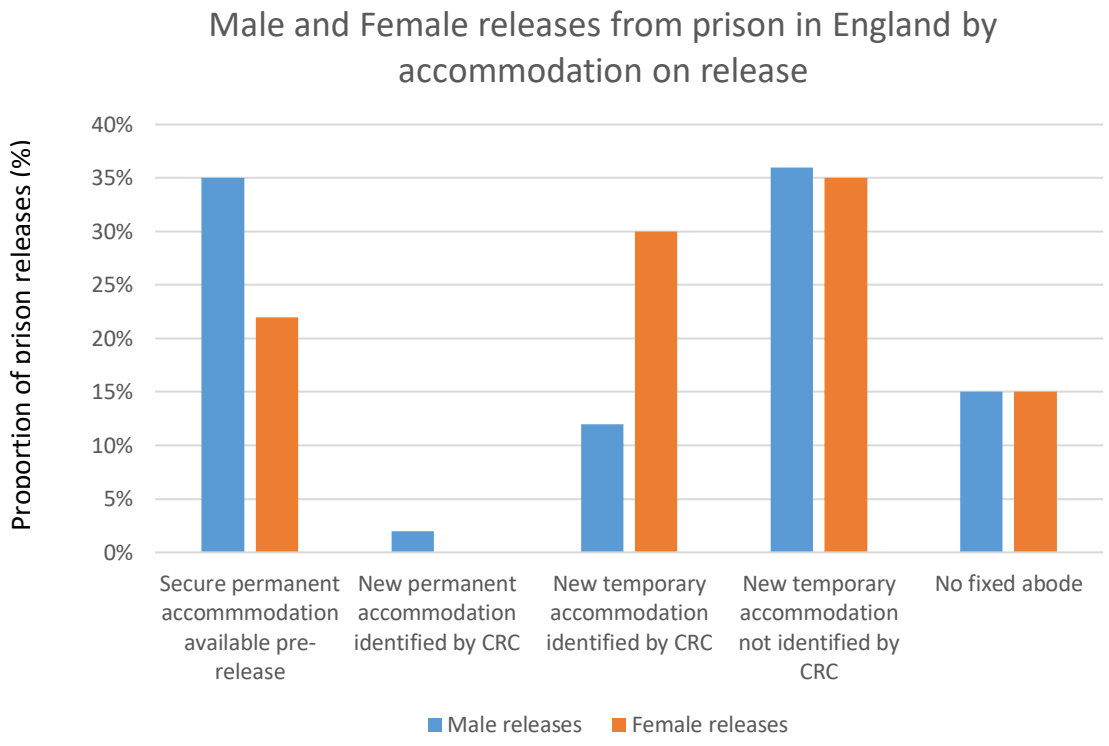


Figure 28. Accommodation status for prisoners released after completing short sentences in 2015 from 4 prisons inspected by HMI Probation

Data source HMI Probation, 2016.

Work is needed in Swindon to address the issue of homelessness in people released from prison. Bridge Services accommodation for people being released from prison received 14 referrals in 2018. This is a small fraction of the total number of prison releases, and Bridge

Services does not have the capacity to support all those with housing needs, nor is it the appropriate solution for everyone. Probation services in Swindon report commonly facilitating engagement of their clients with other support services, including primary care, substance misuse and housing options. As the continuity between prison and the community, probation workers appear key to successful outcomes for individuals. Anecdotally, from discussions with those working in support services, prisoners often do not report, or are not aware, they are likely to become homeless on release. This makes prevention particularly challenging, and suggests the assessment process may benefit from review.

Examples of good practice associated with better accommodation outcomes were identified in other local authority areas, including:

- mentors,
- CRC subcontracting Shelter to provide in-reach to prisons, and
- CRC referring individuals with complex needs to support services before release.

Many of the findings of the national HMI Probation report centre on poor connections and culture-clashes between prisons and the community increasing the likelihood of poor outcomes for prisoners after release (HMI Probation, 2016). Additional resources have recently been allocated to the Swindon and Wiltshire CRC for an enhanced Through the Gate Service, with the aims of building capacity to better manage prison releases. The CRC report they are working with the prisons to develop pathways and inter-agency links in this area of need.

9.6 Summary and Recommendations

- There are established links between offending and homelessness in the national evidence-base, and the local data. Involvement of community rehabilitation companies can have a positive impact on housing outcomes for those being released from prison
- Housing outcomes for those coming out from prison to Swindon are generally poor, particularly for those who have been sentenced multiple times
- The support and pathways for those being released from prison to the Swindon area require improvement, with a particular focus on those with a history of multiple offences
- SBC have to work with probation services and prisons commonly releasing to the Swindon area around the new Duty to Refer and the pathways for those referrals
- Better ways of working between prisons, community probation services and homeless support services should be developed, including consideration of a multi-agency forum or network
- Probation services should continue to develop the MECC approach to support ex-offenders with substance misuse needs or housing needs to engage with service

Chapter 10 Homeless Health Outcomes, Healthcare service use and provision

In this section the health outcomes for people with experience of homelessness will be discussed. Usage of healthcare services will be discussed, current service provision will be described, alongside possible areas for development.

10.1 Health inequalities

Crisis (2012) reported on causes of death for homeless people between 2001 and 209 (shown in Table 41). Standardised mortality ratios (SMRs) are presented. These compare the likelihood of a homeless person dying of disease, to a person of a similar age and sex from the general population. An SMR of 710 for alcohol means a homeless person is 7.1 times as likely to die from alcohol compared to a member of the general population.

Homeless people are more likely to die from all these causes than the general population. Further, they die at younger ages. All these causes of death therefore represent causes of health inequality for homeless people.

Cause	**SMRs for homeless people**	**Average age of death**	
		Homeless people	General population
Alcohol	710	48	51
Drugs	1971	34	35
Suicide	340	37	46
HIV & Hepatitis	682	41	-
Respiratory	306	56	76
Heart attacks	190	59	75
Falls	716	45	77

Table 41. Average age of death for homeless people and the general population from different causes.

Homeless people: people in homeless accommodation or of no fixed abode.
Standardised Mortality Ratios (SMRs) for different causes of death. (Crisis, 2012)

10.2 Physical health

Being homeless can preclude a healthy lifestyle. Nationally, Homeless Link (2014a) found that 77% of homeless people smoke tobacco raising the risk of respiratory, cardiovascular disease and cancer. In Swindon, Threshold (2019) report in their Health Audit that:

- 79% of homeless people sampled in Swindon smoke tobacco, of whom 48% would like to stop.
- Only 36% of smokers reported being offered support by a professional to stop smoking.
- The average homeless person eats 1-2 portions of fruit and vegetables per day, and one meal per day is normal (Threshold, 2019).

Table 42 shows results from the Swindon Threshold Health Audit (Threshold, 2019), for a range of conditions. 68.2% of the group sampled reported a long standing illness of

disability, with fewer than half of these individuals saying they received treatment that met with their needs. A wide range of physical and mental conditions were covered with reported prevalence summarised below:

Condition	Lifetime Prevalence
Skin problem or infection	24.6%
Hepatitis C	5.9%
Liver problem	5.9%
Heart problems	7.0%
Chronic lung problems	9.4%
High blood pressure	10.6%
Diabetes	5.9%
Dental problems	30.5%

Table 42. Prevalence of medical conditions in Homeless people participating in the Threshold Health Audit (2019).

85 people in Swindon with experience of homelessness answered questions on their physical and mental health.

The difficulties homeless people often experience with mainstream health service mean that long term health conditions are not always treated effectively, and it is increasingly recognised that homeless people often experience multi-morbidity with poorly managed long term conditions (Crisis, 2012, Pathway, 2018). Threshold identified 38% of survey respondents as requiring treatment for physical conditions and not receiving it, including individuals with Hepatitis C and TB. Considering wider health promotion, 56% of homeless women over 25 years reported they had not had a cervical smear in the last 3 years, and only 3.5% and 18% had been fully vaccinated against hepatitis B and influenza, respectively (Threshold, 2019). There is not clear guidance that homeless people should be vaccinated against these diseases, but they are more likely to fall into risk groups that require vaccination.

10.3 Infectious diseases

Homeless people are more at risk of from infectious diseases than the general population. The following pose particular risks (Bowen, 2019, PHE, 2018a, Beijer et al, 2012, Thomason, 2013):

- Tuberculosis
- Hepatitis C
- HIV
- Hepatitis A
- Chronic skin infections

These infections are important as a cause of premature mortality and morbidity amongst homeless individuals, but also as under-diagnosis challenges control in the wider population. Considering these diseases is relevant in the Swindon context as locally, Swindon has a high proportion of late diagnoses of HIV, and higher than regional average TB rates (PHE, 2018b, Data source: PHOF). The global context is that we are aiming for Hepatitis C and TB eradication.

Some of the above infections are transmitted by needle use by people who inject drugs. In the Homeless Link (2014a) survey, 39% of homeless people reported a history of substance misuse issues that may cause exposure to blood borne viruses (HIV, hepatitis B and C). The Swindon Threshold Housing Audit (2019) found some individuals with Hepatitis C and TB,

but numbers (<5%) are too small to be reported here. Of concern, this included individuals who had not received treatment which puts at risk the health of the individual, close contacts, and the wider population.

10.4 Acute Services

Nationally, the estimated annual cost of unscheduled care for homeless patients is eight times that of the housed population. Care is often characterised by crisis management at multiple disconnected points of episodic intervention, so that excluded people end up in the most expensive parts of the system – hospitals (Hewett, 2017, Pathway, 2018). Healthcare demand is also complicated by those who use A&E as emergency accommodation, reported by 18% of single homeless people (Crisis, 2011).

Data for health service use is limited by homelessness generally being self-reported by patients. People may choose to give, or refuse to give, an address for various reasons. Patients who do not give an address are generally identified as being of “no fixed abode”, and this is used to code the homeless population, thus the broader spectrum of homelessness is not well captured.

Attendance at Great Western Hospital (GWH) A&E

Using hospital data, the CCG report that during 2018 a total of 128 homeless people presented themselves to Great Western Hospital (GWH) A&E, resulting in 257 A&E attendances. The data around these attendances is summarised below:

- Consistent with national evidence, compared to the general population individuals who are homeless in Swindon are likely to be high users of A&E.
- Most homeless individuals (64.8%) using A&E in 2018 were seen once, with 45 people using it more than once.
- Homeless peoples’ use of acute services follows general patterns of A&E attendances considering times of the day and the year, even though poor weather may have a more direct effect.
- 83 (32%) of the attendances reported were from individuals aged between 35 to 44 years. Consistent with demographics of the homeless rough sleeping population in Swindon, most of the attendances were by males (86%) and the most frequent ethnic group was British (79%).
- Consistent with the high burdens of poor mental health and substance misuse, poisoning (including overdose) was the most frequent diagnosis reported for homeless individuals. Poisoning and psychiatric conditions together accounted for 30.7% of attendances.
- Of the 128 homeless individuals who presented to A&E, 45 are registered at Carfax Medical Centre (35%), 51 (40%) were registered to other Swindon Practices and 32 (25%) had unknown practice codes at the time of attending A&E (25%).

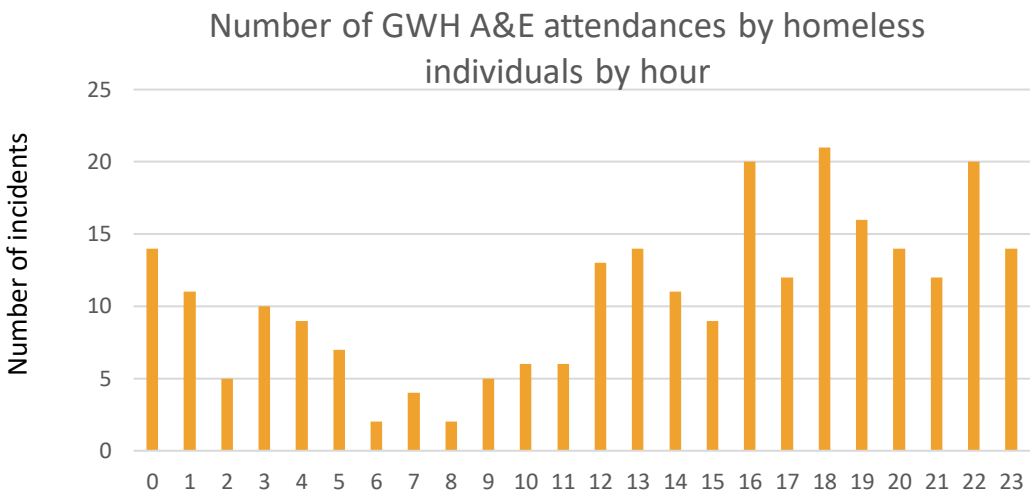


Figure 29. Number of A&E attendances by homeless individuals by hour of the day.

GWH: Great Western Hospital.

Data source: Swindon CCG.

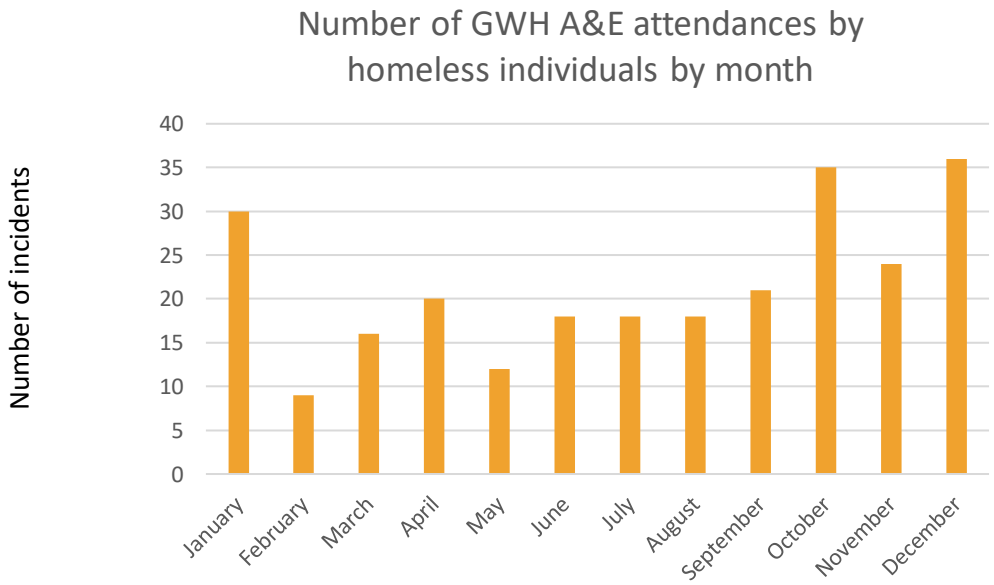


Figure 30. Number of A&E attendances by homeless individuals by hour of the day.

GWH: Great Western Hospital. Data source: Swindon CCG.

Number of A&E attendances	Count	%
1	83	64.8%
2-4	34	26.6%
5/+	11	8.6%
Total	128	100.0%

Table 43. Number of A&E attendances per homeless individual at GWH in 2018.

Age	Number of attendances	% of attendances
15 - 19	6	2.3%
20 - 24	7	2.7%
25 - 29	36	14.0%
30 - 34	29	11.3%
35 - 39	38	14.8%
40 - 44	45	17.5%
45 - 49	14	5.4%
50 - 54	20	7.8%
55 - 59	31	12.1%
60 - 64	16	6.2%
65 - 74	7	2.7%
Not known	8	3.1%
Total	**257**	100.0%

Ethnicity	Number of attendances	% of attendances
White British	202	78.6%
Any other white background	11	4.3%
Any other Asian background	9	3.5%
Any other ethnic group	19	7.4%
Not known	16	6.2%
Total	**257**	100%

Tables 44-45. Age, gender and ethnicity breakdown of A&E attendances by homeless people in 2018 at GWH A&E.

Data source: CCG

Diagnosis Condition	Number of attendances	% of attendances
Poisoning (including overdose)	60	23.30%
Laceration/contusion/abrasion/sprain	22	8.60%
Psychiatric conditions	19	7.40%
Dislocation/fracture/joint injury/amputation	13	5.10%
Infection: Local or other	12	4.70%
Respiratory conditions	11	4.30%
Head injury	11	4.30%
Urological conditions (including cystitis)	6	2.30%
Gastrointestinal conditions	5	1.90%
Other vascular conditions	5	1.90%
Dermatological conditions or soft tissue inflammation	5	1.90%
Nothing abnormal detected	17	6.60%
Other diagnosis	13	5.10%
Diagnosis not classifiable	58	22.60%
Total	**257**	100%

Table 46. Diagnosis coded for GWH A&E attendance amongst homeless individuals in 2018.

1. Other diagnosis: diabetes and other endocrine conditions, haematological conditions, Central Nervous Conditions, Cardiac Conditions, social problem

Homeless people in Swindon should be able to access the same GP out of hours services, and 111 support as the general population. It isn't clear from this data whether people chose to use A&E due to preference, practicalities or medical need.

In total during 2018, homeless attendances at GWH A&E cost around £34,700 (PbRT Tariff MFF). Ambulance usage represents another potentially avoidable source of expensive healthcare use by this population. Booth House reported making 33 calls to request an

ambulance in one year (2018/2019), and Culvery Court reported making 20 calls to request an ambulance in 7 months (Nov 2018-May 2019). Addressing mental, physical and substance misuse issues in the community may have avoided some of these call-outs, hence saving resources and improving outcomes for individuals.

Admissions to GWH

Using hospital data, the CCG report that during 2018:

- A total of 50 homeless people were inpatients at GWH, resulting in 81 episodes.
- 53% of the cases were reported between August and November.
- Substance misuse was the most common reason for admission, and was commonly present in those admitted for other reasons.
- The individuals admitted multiple times had long term medical conditions including diabetes mellitus and chronic obstructive pulmonary disease.
- 60% of homeless in-patients stayed at GWH for no longer than 1 night, it isn't clear how many of these admissions were related to a need for emergency accommodation

Number of admissions	**Count**	**%**
1	32	64.0%
2	13	26.0%
3/+	5	4.0%
Total	**50**	**100%**

Length of Stay	**Count**	**%**
Same day	30	37%
1 night	19	23%
2-4 nights	15	19%
5 - 10 nights	12	15%
10+ nights	5	6%
Total	**81**	**100%**

Diagnosis	**Primary Diagnosis**	**Secondary Diagnosis**
Mental and behaviour disorder due to Substance Misuse	**14**	**30**
Other neurological problems	**11**	**-**
Problems due to Trauma and Injuries	**10**	**-**
Poisoning	**8**	**-**
Chronic Pain	**8**	**-**
Depressive episode	**-**	**13**
Personal history of self-harm	**-**	**12**

Tables 47-49. Number of admissions per homeless individual to GWH in 2018 and primary and secondary diagnoses.

Length of Stay for homeless individuals admitted to GWH in 2018.

- In total during 2018 inpatient episodes for homeless individuals cost around £66,240 (PbRT Tariff MFF).
- The individuals with multiple admissions for long term conditions accounted for 29% (£19,467) of the total.
- 51 episodes (62.9%) resulted in a discharge destination of "Usual Place of Residence".

A minority of individuals were discharged to temporary accommodation, a penal establishment, police station or another NHS hospital provider. Other discharge destinations (28.4%) were not known. Given that the majority of admissions were for less than 2 nights it

seems unlikely that “usual place of residence” refers to discharge to a settled accommodation option. The Swindon Threshold Health Audit (2018) found that only 28.5% of homeless people admitted to hospital were discharged to suitable accommodation, and only 39.3% reported being asked by staff if they had somewhere suitable to go to. This is an area for development in the context of the new Duty to Refer, and also a focus in the Pathway Report which emphasises the need to capitalise on contacts with homeless individuals to improve all outcomes (Threshold, 2019, Pathway, 2018).

There are challenges around the Duty to Refer, as the GWH cares for patients from up to five different local authorities. With reference to Swindon, a clear referral pathway using either email or telephone has been established, and work is now ongoing to educate staff at GWH around this responsibility and the practicalities. No data is yet available on referrals made, however this is an area of focus and being collated prospectively.

Overall, admissions and A&E attendances are commonly related to substance misuse and mental health. However, long term physical conditions are also an important cause of multiple admissions. This reinforces the importance of addressing physical and mental health proactively for this population.

10.5 Community Health Care

General Practice

Homeless people, particularly rough sleepers are less likely to be registered with a GP (Elwell-Sutton, 2017). Many of the services which support homeless people in Swindon advocate or require registration with a GP. The Carfax Medical Centre has historically provided primary care for homeless individuals in Swindon. At the end of 2018/19they had 65 individuals registered with them who self-identified as homeless (rough sleeping, staying in a hostel or sofa surfing). If the patterns of GP registration amongst homeless people who attended GWH A&E are representative of the Swindon homeless population, this means approximately 120 homeless people are either registered at other practices or are unregistered.

Carfax Medical Centre do not provide a specific service for homeless individuals, (which would include blood borne virus (BBV) screening and health checks) but work to adapt their universal service to the homeless population. This includes flexibility around appointments, and working directly with individuals to address their needs. The CCG recommended health checks for physical and mental health should be made available to homeless people; work is needed to consider in what setting these are best provided.

Walk in centre

Between April 2018 and February 2019 there were 53 attendances at the Walk in Centre from 18 homeless individuals. Similar to the patterns seen with admissions and A&E, a minority of individuals used the service many times. Interestingly individuals were commonly registered at GP practices in the Swindon area, meaning homeless individuals still use urgent care facilities if they do have established primary care available. The needle exchange is located at the Walk in centre, and it isn’t clear how many attendances related to this service.

Community care needs

It is known that homeless people are at increased risk of poor outcomes in the following areas of community care needs (Crisis, 2012, Pathway, 2018):

- Dental Care
- Health Improvement (including smoking cessation and screening)
- Sexual health (including contraception)
- End of Life Care
- Infectious disease screening: blood-borne viruses (HIV, Hepatitis B and C) and TB
- Wound care
- Mental health

In general, homeless people in Swindon use the mainstream health services, which may be adapted to make access easier for them. Therefore, we must continue to consider equity of access and challenges to providing good quality care to the homeless in these different settings. Innovation and improvements can come from within specialist services, for example:

- Prospect Hospice are undertaking work on improving end of life care for homeless people by training homeless support services in assessing for the need for end of life care, and how to refer, as historically they have had very few referrals.
- The sexual health team run weekly outreach clinics from a van for Sex workers in Swindon including sexual health screens, dried blood spot testing for blood-borne viruses, contraception and cervical screening. They work with the Nelson Trust, housing and probation to support assessment and treatment for vulnerable homeless women. Contraception and cervical screening are particularly difficult to address for this population.

Previously, Swindon information booklets have been available for homeless people to signpost to healthcare services. However, information by itself may not be sufficient to improve healthcare access, and in other areas specialist primary care is commissioned for homeless people that often combines some of the issues listed above.

There are generally three models used to provide healthcare services to homeless people:

- Specialist homeless health centres
- GP practices with homeless services
- Mobile homeless health teams

These interventions have the potential to improve health outcomes as well as prevent A&E visits or admissions. However, there is a lack of evidence around the best model of care, and it depends on local homeless populations and settings. One recent development in other areas is the Pathway model, aiming to bridge the gap between primary and secondary care through community-based specialist homeless health workers (Crane, 2018a).

Crane (2018, 2018a) maps out these primary care services nationally in a valuable resource. The South West has the lowest number of specialist primary health care services of any region, and commonly managers of homeless support services reported problems accessing primary health care for clients (Crane, 2018a). Difficulties came both from homeless peoples' pattern of service use, as well as staff attitudes and training in issues commonly affecting

homeless people. Nationally, 49.5% of day centres, and 14.3% of hostels host outreach health clinics at least weekly.

Swindon CCG have established a homelessness and healthcare network, which is an example of good practice in facilitating co-ordination and co-operation between providers to improve outcomes for homeless people. In addition the Integrated Care Clinical Board will be undertaking work to ensure healthcare in Swindon meets the needs of the homeless, working with those with direct experience of providing support to homeless people locally.

10.6 Summary and recommendations

- Nationally, homeless people are known to have poor health outcomes, including premature mortality from a variety of causes
- In Swindon, homeless people appear to be high users of acute services, most commonly for disorders relating to substance misuse and psychiatric issues. It isn't clear from the data available why homeless people choose to use certain healthcare services.
- The Duty to Refer has recently come in, and it is currently unclear to what extent referrals are being made to housing, and discharges to the street being avoided
- Most homeless people in Swindon appear to register with the Carfax medical centre, although there is likely a significant proportion who are unregistered or registered elsewhere
- The healthcare needs of the homeless are a specialist area, and commissioners and providers should consider a specialist commissioned community service (with potential for hospital in reach), and ensuring Pathway (2018) standards are met in the mainstream service
- Homeless health checks could be piloted, particularly for identifying and managing, or referring: substance misuse, poor mental health, long term physical conditions, wounds or ulcers, infectious diseases (HIV, hepatitis B and C, TB), contraception, screening and other sexual health needs
- Homeless people would benefit from a targeted smoking cessation service
- SBC have to work with providers of healthcare around the new Duty to Refer and the pathways for those referrals

Chapter 11 Stakeholder consultations

For this JSNA the authors met with stakeholders from across the healthcare system, voluntary sector, local authority, and homeless support services. We are indebted to them for their time and contributions to the work, and for sharing data with SBC where applicable. Through interviews and discussions in which notes were taken, they provided learning around the support systems in place for homeless people in Swindon, the issues contributing to homelessness locally, and how the different organisations involved work together. Within SBC the JSNA included contributions from Public Health, Housing, Children's services, and supported accommodation commissioning. See appendix 1 for a full list of local stakeholders involved in the work.

Areas of strength in the Swindon system highlighted by multiple stakeholders included:

- The number of people working in the different sectors with a desire to improve the picture of homelessness

- The Housing First model
- Development of outreach and in reach services across Swindon, particularly from housing options, mental health and substance misuse services
- Developing collaboration between the different support services, with forums such as the Rough Sleeper Panel facilitating working relationships around shared objectives
- An increasing understanding of a trauma-informed approach towards homeless individuals in all sectors

Themes that were consistently raised as difficult issues or areas needing development included:

- Breaking the cycle of rough sleeping
- Engaging with some homeless individuals being very challenging and requiring multiple offers of engagement
- Support for homeless people from substance misuse and mental health services sometimes not meeting the needs of the individual in a timely way
- Difficulty of shifting from managing crises towards preventative work
- Shortages of accommodation options for homeless people, including emergency and resettlement options
- Releases from prison involving limited planning
- Multiple stakeholders were concerned about economic changes in Swindon such as the closure of the Honda factory and the potential impact on homelessness

Chapter 12 Service User consultations

12.1 Aims and objectives

The JSNA aims to understand the local needs and drivers of homelessness, to enable the delivery of efficient and effective services. The statistics presented in this JSNA are important, but to try and understand the real story in Swindon, we needed to speak to people with experience of homelessness. Socially marginalised groups such as the homeless do not have a strong voice nationally. Yet working with these groups means we can understand what is important to them, and enable services to best meet their needs.

Both Threshold and the CCG have recently completed engagement work in Swindon, specifically around understanding the health needs of single homeless people in Swindon and the issues homeless people can face accessing or using healthcare services. This engagement work provides many valuable points for learning, and feeds into the JSNA. To build on this, the JSNA steering group wanted to understand more of the complexity of homelessness, and how people in Swindon find accessing and using services beyond the healthcare system. To this end, engagement work was undertaken to try and improve our understanding of the journeys through homelessness, interactions with services, and potential points for intervention, with an emphasis on local understanding. The research did not aim to capture a representative sample of homeless people in Swindon, rather to highlight the range of experiences, and explore differences and similarities. For this reason, and for data protection, numbers are not reported, and the focus is on overall themes, with quotes given to illustrate pertinent points.

12.2 Threshold Health Needs Audit

In September 2018 Threshold lead an audit to understand the health needs of single homeless people in Swindon. They undertook a detailed survey with 85 people, most of whom had experience of rough sleeping. At the time of the survey, 11% were sleeping rough, with 69% in hostels, and 20% in squats, sofa surfing, or other temporary accommodation. Specific points around health needs can be found in detail in the full report (Threshold, 2019).

Conclusions included:

- Significant proportions of homeless people in Swindon have complex social vulnerabilities and contributory factors, including incarceration and time in local authority care
- Discharges from hospital were often followed by readmission, and claims of being discharged to the street were common
- Many homeless people in Swindon have issues with alcohol and substance misuse
- Mental health problems were common amongst homeless people, and a frequent cause of admission to hospital, including for self-harm or attempted suicide
- Most homeless people reported a long standing illness or disability, and most were taking a form of prescribed medication
- Most homeless people are registered with a GP, however it is common for treatment for physical and mental health conditions to be absent, or to only partially meet the felt needs of this population

12.3 CCG: Engaging with Swindon's Homeless Community

In September 2018 in response to concerns raised by Threshold, the CCG reviewed cases of homeless people being discharged from hospital, and undertook engagement with homeless people to understand the local experience.

Conclusions included:

- Homeless health checks for physical and mental health issues should be available, alongside healthy living and wellbeing advice
- CCGs should ensure continuity of care for homeless people, including when they are outside the geographical area for short periods (e.g. prison)
- Partnership working is required, including gaining consent for, and facilitating, data sharing between organisations
- Homeless people should have a nominated safe address and trusted person (support worker) who can receive written information about them

12.4 JSNA Engagement

The lead author for the JSNA interviewed individuals receiving services from Booth House, Culvery Court, the Swindon Night Shelter, Housing First, and Swindon Borough Council Temporary Accommodation. Interviews were usually completed on site, with a support worker present or readily available. The Temporary Accommodation interviews were done

over the phone. Permission was given to report on themes and ideas, and to use quotes, preserving anonymity.

Due to the settings people were recruited from, most of the individuals had experience of rough sleeping, but had also cycled through different accommodation settings with varying degrees of stability. There was a range in how long people had experienced homelessness for, from a few weeks to over a decade. Interviewees ranged in age from 20 to 62 years, and were mostly male.

There were a great variety of journeys and difficult life events described during the interviews. It was a privilege to be trusted with the stories people told. Results of the interviews are discussed below using a prevention framework of primary and secondary prevention. Mental health and substance misuse are considered separately. Quotes are taken from the interviews, names and ages are not reported to protect participants' identities.

12.5 Journeys through homelessness in Swindon

"I don't want to be here. But I am."

Primary prevention: Reasons for homelessness

Participants often attributed their homelessness to a single factor, but described a more complex causative network. Participants were not directly asked about their childhoods, but in many cases volunteered descriptions of difficult childhoods, time in care, or adverse childhood experiences (ACEs). It was also common to have relocated away from friends and family, including from abroad. This created a picture of a fragile or absent social support networks. Most participants combined this background with a substance misuse and/or mental health issue.

Most participants described their homelessness starting with breakdown or loss of a close relationship, generally with a partner or carer. This relationship breakdown often coincided with the participants' substance misuse or mental health issues, but in other cases was due to domestic violence, the death of their significant other, or natural ending of the relationship. There were a few participants who described poor physical health directly causing by preventing them from working. Finally, a few participants also described becoming homeless on being released from prison, although many more described experience of probation services as part of the complex social picture.

There appeared to be a distinction between the cases described above, and the minority of individuals where the evidenced risk factors for homelessness were absent. These individuals did not describe substance misuse, mental health issues, time in prison, or a background of time in care or fragile social networks. In these cases, relationship breakdown was also a common precipitator, often coinciding with unexpected unemployment or other causes of financial difficulty, and eviction from their private rental accommodation.

Primary Prevention: Housing Support

"I had a dignity, I didn't want to go there"

Participants discussed seeking support from Swindon Borough Council (SBC) around housing. Although nearly all participants described a period of difficulty in stable

accommodation before becoming homeless, very few people reported approaching SBC at this stage. Generally this happened when the participant was in crisis without a roof. Barriers to approaching SBC when problems such as rent arrears or relationship difficulties were putting them at risk of homelessness included:

- A sense of pride
- Resistance to accepting homelessness as an issue affecting them
- Lack of awareness of council services
- Lack of confidence to approach the council without support
- Difficulties with their private landlords

"*Everyone I've met has done everything they can"*

Reassuringly, participants found the SBC processes easy to navigate once engaged, and multiple participants said that when they did go to SBC it was "*easier than I expected.*" A few participants reported being referred to SBC by other services for homelessness prevention, but, again, in general, this was at crisis point. Those individuals in temporary accommodation provided by SBC were very positive about the support given to them by SBC.

Secondary and Tertiary Prevention: Journeys through homelessness

"*you're in here always knowing you'll be back out"*

Whatever the reasons identified for homelessness, participants who had experienced housing issues for more than a few months all described moving between categories of homelessness. They often described transitioning from stable accommodation to rough sleeping through a period of sofa surfing, and then intermittently rough sleeping, in between sofa surfing and staying in hostels. This is consistent with national evidence that rough sleepers often cycle through temporary accommodation (Rose, Maciver and Davies, 2016).

Barriers to being housed by SBC or accessing financial support included:

- No address or proof of identity to access Universal Credit payments
- No priority need due to being a single male without associated vulnerabilities (this is a part of previous homelessness legislation around who local authorities have a duty to)
- Having No Recourse To Public Funds as a non-UK national
- Having rent arrears, or other unpaid debt
- Requirement to house a pet

Participants did not identify substance misuse or mental health issues as barriers, yet did describe times where these prevented interaction with SBC. Participants did not generally find it a barrier to access emails or a mobile phone, although being available for appointments at specific times was sometimes difficult. Time spent in prison was described as disruptive to the process of securing housing, but also a temporary solution to an acute housing need.

Disruption in families was common. Some individuals described being separated from children, temporarily or permanently. This was a source of distress to participants, and often a part of the pathway into homelessness. In extreme examples participants described having children whilst living on the streets, and coming back to the streets following birth, with separation from their children at that point.

Secondary and Tertiary Prevention: Accommodation

All participants receiving support from Booth House, described the process of obtaining emergency accommodation as a source of significant stress. However, it was accepted that this was a supportive intervention for those on the street with no other option. The hostels were generally described in mixed terms. Participants found them essential for moving off the streets in the lack of settled accommodation options, but also found them stressful and associated with exposure to risks including drug use, and other homeless people with difficult behaviours.

For participants where they had achieved a more stable situation with accommodation, positives that enabled this were identified as:

- Support workers who they developed a close working relationship with, who had life experience relevant to their own issues
- Addressing mental health issues and/or substance misuse issues
- Support from family and friends, including remediation of relationships
- Successful working with SBC housing officers, including the outreach team

Secondary and Tertiary Prevention: Rough Sleeping

Individuals invariably described rough sleeping as difficult and dangerous. Some people chose to be around others in commonly used locations, whilst some preferred to sleep in locations like disused sheds to avoid interaction. Negative impacts on physical and mental wellbeing were well-described by most participants, and consistent with the knowns risks associated with rough sleeping. A specific difficulty was described around keeping identification documents safe, and the impacts this had on trying to access benefits, with potentially long delays and expenses around getting replacement documents.

12.6 Service Engagement

"I've got my tent and I go to appointments. But I might just disappear"

Engagement with services including probation, mental health services, substance misuse, housing support workers and SBC housing options officers were discussed. Participants described periods where they found it easier or more difficult to engage, but generally struggled to identify reasons for this. Participants felt it was beneficial to have support provided flexibly in different settings, and for frontline service workers to have knowledge or experience of mental health issues.

Participants were generally aware of "terms of engagement". Whilst some participants found terms of engagement, and expectations around substance misuse, personal development sessions or social enterprise engagement supportive, others found this too restrictive for any engagement. It was expressed by multiple individuals that engagement had to be an internal and an external process, meaning internal motivation was required, with support provided by the service in a way that worked for them.

Multiple participants referred to homeless people they knew who didn't want to be housed. This was attributed to a lack of external systems to enable housing, alongside becoming entrenched in rough sleeping and not wanting to engage with any services. Multiple participants also expressed frustrations at the lack of external processes in place to address their own housing situation. No participants included in this work expressed a desire to

maintain their current situation, although individuals more entrenched in homelessness may have been under-represented due to avoiding the services visited, or choosing not to be interviewed.

12.7 Long Term Goals

"It gave me a sense of self-worth"

When asked about their long term goals, almost all participants stated they wanted stability. In general, this referred to accommodation, and commonly was combined with a desire for employment and stability in families. However, as demonstrated by the quote above, there was little evidence of long term planning or a real belief in an ability to achieve these goals. Despite acknowledging that certain behaviours were associated with previous difficulties, very few participants associated substance misuse or criminal behaviours as potential barriers to achieving their goals. Access to training and paying for qualifications were barriers to achieving goals. A few participants expressed a desire to support other homeless people. All those who were engaged with the social enterprises or in paid employment described finding motivation in the ability to develop skills, and support other homeless people. Other participants described admiring those who had moved into employment and out of homelessness.

12.8 Issues associated with homelessness

The main issues raised by participants were probation, substance misuse, health and misconceptions of homelessness.

Probation

Multiple participants described time in prison, generally for short periods. For the minority this was described as a deliberate choice in response to periods of homelessness. None of the people who had experience of being in prison reported being offered support with accommodation before being released. It was common to describe being released to the streets and reporting to SBC in an accommodation crisis. Generally they described their relationship with probation as supportive, and there were cases described where this had facilitated engagement with substance misuse, although this was not always linked to a desire to change their behaviour.

Substance misuse

Attitudes around substance misuse were complex. All participants felt they were surrounded by drugs and alcohol, both on the streets and in many temporary accommodation options. Participants who were not using drugs or alcohol consistently made the distinction between themselves and homeless people who did have these issues.

"*Drugs have destroyed my life. But I've still got a life to live."*

Most participants described some experience with drugs or alcohol at some stage of being homeless. Some participants stated that they could only see it as possible to stop misusing once they were stably housed, and others stating that they needed to stop misusing substances in order to achieve housing. Individuals would often link previous times when they had reverted to rough sleeping with substance misuse, yet did not generally state that it was a barrier to achieving their long term goals. As demonstrated by the quote above, they acknowledged the profound negative impact of drugs, yet had aspirations to move through substance misuse.

It was not clear what prompted individuals to engage with substance misuse services. Participants commonly described repeated failed attempts to engage, although reported good experiences of working with substance misuse services through the changes seen in providers over the years. Issues raised included waiting times for assessments and prescriptions, practicalities around mobile phones for booking appointments, and the restriction to group therapy only. Not all the issues raised were consistent with the data available from Turning Point, including waiting times for instance, or the rest of the participants' interviews, including mobile phone difficulties. This might be expected with serious drug addictions.

Health and long term goals

"When you're homeless your mindset is temporary"

The descriptions of physical and mental health were consistent with the Threshold and CCG findings. Participants almost all had a registered GP, but found it difficult to prioritise their health with the stress of homelessness, and, frequently, the complications of substance misuse. Aspirations to a healthier lifestyle were expressed by most individuals who did appear to value their health. However, most were in temporary accommodation, or rough sleeping, and did not think it was realistic to stop smoking or adopt a healthier lifestyle until their housing situation was more stable. Participants described how it was easier to manage physical and mental health when their housing was more stable. Similar to housing issues, participants generally described seeking help with their physical and mental health when they reached a form of crisis, often necessitating an A and E visit or admission.

Misconceptions

"*you're homeless and everyone thinks they know you"*

Many of the participants were concerned about the stereotypes of homelessness and were keen to impress that there are individual stories behind being homeless, and individual coping mechanisms. Those who were not misusing substances consistently made the point that not all homeless people have this issue. There was also a concern that we realise the desire to move back into mainstream society that many feel, and that their lifestyle is neither a choice nor desirable. Anti-social behaviours were raised by a few participants, who wanted to draw the distinction between themselves and those involved.

12.9 Conclusions

Key findings were:

- Homelessness is not a single story, and there are many reasons behind it. Anyone can be at risk of homelessness if their personal or social circumstances deteriorate.

Descriptions of time in prison, poor mental and physical health, and substance misuse were common, but not universal.

- Most people approach the council for support at crisis point. Barriers to approaching the council earlier included the stigma attached to homelessness, and a lack of awareness of council services.

- Journeys through homelessness are complex, often involving cycling between rough sleeping and temporary or emergency accommodation.

- Rough sleeping is difficult and dangerous for a person's mental and physical health. A few choose to rough sleep, but most do not.

- Positive experiences that helped resolve homelessness included support workers, addressing mental health and/or substance misuse issues, and social support networks.

- Long term goals for homeless people centred on wanting stability in accommodation, employment, relationships and their physical health.

Many of the findings from the JSNA engagement work are consistent with the peer-reviewed published literature, and with the CCG and Threshold reports. It was a privilege to be trusted with these stories, which add weight to the evidence base and the quantitative assessment of local needs in the JSNA. Homelessness in Swindon is often associated with difficult life experiences some years earlier. This reinforces the importance of **the life course approach in primary prevention**, where we work to improve peoples' lives from an early age. However, even those with seemingly stable lives can experience life events that precipitate a relatively **quick transition to homelessness**. There appears to be a sense of **stigma** around seeking support from SBC for homelessness, combined with a lack of awareness of services. In the context of the prevention duty, this is an area for development, to facilitate residents seeking support before crisis point.

Identifying intervention points for secondary prevention to relieve homelessness in Swindon is challenging. Barriers to this include **personal factors** for that individual, as well as wider **structural issues** such as availability of housing. Considering housing and the wider issues that often affect homeless people, it can take some time for individuals to engage with services, and what works for one person often doesn't work for another. Participants described windows of engagement, and attached value to relationships built up with support workers. This may necessitate a **prolonged pre-engagement period**, with repeated offers of support, and development of terms of engagement that incorporate that individual's needs. Given the frequent occurrence of traumatic events in these people's lives, a trauma-informed approach to the engagement process is needed.

It is common for individuals to **present to services in crisis**. This applies to housing, healthcare and other support services. Many of these individuals have complex needs that make forward planning difficult, and for those who appeared better equipped to navigate the system, other barriers were identified to early presentation to services. Nonetheless, participants consistently described a desire to improve their situation, and **valued things like their health**. More difficult was making plans beyond meeting their immediate needs, supporting the CCG recommendations for tailored prevention and health checks.

Transitioning between **prison** and the community appeared particularly difficult, and many had experience of probation usually in the context of complex needs. Those with more complex needs seemed to find it especially difficult to plan long term and engage with services, though still valued support and had long term aspirations to stability.

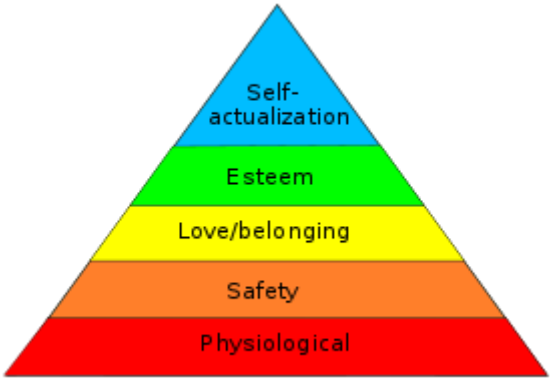


Figure 31. Maslow's hierarchy of human needs.

In keeping with Maslow's hierarchy of needs, participants find it difficult to conceptualise self-development when their basic needs are not being met, and risky environments can change what is rational behaviour (Barnett and Whiteside, 2002). It is therefore unsurprising that none of the participants rough sleeping had more than vague aspirations to long term stability, and were **focussed on immediate needs**. Additionally, for many **substance misuse was counter-productive to meeting those needs**. However, offering opportunities for self-development, such as the social enterprises, can provide internal motivation to engage with those services aiming to support, treat and house homeless individuals. Housing First is a move away from the staircase model of housing support where people must be housing ready to be moved into settled accommodation, however throughout the homelessness system we must think of peoples' needs beyond housing. The diagram below is a more holistic representation of needs in homelessness.

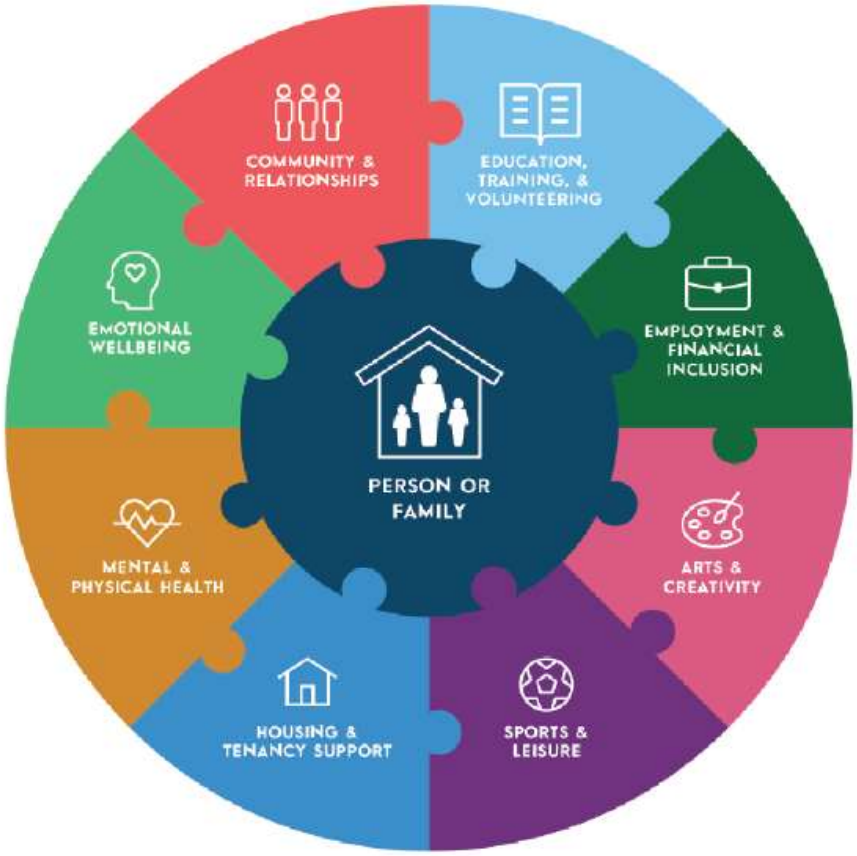


Figure 32. The jigsaw of human needs.

Data source: Greater Manchester Homelessness Strategy, Manchester City Council, 2018.

12.10 Summary Recommendations

The recommendations below have fed into the final recommendations at the end of the JSNA:

- SBC should consider work to facilitate residents seeking support before crisis point. This might include disseminating information about accessing the council and work to destigmatise seeking housing support, as well as continuing the outreach model of housing options support.

- There could be a programme to develop peer supporters, and they could also be included as homelessness champions in decision-making about homelessness services.

- People with lived experience of homelessness can provide valuable support to others. Opportunities for self-development should be part of support services, and lead to employment and training there possible.

- Lived experiences of homelessness differ widely, and homelessness support services must work to understand the needs of the individual beyond housing, as seen in the jigsaw of needs. We must continue to invest resources into support workers with time to build up positive relationships with those individuals whose needs are more complex, and can be more difficult to engage with.

- All those working with homeless individuals should have basic training on providing trauma-informed care or support.

- People coming out of prison need better support to prevent homelessness and reoffending, particularly in cases where there is a cycle of reoffending and a clear link to a housing need.

- SBC and outreach workers should work with homeless individuals to ensure they have the identification documents required to access financial support and accommodation

Chapter 13 Best practice / evidence of effectiveness and cost-effectiveness

13.1 General Findings

LGiU (a local authority membership organisation) commissioned a report into homelessness which found that tackling homelessness and addressing its causes is a long-term project that needs to draw on partners and organisations from across the public sector. In short, it cannot be solved by homelessness services alone. The Homelessness Reduction Act (2017) has expanded the responsibility of English local authorities towards those deemed eligible and unintentionally homeless. This has brought welcome improvements to the process, but it does not amount to prevention. It addresses the issue at one point in the chain, when the risk of homelessness is already acute. They conclude that prevention is a much wider, long-term project, and must be supported by adequate central government funding and a commitment to address the housing crisis (LGiU, 2019).

PHE (2018) reviewed the evidence around homelessness, with an emphasis on those with complex needs. It was clear that no single intervention alone will reduce or prevent homelessness. A system-side, integrated approach is needed to ensure that there is a range of services available to meet the needs of those with highly complex needs. Evidence suggests that having appropriate long-term accommodation can have a significant impact on those with complex needs, who are often the most socially isolated and excluded people within our communities. The following themes emerge from the evidence review:

- Early intervention in the context of homelessness
- Integrated working
- Interventionist approaches

It is beyond the scope of the JSNA to review the evidence base for all the subgroups of interest with regard to homelessness prevention. However, the above principles can be applied, along with close partnership working between specialist support services and general homelessness prevention and relief services to improve the situation for these groups. This must sit alongside work to reduce the personal risk factors that lead to homelessness and other poor outcomes, such as sex working, exploitation, substance misuse and poor mental health. The wider structural factors such as poverty and the housing

crisis may seem removed from local government's control, however work to understand the how these factors drive homelessness locally will allow more effective interventions.

13.2 Rough Sleeping

In 2017 an evidence review was published that was commissioned by Crisis into interventions to end rough sleeping (Mackie et al, 2017). Over 500 published studies were reviewed, and interviews done with 11 international homelessness experts. Five key principles were identified that should underpin the approach to rough sleeping:

1. ***Recognise heterogeneity*** – of individual rough sleepers' housing and support needs and their different entitlements to publicly funded support. Local housing markets and rough sleeper population profiles will also vary across the UK.
2. ***Take swift action*** – to prevent or quickly end street homelessness, through interventions such as No Second Night Out (NSNO), thereby reducing the number of rough sleepers who develop complex needs and potentially become entrenched.
3. ***Employ assertive outreach leading to a suitable accommodation offer*** – by actively identifying and reaching out to rough sleepers and offering suitable accommodation.
4. ***Be housing-led*** – offering swift access to settled housing including the use of Housing First
5. ***Offer person-centred support and choice*** – via a client-centred approach based on cross-sector collaboration and commissioning. Personalised Budgets are a good example of this.

Specific interventions are considered below.

Hostels and Shelters

There is a lack of evidence around the effectiveness of hostels and shelters, aside from comparisons made to Housing First in Randomised Controlled Trials (RCTs) conducted outside the UK. They provide immediate relief from life on the streets, however residency is often complicated by exposure to drug misuse and communicable diseases, and is frequently associated with a deterioration in mental health. Further, they are difficult environments for the range of individuals who experience homelessness to live safely together, and can be a very challenging work environment for staff. Expert consensus is that they serve a purpose as short term options, but must be linked to move-on housing options. This statement also applies to supported housing, which can be a longer term solution, but must also lead to a more permanent housing situation.

Housing First

Housing First (HF) moves away from the staircase model of housing support, and provides permanent housing to rough sleepers without preconditions regarding recovery from (or participation in treatment for) substance misuse or mental health problems. Person-centred support is provided on a flexible basis for as long as individuals need it. Initially developed in the US, it marks a significant departure from the traditional 'treatment first' or staircase approach. Development in the UK is ongoing, with only an increasing number of projects operational.

This is the housing intervention with the strongest evidence-base. Mackie et al (2017) identified multiple randomised controlled trials (RCTs) and qualitative studies which provide support for the effectiveness of Housing First. The best outcomes are for housing retention

(around 80%), particularly considering the intervention aims to house those with complex needs. The evidence for improvement in physical and mental health is weaker, but comparable to other “Treatment as Usual” interventions. In general, improvements in levels of substance misuse, and criminal activity are also seen with Housing First. The latter findings contribute to the likely longer term cost-effectiveness of this expensive intervention.

It is an intervention variably applied. Most homeless people appear to prefer scatter-site accommodation, which is associated with lower rates of substance misuse and criminal activity than congregate-living Housing First. There are evidence gaps around longer term impacts, and effectiveness for subgroups beyond complex needs. Limitations identified included availability of housing for Housing First, and the reliance on high quality, multi-disciplinary support for the model to work.

Common Ground

Generally used in the US and Australia, Common Ground refers to accommodating rough sleepers alongside people on low or middle incomes in a mixed community. On-site health and social support, retail and leisure facilities are provided alongside a 24 hour concierge service. Whilst some of the housing retention outcomes are positive, there is very limited evidence for this intervention, with outcomes generally appearing poorer than for Housing First. Further, concerns are raised around divisions between residents, and the challenge of balancing support needs with intrusion, for very diverse groups.

Social Impact Bonds

Social Impact Bonds (SIBs) are a new form of financing social programs that gather private investments to fund specific providers to deliver a service or program. They are increasingly being used in response to homelessness in a number of countries (including the US, Canada, Australia and Portugal), and have been trialled in the UK.

There is, as yet, limited evidence on SIB effectiveness. They can be used to fund evidence-based programmes such as Housing First, and evidence from London did show encouraging outcomes around achievement of stable housing in the medium term, and for employment outcomes. Further evaluation of their full impact is needed, and the reviewers concede that this is a complex intervention with outcomes likely to vary in different contexts.

Residential Communities

Residential communities refers to accommodating homeless people in a congregate (but usually geographically isolated) community. Two key models include: a) residential Therapeutic Communities which are based on a well-established therapy model that supports clients to recover from substance misuse; and b) Emmaus communities which are described as self-financing mutually supportive communities where residents live and work together. Modified TCs have been implemented in homeless shelters within the US, and Emmaus communities operate in a number of rural locations in the UK.

Evidence on therapeutic communities consistently indicates that the model is effective in reducing levels of substance misuse, mental health problems and involvement in criminality, including when employed in homeless shelters. However, attrition rates are high. Evaluations of Emmaus communities suggest that they can improve residents’ quality of life, but the way of life is attractive to a fairly limited clientele. Evidence regarding the impact of either model of residential community on housing outcomes is negligible or non-existent.

No Second Night Out (NSNO)

Currently operating in England only, NSNO aims to assist those new to rough sleeping by providing an offer that means they do not have to sleep rough for a second night. There is widespread variation in the way NSNO principles are practiced, but it typically consists of some combination of assertive outreach, public engagement, and support to access temporary accommodation and/or reconnection. Service users' needs are assessed in NSNO 'hubs'.

NSNO is effective in quickly finding the vast majority of service users temporary accommodation, with only a minority recorded as returning to the streets in the short term (in that locality, at least). Limited availability of housing can undermine the effectiveness of NSNO, and contributing to overly long hub stays. Long waits for rough sleepers to be 'found' and have their status confirmed by outreach workers also restrict its effectiveness in some contexts. Further to this, time-limited funding has been a key barrier to lasting implementation. In practice, a wider client group than first time rough sleepers needs to be addressed and there is limited evidence of how NSNO works for different subgroups.

Reconnection

Reconnection involves returning rough sleepers to their 'home' area. Some reconnections are 'international' involving repatriating immigrants to their country of origin; others 'domestic' where rough sleepers are relocated to an area where they do have established connections within their home country. The level and nature of support involved with reconnections varies dramatically.

There is very limited evidence for the reconnection. A single UK study indicates that outcomes for rough sleepers vary dramatically. Some do access housing and re-engage with support services in the recipient area, but others sleep rough in the recipient area, return to the identifying area, or refuse the reconnection offer entirely. Reconnections are most likely to be effective when targeted rough sleepers are newly homeless or recent arrivals to the identifying area, have a (recent) history of service use in the recipient area (i.e. where they are reconnected to), and/ or have 'meaningful' connections in the recipient area. Conversely, reconnection appears least likely to work when: rough sleepers are resistant to the idea of returning; targeted individuals have a long history of homelessness; and/or recipient areas are geographically very distant from identifying areas. The provision of sufficiently intensive and tailored support is a critical ingredient in any successful reconnection.

Reconnection can be implemented without considering what is best for the individual, although perspectives on international reconnections are mixed as generally those who remain in the UK will have no recourse to public assistance.

Personalised Budgets

Personalised Budgets have been used in the UK to support entrenched rough sleepers. Support workers have access to a budget for each rough sleeper (£2,000-£3,000) which they can spend on a wide variety of items (from a caravan to clothing) in order to help secure and maintain accommodation. Importantly, rough sleepers identify their own needs and help to shape their own support plan.

The evidence base is limited to a relatively small number of pilot project evaluations, and evidence is particularly lacking for effectiveness for different subgroups.
Pilot projects generally demonstrate accommodation is secured and maintained in around 40-60% of cases. Significantly, the suitability of accommodation is determined by the rough sleeper, so housing outcomes are difficult to compare.

Qualitative data suggest many positive impacts beyond housing, including: health improvements and more appropriate access to healthcare, reductions in substance misuse, re-establishing positive social networks, improved self-esteem, increases in social welfare claims, and improved engagement with other services and agencies. The London pilot estimated costs of £4,437 per individual – around £1,300 more than standard outreach. The wider benefits suggest that in the longer term this intervention is likely to be cost-saving. As personalised budgets are in their infancy, there are implementation issues around funding, timeliness of payments, limits to what can be bought, and access to accommodation.

Street Outreach

Operating in some form in various countries, street outreach is an important component of many rough sleeper interventions. Street outreach is the delivery of services to homeless people on the street. Assertive Outreach is a particular form of street outreach that targets the most disengaged rough sleepers with chronic support needs and seeks to end their homelessness. It can be defined by three distinctive facets: 1] The primary aim is to end homelessness; 2] Multi-disciplinary support; 3] Persistent, purposeful, assertive support.

Assertive Outreach has proven to significantly reduce the number of rough sleepers, with numbers reducing by approximately two thirds within three years under the Rough Sleeper Unit Programme in England. Housing retention is significantly better when outreach leads to permanent, self-contained accommodation. Key barriers to effective implementation of assertive outreach include: 1] the absence of a suitable permanent housing offer; 2] the absence of suitable multi-disciplinary support; 3] overcoming negative perceptions amongst rough sleepers about outreach services. There are also mixed views on enforcement, which may prompt individuals to take up offers of accommodation, when combined with outreach, but may also “push” individuals into more dangerous circumstances, or make them harder to reach.

13.3 Funding and cost-effectiveness

Short term or insufficient funding streams are identified as a barrier to successful implementation of most evidence-based interventions (Mackie et al, 2017). The WPI Economics 2019 report into local authority spending on homelessness states that any future system of funding needs to meet three principles:

- **Sufficiency**: local authorities need sufficient funding to act reactively in crisis situations, and focus on homelessness prevention
- **Certainty**: additional funding streams are often for short periods, and local authorities and providers require certainty around funding
- **Directed**: funding must be directed to those that need it, options to ensure this happens include ring fencing or policy or central government expectations

The report makes recommendations for central government, including clarity on targets around homelessness, provision of funding to local authorities with mechanisms to ensure that funding is spent on activities that genuinely and sustainably reduce homelessness,

restricting the use of time-limited funding, and better collection and publishing of costs of homelessness to other public bodies. These same principles apply to local authority decisions on spending on homelessness.

It is estimated that a single person sleeping rough for 12 months in the UK costs £20,128. The longer someone is homeless, and the more often they experience homelessness, the greater the societal cost (Crisis, 2015). There is international concern, both in Europe and North America, that sustained and repeated homelessness has significant impacts on public expenditure. Costs for health care systems, including mental health services and emergency services at hospitals are high, as are many costs for the criminal justice system. People who experience homelessness for three months or longer cost on average £4,298 per person to NHS services, £2,099 per person for mental health services and £11,991 per person in contact with the criminal justice system (Crisis, 2016).

It is not always less costly to prevent homelessness, however in analysing 86 cases, Crisis (2016) concluded that prevention of homelessness would have been cost-saving in 65% of cases, compared to a year of homelessness. The average estimated reduction in public spending per person per year of homelessness prevented is £9,266. These savings are largely from reductions in use of NHS, drug and alcohol, mental health and the criminal justice system that are seen in housed populations. This makes the case for adequate funding of preventative and enhanced evidence-based models of support, such as Housing First.

13.4 Examples of good practice and innovation

At a national forum for Homelessness (Inside Government, 2019), innovative models for providing funding, and for homelessness prevention and support were identified from different areas. These included:

- Tap London - £3 contactless card donations for the general public which are distributed to London homelessness charities
- Greater Manchester homes partnership – Social impact bond to provide accommodation with third party investors and a payment by results system
- BEAM – crowd funding for support and payment for education or training to achieve employment for homeless individuals
- Hope into Action – providing housing and support to those being released from prison through investment by the general public
- One Festival of Homeless Arts - brings together works of art in many forms, from theatre and film, to sculpture and photography, as well as traditional visual art, all of which have been created by artists who are or have been homeless.

Other examples of good practice from different local authorities were themed around meeting an individuals' needs through collaboration between services, and developing gateway or hub models of support lead by councils, often with an outreach component. These hubs, as in Croydon, brought together other commonly needed support services such as mental health and substance misuse, but also involved training housing options officers in assessing and addressing needs beyond housing.

LGiU (2019) criticise advocating the above interventions, as they cannot replace adequate central funding and initiatives, however, action is needed at every level to support individuals, families and communities.

Chapter 14 Projections, forecasts and alternative future scenarios

14.1 Future projections

Currently, there is uncertainty around the future of house prices, the wider economy, and the changes we may see around Brexit and beyond. However, more certain is that population growth will continue and the shortfall in affordable accommodation is predicted to worsen. Modelling predictions for homelessness from Bramley (2017) show that, overall, homelessness nationally is predicted to rise, with particular increases seen in rough sleeping and those in unsuitable temporary accommodation.

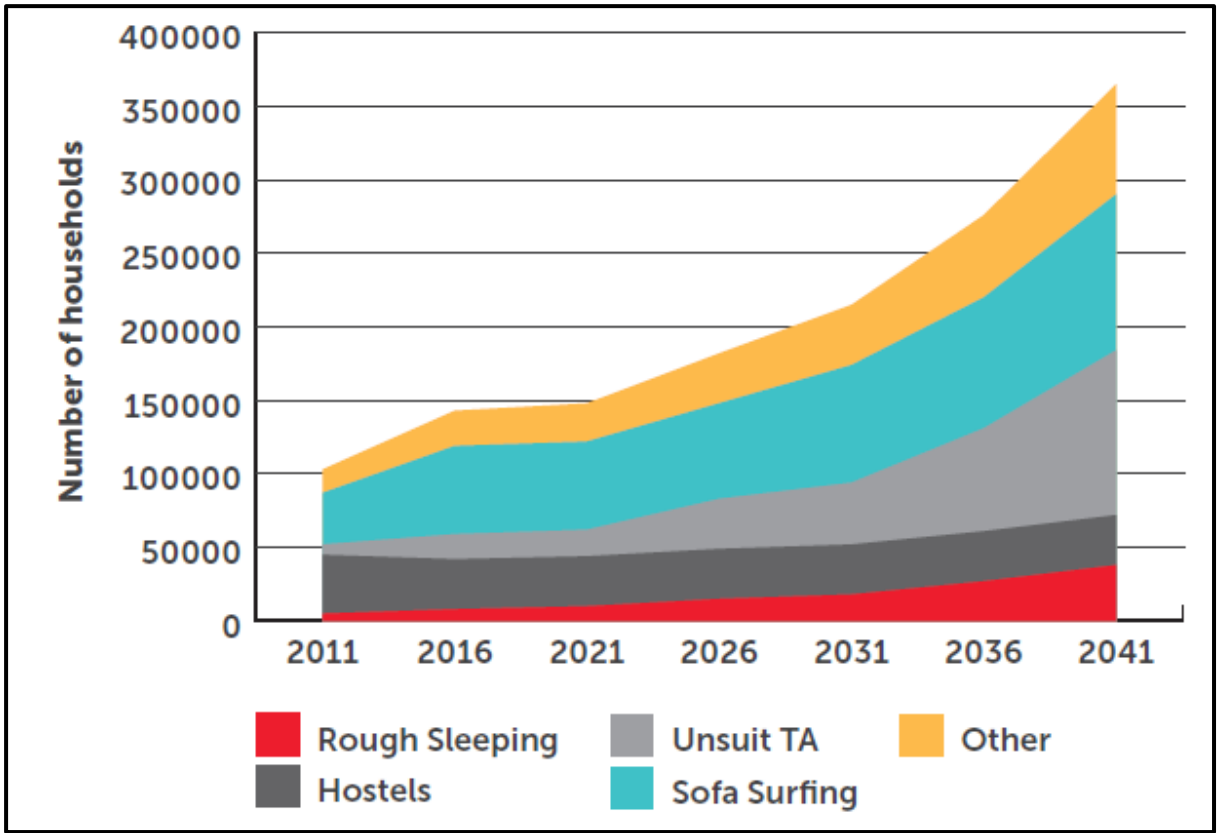


Figure 33. Baseline forecasts of core homelessness for England, 2011-2041.

Data source: Bramley, 2017.

Modelling work using local authority data from 1993-2008 shows that a 1% increase in house prices predicts a 0.18% increase in the share of households that are homeless. Conversely, a 1% increase in household income is associated with a 0.48% decrease in homelessness. Moreover, supply of social lettings is positively correlated with homelessness levels potentially reflecting the market effect of increased supply leading to increased demand. On the other hand, increased private renting appears to be associated with reduced homelessness levels. This finding could indicate that increased supply of housing opportunities in the private sector can prevent some people from becoming homeless, thus, resulting in homelessness reduction (MHCLG 2019b).

In agreement with previous literature on the predictors of homelessness in the UK, the model reveals that homelessness projections correlate with changes in affordability of housing,

poverty and personal characteristics (for example, gender and marital status). Moreover, the findings of the model highlight the contribution of prevention measures in tackling homelessness. The introduction of a comprehensive set of homelessness prevention schemes is predicted to reduce acceptance rates by 48% on average (MHCLG 2019b).

The place-based determinants of homelessness relevant to Swindon include the projected population increases relative to housing availability. It is projected that the number of households in Swindon will grow by 1,377 dwellings per annum to 2037 (ORS, 2017). It will be a challenge to meet this demand. There are other changes including the closure of the Honda factory that will impact on the profile of unemployment, and create financial and relationship pressures for families that could predispose to homelessness. All stakeholders must react to these changes to develop robust support systems for those at risk of homelessness, as well as having a strong focus on the factors described here which predispose to homelessness, so that as many cases can be prevented as possible.

14.2 Changes in Legislation

The full impact of the Homelessness Reduction Act (2017) on demand and supply of social housing, and prevention of homelessness remains to be seen. There are other potential changes in legislation which may impact directly on homelessness, and the issues surrounding it. In the Rough Sleeping Strategy (MHCLG, 2018), the government are committed to reviewing the Vagrancy Act (1824), with a report due in March 2020. The Vagrancy Act (1824) criminalises rough sleeping and begging, and is still used nationally. Concerns have been raised that it does not address the root causes of rough sleeping, and can put rough sleepers at risk, forcing them to sleep in more dangerous locations. If it is repealed there will still be legislation to address some of the other anti-social behaviours that can be associated with rough sleeping. Finally, the government has announced a plan to end Section 21 evictions – so called “no fault” evictions. These are identified as a cause of family homelessness, and the objective is to create a market where open-ended tenancies are the norm (MHCLG, 2019c). Changing the private rental market towards more secure tenancies of at least 3 years is also a recommendation from the recent LGiU report (LGiU, 2019).

Chapter 15 Conclusions and recommendations

15.1 Conclusions

Homelessness is a complex entity, and this JSNA cannot completely describe homelessness in Swindon, however it does paint a picture of multiple vulnerable groups and varied experiences that put individuals and families at risk of poor outcomes. It is acknowledged nationally that data collection at the local level can be challenging, yet this should be a focus as it can drive targeted, effective prevention (LGiU, 2019).

Structural factors such as the housing shortage, benefits changes and unemployment are identified, alongside individual factors such as poor mental health and substance misuse. The ways these factors coincide and inter-relate means that action is required at multiple levels, with a strong emphasis on prevention, to improve homelessness locally. This goes beyond providing adequate social housing, and the importance of drivers such as poverty,

adverse childhood experiences, and spending time in the care system requires an upstream approach to homelessness.

Rough sleeping is the worst manifestation of homelessness and although it only affects a relatively small number of people it can have far reaching consequences for those individuals. The issue is multi-faceted and complex and the Council cannot tackle rough sleeping alone. As with all homelessness, there must be a focus on prevention and rapid intervention. To achieve this, strong partnership working is required between all stakeholders, to deliver a multi–agency approach across the whole community. People with experience of homelessness also have needs and potential beyond housing, and these should be considered in personal plans to include individuals' potentials to work and develop.

Examples of good practice of partnership working in Swindon are identified, including the Rough Sleeper Panel, the MARAC, and the Homelessness and Healthcare network. Individual services have also developed strong approaches to support individuals and families, including Housing First, the personal assistants for care leavers, and the sexual health outreach clinics. To reach more people at risk of, and experiencing, homelessness, even stronger partnership working is required, combined with learning from other areas. Although these individual services may benefit their service users, there will be those who fall through the cracks and are less likely to receive support, including the entrenched homeless, those with no recourse to public funds, individuals with complex needs, and those who do not seek the support of services. The intensity of support required to reach and engage with these individuals must be balanced against the high personal and societal cost of homelessness.

15.2 General recommendations

There are many positive interventions, and examples of partnership work around homelessness in Swindon. The recommendations aim to build on our strengths, and highlight any gaps.

Overarching recommendations

- To build the local strategic approach to homelessness, informed by the findings of this JSNA, and to continue developing the Swindon Homelessness Strategy.
- To ensure an ongoing upstream approach to homelessness, with a focus on prevention.
- To ensure that assistance for those finding themselves homeless or at risk of homelessness is quick, practical and tailored to individual needs.
- To recognise that reducing homelessness requires inter-organisation collaboration and a shared commitment, particularly for vulnerable groups such as victims of domestic abuse, care leavers, refugees and asylum seekers and sex workers.
- Homelessness can be linked with mental health and substance misuse issues. To support people with complex needs we should continue to build links between these services to enable effective referrals and interventions.
- To ensure that local data is available to understand the local homelessness profile, and future demand. Providers of support services should use this data to gain a better understanding of the needs of the wide variety of groups experiencing homelessness, the impact of the Homelessness Reduction Act (2017) and the Duty to Refer.

Prevention: To ensure an upstream approach to homelessness, with a focus on prevention

- SBC should consider work to improve access to information, including digital solutions, so that people in Swindon are aware of the services and support available around homelessness, and that engagement with services occurs before crisis point. This might include how to access the council, and work to destigmatise seeking housing support.

- SBC and providers of homeless support services should monitor locally the impact of legislative and benefits changes, including Universal Credit, and anticipate the impact of such changes upon support services.

- All people working across public services need to be versed in homelessness, the legislation, and why homelessness is important. Training should also be given in trauma-informed support and awareness of mental health issues and services. The PHE resource for homelessness could be a useful training tool (PHE, 2019)

- SBC will continue to work with private landlords to maintain stable tenancies where possible, and continue to review how to sustainably maintain SBC housing stock.
- To ensure a continued focus on improving the supply and access to affordable housing that will provide solutions to meet diverse housing needs across the Borough and avoid emergency housing placement.

Intervention**: **To ensure that assistance for those finding themselves homeless or at risk of homelessness is quick, practical and tailored to individual needs

- Rapid intervention is needed for those experiencing rough sleeping, encompassing a No Second Night Out objective. This should build on existing provision.
- Homeless people may require identity documents and a registered address to access welfare support, education, employment and training. All support services should consider these needs, and provide a registered address where required.
- Personal support workers, such as the Personal Advisors for Care Leavers, or the Housing First Support workers are examples of good practice. This model could be expanded for other vulnerable groups, including individuals with complex needs.
- Lived experiences of homelessness differ widely, and homelessness support services must work to understand the needs of the individual beyond housing, as seen in the jigsaw of needs. Individuals' goals and progress should be monitored using objective tools like the outcomes star.
- Points of contact with homeless people are an opportunity for intervention to reduce the risk of repeated homelessness. A Making Every Contact Count (MECC) approach may be beneficial as these individuals may need multiple offers of engagement. MECC could be used to address mental and physical health proactively, alongside social and housing needs.

Collaboration**: **Reducing homelessness requires inter-organisation collaboration and a shared commitment, particularly for vulnerable groups such as victims of domestic abuse, care leavers, refugees and asylum seekers and sex workers.

- Pathways for referrals between services and organisations (including the Duty to Refer) need to be efficient, effective and monitored.

- Inter-organisation collaboration through panels such as the Multi-Agency Risk Assessment Committee, the Rough Sleeper Panel, or the Young Person Housing Panel

represent examples of good practice. This model could be expanded to other areas supporting vulnerable or complex individuals.

- SBC and other organisations, including the voluntary sector, should consider how best to support those with No Recourse To Public Funds, and to build referral pathways with The Harbour Project to assess housing needs for asylum seekers and refugees.

***Innovation**:*

- Novel programmes should be considered including community donations to homelessness charities as an alternative to begging, social impact bonds and expanding Swindon's social enterprise schemes.
- People with lived experience of homelessness can provide valuable support to others. Opportunities for self-development should be part of support services, and lead to employment and training where possible, including the use of social enterprise. There could be a programme to develop peer supporters, and homelessness champions in decision-making about homelessness services.
- The impact of the sexual health outreach model of health care should be evaluated, and considered for expansion to reach the wider homeless population by commissioners.

15.3 Recommendations for specific groups

Recommendations for Mental health, Substance Misuse and Homelessness

- Mental health needs (including suicide prevention) must be considered in the homeless population in Swindon. Currently, work is ongoing to identify how best to provide specialist care in this area. Models of service provision could include specialist mental health workers within homelessness, and CMHT outreach into homeless settings would benefit those with mental health and housing issues
- A positive approach to mental health in Swindon's homeless populations should make available evidence-based interventions to homeless people to promote good mental health
- There should be an emphasis on engaging with, and supporting completion of treatment, for adults and children with substance misuse and housing issues in Swindon
- Homeless support services and substance misuse services need to work together to support those with substance misuse issues into treatment, this may include writing personal support plans, criteria for support with individuals, continued treatment in transitioning between prison and the community
- To facilitate collaboration between substance misuse services, mental health services, probation and housing, commitment to attendance at the CCG Homeless and Healthcare network or the Rough Sleeper Panel could be considered contractually

Recommendations for offenders and those being released from prison

- The support and pathways for those being released from prison to the Swindon area require improvement, with a particular focus on those with a history of multiple offences
- SBC, probation services and prisons commonly releasing to the Swindon area need to work together around the new Duty to Refer and the pathways for those referrals
- Better ways of working between prisons, community probation services and homeless support services should be developed, including consideration of the Homelessness and Healthcare network model adapted to the probation and prison services
- Probation services should continue to develop the MECC approach to support ex-offenders with substance misuse needs or housing needs to engage with service

Recommendations for Healthcare and Homelessness

- The healthcare needs of the homeless are a specialist area, and commissioners and providers should consider a specialist commissioned community service (with potential for hospital in reach), and ensuring Pathway (2018) standards are met in the mainstream service
- Homeless health checks could be piloted, particularly for identifying and managing, or referring: substance misuse, poor mental health, long term physical conditions, wounds or ulcers, infectious diseases (HIV, hepatitis B and C, TB), contraception, screening and other sexual health needs
- Homeless people would benefit from a targeted smoking cessation service
- SBC and providers of healthcare should continue to work together around the new Duty to Refer and the pathways for those referrals

Chapter 16 References

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Chapter 17

17.1 Appendix 1: Local stakeholders

Local stakeholders involved in the engagement work include:

- Booth House, Salvation Army
- Culvery Court, Sanctuary Supported Living
- Swindon Foyer, Stonewater Housing
- Swindon Clinical Commissioning Group
- The Nelson Trust
- The Harbour Project
- HOSTS (Homeless Organisations Standing Together in Swindon)
- Great Western Hospital Acute Trust
- Avon and Wiltshire Mental Health Partnership NHS Trust
- Turning Point Substance Misuse Service for Adults
- U Turn Substance Misuse Service for Young people
- Threshold Housing Link
- Carfax Street Medical Practice
- Medvivo (community health and care provider)
- Sexual Health Services
- BGSW and DDC Probation Services
- Wiltshire and Swindon Police
- Health Watch
- Swindon Caring Hearts
- Big Breakfast Plus
- SSAFA: the Armed Forces charity
- Public Health England and the Health Protection Team, South West

17.2 Appendix 2: Interview prompts for service user engagement

Background:

Explain the JSNA methods and purpose, and the role of public health. The overall aims are to identify what is working well, what isn't working so well, and understand their experiences, particularly their journey through homelessness and interactions with different services.

Any information given will not be linked to them, but some quotes may be used where useful, and general themes identified.

They have the right to decline to answer any question or end the interview at any stage.

The interviewer is not part of the housing team and this interview will have no bearing on applications for housing, however concerns will be escalated to the relevant team if needed.

Questions:

1. Can you tell me about your experiences/current circumstances?
    a. Include directions to clarify route through "homelessness"
2. Can you tell me about your experience of XXXX service? (adapt to where relevant)
    a. Could include housing first, supported living, hostel, so on.
3. Have you had contact with other homeless support services?
    a. Expand to describe experience
4. Have you had contact with healthcare services or mental health services, and would be happy to tell me about that?
5. Have you had contact with Turning point or other drug and alcohol services and would be happy to tell me about that?
6. Are there any factors you can identify that lead to an interaction with XXXX service going well, or going badly?
7. Did you feel you expected the same things as the services, when thinking about your relationship with them, and different responsibilities and goals for what you wanted to achieve?
8. How do you feel the different services work together to support you?
9. What are your long term goals?
10. What do you feel are the issues we should be focussing on?
11. Are there any other things you want to bring up around your housing situation, or overall health and wellbeing?