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Health Matters

The health needs of homeless people in Wales

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About Cymorth Cymru

Cymorth Cymru is the umbrella body for providers of homelessness and housing related support services in Wales. Cymorth Cymru acts as the 'voice of the sector', influencing the development and implementation of policy that affects our members and the people they support. We work in partnership with members and other stakeholders to prevent and reduce homelessness and improve the quality of life for people who are marginalised or at risk of housing crisis across Wales.

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Introduction

We are pleased to publish Health Matters, a report about the health needs of homeless people in Wales. We would like to thank our partners and colleagues from the Welsh Government, Shelter Cymru, local authorities, homelessness organisations and health services who helped us to conduct the audit, analyse the results and develop the recommendations. In particular, we are extremely grateful to the people who shared their views and experiences of health problems and homelessness. Without them, this report would not exist. We must now ensure that their invaluable contributions lead to improvements in policy and practice.

This report highlights how health problems can be both a cause and consequence of homelessness. 33% of respondents told us that health problems were a primary or secondary cause of their homelessness and approximately 30% said that their health had got worse over the past twelve months. Over 30% said they needed more help and support for their health problems and many faced barriers to health care, including lengthy waiting lists and being unable to get appointments. Of those who had been in hospital, a quarter were discharged onto the street or into unsuitable accommodation, which doubled their chance of re-admission.

The audit also highlights the extent of public health and wellbeing issues among homeless people, with 67% being smokers, 70% not being vaccinated against hepatitis B or the flu, and 40% having fewer than two meals per day. More than 60% of respondents over 40 years old had not had a NHS health check in the last twelve months, and at least half of eligible women did not have regular cervical smear tests or breast examinations.

Although this report contains a large number of recommendations, there are some key themes throughout. We would like health, housing and homelessness services to **make every contact count**, using these opportunities to identify people's health and housing needs and help them to access appropriate support. Another important theme is **collaboration between services** to ensure that people's health and housing needs are better met. There is lots of existing good practice which could be extended across Wales, including sharing of expertise, co-location of staff and joint working. We are also keen for **innovative, trauma informed and person-centred approaches** to be rolled out across Wales, that recognise the challenges and barriers that homeless people face. This includes developing new and innovative solutions in both health and housing services, as well as sharing existing good practice.

The recommendations in this report provide an opportunity to transform people's lives - and also deliver savings to public services through early intervention and prevention. We look forward to working with partners to take this work forward.

Katie Dalton
Director, Cymorth Cymru

Our thanks to Dr Jacqueline Campbell and Shelter Cymru for conducting the research and data analysis on behalf of Cymorth Cymru.

2. Policy context

In 2016 the Welsh Government commissioned Cymorth Cymru to conduct an audit of the health needs of homeless people in Wales. With the support of Shelter Cymru, a pan-Wales audit was conducted during 2016. This was based on the Homeless Health Needs Audit in England, which was developed by Homeless Link in partnership with the Department of Health in England and Public Health England.

The audit in Wales used the same questionnaire as in England, with minor adjustments to reflect the Welsh context. We asked organisations that work with people experiencing homelessness to encourage and assist them to complete the survey, which was available online and as a paper copy. The purpose of the audit was to:

- Gain an insight into the current health problems facing the homeless population.
- Inform health and housing commissioning.
- Inform Welsh Government policy and priorities.
- Continue to build closer links between health and housing.

Housing (Wales) Act 2014

Part 2 of the Housing (Wales) Act 2014 reformed homelessness law in Wales with the aim of ensuring that people who are homeless or at threat of homelessness receive help as early as possible. It includes a new duty on local authorities to help anyone threatened with homelessness within 56 days; a duty to support any homeless person to help them secure a home; and new powers for local authorities to discharge their homelessness duties through finding accommodation in the private rented sector.

The purpose of the legislation is to achieve:

- Fewer households experiencing the trauma of homelessness; better, more targeted, prevention work
- Increased help, advice and information for households who receive limited assistance under the previous legislation
- More focus on the service user, helping them to address the causes of homelessness and make informed decisions on finding solutions to their housing problem
- More effective use of the private rented sector as a solution to homelessness
- A stronger emphasis on co-operation and multi-agency working

The legislation came in to effect in April 2015. Additional resources have been provided for local authorities to support the change to the more prevention-focused approach. Although comparisons cannot be made to statistics gathered prior to the change in legislation, the homelessness data suggests that the legislation is proving successful in helping to prevent homelessness in Wales.

Rough Sleepers Count

In February 2017 the latest Rough Sleepers' Count was published by the Welsh Government. Due to differences in methodology, the data cannot be compared directly with the previous Rough Sleepers Count in 2015. However, the figures indicate that there has been an increase in rough sleeping in Wales. Concerns have been raised that the new legislation is successfully preventing homelessness for many people, but that more needs to be done to support people who are already homeless - especially those with complex needs who may or may not be engaged with services.

Standards for Improving the Health and Well-being of Homeless People and Specific Vulnerable Groups

The Welsh Government's Health and Care Standards, which came into force in 2015, set out the guiding principles for delivery of health services in Wales, including the need for easy and timely access to primary care services, people are supported to get help when they need it and in the way they want it, and efforts are promoted to reduce health inequities. In 2013 the Welsh Government published revised 'Standards for Improving the Health and Well-being of Homeless People and Specific Vulnerable Groups'. They include five standards for ensuring that homeless people have full and fair access to health services:

1. Leadership: The Health Board demonstrates leadership driving improved health outcomes for homeless and vulnerable groups.
2. Joint working: The Health Board works in partnership with the Local Authority, service users, the Third Sector and stakeholders to improve health and contribute to the prevention of homelessness.
3. Health intelligence: The Health Board works in partnership with the Local Authority, service users, the Third Sector and stakeholders and demonstrates an understanding of the profile and health needs of homeless people and vulnerable groups in their area.
4. Access to healthcare: Homeless and vulnerable groups have equitable access to the full range of health and specialist services.
5. Homeless and Vulnerable Groups' Health Action Plan: The Health Board leads the development, implementation and monitoring of the HaVGHAP in partnership with the Local Authority, service users, the Third Sector and other stakeholders.

The HaVGHAPs should set out how services are planned and delivered to meet the health needs of homeless people and those at risk of homelessness, with the aim of addressing the social determinants of health, health inequalities and cycles of poor health and homelessness. These principles are also relevant to the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015.

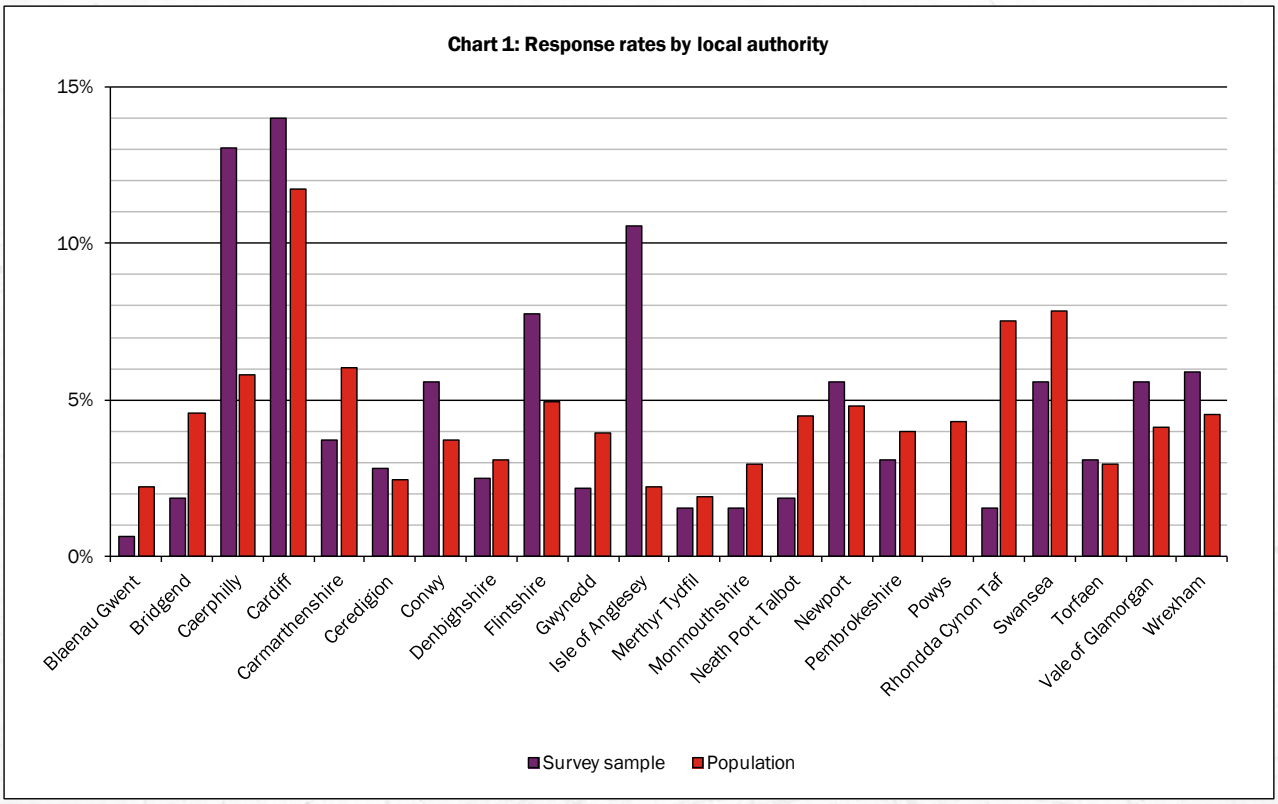
Other relevant policy and legislation

- Wellbeing of Future Generations (Wales) Act 2016
  http://gov.wales/topics/people-and-communities/people/future-generations-act/
- Social Services and Wellbeing (Wales) Act 2015
  http://gov.wales/topics/health/socialcare/act/
- Together for Health
  http://gov.wales/topics/health/publications/health/reports/together/
- Mental Health (Wales) Measure 2010
  http://gov.wales/topics/health/nhswales/mental-health-services/law/measure/
- Together for Mental Health
  http://gov.wales/topics/health/nhswales/mental-health-services/policy/strategy/
- Working together to reduce harm
  http://gov.wales/topics/people-and-communities/communities/safety/substancemisuse/publications/strategy0818/
- Service framework for the treatment of people with a co-occurring mental health and substance misuse problem.
  http://gov.wales/topics/people-and-communities/communities/safety/substancemisuse/publications/substance-misuse/?lang=en
- Hospital Discharge Protocol for Homeless People in Wales
  http://www.publichealthnetwork.cymru/files/5214/4613/4011/Hospital_Discharge_Protocol_for_Homeless_People_in_Wales_John_Bradley__Rhiannon_Hobbs_2014.pdf

3. Demographics

322 usable survey responses were collected from homeless people across 21 local authorities in Wales, including people who had slept rough; stayed in a hostel, foyer, refuge, night shelter or B&B; stayed with friends or relatives because they had no home of their own; or applied to the council as homeless. According to Welsh Government statistics, a total of 6,891 households were assessed as being homeless and owed a duty to help secure accommodation during 2015-16.

Chart 1 shows the response rates for each local authority alongside the geographic distribution of the Welsh population (statswales.gov.wales, 2016).



The relatively small sample size makes it difficult to conduct the analysis at the local authority level. Moreover, it is advisable to group the 22 Welsh local authorities into seven health boards (HB) to reflect the current healthcare provision management. The mapping between local authorities and the HBs are as follows:

- Abertawe Bro Morgannwg University Health Board (ABM UHB): Swansea, Neath Port Talbot, Bridgend.
- Aneurin Bevan University Health Board (AB UHB): Blaenau Gwent, Caerphilly, Monmouthshire, Newport, Torfaen.
- Betsi Cadwalader University Health Board (BC UHB): Isle of Anglesey, Conwy, Denbighshire, Gwynedd, Flintshire, Wrexham.
- Cardiff & Vale University Health Board (CV UHB): Cardiff, Vale of Glamorgan.
- Cwm Taf University Health Board (CT UHB): Merthyr Tydfil, Rhondda Cynon Taf.
- Hywel Dda University Health Board (HDd UHB): Ceredigion, Pembrokeshire, Carmarthenshire.
- Powys Teaching Health Board (P THB): Powys.

The survey sample is generally in line with the general population distribution at Health Board level (Chart 2). However, there were unfortunately no responses from people within the Powys Teaching Heath Board area.

The age range of the sample (Chart 3) is slightly biased towards young people compared to the population demography (Census, 2011).

Other demographics of the sample include:

- 63% of respondents identified themselves as male and 37% identified as female.
- 91% described themselves as heterosexual
- 96% were white, and 94% were UK citizens, but only 2 of them (0.6%) were refugees
- 84% of respondents had recourse to public funds or benefits
- Among respondents, 27% are "permanently unable to work due to long-term sickness or disability", and another 9% "intend to look for work but prevented by temporary sickness or disability". Individuals with health issues that prevent them from working account for more than one third of the sample, as highlighted in Chart 4 below.

Chart 2: Response rates by health board area

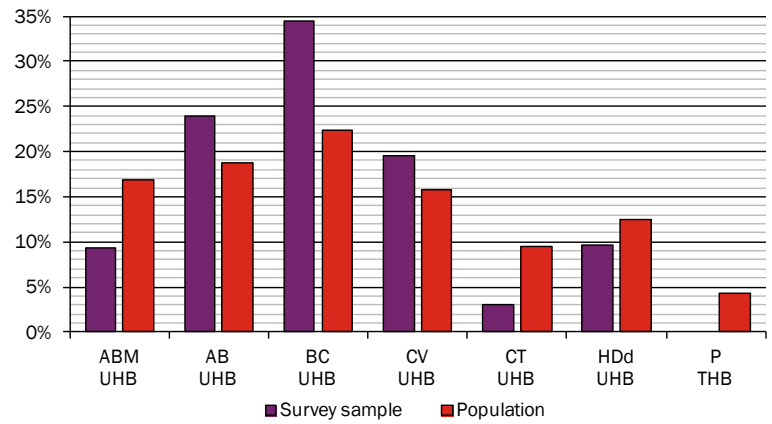


Chart 3: Response rates by age

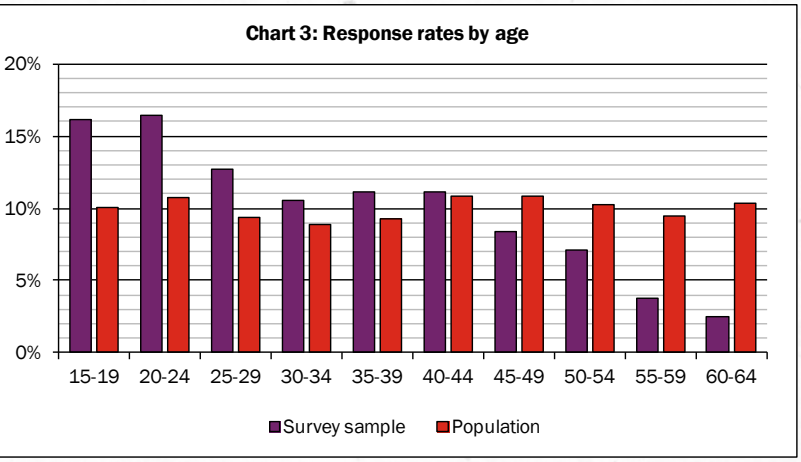
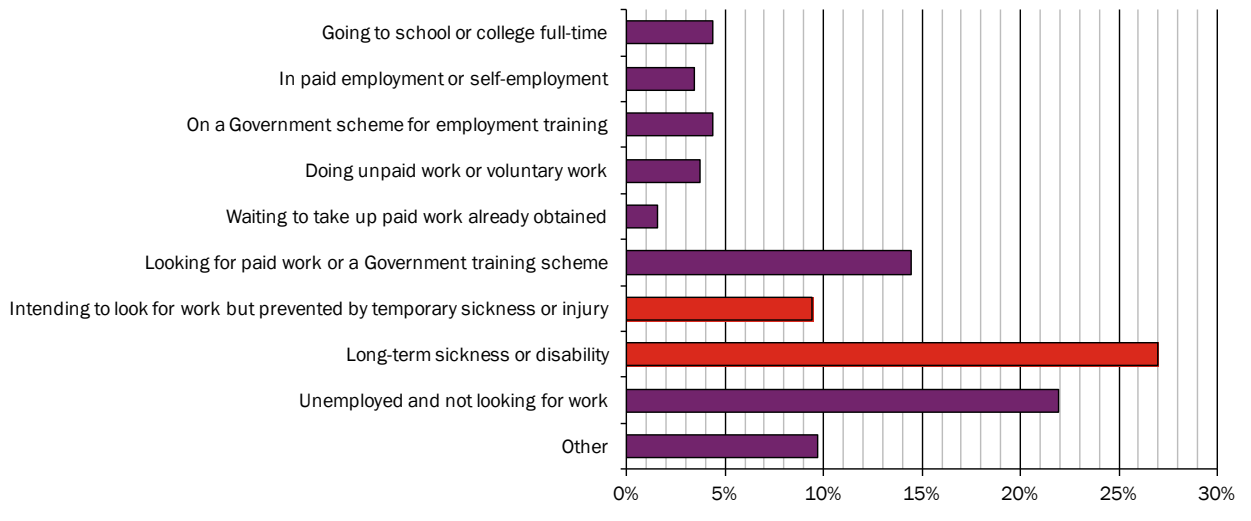


Chart 4: Education, training and emploment status



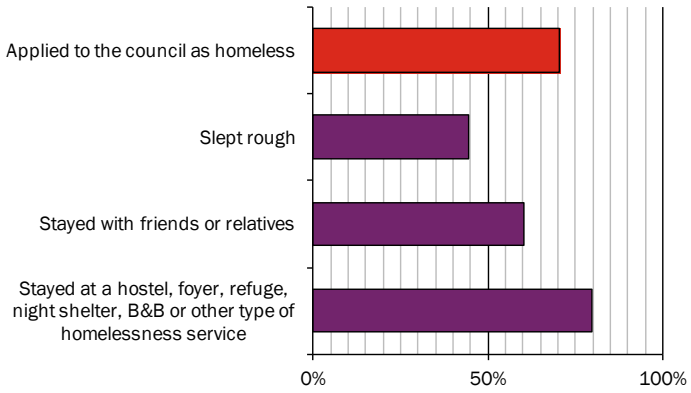
4. Homeless status

Where people have stayed

As shown in Chart 5, the majority of the sample have at some point stayed in a hostel, foyer, refuge, night shelter or B&B (80%), or stayed with friends or relatives (60%). A significant minority (44%) have slept rough.

A point of interest is that only 70% of the sample had made a homeless presentation to their local authority.

Chart 5: Have you ever done any of the following?



Presenters and non-presenters

We can distinguish between two types of homeless person for the benefit of the analysis:

- **Presenter:** Presented to the local authority council as homeless
- **Non-presenter:** Did not present to the local authority council as homeless

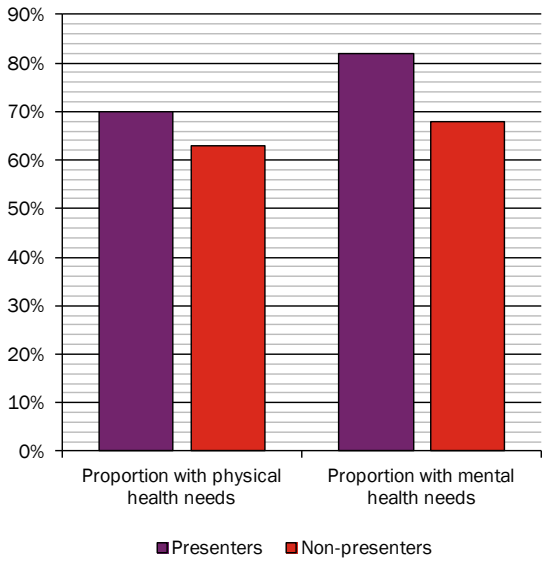
The distinction between those that present as homeless and those that do not is meaningful because Presenters report more physical and mental health needs than Non-presenters.

As illustrated in Chart 6, 70% of the Presenters have physical health needs, compared to 63% of the Non-presenters. 82% of Presenters reported mental health needs compared to 68% of Non-presenters.

Those with physical (12.6% higher) or mental health (19.6% higher) issues are more likely to present as homeless than those that do not. Presenters rate their health 6.18% lower than people who do not present.

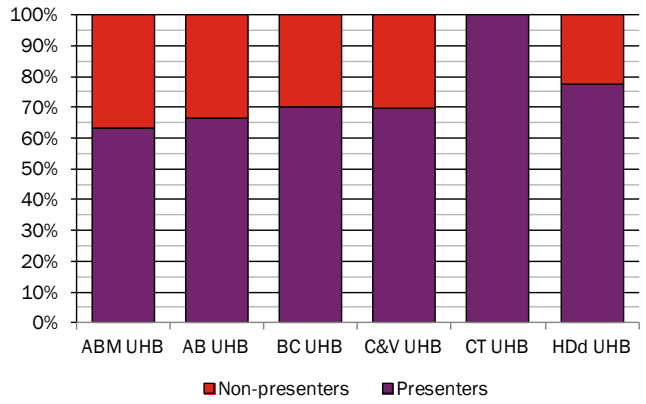
There is no significant difference in homeless presentations across different age groups, but there is weak evidence that the youngest group (16~25) present more often.

Chart 6: Physical and mental health needs - presenters vs non-presenters



A geographic distribution of Non-presenters is shown in Chart 7. Apart from Cwm Taf (where all homeless people in the sample have presented as homeless), other HBs seem to have similar proportions of homeless people that have not presented as homeless to the council. Nevertheless, if a homeless person is from the urban area (i.e. Cardiff, Swansea and Newport) of the HB then the chance of them presenting as homeless is lower (26.7%~29.1% lower) than rural areas.

Chart 7: Presenters vs. non-presenters by health board



This distribution can be further decomposed by gender and age, as illustrated by Chart 8 and Chart 9. In most health board areas, the demographic structure of the Presenters are quite similar. There are two exceptions: the Abertawe Bro Morgannwg UHB area has remarkably more female homeless individuals who presented as homeless to the council than the other HBs, while the Cwm Taf UHB area has more young homeless people (age group 16-25).

Chart 8: Presenters vs. non-presenters by gender and health board

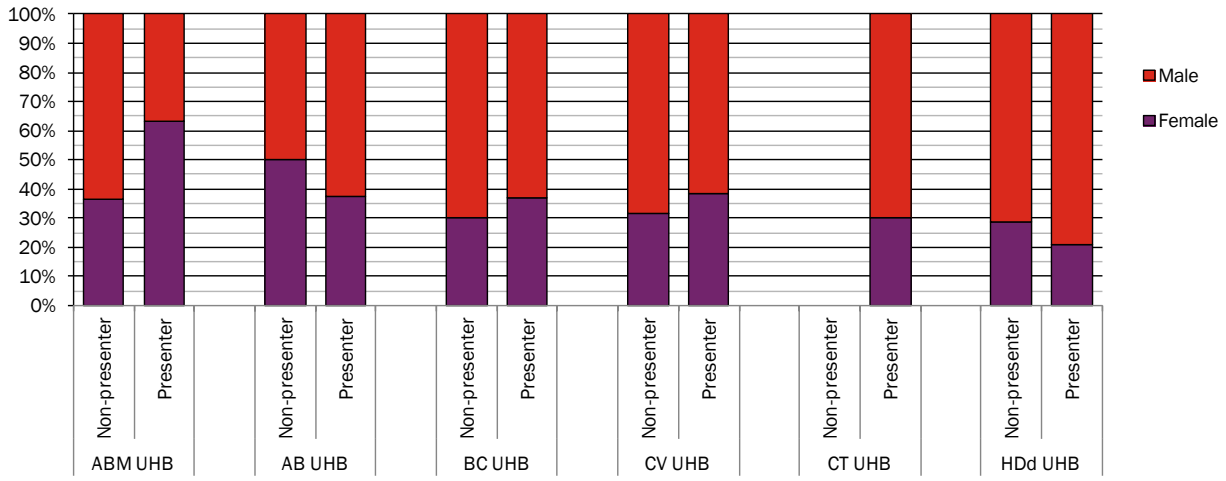
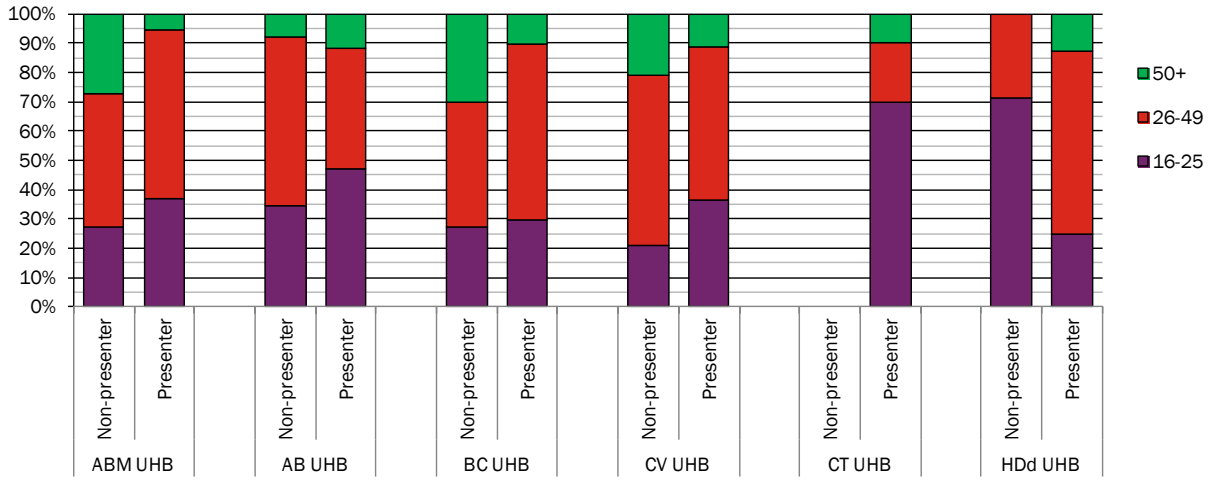


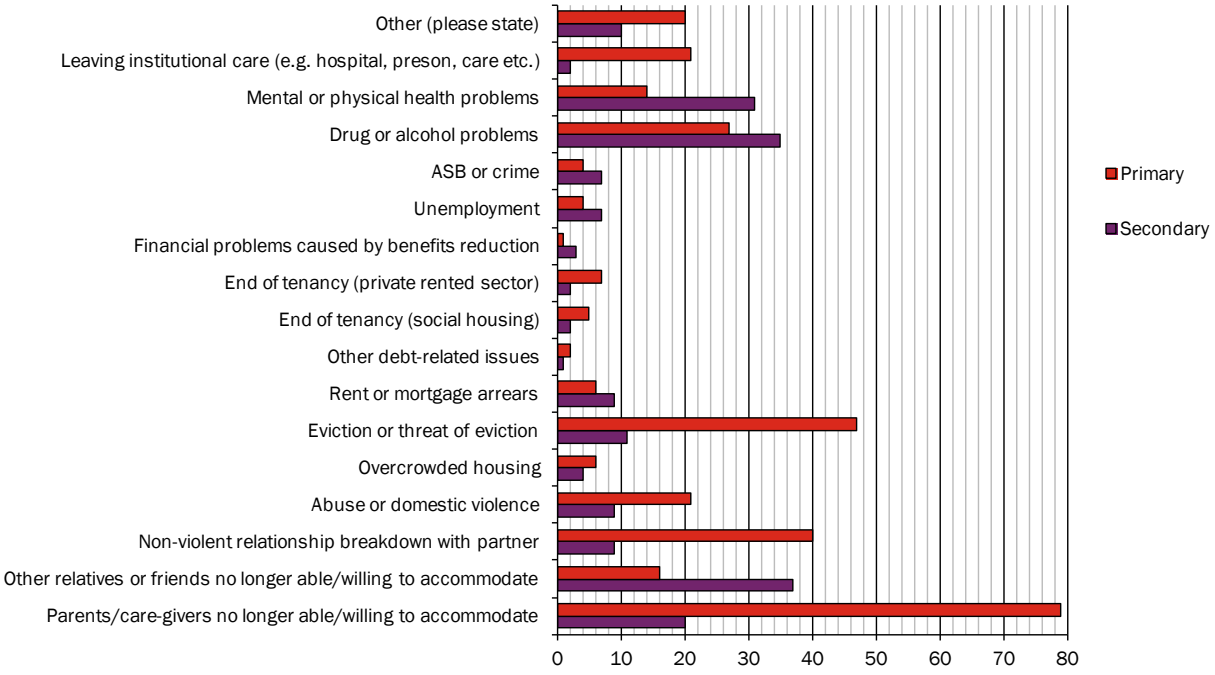
Chart 9: Presenters vs. non-presenters by age and health board



5. Causes of homelessness

The primary and secondary reasons stated as the cause of current homelessness are shown in Chart 10. The top three primary reasons are: (i) parents/care-givers no longer able/willing to accommodate; (ii) eviction or threat of eviction; and (iii) non-violent relationship breakdown with partner. In contrast, the top three secondary reasons are: (i) other relatives or friends no longer able/willing to accommodate; (ii) drug or alcohol problems; and (iii) mental or physical health problems. The health issues account for 4% of primary reasons and 10% as secondary reasons.

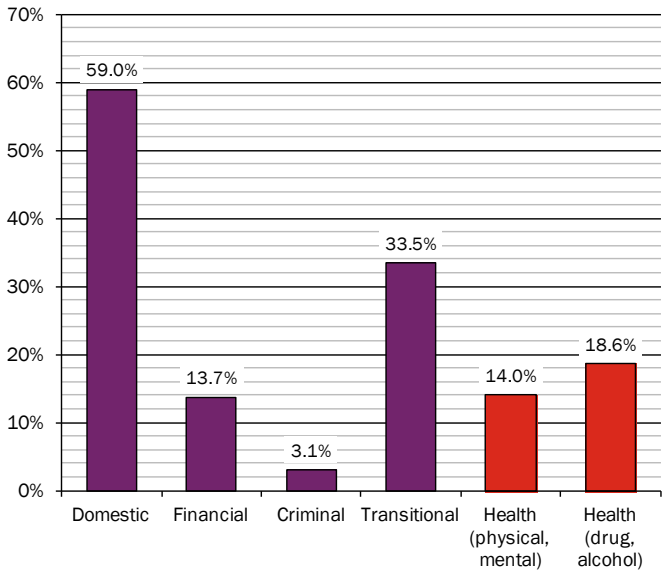
Chart 10: Primary and secondary causes of homelessness



If we include "drug or alcohol problems" as part of a broadly defined health issue, then 33% of the sample state that their current homelessness is caused, at least in part, due to a health problem. This implies that health issues are a risk factor for homelessness.

The reasons listed in Chart 10 can be grouped into five general categories: (i) domestic[1], (ii) financial[2], (iii) criminal, (iv) transitional[3], as well as (v) health, which are further decomposed into physical, mental and drug/alcohol issues. Chart 11 summarises the proportions of homeless people answering "yes" to each category (as either primary or secondary reasons).

Chart 11: Causes of homelessness



1 Includes: parents/care-givers no longer able or willing to accommodate, other relatives or friends no longer able or willing to accommodate, non-violent relationship breakdown with partner, abuse or domestic violence, and overcrowded housing.
2 Includes: rent or mortgage arrears, other debt-related issues, financial problems caused by benefits reduction, and unemployment.
3 Includes: eviction or threat of eviction, end of tenancy (social and private housing), leaving institutional care (e.g. hospital, prison, care etc.)

6. Health status and needs

There are three broadly defined health issues: (i) physical health, (ii) mental health and (iii) drug/alcohol use. Overall, 57% of the sample stated that they have "long-standing illness, disability or infirmity". Their health needs and their access to support vary with geography (e.g. health board and urban location) and demography (e.g. gender, age). This section focuses on the health needs of homeless people, including both their general health state and their detailed health needs in the domains of physical, mental and alcohol/drug use.

General Health State

Homeless people were asked to rate their current health state on a scale of 0-100 (where the best state imaginable was 100 and 0 was the worst state imaginable). The mean figure given by our sample was 62 out of 100, with a median of 65 out of 100. The geographic difference is very small across Welsh HBs (Chart 12). Cwm Taf UHB area achieves the highest average self-rated health score, while Aneurin Bevan UHB area has the lowest. The gap between the two extrema is less than 5 out of 100.

This general health state can be further decomposed across gender, age and location. The average score is summarised in Table 1. In terms of gender, in all HBs apart from Cwm Taf, females tend to rate their health higher than males do. Not surprisingly, older adults have a lower than average health score, but again Cwm Taf is an exception where the youngest age group has a considerably lower score.

Our analysis looked at differences in self-reported health state between homeless people in urban and rural areas (location). There are three urban local authorities in Wales (Cardiff, Newport and Swansea) spanning three HBs, but there will be some rural areas and some urban areas in each of the three HBs. We found that homeless people in urban areas are likely to have a worse self-reported health state, especially in Newport (Aneurin Bevan), than those in rural locations. Although the Abertawe Bro Morgannwg UHB area has a higher health score in the urban area than its rural counterpart, the score is not significantly higher than the average score of all the rural areas.

Chart 12: Mean health score by health board

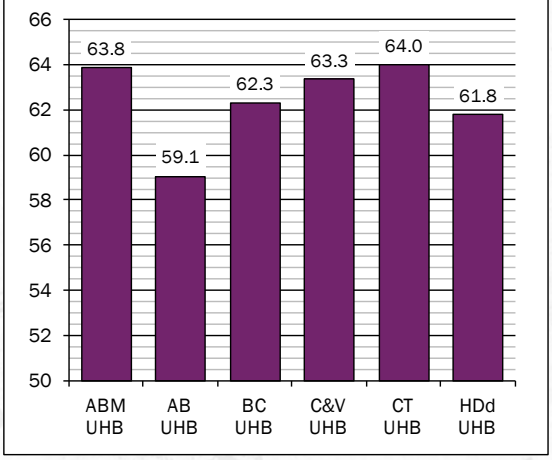


Table 1: Geographic variation of overall health state by gender, age and location

Health Board	Gender		Age group			Location	
	Male	Female	16-25	26-49	50+	Rural	Urban
ABM	59.21	67.88	70.80	60.13	61.25	61.33	65.50
AB	55.64	63.88	72.91	50.17	42.00	62.68	47.22
BC	61.11	64.51	67.59	61.84	54.50	62.31	NA
CV	59.20	70.52	70.35	61.53	54.56	70.94	60.29
CT	70.00	50.00	57.14	85.00	70.00	64.00	NA
HDd	60.21	67.14	77.73	51.18	63.33	61.77	NA
Overall	60.90	63.99	69.42	61.64	57.61	63.84	57.67

When asked “compared to twelve months ago, how would you say your health is now?”, approximately 30% of the sample stated that their health has deteriorated in the last year (Chart 13).

However, Non-presenters are more likely to have experienced a deterioration in health in the last 12 month (30%) compared to those that have presented as homeless (26%). This possibly indicates a positive role of the local authority in maintaining the health state of homeless people via access to support.

Homeless people in Wales suffer most from physical pain/discomfort and mental anxiety/depression (Chart 14).

The next few pages of this report will explore physical health, mental health, and drug and alcohol use issues in more detail.

Chart 13: Compared to twelve months ago, how would you say your health is now?

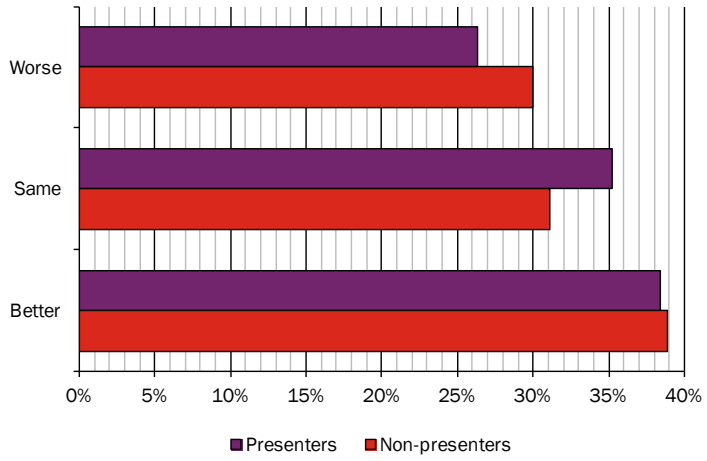
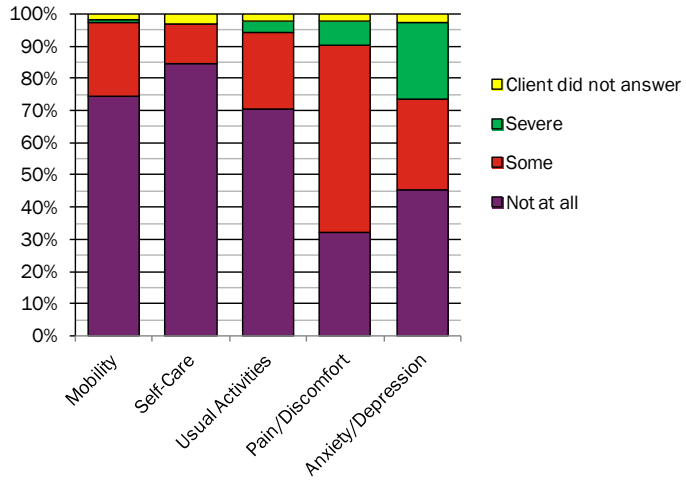


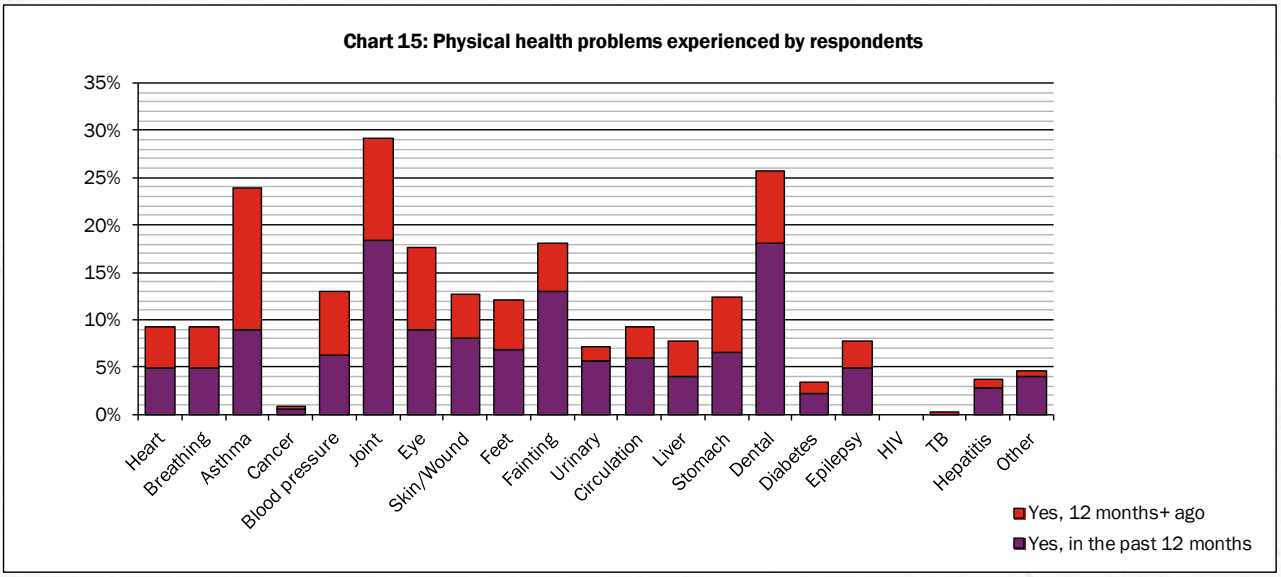
Chart 14: Health issues experienced by respondents



Physical Health Needs

The histogram below (Chart 15) shows the percentages of the sample having physical health problems, disaggregated by the time since they have had these issues. Many of these problems developed in the past 12 months, indicating a negative impact of homelessness on health.

Note that many people have more than one physical health issue, and the sum of the percentages exceeds 100%. On average, each homeless person has 2.29 physical health problems. Of those with physical health issues, 71% are currently receiving support or treatment for the issue, 26% would like more help and support to address the issue. However, 10% of people in need of support or treatment for a physical health issue have not received any.



The physical health needs of homeless people also vary across gender, age and location. The proportions of the sample that have physical health needs are reported in Table 2. Females (60%) are less likely to have physical health needs than males (73%), and older people have significantly stronger needs for physical healthcare than the youngest group (49%). Homeless people living in an urban area are more likely to have physical health needs (84%) compared to those who are living in more rural areas (62%).

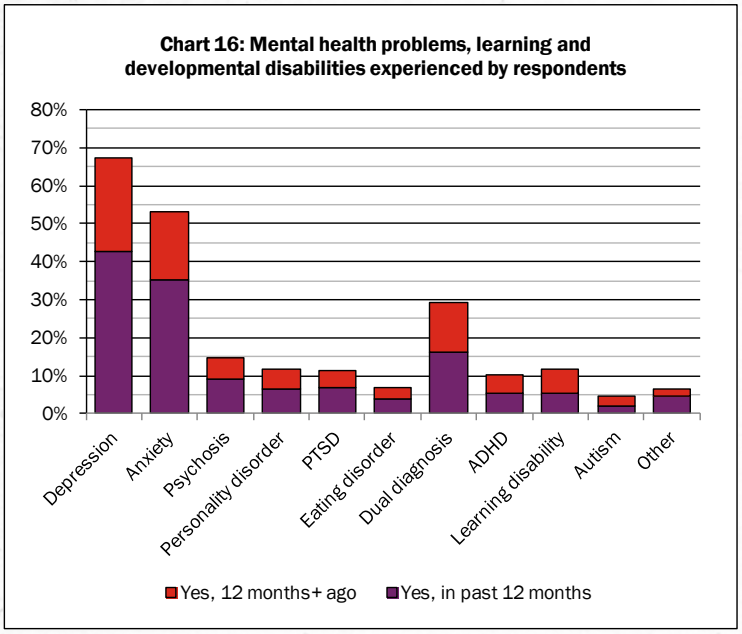
Table 2: The geographic variation of physical health needs by gender, age and location

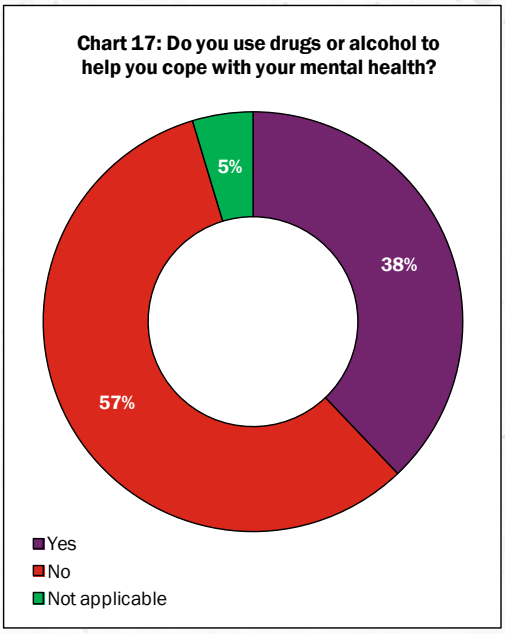
Health Board	Gender		Age group			Location	
	Male	Female	16-25	26-49	50+	Rural	Urban
ABM	71.4%	68.8%	50.0%	81.3%	75.0%	58.3%	77.8%
AB	80.0%	59.4%	63.6%	77.8%	75.0%	66.1%	88.9%
BC	58.3%	56.4%	37.5%	63.9%	72.2%	57.7%	NA
CV	82.5%	69.6%	65.0%	82.4%	88.9%	55.6%	86.7%
CT	71.4%	33.3%	42.9%	100.0%	100.0%	60.0%	NA
HDd	75.0%	71.4%	36.4%	100.0%	66.7%	74.2%	NA
Overall	73.1%	59.8%	49.2%	84.2%	79.6%	62.0%	84.4%

Mental Health Needs

As for the mental health issues (Chart 16), the most common mental health problems are depression and anxiety, from which more than half of those with mental health issues are suffering. On average, each homeless person has 2.28 mental health problems.

As illustrated by Chart 17, 37.8% of respondents stated that they use drugs or alcohol to cope with their mental health issues (self-medicating).





Similar to the physical health needs, the mental health needs of homeless people vary across gender, age and location. The proportions of homeless people who have mental health needs are reported in Table 3. Again, on average, males are more likely (85%) than females (74%), to have mental health issues, but this pattern is violated in ABM and BC. As for age, those aged 26-49 suffer the most mental health issues (90%) than the youngest (73%) and oldest (79%) age ranges. Homeless people living in urban areas are more likely to have a mental health issues (87%) than those living in the rural areas (77%).

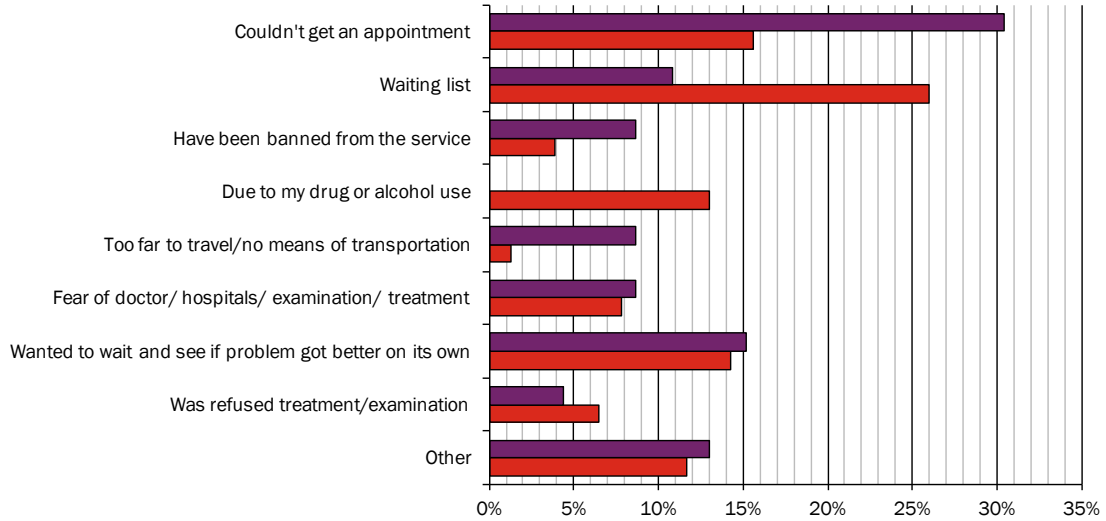
Table 3: The geographic variation of mental health needs by gender, age and location

Health Board	Gender		Age group			Location	
	Male	Female	16-25	26-49	50+	Rural	Urban
ABM	85.7%	93.8%	90.0%	93.8%	75.0%	83.3%	94.4%
AB	75.6%	59.4%	51.5%	86.1%	62.5%	62.7%	88.9%
BC	76.4%	84.6%	65.6%	88.5%	72.2%	79.3%	NA
CV	77.5%	65.2%	70.0%	76.5%	66.7%	61.1%	77.8%
CT	100.0%	66.7%	85.7%	100.0%	100.0%	90.0%	NA
HDd	91.7%	71.4%	72.7%	94.1%	100.0%	87.1%	NA
Overall	84.5%	73.5%	72.6%	89.8%	79.4%	77.3%	87.0%

Barriers to physical health and mental health services

People can face different barriers to treatment and support depending on the type of health problem they are experiencing. The reasons that respondents gave for not being able to access healthcare are summarised in Chart 21. The most common reason is the person "couldn't get an appointment" (30%) for physical health issues and "waiting list" (26%) for mental health issues. These two reasons together account for about half of the lack of access to the healthcare services for both physical and mental health issues. For mental healthcare services, 13% of respondents stated that their drug or alcohol use was the reason they were unable to access healthcare. This highlights that drug/alcohol use is not only a health issue per se but it also prohibits access to healthcare treatment and support, especially for mental health issues.

Chart 21: Main reason for not receiving the examination or treatment



Drug/Alcohol Use Problems

Among the 322 respondents, 26 (8%) participants had both drug and alcohol problems, and less than two thirds have neither problem. In particular, drug problems seems to be more prevalent (about a quarter) than the alcohol problem (about one fifth).

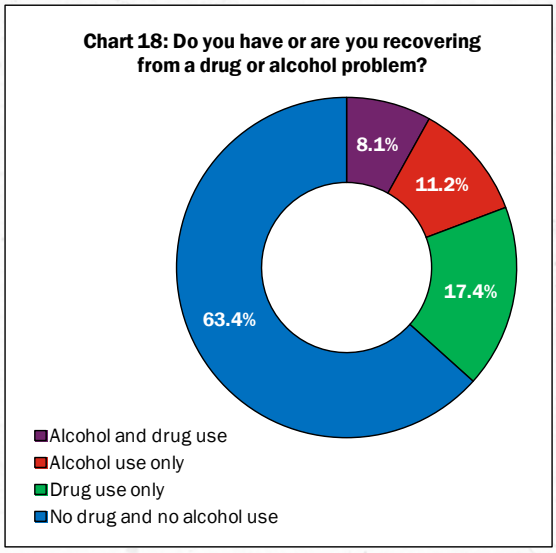


Table 4: Drug use and alcohol use

	Alcohol Use = No	Alcohol Use = Yes	Total
Drug Use = No	204 (63.4%)	36 (11.2%)	240 (74.5%)
Drug Use = Yes	56 (17.4%)	26 (8.1%)	82 (25.5%)
Total	260 (80.7%)	62 (19.3%)	322 (100%)

The most common drugs taken by people in the last 12 months are cannabis/weed (36%), amphetamines/speed (16%) and heroin (14%). 12% of respondents have had an alcoholic drink almost every day for the past 12 months. On a typical day of drinking the median number of units is 7. The geographic and demographic differences of drug and alcohol use are summarised in Table 5 and Table 6. Males, those in the 26-49 year old age group and people living in urban locations are more likely to have issues with drugs and alcohol.

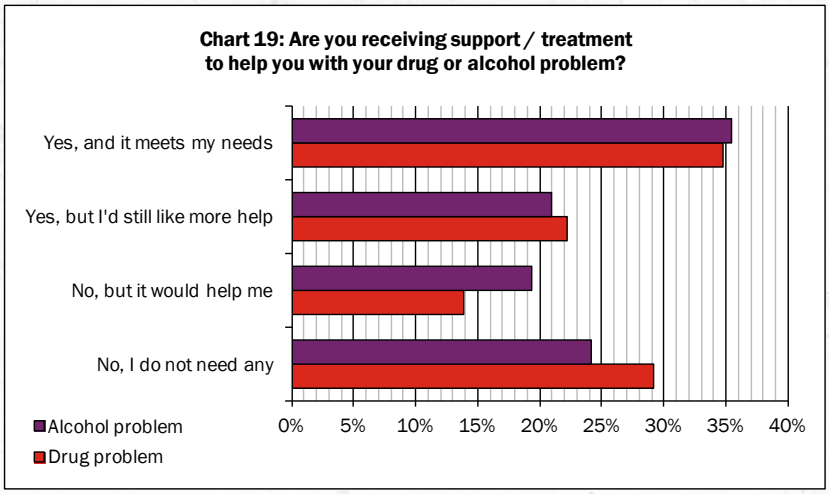
Table 5: The geographic variation of drug use by gender, age and location

Health Board	Gender		Age group			Location	
	Male	Female	16-25	26-49	50+	Rural	Urban
ABM	35.7%	18.8%	10.0%	37.5%	25.0%	8.3%	38.9%
AB	35.6%	25.0%	21.2%	44.4%	12.5%	20.3%	66.7%
BC	34.7%	5.1%	12.5%	32.8%	16.7%	24.3%	NA
CV	25.0%	17.4%	10.0%	29.4%	22.2%	11.1%	26.7%
CT	28.6%	0.0%	0.0%	100.0%	0.0%	20.0%	NA
HDd	25.0%	14.3%	9.1%	29.4%	33.3%	22.6%	NA
Overall	30.8%	13.4%	10.5%	45.6%	18.3%	17.8%	44.1%

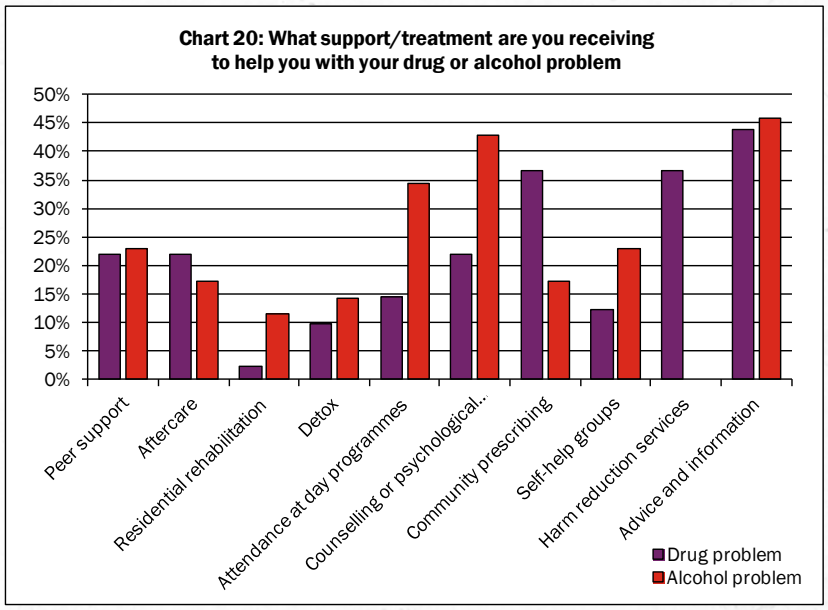
Table 6: The geographic variation of alcohol use by gender, age and location

Health Board	Gender		Age group			Location	
	Male	Female	16-25	26-49	50+	Rural	Urban
ABM	21.4%	31.3%	20.0%	31.3%	25.0%	16.7%	33.3%
AB	24.4%	6.3%	3.0%	25.0%	37.5%	11.9%	33.3%
BC	23.6%	15.4%	3.1%	24.6%	38.9%	20.7%	NA
CV	17.5%	8.7%	5.0%	17.6%	22.2%	11.1%	15.6%
CT	14.3%	0.0%	0.0%	50.0%	0.0%	10.0%	NA
HDd	29.2%	14.3%	0.0%	35.3%	66.7%	25.8%	NA
Overall	21.7%	12.7%	5.2%	30.6%	31.7%	16.0%	27.4%

Combining those people who are not receiving any support or treatment for their drug or alcohol problem and those that are receiving support but feel they need more help results in approximately 40% of homeless people with drug or alcohol requiring more/ better access to healthcare services (Figure 16).



For those who have received, or who are receiving, support/ treatment for both drug and al-cohol problems, the most common form of support is advice and information (e.g. from GPs, A&E departments). Other more formal treatments, such as detox, residential rehabilitation and aftercare, only account for a low percentage as shown in Figure 17.



Comparison with English health audit and general population

The following table highlight the results from the Welsh audit compared to an English homeless sample and the general population.

Compared to the research done by Homeless Link[1], homeless people in Wales have approximately a 30% higher chance of experiencing both physical and mental health problems than homeless people in England, but are approximately 10% less likely to have drug issues. Nevertheless, the rates of physical and mental health problems and drug use among Welsh homeless people are much higher than for the general public in England[2].

Table 7: Comparison of prevalence of physical health problems, mental health problems and drug use problems

	Homeless people (Wales)	Homeless people (England)	General public (England)
Physical health problems	68%	41%	28%
Mental health problems	78%	45%	25%
Drug use problems	25%	36%	5%

1 Homeless Link (2014) http://www.homeless.org.uk/facts/our-research/homelessness-and-health-research
2 The comparable data for the Welsh general public are not available.

7. Pre-use, Interim-use and Post-use

Pre-Use Access: GP and dentist registration

9% of homeless people are not registered with a GP or homeless healthcare service, and more than half of respondents (51%) are not registered with a dentist. 3% and 7% of respondents have been refused registration to a GP and dentist respectively. The main reason for being refused GP registration is not clear, but for dentist registration the main reason is the limited availability of places. Chart 22 shows the breakdown of homeless people in each HB that haven't registered with a GP/Homeless Healthcare Service or dentist.

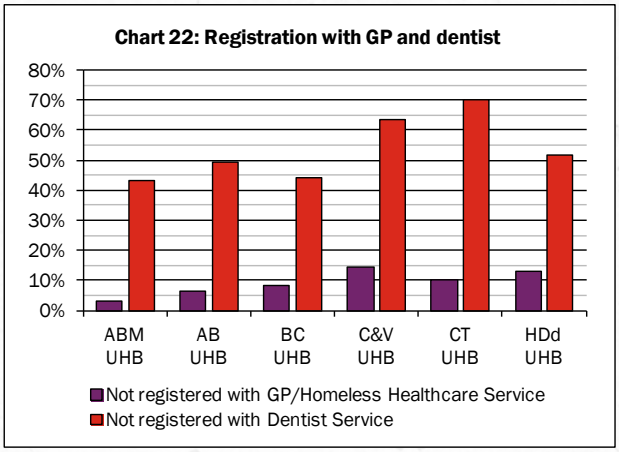


Table 8 and Table 9 summarise the geographic-demographic decomposition of the registration rates of GP and dentist services. In most helth board areas, females have higher registration rates for both GPs and dentists compared to males (GP: 93% versus 90%; dentist: 62% versus 38%). There is a different trend between GP and dentist registration rates over different age groups and rural/urban areas. Those in the middle age group (26-49) have the highest GP registration rate (95%), but the youngest group (16-25) have the highest dentist registration rate (55%). Those who live in the urban areas have a slightly higher GP registration rate, but a lower dentist registration rate, compared to those who live in the rural areas.

Although not statistically significant, data indicates that registration with a GP/dentist reduces the chance of having physical and mental health issues, resulting in a higher self-reported health score. Thus access to the health service does play a key role for homeless people.

Table 8: Geographic variation of GP registration by gender, age and location

Health Board	Gender		Age group			Location	
	Male	Female	16-25	26-49	50+	Rural	Urban
ABM	92.9%	100.0%	100.0%	100.0%	75.0%	100.0%	94.4%
AB	93.3%	93.8%	90.9%	94.4%	100.0%	93.2%	94.4%
BC	93.1%	89.7%	84.4%	98.4%	83.3%	91.9%	NA
CV	85.0%	87.0%	80.0%	88.2%	88.9%	77.8%	88.9%
CT	85.7%	100.0%	85.7%	100.0%	100.0%	90.0%	NA
HDd	87.5%	85.7%	81.8%	88.2%	100.0%	87.1%	NA
Overall	89.6%	92.7%	87.1%	94.9%	91.2%	90.0%	92.6%

Table 9: Geographic variation of dentist registration by gender, age and location

Health Board	Gender		Age group			Location	
	Male	Female	16-25	26-49	50+	Rural	Urban
ABM	42.9%	68.8%	90.0%	37.5%	50.0%	50.0%	61.1%
AB	51.1%	50.0%	57.6%	41.7%	62.5%	57.6%	27.8%
BC	47.2%	71.8%	50.0%	59.0%	55.6%	55.9%	NA
CV	25.0%	56.5%	35.0%	41.2%	22.2%	55.6%	28.9%
CT	14.3%	66.7%	42.9%	0.0%	0.0%	30.0%	NA
HDd	45.8%	57.1%	54.5%	47.1%	33.3%	48.4%	NA
Overall	37.7%	61.8%	55.0%	37.7%	37.3%	49.6%	39.3%

Interim-Use Access

In the last twelve months, over 80% of the sample have been to the GP or homeless healthcare service at least once, more than 40% have been to A&E or admitted to hospital, and more than 30% have used an ambulance (Chart 23). Among the reasons for using A&E, an ambulance or being admitted to hospital, physical health problems and suicidal behaviour are the two most common reasons (about 40%), while drug use and alcohol use are also significant, accounting for about 20% of the use of healthcare services (Chart 24).

Chart 23: Health services used over the past 12 months

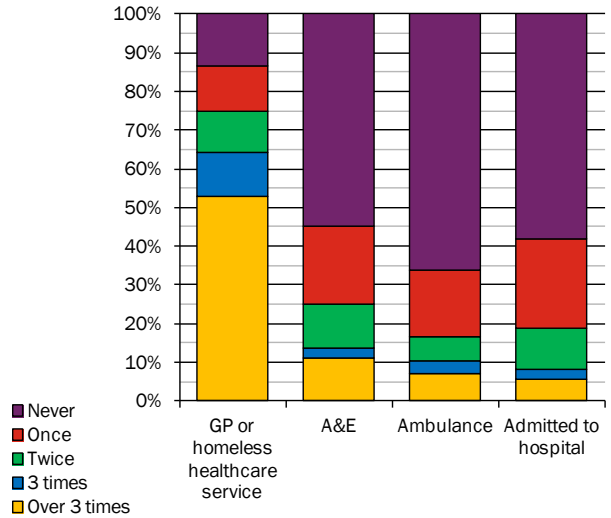
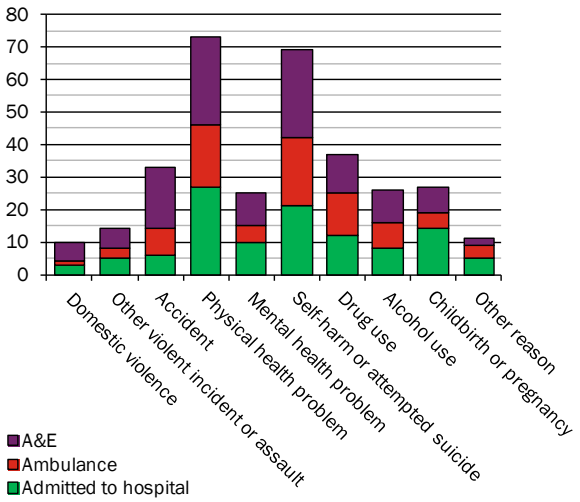


Chart 24: What was the primary reason for using these services?



Post-Use Access

On discharge from hospital, only 65% of the sample was asked by staff if they have anywhere suitable to go, and 11% of them were discharged onto the street. Although 77% of homeless people were discharged into accommodation, 13% said “it was not suitable for my needs” (Chart 25).

Poor post-discharge care may increase the chance of being readmitted to hospital. As shown in Table 10, the chance of being readmitted is doubled if no suitable post-discharge accommodation is arranged.

Chart 25: Where did you go when you were discharged from hospital?

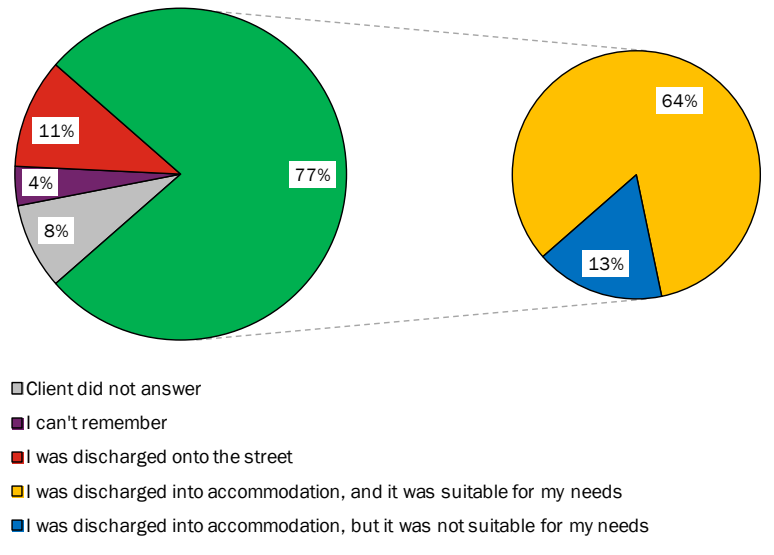


Table 10: Comparison of re-admission rates following discharge into suitable and unsuitable accommodation

	Re-admitted into hospital	Not re-admitted into hospital
Suitable accommodation	11.7%	88.3%
Unsuitable accommodation	20.7%	79.3%

8. Health behaviours

Experience of homelessness can make it difficult for people to maintain healthy lifestyles. Financial barriers can affect diet and lack of access to healthcare services can mean that people are unable to benefit from recommended check-ups, screenings and vaccinations.

67% of respondents smoked cigarettes, cigars or a pipe but only 21% of smokers wish to give up. In England, the rate of smoking among the homelessness population is 77%[1], and 41% of those people wish to give up. In the general population, Homeless Link cite that 20% of the population smoke and as much as 63% wish to quit[2].

70% of the respondents have not had a vaccination against hepatitis B nor flu. A similar pro-portion has not had a sexual health check in the last 12 months and a quarter of them do not know where to go for advice for sexual health or free contraception.

For homeless people over 40 years old, over 60% of them have not had a NHS health check in the past 12 months, and at least half of the eligible female respondents do not have cervical smears or undertake breast examinations on a regular basis. 84% of respondents say they have no problem with self-care but 12% say they have some problems with washing or dressing themselves.

Chart 26: Prevelence of smoking among homeless samples and general population

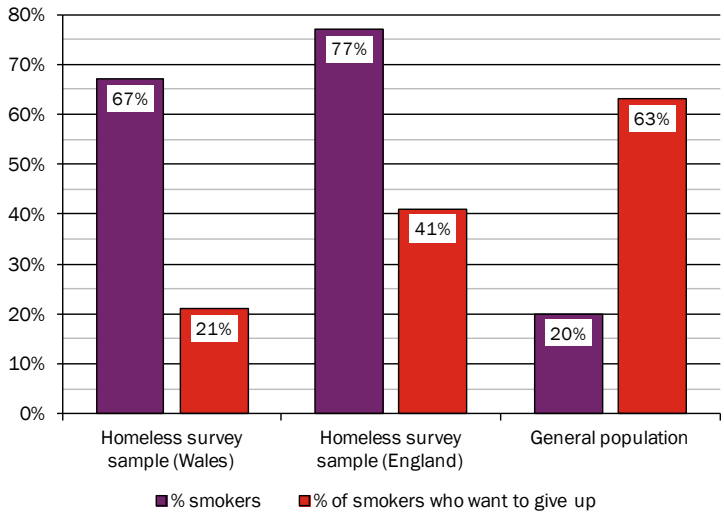
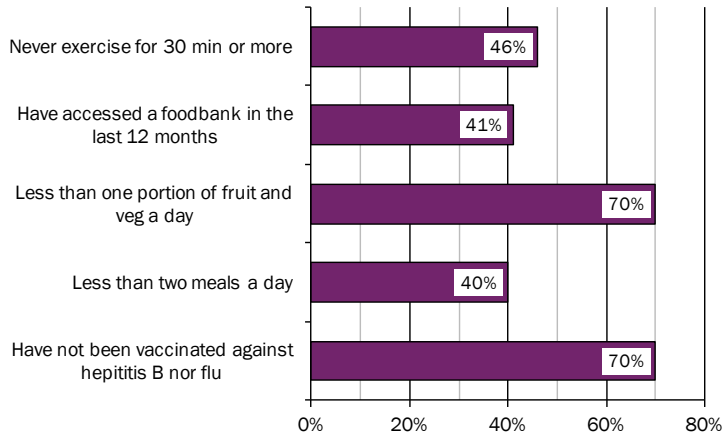


Chart 27: Health behaviours of survey sample



We found that 40% of homeless people have less than two meals a day, and more than 70% of them have less than one portion of fruit a day. 41% have accessed a food bank in the last twelve months. Finally, 46% of Welsh homeless people never do any exercise.

Data indicates that while public health campaigns have had a positive impact on the general population's health, the same cannot be said for people who are homeless. Support for homeless people to achieve a healthy lifestyle can reduce the demand and need for healthcare services. The survey found that adopting a good lifestyle (e.g. vaccinations, check-ups, good nutrition etc.) can marginally raise self-reported health scores by 4.5%[3].

1 http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf
2 Source: Nutrition Survey 2011; Homeless Link's Health Needs Audit
3 Structural equation modelling was used

9. Recommendations

In December 2016 Cymorth Cymru organised an expert round-table, which included representatives from the Welsh Government, Public Health Wales, health boards, local authorities and homelessness charities. The meeting discussed the findings of the audit, best practice and potential solutions to some of the issues raised by its findings. The following recommendations have since been developed for consideration.

Improving access to healthcare services

- Health Boards: Pilot assertive outreach support for people who have experienced repeat and/or long term homelessness.
- Health Boards: Arrange for GPs and dentists to regularly visit homelessness centres.
- Health Boards: Encourage GP surgeries to register homeless people as 'care of the surgery' if they don't have an address, rather than turning them away.
- Health Boards: Consider running emergency clinics and drop in services for homeless people, rather than requiring them to book appointments.
- Health Boards: Consider walk in / open access substance misuse services.
- Health Boards and Local Authorities: Increase awareness that people can access Local Primary Mental Health Support Services without a fixed address.
- Health Boards: Increase awareness of Part 3 of the Mental Health (Wales) Measure that enables people to re-access secondary mental health services more quickly.
- Health Boards and third sector: Support Rough Sleeper Intervention Teams to assist homeless people to access and register with health and dental services.
- Local Authorities: When 56 day homeless duty is being applied, ensure all health needs are assessed, including physical health, mental health, alcohol and substance use issues.
- Local Authorities: Ensure that when homeless people access services they are encouraged and helped to register with a GP and a dentist.
- Social landlords: Use pre-tenancy support to identify health needs and support people to access appropriate physical health, mental health, and substance misuse services.
- Social landlords: Support tenants at risk of eviction to identify and access appropriate physical health, mental health and substance misuse services.

Making contacts count

- Health Boards: Increase primary care use of social prescribing and signposting/referrals to housing and debt advice and support services.
- Health Boards: Ensure that mental health Care and Treatment Plans address people's accommodation needs and risk of homelessness - and ensure care coordinators work with appropriate partners in social housing, local authorities and third sector to address needs.
- All services: Consider the introduction of a 'Don't let go service' - where one person coordinates the health and housing needs of a homeless person to avoid them becoming lost in the system or losing contact with services entirely.
- All services: Adopt trauma informed and psychologically informed approaches to supporting with people who are homeless or at risk of homelessness.
- All services: Ensure health, criminal justice, homelessness and housing related support services are aware of each others services and how to access or refer to them.

Recommendations (cont.)

Co-occuring mental health and alcohol/substance misuse

- Health Boards: Focus on effective implementation of the *Service framework for the treatment of people with a co-occurring mental health and substance misuse problem* - to prevent homeless people with a dual diagnosis from being bounced between services.
- All services: Monitor and address the impact of new psychoactive substances on the health and wellbeing of homeless people.
- Health Boards and police: Provide treatment and support to people experiencing a mental health crisis who have used alcohol or substances - do not turn away or use police cells.

New approaches for people with the most complex needs

- All services: Work collaboratively to develop Housing First models for homeless people with the most complex needs / co-occuring mental health and substance misuse problems.
- All services: Consider specific approaches to meeting the health and housing needs of young, single homeless people who face the additional challenges of welfare reform and not having priority need status.

Multi-agency co-location

- Health Boards and Local Authorities: Consider placing housing and homelessness staff (statutory or voluntary sector) on hospital wards to help people to address housing issues and maintain/secure their tenancy while in hospital.
- Health Boards and Local Authorities: Consider placing staff with mental health and substance misuse expertise (statutory or voluntary sector) in housing and homelessness departments to help identify issues, give advice and signpost/refer to appropriate services
- Health Boards: Consider placing staff from third sector organisations with housing and debt expertise in GP surgeries.
- Health Boards and Local Authorities: Consider placing nurses with prescribing capabilities in homelessness centres.

Improving discharge from hospital

- Health Boards and Local Authorities: Ensure all patients have their housing needs assessed before discharge and are assisted by housing and homelessness staff (statutory or voluntary sector) to help address housing issues and maintain/secure their tenancy while in hospital.
- Health Boards, local authorities and third sector: Work in partnership across health and housing to prevent delays in discharge and prevent people being homeless or at risk of homelessness when they are discharged from hospital.
- Health Boards: Discharge people who are homeless or at risk of homelessness to specialist homelessness health services and/or professionals.
- Health Boards: Ensure local hospital discharge protocols are in place which meet the standards in the Hospital Discharge Protocol for Homeless People in Wales, and applied consistently.

Recommendations (cont.)

Assessing population need and planning delivery

- Health Boards and Local Authorities: To re-prioritise the development, review and implementation of the Standards for Improving the Health and Well-being of Homeless People and Specific Vulnerable Groups' including HaVGHAPS
- Welsh Government and Public Health Wales: To support and monitor implementation of the Standards for Improving the Health and Well-being of Homeless People and Specific Vulnerable Groups, including HaVGHAPS.
- Local Authorities: Ensure that the impact of homelessness on health and wellbeing is considered and addressed as part of population needs assessments.
- Health Boards and Local Authorities: Include homelessness as part of impact assessments when considering service design and development.
- Regional Collaborative Committees, Public Service Boards, Regional Partnership Boards: Consider health of homeless people as an agenda item or as a joint workshop. Support and facilitate the sharing of best practice regionally and nationally.
- All services: Support appropriate information sharing to improve assessment of needs and access to health and support services.

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