Preventing homelessness to improve health and wellbeing

Evidence review into interventions that are effective in responding to health and wellbeing needs amongst households at risk of homelessness

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KEY FINDINGS

Public Health England (PHE) commissioned Homeless Link to conduct a rapid review to better understand homelessness prevention interventions that have been developed in response to identified health and wellbeing needs amongst households who are at risk of homelessness. PHE is interested in preventing ill-health and reducing health inequalities through addressing the wider determinants of health. The home has been identified as one of these factors. Ill-health puts some households at a greater risk of homelessness and can also be a trigger of homelessness. The review focused on the following aims:

- To understand more about the relationship between health, wellbeing and homelessness, for example the extent to which it plays a part in a household’s homelessness, or the impact of homelessness on health.
- To discover opportunities to identify and respond to health and wellbeing needs amongst the ‘at risk’ populations at an earlier point to improve outcomes.
- To identify cost effective practical interventions that others can learn from.
- To provide local authorities and their partners with a resource that can be used to inform commissioning decisions around health, wellbeing and homelessness.

Key findings from the review are:

- Homelessness prevention has been an increasing focus for local authorities since the Homelessness Act 2002 and its requirement for local authorities to devise prevention focused homelessness strategies in 2003.
- Models of preventative action are identified in three stages and can be applied to homelessness: primary prevention which minimises risk, secondary prevention which targets individuals or groups at risk, and tertiary prevention requiring intervention once a problem arises to stop it getting worse (Community Links 2014; Busch-Geertsema and Fitzpatrick 2008, Pawson 2008).
- Whilst many studies have looked at early intervention within a housing setting, for example in-tenancy support administered through a housing provider or local authority, there are few studies to show how effective interventions have been in responding to health and wellbeing needs amongst households at risk of homelessness. Where outcomes have been measured the interventions have mainly been evaluated through qualitative methods.
- The majority of interventions were housing rather than health-led and emerged in response to locally identified need or were implemented as pilot projects. Submissions of current practice were mainly focused on secondary and tertiary prevention of homelessness to prevent repeat homelessness and target ‘at risk’ groups. There were few examples which focused on primary prevention.
- The rapid review has identified the following four models of practice within four main settings:
Models of current practice mainly consist of holistic in-tenancy support, hospital discharge services and community outreach health and housing support targeted at vulnerable groups, including former rough sleepers, young people, and households with complex needs and entrenched issues, such as alcohol and substance misuse and antisocial behaviour.

The models and evidence found in the rapid review were tested in four workshops – three user involvement groups who have all experienced homelessness or been at risk of homelessness and one group with professionals working in housing, homelessness and health. The barriers identified in the workshops to implementing the models in practice are outlined below:

Drawing together the evidence collected through the academic and grey literature and the current practice case studies from the call for evidence submissions, there are a number of gaps that have been identified in three main areas:

1. **Gaps in current practice** – there is very little evidence of homelessness prevention activity that takes place in response to associated health and wellbeing needs. Aside from activity occurring at the more acute end of the homelessness scale such as hospital discharge projects and services which target vulnerable groups, the review has shown that primary prevention activity is not widespread and is mainly led by housing rather than health commissioning.

2. **Gaps in evidence** – whilst the review has highlighted some studies which look at Randomised Control Trials (RCTs) and full outcome evaluations this methodology has not been consistently applied across all studies. There is a lack of evaluation among current practice and future studies should also consider methods such as SROI, social impact and social values measurements.
3. **Gaps in interventions for certain groups** – the review has shown that proactively targeting prevention activity at particular groups is an effective way of preventing homelessness (secondary and tertiary models of prevention). Some groups have been adequately captured in current practice but there are some ‘at risk’ households which are not represented: ex-armed forces, LGBTQ groups with health needs, migrants, both families and single people that fall outside the multiple and complex needs group.

The results from the evidence review have led us to make the following recommendations for policy and practice:

**Stronger leadership and joint strategic working**
- Joint Health and Wellbeing Strategies should include clearer priorities about homelessness prevention. Each local Joint Strategic Needs Assessment (JSNA) should clearly identify who is at risk of and experiencing homelessness in the local area; and the impacts on health and wellbeing for these groups.
- Basic health and housing literacy is essential for everybody working in a health and housing setting. Local leaders should provide clear and co-ordinated direction to all agencies and individuals to ensure that ‘every contact counts’, and equip the workforce to do this.
- Local leaders should help embed a ‘prevention first’ approach, identifying opportunities to prevent and intervene earlier for ‘at risk’ communities. This should consider the role of communities, the voluntary sector, and any workforce that comes into contact with ‘at risk’ groups, including, primary and secondary health care, allied health professionals, social care, housing and homelessness, criminal justice, employment and education.

**Access to advice and early intervention**
- Extend availability of primary homelessness prevention in primary and secondary health care settings. The Care Act’s requirements for information, advice and guidance provide renewed opportunity for Health and Wellbeing Boards to review and extend this provision, working with local and national voluntary sector advice agencies.
- There needs to be greater engagement with schools, educational establishments and early year’s services by housing and health professionals to raise awareness and share effective practice in identifying children and young people at risk of homelessness. This should include training for school nurses, health visitors and staff that make home visits to households prior to starting school.
- Public Health and NHS managers should ensure frontline health professionals can identify appropriate services in their area to refer people at risk of homelessness to - e.g. through provision of online resources and stronger partnerships with local voluntary sector providers.

**Improve data collection and evaluation**
- Improve the recording and sharing of data to enable services to target interventions at those at risk of homelessness, and evidence what works. The housing status of those accessing health services should be routinely measured, alongside the health and accommodation outcomes of interventions.
- Local public health teams should help develop and promote ways for services to evaluate cost effectiveness and show return on investment for interventions. The development of effective prevention ‘metrics’ would help demonstrate how prevention activity achieves improvements across shared outcomes in a locality.
- At a national level, the partners to the housing and health memorandum of understanding (MOU) have an opportunity to continue to support health, social care, housing and homelessness sectors to address gaps in evidence to inform new ways of working.
BACKGROUND

Public Health England (PHE) is the national public health agency which fulfills the Secretary of State for Health’s statutory duty to protect health and address inequalities, and promote the health and wellbeing of the population of England. This includes supporting local authorities and clinical commissioning groups (CCGs) to identify local level need by providing evidence and knowledge on local health needs, alongside practical and professional advice on what to do to improve health, and by taking action nationally.

PHE is interested in preventing ill-health and reducing health inequalities through addressing the wider determinants of health. The right home environment is critical to health and wellbeing; good housing helps people stay healthy, and provides a base from which to sustain a job, contribute to the community and achieve a decent quality of life. Safe and suitable housing also aids recovery from periods of ill-health or admissions in hospital, and it enables people to better manage their health and care needs by integrating health services alongside any support they might need to stay in their accommodation.

Without good housing we know health and wellbeing are affected: poor conditions and precarious housing circumstances impact on physical and mental health. There has been substantial research concerning the impact that inadequate housing and homelessness has on health and wellbeing. A review by the Parliamentary Office of Science & Technology in 2011 found that poor housing is associated with increased risk of cardiovascular diseases, respiratory diseases, depression and anxiety. Further, the review concludes that data linking ill-health to housing related hazards was strongest concerning accidents in the home (these are among the top ten causes of death for all ages) and cold homes (linked to cardiovascular, respiratory and rheumatoid diseases, as well as hypothermia and poorer mental health). A review on the impact of bad housing on health conducted by NatCen for Shelter in 2013 further identified factors that can impact on health and wellbeing (Barnes et al, 2013). As well as the impact poor conditions such as overcrowding, damp and indoor pollutants have on physical health and mental health, the review also examined the impact lack of security of housing had on households. Children in families who had to move frequently were at particular risk of poor outcomes. The review identified research which showed that families living in temporary accommodation reported a range of health problems such as depression, eczema and asthma.

Generally speaking, the health of older people, children, disabled people and people with long-term illnesses are at greater risk from poor housing conditions. Ill health also puts some households at a greater risk of housing need – for example poor physical and mental health can make it harder to access and sustain tenancies, so is also a trigger of homelessness.

Once people experience more acute forms of housing need, for example homelessness or prolonged periods of rough sleeping, the rate at which health problems occur increases rapidly. Evidence suggests that single homeless people1 – those who are not typically owed a statutory duty to find accommodation by their local authority – are particularly affected by poor physical and mental health. A health audit of 2,500 single homeless people conducted by Homeless Link in 2014 found that 73% of people reported a physical health problem, and 41% said this was a long term physical health problem (compared to 28% of the general population). Forty five per cent had been diagnosed with a mental health issue compared to 25% of the general population. Factors which contribute to unhealthy lifestyles such as smoking, drug and alcohol use were also more prevalent than the general population (rates of 77%, 39% and 27% respectively) (Homeless Link, 2014a). Research has also highlighted higher rates of communicable health

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1 Single homeless people generally understood to be those who are homeless but do not meet the priority need criteria to be housed by their local authority. Many, nevertheless, have significant support needs. They may live in supported accommodation, e.g. hostels and semi-independent housing projects, sleep rough, sofa surf or live in squats. Single homeless people may be in a relationship, or have children who are not currently living with them.
conditions such as TB among this group, and higher rates of premature mortality (St Mungos Broadway 2014, Crisis 2011).

Some attempts have been made to identify the cost of homelessness to the public purse including the NHS. In 2010 the Department of Health estimated that people who are sleeping rough or living in a hostel, a squat or sleeping on friends’ floors consume around four times more acute hospital services than the general population, costing at least £85m in total per year.

There has been increasing focus on homelessness prevention by local authorities since The Homelessness Act 2002 and its requirement for local authorities to devise prevention focused homelessness strategies in 2003. This is reflected in the trends in homelessness figures which saw a steady decrease in statutory homeless acceptances until 2011/12. In 2003/04, 135,420 households were accepted as homeless, which fell to 44,160 in 2010/11. Levels of homelessness acceptances during 2013/14 were 52, 250 households. At the same time the number of homelessness prevention and relief cases has increased since they began to be recorded in 2009/10 (165,200 households were prevented or relived from homelessness in 2009/10 and this increased to 227,800 in 2013/14)². The previous coalition government’s homeless prevention strategy ‘Making Every Contact Count’ emphasises that local housing authorities should be working with their health and wellbeing partners in their efforts to prevent and respond to homelessness (DCLG 2012a).

Whilst there is no clear number of the people ‘at risk’ of homelessness there are certain groups who are covered in this review who are more at risk than others due to their housing or personal circumstances. In terms of households who are vulnerably housed, there are currently 60,940 households living in temporary accommodation, 4.8 million homes fail to meet the decent homes standard³ and 666,000 households living in overcrowded conditions⁴. Looking at more ‘at risk’ groups, 18,475 offenders were released from custody in the quarter ending December 2014⁵ and there were 14,460 looked after children aged 16 and over in March 2014⁶.

PHE are interested in understanding current homelessness prevention practices and their cost effectiveness and the groups more ‘at risk’. This will enable PHE to support local authorities and their partners to refocus resources on preventive activity that will deliver savings and have a positive impact on people’s health and wellbeing.

Aims
PHE commissioned Homeless Link to conduct a rapid review to better understand homelessness prevention interventions that have been developed in response to identified health and wellbeing needs amongst households who are at risk of homelessness. The diagram on page 9 sets out the typical process this might take and one example of the type of intervention this might include:

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² Homelessness acceptances refer to the number of households who approached their local authority for homelessness assistance and a ‘main homelessness duty’ has been owed. This takes place where the authority is satisfied that the applicant is eligible for assistance, unintentionally homeless and falls within a specified priority need group. It is not always an accurate picture of levels of homelessness and need as households may not be eligible for assistance, they may be turned away by the local authority or they may decide not to approach their local authority for help at all.
⁴ Ibid
⁵ Offender Management Statistics Quarterly Bulletin, England and Wales, October to December 2014
⁶ Children looked after in England, including adoption 2013 - 2014
The review is focused on the following aims:

- To understand more about the relationship between health, wellbeing and homelessness, for example the extent to which health plays a part in a household’s homelessness, or the impact of homelessness on health
- To discover opportunities to identify and respond to health and wellbeing needs amongst the ‘at risk’ populations at an earlier point to improve outcomes
- To identify cost effective practical interventions that others can learn from
- To provide local authorities and their partners with a resource that can be used to inform commissioning decisions around health, wellbeing and homelessness

Research questions
The rapid review is focused on early prevention practice and associated solutions. The primary focus is not a review of interventions to address homeless people’s clinical health needs. Clinical health interventions for homeless people in primary and secondary care settings were recently the subject of a very thorough evidence review commissioned by the Inclusion Health Programme[7] and the Marmot Review[8] looked at tackling health inequalities, of which housing was part of. But there is very little on the role of upstream services in community and other settings where an issue of health and wellbeing may trigger an identification of risk of homelessness occurring in the first place. This rapid review will therefore answer the following broad research questions:

- How is homelessness and housing need currently identified within health, community and other settings?
- What interventions have been developed within health, community and other settings which respond to these needs in order to prevent homelessness and associated ill health?
- What evidence is there for the effectiveness of these interventions?
- What can we learn from these interventions to inform future commissioning and delivery for homeless and at-risk populations?

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More specifically for each intervention identified through the review:

**Defining the problem**
- How and when were local ‘health, wellbeing and homelessness’ problems defined?
- What problems have been defined, and to what level of detail?
- How was this intelligence used to inform interventions?
- In summary what can we learn from approaches to defining the problem?

**Solutions**
- What effective interventions have local organisations put in place to prevent or respond to homelessness, health and wellbeing being needs amongst 16-25 year olds and over 25s?
- Can interventions be applied within different communities (including BME, offenders, mental health, drugs, and alcohol)?
- In summary: what cost effective solutions exist that other local areas could adopt that will achieve better health and wellbeing outcomes for the ‘at risk of homelessness’ and ‘homeless’ populations?

**METHODOLOGY**

There are three stages to our methodology:

1. **Literature Review**
   The literature review was carried out in two parts. The initial search concentrated on peer reviewed academic literature and the second part of the search looked at grey literature. We developed a search strategy using key words associated with the subject of the rapid review (full details of this strategy can be found in appendix 1) which was set to the parameters of literature from the past ten years in the UK. However this initial search framework did not find sufficient peer reviewed evidence and the search was widened to include a wider geographical area which covered Western Europe, Australia, Canada and the US. The grey literature search mirrored the search terms from the peer reviewed academic evidence. Themes were drawn out from these searches to develop a typology of practice and frame the call for evidence examples that were returned.

   We assessed the quality of each piece of evidence against a number of criteria including appropriateness of the methodology, sample size, cohort, scale, location, quality of evidence, whether it measured outcomes and/or cost effectiveness.

2. **Call for evidence**
   We issued a call for evidence across statutory and voluntary agencies to collect examples of prevention activity and interventions delivered by professionals working in a range of sectors including health, social care, education and employment which act early to prevent homelessness and ill health together. This was carried out using a proforma template (see appendix 3) which asked respondents for information regarding type of intervention, location, scale, target client group, cost, funding, and outcomes. The call for evidence was distributed through the Homeless Link research forum, social and health policy portals, the National Practitioner Support Service, Making Every Adult Matter Coalition, and through the Queens Nursing Institute Homeless Health Initiative. It was also advertised on the Homeless Link website. We received 31 submissions in total and have assessed each of the submissions according to how they fit with the intended brief and the quality of information received which included if they have been formally evaluated (a full list of these submissions is available in appendix 2).
3. Review workshops
As part of the analysis process we carried out four workshops with stakeholders and key informants to share and test the findings and inform the recommendations. The purpose of these sessions was to:
- Discuss and share the approaches and models identified in the review.
- Consider which present credible solutions to replicate.
- Understand and identify any barriers to replicating practice.
- Understand and identify any changes/conditions required for successful adoption so these can be incorporated into the recommendations for PHE.

During these workshops we focused on understanding and testing the models identified to explore the following issues:
- How far the interventions offer responsive and accessible options for people at different stages of housing need.
- How the different models identified could work more effectively for people facing homelessness.
- The potential barriers people might face in accessing these effectively.
- How service users could best shape and inform their delivery/replication.

Workshops were conducted with three service user involvement groups and representatives from the housing and health sector with expertise around prevention:
- The London Pathway peer research group (five members who have all had personal experience of homelessness).
- Shelter Birmingham user involvement group (seven members, six of whom English was a second language who have all been homeless or been at risk of homelessness).
- St Basil’s National Youth Reference Group (NYRG) (young people aged 16-25 from across England who are homeless/have experienced homelessness).
- The sector stakeholder group included representatives from local authority housing departments, local authority Public Health, Public Health England, the voluntary sector, and a national network of homeless health practitioners.

The workshops discussed the findings with people at different stages of the life courses which included single households, those with dependent children, older people and young people aged between 16 and 25.

Structure of this review
The evidence review findings are split into three sections. The first looks at the definition of homelessness and outlines how prevention practice has been typologised by academics in recent years, and the policy context and agenda of homelessness prevention practices under legislation since 2002. The second section draws on academic and peer reviewed evidence as well as grey literature and models of current practice received through the call for evidence. This looks at four main models of practice. The third section sets out findings from the service user and stakeholder workshops which identified barriers and opportunities to delivering the four models of services set out through the evidence review. Finally, conclusions are drawn from the findings and a series of recommendations are set out for policy and practice.
SECTION 1: HOMELESSNESS PREVENTION

Definitions of homelessness
In England homelessness is legally defined, and protections are given to certain homeless groups. Under the legal definition, a person is considered homeless if they have no home in the UK or anywhere else in the world available to occupy. This includes people facing eviction, those living in temporary accommodation, squatters, rough sleepers, people at risk of violence, those housed in property potentially damaging to their health and those who cannot afford their current accommodation.

In England, not all homeless people who meet the legal definition of homelessness will be provided with housing. Under the 1996 Housing Act, local authorities have a statutory duty to find accommodation for households deemed to be homeless, eligible and in ‘priority need’. Most commonly, ‘priority need’ applies to adults with dependent children and/or households with a vulnerable member. Many non-statutory households are single homeless people.

Whilst the definition of homelessness in England is set out in law, there are distinctions made between the varying circumstances of homelessness. There is often a distinction made between ‘statutory’ and ‘non-statutory’ homelessness and there is widespread acceptance that homelessness is more than just rooflessness. The ETHOS typology of homelessness and social exclusion was developed in 2005 as a means of improving understanding and measuring different types of homelessness across Europe. The ETHOS categories are:

- Rooflessness (without a shelter of any kind, sleeping rough).
- Houselessness (with a place to sleep but temporary in institutions or shelter).
- Living in insecure housing (threatened with severe exclusion due to insecure tenancies, eviction, domestic violence).
- Living in inadequate housing (in caravans on illegal campsites, in unfit housing, in extreme overcrowding).

The ETHOS approach understands homelessness as a process rather than a static event that can occur at different points in people’s lives. In recent years commentators have developed the homelessness pathway to map out the different routes into homelessness, which identifies the different groups that are more likely to become homeless than others.

The triggers and causes of homelessness have been broadly defined as either structural or individual/personal factors. However both are often interrelated and it is difficult to disentangle these from each other (Fitzpatrick 2005, Jones and Pleece 2010). Harding et al (2011) set out the structural and individual/personal factors out below. Some recent studies of homelessness have moved away from viewing homelessness in terms of causality, instead conceptualising homelessness as careers and pathways (Ravenhill 2008, Clapham 2003). Homelessness and housing choices are not viewed as linear but rather that can change significantly over the life course dependent on factors such as relationships, economic status and health.

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9 Priority need categories set out under the Housing Act 1996 and the Homeless (Priority Need) Order 2002 are pregnant women and those with dependent children, homeless as a consequence of flood, fire or other disaster, aged between 16 and 17 unless owed an accommodation duty by children’s services, care leavers under 21, a ‘vulnerable’ person as a result of old age, mental illness or disability, leaving prison or Armed Forces, being in care, at risk of violence or threats of violence.
## Preventing homelessness to improve health and wellbeing, Homeless Link, 2015

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<th>Structural</th>
<th>Individual</th>
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<tr>
<td>Housing demand (linked to demographic trends)</td>
<td>Family disputes / Childhood disputes</td>
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<tr>
<td>Lack of affordable housing (Eviction / Repossessions)</td>
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<td>Poverty</td>
<td>Physical and emotional abuse</td>
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<td>Unemployment/ welfare benefits</td>
<td>Poor physical health and mental health problems</td>
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<td>Ethnicity</td>
<td>Institutionisation / Offending behaviour (Care, prison, armed forces)</td>
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<td>Changing trends in family formation and fragmentation</td>
<td>Drug or alcohol misuse</td>
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Source: Harding, Irving and Whowell 2011

For the purposes of this research ‘homelessness’ is not limited to the statutory definition of homelessness used by local authorities. We have used the ETHOS definition of homelessness to include everyone who does not have a stable home which takes account of people who are staying temporarily with family or friends, living in very overcrowded conditions, living in a hostel or night shelter, at risk of violence or abuse in their home, and people who have no legal right to live where they are.

### Models of homelessness prevention

Homelessness can be viewed as a sliding scale of housing need, ranging from rough sleeping at the acute end of the spectrum to those households who are already in accommodation but may be at risk of homelessness due to individual or structural factors. Homelessness prevention services and interventions can help alleviate or stop homelessness at different points on this scale. Using the definitions set out in the National Audit Office’s (NAO) Early action: landscape (2013), Community Links (2014) have developed a consistent definition for early action through their Early Action Task Force. They propose that early action is a fundamental principle which should influence the way government and civil society spend their resources and measure their success, and which can be applied across a range of areas including older people, youth services and ex-offenders. They have developed the following four stages for prevention action:

- Primary prevention/building readiness: preventing or minimising risk of problems arising.
- Secondary prevention: targeting individuals or groups who are high risk.
- Tertiary prevention: intervening once there is a problem to stop it getting worse and redress the situation.
- Acute spending: spending which acts to manage the impact of a strongly negative situation but does little or nothing to prevent negative consequences or the situation reoccurring in the future.

Models of prevention activity have previously been identified and developed within studies of the homelessness sector. Pawson (2008) and Busch-Geertsema and Fitzpatrick (2008) categorise homelessness prevention as primary, secondary (or precautionary) and tertiary:

- Primary homelessness prevention involves action to avoid a household becoming homeless, which is applied to either the whole or large parts of the population. This has been defined as either action where there is a perceived threat, for example an eviction date, or in the context of structural interventions such as increasing the supply of affordable housing (Shinn 2007).
- Secondary prevention is defined as action to prevent future homelessness from occurring, based on the judgement that the household is a high risk group, for example 16-18 year old former care leavers.
Tertiary homelessness prevention is defined as rapid rehousing or resettlement and minimising repeat homelessness for those people who have already experienced homelessness. The Community Links definition of tertiary prevention could also apply to those groups who have already experienced homelessness and may still be living in unstable housing such as ‘troubled families’ or people living in longer term hostel accommodation. Acute spending would refer to providing emergency accommodation such as bed and breakfast to households who find themselves with nowhere else to go.

**Measuring homelessness prevention**

Crane et al (2005b) argue that whilst governments, policy makers and service providers in the UK, Canada, Australia and the US have been increasingly developing homelessness prevention policies and practice there has been little rigorous evidence about whether this is effective. This is reflected by an NAO report in the same year which concludes that there is little evidence about the cost-effectiveness of homelessness prevention practice. This is mainly because the outcome of homelessness prevention (i.e. not becoming homeless), is unobservable and immeasurable. Crane et al (2005b) argue that while evaluations recognise the need to look at a systems level in which controlled comparisons are required, it is an indicated or case led approach that offers the most promising way of evaluating the effectiveness of homeless prevention programmes.

The most comprehensive review of individual homelessness prevention schemes in the UK was conducted by Pawson et al (2007). This concludes that the most widely adopted approaches to homelessness prevention are enhanced housing advice, rent deposit or other schemes to access private rented tenancies, domestic violence victim support and tenancy sustainment. The study identified patchy monitoring and evidence of cost effectiveness among the services and models they examined and recommended that local authorities should monitor the effectiveness of homelessness prevention within individual projects. Changing numbers of statutory homeless households can only offer an indication of effectiveness of homelessness prevention activity (Pawson et al, 2007). Without a specific evaluation on individual prevention services that have taken place in a local authority area it is not possible to show which approaches are better than others, for example rent deposit schemes as opposed to tenancy sustainment advocacy (ibid).

**Conclusions**

The severity of homelessness and housing need is viewed on a sliding scale, and whilst homelessness is clearly defined in law, there are varying distinctions made between the different categories of homelessness that exist. As the ETHOS typology of homelessness maps out, homelessness takes many different forms, so the opportunities to prevent it can also take place at different points. However, the complexity of homelessness and its causes can make this difficult. As well as broad prevention targeted at large parts of the population (primary prevention) there are ways of targeting resources at groups that are more at risk of homelessness (secondary prevention) and those that have already experienced homelessness (tertiary prevention). Early prevention action is recognised across a wide range of sectors including criminology and medicine, and the next section examines in more detail the evidence of homelessness prevention and its effectiveness in response to health and wellbeing needs.
SECTION 2: HOMELESSNESS PREVENTION IN RESPONSE TO HEALTH AND WELLBEING NEEDS – A REVIEW OF THE EVIDENCE

This section discusses the evidence identified through peer reviewed academic literature, grey literature and the submissions we received from our ‘call for evidence’. From these sources, a typology of four models of intervention has been identified which fit within the primary, secondary and tertiary stages of prevention action set out in section one. These are:

- Welfare rights and consumer advice (includes housing advice) – primary and secondary prevention.
- In-tenancy\(^{10}\) holistic support – secondary prevention.
- Targeted support and advocacy to people leaving institutions – secondary and tertiary prevention.
- Critical time identification targeted at groups in the community – secondary and tertiary prevention.

The evidence from the review found that models of intervention are administered through four main settings:

- Primary health care – GPs, walk in health centres.
- Secondary health care – hospitals.
- Health based community and outreach support – home visits, clinics in community settings.
- Non-health based community and outreach support – community centres, jobcentres, schools and colleges.

TYPOLOGY 1: WELFARE RIGHTS AND CONSUMER ADVICE

Advice and homelessness prevention
The links between financial exclusion, debt and homelessness are well documented. A literature review of homelessness and financial exclusion found that financial hardship may be exacerbated by difficulties encountered in accessing benefits, and poor physical and mental health (Wallace and Quilgars 2005). In studies of homelessness pathways, experiences of poverty and low income are seen as contributing characteristics. Therefore a lack or loss of income due to ill-health is a risk factor leading to homelessness, and timely welfare rights and consumer advice could help alleviate this. The studies identified in this section are mainly concerned with holistic advice services which include welfare benefits, debt, employment and housing rather than standalone studies on housing advice.

Need for the intervention and target groups
Many welfare benefits go unclaimed and a lot of people who do not claim benefits are living in poverty and have health needs (NIHR 2011). In their systematic review, the National Institute of Heath Research (NIHR) conclude that the evidence review from 2006 to 2010 showed that welfare rights advice improves some people’s financial position at least in the short term, and this improvement is most likely to link to improved wellbeing and mental health at least in the short term. The review by NIHR also highlights grey literature to suggest people believe their physical health improves also, but they conclude that there is insufficient evidence from which to draw conclusions. Studies prior to 2006 indicate that welfare rights advice given via a health setting has financial benefits and improves mental health and wellbeing but does not suggest any improvements to physical health.

\(^{10}\) The call for evidence was sent to the Homeless Link Research Forum, social and health policy portals, the National Practitioner Support Service, Making Every Adult Matter Coalition, Queens Nursing Institute Homeless Health Initiative.

\(^{11}\) In-tenancy support refers to support and services available to people living in their own homes to help them live independently and successfully maintain their accommodation.
Pleasance and Balmer (2007) conclude that analysis of the English and Welsh Civil and Social Justice Survey (CSJS) provides evidence that housing rights problems are not only associated with mental illness, but may have a role in bringing about and exacerbating mental illness. They argue that the causal role of housing rights problems in mental illness requires the co-ordination of information, advice and support services. People with mental health issues can face a number of barriers accessing services which are associated with retreating behaviour, fear of disclosure, real and perceived communication problems, and other capability issues (Karras et al, 2006, Thornicroft et al, 2007, Rose 1996, Vasiliou 2006 and Watson et al, 2004). Pleasance and Balmer argue there is a clear case to provide advice and support services for those with mental health issues and to ensure these services are easily accessible for this group.

There is also a reciprocal relationship between mental health issues and welfare assistance. Parsonage (2013) draws on secondary evidence to conclude that mental ill health is much more common among people facing welfare problems than among those who have no such problems, and equally that welfare problems are much more common among people who have poor mental health than those who enjoy good mental health. Not only are people with severe mental health problems amongst those most in need of welfare advice but they are least able to access it effectively (Parsonage, 2013).

Studies have also identified that cancer patients are in need of welfare benefits advice as the diagnosis, treatment and aftercare of cancer is associated with financial stress (Moffatt et al, 2012, Hanratty et al, 2007).

There are also specific problems associated with housing and homelessness among young people aged under-25. Housing and homelessness were the most common issues faced by clients of youth advice agencies (62.2%) the next highest issue was benefits problems (29.8%), (Balmer and Pleasance, 2012). The study also found that clients of youth advice agencies had very high rates of mental illness; much higher than any comparison cohort identifiable through CSJS data. Around two-thirds scored four or more on the GHQ-12 (a screening device for the detection of common mental illnesses in the community and non-psychiatric clinical settings (Goldberg & Williams, 1991)), which is commonly used to identify cases of mental illness.

**Developing the solution**

Most of the solutions identified within the evidence are targeted at an identified ‘at risk’ group, and therefore can be classed as ‘secondary’ prevention models, where free personalised advice is administered within a number of health and non-health settings. On the whole these services were pilot projects or had short term funding streams to address the needs of particular groups. The interventions described in this section are:

1. Welfare advice administered to the over-60s in primary care settings.
2. Welfare advice aimed at mental health in- and outpatients in a secondary care setting.
3. Welfare advice for cancer patients in a secondary healthcare and health based community and outreach support
4. Holistic advice services (housing, welfare benefits, debt, mental health) to young people in a non-health community setting (youth advice services).

1. Welfare advice administered to the over-60s in primary care settings

In a randomised control trial (RCT) by Moffatt et al (2006) free targeted welfare advice was offered to people aged over 60 when they booked an appointment with their GP. This was based on previous evidence that welfare advice can lead to financial and non-financial gains, and advice accessed via primary care is viewed positively and is perceived to address both social and health needs (Moffatt et al, 2004). A random sample of 400 participants were selected from four GP registers of which 96 consented to take part and were then randomised into intervention and control groups.
In this study the participants took part in an initial welfare rights interview to define their level of need. The qualitative study sample comprised respondents from intervention and control groups, purposively selected to include those eligible for the following resources: financial only; non-financial only; both financial and non-financial; and none. Participants were given an appointment to see a Welfare Rights Officer from Newcastle Social Services. The participant was given the option to have the appointment at his/her own home or at their GP surgery, and was offered help with filling out forms. The target group were given an appointment straight away and the control group were given an appointment up to six months later.

Fourteen participants received some financial award. The median weekly income gain was £57 (range £10 to £100) representing a 4–55% increase in household income. Eighteen participants were in receipt of benefits, either as a result of the current intervention or because of claims made prior to the study. Around 60% of participants were eligible for some benefits and 40% for financial benefits, confirming that offering welfare advice to older people via primary care is an effective way of identifying those entitled to benefits who would otherwise be unlikely to claim. This is potentially significant in preventing homelessness in older people and improving their quality of life, health and wellbeing.

The intervention was viewed positively by participants and included financial and non-financial benefits. Financial benefits were those that enabled people to stay in their homes such as furniture, adaptations to their homes and paying for bills and preventing debt which could potentially threaten their tenancy. Non-financial benefits were linked to wellbeing as the ease of financial worries helped reduce stress, and greater social independence gained through having more money to spend on day trips and holidays.

2. Welfare advice aimed at mental health in and out patients in a secondary care setting

Another example of welfare advice-based prevention activity is from Sheffield Mental Health Citizen Advice Bureau (SMHCAB), located in the grounds of a psychiatric hospital. The service was originally set up in 1976 to provide advice to patients who were geographically isolated and detained in the grounds of the hospital, but later offered outreach services on the basis that more people with complex mental health problems are supported in the community rather than in hospital (Parsonage 2013).

Based on a pathway model all patients are screened on admission by ward staff and referred to the advice service using a tool developed by the SMHCAB and ward managers. Patients who are referred are then assessed by a specialist adviser to determine the appropriate type and level of support, which may take various forms including signposting or referral to other services, information, advice and case work. About two thirds of patients were referred for case work and if they are discharged during this time they can receive advice in step down accommodation or their own home.

The cost savings of the Sheffield project (Parsonage 2013) have been calculated as reducing hospital inpatient stay at £330 per day. Parsonage (2013) also factors in savings made through preventing homelessness on the basis that people with severe mental illness are at much higher risk of homelessness than the general population, which can be prevented through advice. It concludes that the costs of homelessness can impact on many public services (including the NHS) and saves between £24,000 and £30,000 per case per year12. In addition, the advice services were also estimated to prevent the relapse of severe mental health illness at a rate of 40% which was estimated to save the NHS over £18,000 per episode.

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3. Welfare advice for cancer patients in a secondary healthcare and health based community and outreach support

A welfare advice service for cancer patients was designed to be freely accessible, so that individuals could self-refer, as well as be referred by health, social care or voluntary (charity) sector professionals (Moffatt et al 2012). The staff worked in a range of voluntary (charity) sector and NHS locations throughout the county, including in-patient and out-patient hospital locations and primary care, as well as providing the service via home visits, supported by further contacts by email and telephone. The service comprised of a full personal finance and welfare benefit eligibility assessment, followed by assistance to claim entitlements, follow-up work and representation at appeals and tribunals (for initially rejected claims). The welfare rights advisors also undertook outreach work to voluntary and community groups in order to facilitate awareness among the wider public.

For the period April 2009–March 2010, 1,540 benefit claims were made, of which 1,475 (96%) were successful. Benefits were awarded to those above and below national pension age, with median weekly awards of £70.30 and £115.50 respectively. Financial gains reported included home improvements and offset of lost earnings through their illness. The psychological and social impacts included decreased stress and anxiety, increased independence, social participation and wellbeing.

Bateman (2008) argues that the lack of a national or wider strategy to encourage the development of welfare rights advice linked to healthcare, means that services are often developed opportunistically as a result of a specific trigger. Triggers include local actors championing the idea, lobbying funders or obtaining support from interest groups. Consequently, the provision of advice services is inconsistent across the country. A large-scale survey by Age Concern indicated that in 2006 there were 889 General Practices with some form of linked welfare benefits advice provision (of which 523 are CAB-linked). This amounted to 10.5% of the 8,433 General Practices in England (Bateman 2008). The services were, on the whole, linked to short term funding and anecdotal evidence indicated that once this funding ran out they were not continued. Where services recorded such data, 28,216 people were helped (a significant underestimate because data were only available for about a third of services).

The study found that services that reported better outcomes were those which had strong links with health professionals. Many services had also invested time in formal training of the health professionals linked to their service. This ensured that situations where an advice service could help were clarified, as well as tackling common myths about benefit entitlement. Some GPs were resistant to spend time in training events, and the introduction of accreditation for Continuing Professional Development purposes, which was used by Liverpool’s HABIT project, was one way to address this.

4. Holistic advice services (housing, welfare benefits, debt, mental health) to young people in a non-health community setting (youth advice services)

The welfare interventions described above all took place in a healthcare setting or through health based outreach support. The evidence review found limited evidence of those delivered in non-health settings. One study examined advice and support through youth services, which included help with housing, welfare benefits, debt, and mental health services and referrals (Balmer and Pleasance 2012). Help included advice and information, advocacy, assistance with mental health, referral to a homeless mental health team, help filling out forms, food parcels, use of a telephone and/or simply someone to talk to. A cohort of 188 young people accessing youth advice services were surveyed about the nature of their problems, the type of help they were seeking (i.e. information, advice, counselling, other), what consequences problems had had on their lives and whether they felt the advice had led to improvements in a range of life areas (Balmer and Pleasance 2012). The study concludes that a substantial majority of clients felt that help obtained from advice agencies resulted in improvements in their health, either with regard to how stressed they were (64%), or their health in general (34%). Combining both of these factors, 70% of clients felt that advice
resulted in improvements in stress or health. With regards to housing, out of those reporting housing or homelessness problems, 54.7% reported improvements in their housing situation as a result of advice.

Balmer and Pleasance (2012), using information on the costs of health services, social services and homelessness, conclude that the cost consequence to the health service is £181,068 per 1,000 young clients (£181 per young person). The cost consequence to social services was estimated to be £1,016,028 per 1,000 young clients (assuming six months of contact), while the cost consequence of homelessness was estimated to equate to £1,438,904 per 1,000 young clients. Early advice is seen as making cost savings in a number of areas; for those young people who suggested advice had improved their stress or health, estimated savings in GP costs alone exceeded the cost of advice provision (Balmer and Pleasance 2012). In addition, advice resulting in an improvement in a young person’s housing situation, where the advice intervention cost less than £514 per person receiving the advice, would be cost effective. Given the link between health and homelessness and the prevalence of homelessness problems among young people there is a case for advice in youth settings to prevent homelessness and make savings to the health services.

Summary and conclusions
Evidence from this review shows that most welfare rights and consumer advice has been targeted at particular groups on the basis of their demographics or health needs (secondary prevention). The literature has examined older people aged 60 and over, young people aged 16 to 24, people with cancer and patients in psychiatric hospitals. The evidence suggests that advice can be effective in health settings provided that healthcare staff understand the benefits of advice and are supportive of the service to allow maximum use and access for patients/clients in their care.

As well as preventing homelessness and providing financial gains (to both the client and public services), the studies also showed improvements to mental health and wellbeing especially by decreasing stress and anxiety among the advice recipients.

The evidence in this review shows that many services are funded on a short term basis and due to a lack of national or wider strategy in this area, there is an inconsistent geographical spread of advice services.

How transferable is the intervention for current practice?
The evidence of the financial, health and wellbeing benefits of welfare and consumer advice provides a rationale for the roll out of welfare and consumer advice on a larger scale. Accurate, timely and accessible advice, particularly concerning welfare benefits, was repeatedly raised as an issue by service users in the three workshops that were conducted as part of the review. Participants spoke about the complexity of the welfare system, the challenges navigating this, and of administrative delays leading to periods of extreme financial hardship. This was seen to cause and exacerbate mental distress and other health problems if support and advocacy was not available to address these problems. The case study on page 18 shows this in more detail.

Setting up welfare and consumer advice could be done in two ways; through primary prevention methods where advice is administered to large sections of the population or through secondary prevention where ‘at risk’ groups are identified and targeted. The evidence in this review has shown benefits for older and young people, psychiatric and cancer patients, but there are other vulnerable groups advice could be targeted at dependent on local need, for example people with multiple and complex needs, LGBTQ groups, families with dependent children living in temporary accommodation, young people transitioning from children to adult services.

There are some limitations and considerations in the current economic and political environment that need to be acknowledged when considering commissioning and setting up services:
• There have been widespread cuts to welfare benefits since 2011. Both the amount of, and eligibility for, some welfare assistance is more restricted since the studies in the review were conducted. This means there may be less access to the welfare benefits applied for by people taking part in the studies we have looked at, for example reduced housing benefits and more limited access to local welfare assistance schemes to help buy furniture and emergency costs.

• Legal aid funding (a large source of income for advice services) has also been significantly reduced since 2011, which has impacted on the existence and availability of free advice but also the type of problems funded through legal aid (for example it no longer funds welfare benefit advice and most areas of housing law). Funding for these services would have to be accessed through alternative statutory and voluntary sources.

• There is not conclusive evidence of the efficacy of welfare rights advice in primary care settings for families with young children, substance users and mental health service users (Abbot and Hobby 2003) due to their ‘light’ use of GP practice services. When commissioning services such as welfare primary healthcare settings it would be useful to think of other locations where these groups access help, for example hubs in the community offering a range of services, job centres and local groups.

**Denise’s story – a missed opportunity to prevent homelessness**

Denise is married with six children and lives in her own home with a mortgage. Her husband was diagnosed with mental health issues and is no longer able to work leaving Denise to look after him, her six children and continue working full-time. The relationship with her husband breaks down and he moves out of the family home.

Denise struggles to cope on her own and is soon diagnosed with depression and is signed off work. She has regular appointments with her GP about her depression and tells him about the money problems she has and how she is worried about not meeting her mortgage payments but he does not give her any advice on this and only treats her depression. Her debt increases and eventually she has defaulted too many times on her mortgage, her home is repossessed and she and her family have nowhere to live.

At this point social services become involved with Denise and her family and she has all six of her children placed in care. Social services refer Denise to a housing advice agency where a worker helps her to find affordable rented accommodation which is large enough for her children to come and live with her. Denise feels that her homelessness could have been prevented if she had been referred to the advice service when she first spoke to her GP about her financial worries. If there had been housing or welfare rights advice located in the surgery where Denise was attending her appointments she could have accessed help much sooner.

**TYPOLOGY 2: IN-TENANCY HOLISTIC SUPPORT**

In-tenancy or floating support refers to support and services available to people living in their own homes to help them live independently and successfully maintain their accommodation. It is usually targeted at people who are at risk of losing their homes (i.e. secondary prevention activity).

**Need for the intervention and target groups**

Pawson et al (2008) draws attention to the importance of in-tenancy support in reducing repeat homelessness among recently rehoused social renters and their role of supporting people living in the private sector (both tenants and owner occupiers) who are at risk of homelessness.

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13 Case study based on interview with participant in service user workshops. Names have been changed.
The evaluation of homeless prevention activities undertaken by local authorities and partner agencies by Pawson et al (2008) found that several of the projects were established to cut down on the use of Bed & Breakfast accommodation or address specific problems in the local area that had been identified through examining local need. Examples of these issues included high tenancy turnover and failure, support for clients with complex needs and high numbers of rough sleepers.

Research has identified that there are characteristics of certain groups that make it more difficult for them to maintain a tenancy. Helfrich and Fogg (2007) identify that people with mental health issues often have difficulty maintaining stable housing and functioning independently in the community and support for day to day activities such as budgeting, shopping, and cleaning, can assist them to manage their lives independently (Calyns et al. 2002; Schutt and Goldfinger, 1996). Research on older people and homelessness found that the death of a spouse, ill-health, sudden loss of income/ lack of support network, lack or loss of confidence in coping with bills, contributed to their inability to manage at home and therefore in-tenancy support services were required (Crane et al 2005b, Warne and Crane 2006).

Other groups vulnerable to eviction identified through the Pawson et al (2008) evaluation are households at risk due to anti-social behaviour (Dillane et al, 2001; Jones et al, 2004), former rough sleepers (Busch-Geertsema, 2002; Dane, 1998; Lomax and Netto, 2007; Randall and Brown, 2002), homeless families (Jones et al, 2001; Shelter, 2002a and b) and low income families (Mulroy and Lauber, 2002) and women fleeing domestic violence (Jones, 1998; Levison and Kenny, 2002).

Whilst the trigger for support of losing the tenancy, there are often a number of support needs in addition to housing which can include health and wellbeing indicators. People with substance misuse needs often received floating support to help maintain their tenancies and remain in their treatment programme (Pannell 2006). More recently, the focus on the ‘Troubled Families’ programme has targeted funding at 120,000 families across England who have multiple and complex needs and are in contact with a number of services in their area. Characteristics of these families included mental health problems, a parent with a long term limiting illness or disability, poor or overcrowded housing, and unemployment and put them at higher risk of losing their tenancy (DCLG, 2012).

**Current models of practice: Tenancy support**

Services delivering in-tenancy support were mainly housing led but provided holistic support in a number of areas including health and wellbeing. The Smartmoves service in Stoke-on-Trent provides housing related support to people who are struggling to maintain their home or tenancy. This service is eligible to people from the age of 16 who are owner occupiers as well as renters. In this case the housing issue is the trigger point for help but the service then links in with health services and wider activities to promote better wellbeing, including getting involved in positive activities during the day such as learning, recreation, volunteering or paid work.

**Developing the solution**

Similar to the interventions identified in the previous section the studies on in-tenancy holistic support have focused on ‘at risk’ groups. There are very few published evaluations or research on in-tenancy support which also have a health and wellbeing element. The interventions covered in this section are all based within a home setting:

1. Family Interventions Programme.

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14 The qualifying criteria are households that meet three of the four following criteria: are involved in youth crime or anti-social behaviour; have children who are regularly truanting or not in school; have an adult on out of work benefits; cause high costs to the taxpayer.


2. Life skills support for mental health patients in supported accommodation.

3. Housing First model.

1. Family Interventions Programme

Family Intervention Programmes (FIP), (superseded by the Troubled Families Programme), provided holistic in-tenancy support. The programme took an intensive and persistent multi-agency approach to support the whole family to help them overcome their problems, coordinated by a single dedicated ‘key worker’ (Dixon et al 2010). The aims of the programme were to reduce antisocial behaviour, prevent the families from becoming homeless and improve their outcomes (which included health, family functioning and risk, crime, education and employment). Through the support worker the families followed an agreed contract or Support Plan which sets out the support they will be offered, the actions members of the family agree to take and the goals they will work towards. The Support Plan is reviewed on a regular basis and sanctions, such as the demotion of tenancies, can be used to motivate the family to change.

A final evaluation of the programme was conducted in 2011 and was based on FIPs in 159 local authorities and 8,841 families who were offered and accepted a family intervention (Lloyd et al, 2011). The average length of the family intervention was 11 months and critical to their success was the length of the intervention, with better outcomes achieved the longer the family worked with an intervention. Overall, 76% of families left the FIP for a successful reason. Two areas of the programme were homelessness prevention and health. The health risks reported for families decreased but less than for other indicators. There was, on average, a 34% reduction in the proportion of families with health risks including mental or physical health and drug or alcohol problems. Housing outcomes were measured on the number of housing enforcement actions applied which decreased considerably during the intervention. Fifty-nine percent of families had one or more housing enforcement actions against them at the start of the intervention, with 26% of these families still having at least one enforcement action against them at the end of their intervention (Lloyd et al 2011).

A follow up study in 2012 (Boddy et al) looked specifically at the health related work in FIPs. Findings from the study found that health was a core focus for intensive family intervention and provided consistent evidence that FIP intervention was associated with sustained health gains for many families across health needs. For some of the families taking part in the study, positive changes were noticeable including resolution of long-standing drug or alcohol dependency, and change in their ability to meet their children’s basic health needs, for example nutrition.

2. Life skills support for mental health patients in supported accommodation

A longitudinal study by Helfrich and Fogg (2007) examined how effective life skills modules were for people with mental health issues who had experienced homelessness. The programme worked with 51 individuals who took part in six individual and six group sessions with an occupational therapist to address skills in food, money, self-care management, and safe community participation. Baseline measures were made of the intervention with post-tests and three and six month follow-up measures. Results from the tracking study showed there were statistically significant improvements over time for the room and self-care model which included personal and public hygiene, health, clothing, home cleaning, and home organisation. The preliminary findings from the research indicate that participants had retained the skills taught in the programme which could assist with independent living.

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15 Housing enforcement actions include a warning letter, a visit from a housing officer or a notice seeking possession.
3. Housing First model

The Housing First model places homeless people with complex needs straight into housing rather than requiring them to progress within a 'stepped' model of accommodation which usually entails people moving through hostels and supported accommodation before they are placed in their own tenancy. The Housing First approach provides intensive wrap-around support based on client needs. There have been a number of evaluations of Housing First in both the US and Europe (for example Padgett et al, 2006, Pleace, 2008, Tsemberis, 2010). Rates of tenancy sustainment (i.e. homelessness prevention) range from 70% to 90% (Pleace and Quilgars 2013). Outcomes in relation to mental health and substance misuse were more mixed but were generally positive (Johnsen and Teixeira, 2010). The overall evidence of improved mental health outcomes is also mixed, with some evidence pointing to improvements (Busch-Geertsema, 2013) and other studies showing stabilisation (Tsemberis et al, 2004). Housing First has not been found to lead to deterioration of mental health.

On other health and wellbeing outcomes a study by Sadowski et al (2009) showed that Housing First clients spent fewer days in hospital and had fewer emergency visits than homeless people in more traditional service settings. But there is very limited evidence on the impact on people’s physical health (Pleace and Quilgars, 2013) and the impact on substance misuse and psychiatric symptoms (Pearson et al 2009). Whilst there has been some research which has identified a reduction in alcohol use there is some uncertainty of the positive outcomes for people with severe and active addictions (Kertesz et al 2009, Kertesz and Weiner, 2009).

<table>
<thead>
<tr>
<th>Blackburn with Darwen Borough Council: Transforming Lives Programme (including Troubled Families)</th>
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<tbody>
<tr>
<td><strong>What is the intervention?</strong></td>
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<tr>
<td>Transforming Lives is a multi-agency project in Blackburn which works with families with rent arrears and at risk of eviction, and young parents under 25. The project was set up in April 2012 and funds two housing needs support officers. Each household referred to the project is appointed a lead professional/case manager to coordinate the service interventions that take place and manage the outcomes for the family.</td>
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<tr>
<td><strong>Which partners are involved?</strong></td>
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<tr>
<td>The services and organisations involved in the programme are:</td>
</tr>
<tr>
<td>- Police</td>
</tr>
<tr>
<td>- Adult services</td>
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<tr>
<td>- Children’s services (early help and social care)</td>
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<tr>
<td>- Neighbourhood/community development services</td>
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<td>- Voluntary sector services/partners</td>
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<td>- Health and wellbeing services</td>
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<td>- Substance misuse services</td>
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<td>- MASH</td>
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<td>- Environment services</td>
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All referrals received by the multi-agency Transforming Lives panel are checked against their housing needs. If there are known concerns regarding health issues, ASB, tenancy problems or education the housing needs officers become involved in the multi-agency response to addressing all the concerns of the family. Where referrals meet the Troubled Families criteria or where the concerns relate primarily to housing issues, housing needs support officers become lead professional for the family, coordinating the team around the family and managing the actions to address the causes of the concerns rather than just addressing the presenting symptoms in silo.
What are the outcomes from the intervention?
A number of outcomes for the programme including health and wellbeing indicators are measured. In terms of personal outcomes these include:
- Reduced interaction with social care services
- Reduced offending
- Reduced hospital admissions and A&E attendances
- Improved skills and education
- Gaining employment
- No further incidents of abuse
- Reduced alcohol/substance consumption
- Improved mental wellbeing

Is it cost effective?
A costed case study of a family enrolled in the programme is set out below.

The Davis family were referred to the Troubled Families programme due to the extreme number of ASB calls that had been made in November 2012 after discussions about the case at an Anti-Social Behaviour Panel. Around 500 calls in six months were made to Lancashire Constabulary and the local authority for ASB and noise prior to the intervention. There were disrepair and conditions issues in the property they were living in and the family had frequently moved. The key worker moved the family into a new private rented property and there has been significant improvement in their living conditions since then.

Other outcomes from the intervention have included:
- Child A returning to College in September 2014.
- Child C school attendance previously less than 60%, now attending full-time.
- Police reports are currently eight in the last six months.
- Child A has returned to live at the family home.
- Mum was encouraged to access NHS treatment and has obtained new hearing aids.
- Housing conditions have improved since the family moved home in September 2013.

Cost of the family before the intervention took place: £120,427 per year
Cost of the family currently to services: £53,392 per year
**Total Annual savings: £67,035.**
**Expected further savings due to college enrolment: £4,528**

Summary and conclusions
Holistic in-tenancy support is targeted to ‘at risk’ groups who struggle to maintain their tenancy or have a previous history of tenancy failure. As Pawson (2008) notes, existing evaluations of tenancy sustainment services have been largely positive about their benefits for a number of client groups. However, these services have not been delivered in response to a health and wellbeing need but rather triggered by a housing need. There were a number of positive lessons drawn from the tenancy sustainment studies including early contact with the client, quick access to crisis intervention, viewing the service as a befriending rather than management service, and locating the service so that people were aware it existed.

How transferable is the intervention for current practice?
Holistic support allows more than one issue to be dealt with at home and link in with other services. The FIP approach showed that as well as addressing antisocial behaviour, positive housing and health outcomes were also achieved for the families referred to the intervention. This example suggests there is scope for support workers in other sectors to deliver health interventions at home or work, and act as a central contact point to co-ordinate with the input of other services to deliver positive health outcomes. Many of
the current practice examples received from the call for evidence described in-tenancy support which addressed wider health needs as part of tenancy sustainment, showing pockets of existing practice in this area.

Considering further ways the above interventions could be transferred to practice, tenancy support could also be located within health and community settings, for example GPs, clinics and community centres offering health support. The studies set out in the review have focused on families and individuals with entrenched problems and those with mental health issues but the in-tenancy support could apply to any group who are at risk of losing their home who come in to contact with health and wellbeing services. The boxed case study below shows targeted support given to young people.

Again, there are some limitations and considerations in the current economic and political environment that need to be acknowledged when considering commissioning and setting up services:

- The Supporting People funding set up in 2003 allowed major expansion in tenancy sustainment services (Busch-Geertsema and Fitzpatrick 2008). However there have been significant reductions to housing related support (formerly Supporting People) (more commonly referred to as funding which has implications for statutory funding for tenancy sustainment roles and floating support.

### Current models of practice: targeted support for young people

Brook Young Fathers (a local authority commissioned service in Cornwall) provides support to young fathers who are either homeless or at risk of homelessness to access housing and benefits. It aims to help young fathers secure suitable accommodation so they are able to have access to their children.

Another young parent focused service is WILD in Cornwall funded by Comic Relief. An Independent Living Worker offers advice and advocacy for young parents on housing and debt issues including home maintenance, landlord relationships and house conditions.

St Basil’s in Bromsgrove offers a youth homelessness prevention service. This works across a number of areas to provide multiagency support for young people at risk of homelessness. Interventions include family mediation and opportunities for young people to gain a recognised qualification in lif-skills, which can help in areas such as basic living skills, looking at self-confidence and helping to understand how alcohol and drugs can impact on physical and mental health, as well as many other modules. Young people are able to take part in a course called mood masters which takes a holistic approach to preventing issues relating to mental health and covers areas such as anxiety and low mood. Partners include doctors, midwives, mental health teams, health visitors, drug workers and children’s services. The work is carried out at various locations such as GP surgeries, schools and home visits.

Centrepiece’s Health and Wellbeing team offers a range of in-house services to young people aged 16-25 living in Centrepiece services. This support includes comprehensive health assessments, counselling and psychotherapy, and advice and support on sexual health, nutrition and diet, healthy living, and drugs and alcohol. The team works in collaboration with external health services to deliver support in a holistic and person-centred way to address young people’s health needs. Outcomes from the service collected between April 2013 and March 2014 include; 90% of young people increased their physical activity; of the young people receiving a healthy living intervention 90% increased their intake of fruit and vegetables; and of the young people receiving a dual diagnosis intervention, 90% reduced usage, 100% of these were maintained three months after discharge.

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16 Dual diagnosis refers to people with both severe mental illness and problematic drug and/or alcohol use.

Preventing homelessness to improve health and wellbeing, Homeless Link, 2015
HOMELESS LINK

TYPOLGY 3: TARGETED SUPPORT AND ADVOCACY FOR PEOPLE LEAVING INSTITUTIONS

People leaving institutions and the transition back into the community presents a trigger point where there is greater risk of homelessness occurring. This section examines interventions for people leaving hospital, psychiatric care, prisons and young people leaving the care system.

Need for the intervention and target groups

Research carried out in 2010 showed that the total cost of hospital usage by homeless people was estimated to be about four times higher than the general population (Department of Health, 2010). Looking at inpatient costs only, the difference increases to eight times higher among homeless people. A report by Homeless Link and St Mungo’s in May 2012, showed that more than 70% of homeless people had been discharged from hospital back onto the street, without their housing or underlying health problems being addressed. Research by Hewitt et al (2012) of hospital data of homeless patients collected between June and August 2009 found that the patients were admitted under 36 different specialty teams. It found that hospital staff had little understanding of services available for homeless people, and housing support workers described hospital admission as a ‘black hole’ from which patients emerged without a coordinated care plan (Hewitt et al, 2012).

The impact of insufficient discharge procedures further damages patient’s health and increased costs to the NHS through ‘revolving door’ admissions. Taking the steps to identify and address a patient’s housing need, and making effective provision for their ongoing health care following discharge, is now recognised as a key part of effectively preventing homelessness and improving health outcomes (DCLG, 2012a).

As Backer et al (2007) highlighted as far back as 1994, the Interagency Council on Homelessness in the US identified inadequate discharge planning as a significant factor contributing to homelessness among persons with mental illness and/or substance use disorders. Transition periods have been also been recognised as problematic for people moving from hospital care to living back in the community (Herman et al, 2007).

There are also specific needs for people exiting hospital care due to mental health issues and Drury (2008) argues that these patients often feel their housing needs are left unmet. Studies have also examined specific issues with discharging patients from psychiatric institutions (Forchuk et al, 2013). Forchuk et al, (2013) highlighted that the first days and weeks following discharge are particularly high-risk periods, with 43% of psychiatric client suicides occurring within the first month post-discharge.

There are other institutions where transition periods cause problems for people finding and maintaining accommodation. Young people leaving the care system are at greater risk of homelessness and often have problems in relation to physical and mental health problems, alcohol and/or drug abuse, teenage pregnancy, the criminal justice system and unemployment (The Children’s Aid Society, 2005; Senteio et al, 2009). Eleven percent of people aged between 16 and 25 who approached their local authority for homelessness assistance during August 2014 were care leavers (Homeless Link, 2014b).

Ex-offenders leaving prison also struggle to access appropriate accommodation both before and after release (Social Exclusion Unit 2002, Ministry of Justice 2012, Gojkovic et al 2012). Not only is it difficult for appropriate accommodation to be found on their release but people who did have stable accommodation before their arrest often lose it while they are in custody. Alongside homelessness, offenders also have more substance misuse issues, greater levels of mental health problems and are more likely to have a learning disability (Prison Reform Trust 2013). Evidence has also showed that stable housing can reduce the risk of re-offending by about 20% (Social Exclusion Unit 2002).
Developing the solution
Due to recent investment by the DH of £10 million to the homeless hospital discharge fund (HHDF) most evidence can be found relating to people experiencing homelessness leaving hospital. The interventions covered in this section are:

2. Planned discharge programme from a psychiatric unit to homeless accommodation.
3. Housing and income support for psychiatric patients pre discharge.
4. Residential programme of young people leaving care to independent living.

1. Evaluation of Department of Health (DH) Homeless Hospital Discharge Fund (HHDF) which consisted of 52 projects across England

The evidence paints a mixed picture about the effectiveness of discharge planning. Moran et al’s (2005) literature review found that there was very little research which supports the effectiveness of discharge planning and that empirical research would not be cost effective to undertake due to technical difficulties in obtaining the data. In the UK there are often difficulties collating and accessing accurate outcomes data on homeless people who are discharged from hospital (Homeless Link, 2015).

An evaluation of the recent DH £10million HHDF (Homeless Link 2015) classified the interventions in a typology of nine different models. Overall the 33 projects who returned complete data achieved the following outcomes: 69% of patients were discharged into suitable accommodation out of total discharges; this rose to 93% of homeless people in projects which combined NHS and housing staff in multi-agency approaches; 55% of patients received health support on discharge; 58% of patients received housing support on discharge; and of those patients that were admitted into hospital, only 28% were readmitted within 30 days of a prior admission.

A report by the Centre for Health Service Economics & Organisation (CHSEO) in 2011 showed that projects and models which have been implemented to improve admission and discharge practice have demonstrated cost benefits in two different ways: firstly, the average length of stay will change due to a reduction in ‘bed blocking’ as homeless people are more likely to be discharged sooner if their housing and next steps are adequately catered for (however some may stay longer if this is deemed necessary); and secondly, if patients are discharged at a clinically appropriate time and to suitable accommodation they will more ably recover from an illness, resulting in fewer emergency readmissions to hospital within 28 days.

Good discharge planning weaves together people and agencies which provide services for stable and permanent housing, with ongoing psychiatric and psychosocial treatment/rehabilitation, as well as community services (e.g., transportation, money management, medication management, etc.) to support independent living (Moran et al, 2005).

2. Planned discharge programme from a psychiatric unit to homeless accommodation

One randomized control study developed and tested an intervention to prevent homelessness among individuals discharged from psychiatric wards to shelters with no fixed abode (NFA) (Forchuk et al, 2008). This pilot study followed 14 participants who were found to be at risk of homelessness during discharge planning. One half of the participants were provided with immediate assistance in accessing housing, as well as assistance in paying their first and last month’s rent. The control group received usual care, which included a referral to a social worker but no assistance with finding or accessing housing. All the individuals in the intervention group maintained housed status at three and six months following hospital discharge. All but one participant in the control group remained homeless after three and six months.
3. Housing and income support for psychiatric patients pre discharge

A further study by Forchuk et al (2013) looked at the effectiveness of housing and income support offered to psychiatric clients in a hospital setting before being discharged in Ontario, Canada. The intervention was targeted at patients who were going to be discharged to homeless shelters and those with NFA. Both inpatients and outpatients could drop in to the service in the hospital without referral or appointment, and information was also included in brochures available on the wards, bulletin boards and common rooms. A housing advocate helped patients in two ways: i) finding appropriate housing whilst patients are still in hospital and; ii) assisting clients with setting up and in-tenancy support once they had moved in, including supporting clients to call the landlord, setting up payments and at times visiting the potential housing with them, and finding furniture. Analysis of administrative data of people accessing the service found that the number of individuals discharged that were either homeless or NFA decreased from 194 to 15. The number of clients discharged from tertiary care to homelessness or NFA also dropped from 74 to 9. The majority of clients accessing the intervention also acquired housing, with 92.5% of those who were at imminent risk of homelessness being attached to affordable permanent or temporary accommodation.

4. Residential programme of young people leaving care to independent living

Another risk group identified is those leaving care and the transition from the care system to independent living. A study of 24 young people transitioning from foster care through a residential programme which links young people to support and services in their community were screened at two points in time over 12 months (once as they entered the programme and 12 months later) to assess housing stability, as well as employment, income, education, life skills, family relations, and community involvement (Senteio et al, 2009). Pearson Chi Squared analysis on the data showed that fewer clients were homeless or were threatened with eviction at screening 2 compared to screening 1. Analysis showed that unemployment decreased, and income, health care, family or friend support, and community involvement all improved or increased. The authors suggest that these factors all contribute to greater housing stability (Senteio et al, 2009).

Summary and conclusions

Hospital discharge interventions and those transitioning from other institutions focus on a very niche group within a specific health and wellbeing setting, mainly those already experiencing homelessness who are identified whilst staying in hospital. The studies highlighted in the review have shown interventions for patients in hospital for both physical and mental health issues. The evidence in the review shows that good discharge planning, which should consist of sourcing appropriate housing, helping the tenancy set up process and providing in-tenancy support for housing and health needs are vital to improving outcomes for these groups and preventing repeat homelessness. Where care leavers are concerned, longer term support over a 12 month period helps to improve health and employment outcomes as well as tenancy sustainment.

How transferable is the intervention for current practice?

There is a large body of evidence relating to hospital discharge interventions based on the recent large scale investment programme by DH. However, the funding programme only lasted six months and the continuation of these schemes varied geographically, dependent on access to local funding from CCGs, Public Health and housing sources. The case studies of current practice reflect this variation. In many areas they already have the expertise, processes and protocols in place and need continuation funding. Where hospital discharge projects do not exist, current services could provide information on effective practice to assist the set-up of these interventions in other locations.

The hospital discharge interventions could also be translated to other secondary healthcare settings such as psychiatric hospitals but also the transition from prison and care. This would require those
commissioning services to work with local prisons and children’s services to identify which clients in these services will be leaving the institution and when, and how best to work with them at the point of transition.

Current models of practice: hospital discharge or support in acute care settings
There were a number of examples both in the call for submissions and the grey literature that can be described as support in hospital or acute care settings. This can partly be explained by the recent investment of £10 million by the DH which has focussed attention of both commissioners and voluntary and local authority practitioners on improving the hospital discharge process among homeless households.

Examples of current practice include services targeted at specific ‘at risk’ groups. One of these groups is people with high levels of alcohol use. The Framework project (see appendix 2) works with high volume alcohol users (defined as those with more than three alcohol related admissions within a month) in a hospital setting, as typically around a third are homeless and a quarter are living in temporary or hostel accommodation. The service proactively identifies these patients wherever they are in the hospital system. Nurses employed by the service have specific knowledge of housing options and work alongside staff from the Homeless Street Outreach Team.

Another current service is the Brighter Futures A&E Community Support Team which works with people who have complex needs usually triggered by a traumatic incident, such as childhood abuse or ill health, to help them address the underlying causes of their drinking and prevent inappropriate use of A&E. Outcomes from the first nine months of the scheme showed 55% of clients have reduced or no admissions to A&E; and nine of the most frequent attenders at A&E reduced their attendances from 300 in the year before the scheme to just 30 in the scheme’s first six months.

Whilst most examples we received were currently operating in a hospital setting we also received one submission based in an outreach community setting. Brighter Futures also run a project in partnership with a community matron who runs drop-in clinics at a direct access hostel in Hanley, Staffordshire. A small scale study of the programme found that in the 12 months prior to the project being in place 275 A&E visits were made by 21 homeless people. This reduced to 14 visits in 12 months after the service was introduced, a 95% reduction.
Linked to typologies 2 and 3, critical time identification (CTI) is targeted at groups in the community and works on the premise that there are ‘at risk’ groups who have already experienced homelessness and their characteristics and circumstances mean that once back living in accommodation are more likely to become homeless again. Therefore, resources are targeted at these groups to prevent repeat homelessness and stop the problem from getting worse.

Need for the intervention and target groups

Critical time identification interventions are responses developed to prevent recurrent homelessness among persons with severe mental illness by enhancing continuity of care during the transition from institutional to community living (Herman et al, 2007). The model recognises that there are ‘critical times’ where support is needed to prevent repeat homelessness for this group who usually also have multiple and complex needs including substance misuse issues, fleeing violence, offending history and mental health needs.

As other studies have highlighted there are other ‘at risk’ groups which include people who have already experienced rough sleeping and those with substance misuse issues and/or complex and multiple needs (Anderson and Christian, 2003; Fitzpatrick, 2000) as well as families with entrenched issues including antisocial behaviour, youth crime, inter-generational disadvantage and worklessness (Dixon et al, 2010) and care leavers. In these cases the problem is identified based on people’s previous experience and they are usually already known to services. There are also other groups at risk of repeat homelessness relating to those with specific health needs, including HIV/AIDS (Fitzpatrick-Lewis et al, 2011).

There has been a large body of evidence collected on multiple exclusion homelessness (MEH) in the UK (Fitzpatrick et al, 2012; McDonagh, 2011) which highlights some of the risk factors to individuals experiencing repeat homelessness. As Cornes et al (2013, p2) argues “MEH is a particularly useful ‘lens’ for studying integrated practice as it requires an understanding of how homelessness intersects with a wide range of other problems such as mental health issues, drug and alcohol dependencies, and experiences of care and the criminal justice systems”. In terms of defining this group, the findings form the MEH research show that there is an overlap between a number of excluded groups, the most complex being men aged 20 to 49 with an intersection of homelessness, hard drugs, mental health issues and prison (Fitzpatrick et al, 2011). There has been a growing trend by services to look at supporting adults with multiple and complex needs rather than addressing homelessness as an isolated issue.

Current models of practice: targeted support for people at risk of repeat homelessness.

The Equinox hostel link team was established as one of Equinox’s responses to the rise in the number of rough sleepers (377% since 2008) and the lack of alcohol/treatment focused resources in Brighton’s homelessness hostels. The service uses an assertive outreach model which targets the most complex clients – 88% are former rough sleepers and 76% had a hostel eviction abandonment history - and challenges and supports service users to address the issues and obstacles they have to securing permanent accommodation. While initially set up to tackle alcohol and substance misuse it has evolved into a more holistic service to address other health and wellbeing needs, for example psychological assessments and rebuilding relationships. Out of 34 service users supported between January and June 2014, 65% reduced their alcohol/substance intake, 78% reduced the unplanned departure from hostels and 83% reduced their attendance at A&E.
Developing the solution
The interventions covered in this section address two studies of people who have been previously homeless, their long term housing outcomes and the impact of providing support to live in the community on their health and wellbeing:

1. People with severe mental illness
2. Randomised Control Trial (RCT) with people with HIV/AIDS

1. People with severe mental illness

The premise of CTI is to provide support for an identified group that are transitioning back from care in to the community. As Herman (2007) sets out there are three phases to this support: i) intensive support when transitioning from care in to the community; ii) facilitating the client to problem solve on their own and iii) transfer of care to the wider community. The effectiveness of the CTI model has been tested in a RCT with 96 men with severe mental illness leaving sheltered accommodation into housing. The CTI group received the three phased support for nine months and the comparison group received normal services provided by the on-site psychiatric team.

The CTI model was associated with a significant, lasting reduction in post-discharge homelessness (Susser et al, 1997). Over the 18-month follow-up period, the average number of homeless nights was 30 for the CTI group and 91 for the usual services group. Extended homelessness (more than 54 nights) occurred in 10 (21%) of the men in the CTI group, compared with 19 (40%) of the men in the usual services group. The CTI group did not experience increased cases of extended homelessness after the support had ended indicating the phased approach helped to provide sustained skills to maintain a tenancy. An economic analysis was completed which found that the CTI and control group incurred similar costs to service. However the authors concluded that the significantly lower mean number of homeless nights in the CTI group was cost-effective in comparison with usual care.

2. RCT with people with HIV/AIDS

Other RCTs have been conducted with at risk groups. A rapid systematic review of effectiveness of interventions to improve the health and housing status of homeless people found that out of 84 studies identified none were of strong quality while ten were rated of moderate quality (Fitzpatrick-Lewis et al, 2011). Among these was a study of 644 people with HIV/AIDS living either in stable or unstable accommodation (Wolitski et al, 2010; Kidder et al, 2007). The intervention being tested was rental assistance for homeless people living with HIV/AIDS and the impact this had on physical health, access to medical care, mental health status and risk behaviours. The test group were given their own place to live and the comparison group were either staying temporarily with others, living in transitional housing or were homeless. At 18 months, 51% of the test group had housing and analysis showed significant improvements in self-reported physical and mental health. The study also found significant improvements between stably housed versus homeless participants relating to their use of healthcare, perceived stress and detectable viral load (Fitzpatrick-Lewis et al, 2011).

Shropshire Council: Mental Health Single Referral Scheme

What is the intervention?
Shropshire Council Housing Options funds a scheme for people with mental health issues and complex support needs to access housing and housing support. This has been in response to the need for improved joint working across mental health and housing teams, and a shared understanding about the impact of inappropriate housing on mental health and wellbeing.
How much does it cost to deliver?
The scheme was set up in 2005. Current annual running costs are £19,929 (for staff and overhead costs).

Who is eligible for the scheme?
The scheme is open to individuals who are 18 and over, have a mental health illness, have a registered care co-ordinator and a connection to Shropshire.

How does the scheme operate?
The Scheme Coordinator based within the Housing Options Team holds the scheme meeting on a three weekly basis (at Shropshire Council premises) bringing together representation of a wide range of agencies and acts as a platform for discussions about the appropriate accommodation type for individuals who are discussed. The scheme is aimed at individuals who are not capable of maintaining independent accommodation without support. Providing more appropriate accommodation options helps prevent those individuals residing in independent accommodation that could possibly breakdown and lead to risk of or homelessness.

Referrals are submitted to the Scheme Coordinator by the applicant’s Care Coordinator (Health/Social Care/ Housing). Housing advice is provided by a qualified Housing Options Officer, and the case is then presented at the weekly panel meeting, where the suitable supported accommodation placement is identified.

The scheme members work together in order to prevent individuals being discharged from any mental health institution as NFA by exploring the suitability of the scheme projects on a case by case basis.

Which partners are involved?
The partners involved in the scheme are:
- Shropshire Council Housing Options service
- Shropshire Council Adult Social care
- Shropshire Mental Health Services
- Bromford Housing Group
- Trident Reach (housing and support service)
- SASH (supported housing mental health)
- Severnside Housing
- Star Housing
- Shropshire Housing Alliance
- Shrewsbury Homes For All
- Together (mental health support services)

What are the outcomes from the intervention?
The scheme has not been formally evaluated but outcomes from April 2013 to April 2104 have been recorded. Out of 28 eligible referrals made to the scheme the following outcomes were recorded:

- Number of individuals who moved into one of the projects through the SRSMH scheme following assessment: 11
- Number of individuals who have assessments pending further information: 2
- Number of individuals on project waiting lists: 8
- Number of individuals who no longer require accommodation through the SRSMH scheme following acceptance on to the scheme at SRSMH meeting: 5
- Number of individuals not accepted following assessment: 2
Summary and conclusions
The evidence from the review shows that working with at risk groups in the community can have a positive impact on both reducing repeat homelessness and providing a cost effective solution. These targeted interventions both prevent repeat homelessness, and by working longer term with people with greater needs are more likely to lead to improvements in mental and physical health.

How transferable is the intervention for current practice?
Herman et al (2011) suggest that the CTI model can be used with other high risk groups and looks at the merits of applying the model to ex-offenders to reduce the risk of homelessness among individuals leaving prison. The targeted approach with particular at risk groups could arguably be transferred to any vulnerable group with a specific health and wellbeing need and this has been demonstrated through the examples of current practice. These models have targeted support at a number of groups – young fathers, lone parents, substance users, vulnerable migrants, and vulnerable people living in the private rented sector. In addition, our stakeholder workshops identified other at risk groups for people commissioning services to consider which include households fleeing domestic violence, those leaving the armed forces, and the LGBTQ community. Services should use data and intelligence to ascertain which at risk groups exist in their area and the size of the population.

Whilst there are positive health and housing outcomes from targeting support at specific groups who are at risk of repeat homelessness, these tertiary homelessness prevention measures should exist alongside primary prevention interventions to address problems within at risk groups at an earlier stage and reduce the need for critical time interventions later on.

Current models of practice: vulnerable people living in the private rented sector

Bristol City Council has used data and intelligence gathered by the Housing Health and Safety Rating System (HHSRS) together with local NHS health profiles, the house condition survey and other local authority statistics, to predict where the worst housing conditions are to be found, and how they impact on health. This information has been included in their JSNA and helped to highlight the significant impact of below standard housing on the health and wellbeing of some of Bristol’s most vulnerable populations.

This led to a partnership between the Private Rented Sector team and Public Health which targeted the ten most deprived areas of the city. Interventions and support include subsidised energy efficiency improvements, subsidised loans for home improvements, free home fire safety checks, and small adaptations and equipment such as bath boards, grab rails, WC pan risers and grabbers/pickers funded by disabled facilities grants. Bristol also offers support and advice to landlords managing housing for vulnerable people. Bristol City Council has used the Chartered Institute of Environmental Health’s HHSRS Cost Calculator to demonstrate likely cost effectiveness. For example, the excess cold aspect of the initiative alone implies resultant annual savings to the NHS of £7.4 million.

OVERALL CONCLUSIONS FROM THE EVIDENCE REVIEW

The review has addressed four main typologies of practice centred in primary and secondary healthcare, as well as health and non-health community outreach settings. Whilst a number of interventions have been identified there are also a number of gaps which need to be addressed through both future commissioning of services, and also evaluation and monitoring of these interventions:

- There is much focus on why homelessness prevention is important but much of the academic evidence focuses on the policy framework rather than practical interventions and there is little
evidence to show measurable outcomes and how effective these are in health, community and other settings.

- Most interventions are carried out on a small scale or have been piloted and have not been rolled out on a national or broader scale.
- Where interventions have been assessed or evaluated these have mainly used a qualitative methodology.
- Cost effectiveness evidence is very limited and analysis which examines economic savings tends to cover ‘spend to save’ arguments rather than comprehensive cost benefit analysis.
- The majority of interventions are directed by housing partners rather than led by health or other professionals in the community. Where they are administered in a non-housing setting the development of the intervention and the funding arrangements is driven by housing rather than health professionals.

The last case study\(^7\), below, demonstrates a real life health intervention which resulted in a positive housing outcome for the individual.

**Rabia’s story – successful intervention by a health visitor to prevent homelessness**

Rabia is a lone parent with two young children and lives in a private rented property. She was struggling to manage her tenancy and at a regular check-up for her youngest child by her health visitor, the health visitor asked if everything was ok at home. Rabia talked to her about how she wasn’t coping and the health visitor encouraged her to go to her local community centre where they run a weekly outreach housing advice service.

Rabia talked to an advisor about her housing issues which included not having enough furniture, disrepair in the property and dealing with the landlord. The advisor made a formal referral to the advice service and Rabia was assigned a support worker who helped her to access furniture, manage her bills, and also talked to the landlord about the repairs that needed doing.

Rabia is now much happier in the tenancy and wants to stay there, and she feels much more confident about dealing with the landlord.

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\(^7\) Case study based on interview with participant in service user workshops. Names have been changed.
### SECTION 3: BARRIERS AND OPPORTUNITIES FOR EFFECTIVE PRACTICE

Four workshops were carried out with service users – who all had experience of homelessness – and practitioners to test the evidence review findings and inform the recommendations for policy and practice. A summary of the discussions is set out below and answered the following aims:

- Discuss and share the approaches and models identified in the review.
- Consider which present credible solutions to replicate.
- Understand and identify any barriers to replicating practice.
- Understand and identify any changes/conditions required for successful adoption so these can be incorporated into the recommendations for PHE.

#### Table: Summary of workshop discussions

<table>
<thead>
<tr>
<th>Service user workshops</th>
<th>Stakeholder workshop</th>
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<tbody>
<tr>
<td><strong>What other access points are there to deliver homelessness prevention services in response to health and wellbeing needs?</strong></td>
<td>Criminal justice system, ambulance service, social services, GP surgeries, health visitors, walk in clinics</td>
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<td></td>
<td>Multiple and complex need services (e.g. MEAM), drug and alcohol services, domestic violence, midwives, young carers, young people transitioning from children to adult services, care leavers, unaccompanied asylum seekers turning 18, schools who do home visits, troubled families programme children’s centres, armed forces, Job Centres</td>
</tr>
<tr>
<td><strong>What are the barriers to delivering intervention models?</strong></td>
<td>Lack of knowledge and understanding by professionals to provide accurate advice on housing and welfare benefits issues</td>
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<tr>
<td></td>
<td>Lack of knowledge and understanding of clients by professionals e.g. someone not turning up to an appointment is often seen as a lack of engagement rather than in response to a physical or mental health need, or schools do not link reduced attendance to being placed in temporary accommodation</td>
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<td></td>
<td>Reduction in local services including floating support, advocacy, peer support and face to face personalised services – early advice often only provided online which is not accessible to everyone</td>
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<td></td>
<td>Gaps in housing advice provision and funding to prevent homelessness; LA budgets are no longer ring fenced, cuts in legal aid, patchy geographical coverage especially in rural areas</td>
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<td></td>
<td>Limited opening hours to access advice and support especially if you are in full-time employment</td>
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<td></td>
<td>Structural issues: lack of affordable housing, welfare cuts and further reductions in welfare expenditure and legal aid</td>
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<td></td>
<td>Referral processes: not being able to self-refer or walk in to services stops people from accessing help at an earlier stage</td>
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<td></td>
<td>Lack of accurate data collection and outcomes to evaluate services and show their effectiveness for commissioning, but also to identify an individual’s needs e.g. health professionals do not collect housing status for their clients</td>
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<tr>
<td>What are the opportunities for delivering effective practice?</td>
<td>Preventing homelessness to improve health and wellbeing, Homeless Link, 2015</td>
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<tr>
<td>Shortage of information and places to access housing and homelessness advice, people don’t know where to go for help if they are experiencing a housing problem</td>
<td>Conflicting cultures and processes in local authorities, NHS and the voluntary sector – for example different perceptions and processes for identifying need and risk</td>
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<td>Lack of understanding of young people’s issues by professionals, especially mental health and homelessness issues</td>
<td>Local authority structures: reconciling two tier and unitary authorities</td>
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<td>Having an updated internet resource for health professionals to use for housing and homelessness services in their area</td>
<td>Providing resources online in each local area for health professionals to identify the nearest homelessness and housing resources</td>
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<tr>
<td>Work with schools to identify children with behavioural issues who may be at risk of homelessness</td>
<td>Information sharing between health and housing departments and wider organisations including NHS – including more routine sharing of intelligence, outcomes data, and assessments</td>
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<tr>
<td>Using school nurses and training education professionals in housing and homelessness advice</td>
<td>Clearer commitments to be stated in JSNAs and HWBS on homelessness prevention, and strong local leadership from elected members to back a preventative approach</td>
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<tr>
<td>Utilising commitments in the NHS Constitution to reduce inequalities to improve homelessness prevention</td>
<td>Joint commissioning of services between housing departments, public health and CCGs to achieve shared health and housing outcomes</td>
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<tr>
<td>Using television screens in GP surgeries and walk in clinics to upload housing information and advice and signpost to local services</td>
<td>Explore benefits of prevention on a locality basis rather than through costs on individual services and departments, for example B&amp;B accommodation is very costly and also has long term health impacts on people living in it</td>
</tr>
<tr>
<td>Peer homelessness advocates based in GP surgeries</td>
<td>Working outside of individual targets and better utilising existing shared PHE and NHS outcome frameworks to guide investment and delivery</td>
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Principles for effective homelessness prevention
At the workshops with people who had experienced homelessness, participants discussed the principles which should underpin effective prevention, regardless of the model used to deliver support:

- Good communication is key – people needing support are likely to be experiencing anxiety and distress. People want advice from people who will ‘talk with them’ and not ‘at them’, as disclosing issues can be difficult.
- Consider how peer advisors can provide support – it’s better to hear ‘from someone who’s been there’.
- Build on existing community networks and trusted sources of help – they might not always be the obvious ones.
- Advice and support needs to be accessible: this means flexible referral points, shorter waiting times, and the option to self-refer.
- Personalised advice and support is key – problems are usually far better dealt with face to face, rather than online or via complicated phone systems.
- Support should be co-ordinated from one place, and information shared between agencies. This is particularly important where people have transitory or disrupted accommodation bases.
- Prevention services need to consider practical issues for people on low incomes to make sure they can access them – like transport costs particularly in rural areas.
- Signposting is not always enough – advisors need to support people to access the right support if they cannot provide it themselves.

Based on the feedback from the workshops the following practical steps could be implemented to alleviate the challenges that were highlighted:

- Longer health care service opening hours for people to access housing and homelessness help and advice.
- Greater provision of self-referral routes and walk-in housing advice surgeries for people using health, wellbeing and other community services.
- Provision of housing and homelessness advice and information through accessible channels such as a second tier advice line for non-housing professionals, up to date web resources and easy to read advice leaflets.
SECTION 4: CONCLUSION AND RECOMMENDATIONS

This review has highlighted the opportunities many local agencies are taking to improve people’s health and wellbeing through more effective homelessness prevention. It has however illustrated that much more can be done to more fully integrate prevention practice through existing efforts to improve and protect the population’s health, with activity still largely housing-led and reliant on small scale initiatives rather than mainstreamed within local provision.

As partners across local authorities and the NHS look for more efficient use of resources, the case for combined early action around homelessness and health seems clear. Local commissioners already have a duty to integrate services across health, social care and the wider services which contribute to health and wellbeing. The Health and Social Care Act 2012 has also put renewed focus on using local intelligence through JSNAs to underpin commissioning plans and direct resources to tackling the determinants and not just the effects of poor health in our communities. These are just some of the levers which present opportunities for local areas to prioritise prevention activity, and make much bolder ambitions about how these will be achieved.

Yet this review also shows the gaps. The evidence base around the savings early action can achieve remains limited, particularly across both health and housing systems, in part because by its nature it can be hard to show the value gained by something not happening, but also because many interventions have short term funding which makes it difficult to measure and evidence the longer term outcomes. Our discussions with stakeholders and service users also highlight the external pressures – such as welfare reform, rising housing costs, and unstable employment – which for many people at risk of homelessness or on low incomes makes the need for advice and support early on even more critical. The new demands and requirements faced by local authorities through the Care Act 2014 will mean greater promotion of the concept of wellbeing including suitable accommodation and to help prevent the development of needs for care and support. Learning from what works elsewhere and implementing this more widely is an opportunity for these local partnerships to take.

Drawing together the evidence collected through the academic and grey literature and the current practice case studies from the call for evidence submissions, there are a number of gaps that have been identified in three main areas:

1. **Gaps in current practice** – there is very little evidence of homelessness prevention activity that takes place in response to associated health and wellbeing needs. Aside from activity occurring at the more acute end of the homelessness scale such as hospital discharge projects and services which target vulnerable groups, the review has shown that primary prevention activity is not widespread and is mainly led by housing rather than health commissioning.

2. **Gaps in evidence** – whilst the review has highlighted some studies which look at RCTs and full outcome evaluations, this methodology has not been consistently applied across all studies. There is a lack of evaluation among current practice and future evidence should consider methods such as SROI, social impact and social values measurements.

3. **Gaps in interventions for certain groups** – the review has shown that proactively targeting prevention activity at particular groups is an effective way of preventing homelessness (secondary and tertiary models of prevention). Some groups have been adequately captured in current practice but there are some ‘at risk’ households which are not represented: ex-armed forces, LGBTQ groups with health needs, migrants, families and single people that fall outside the multiple and complex need group.
Stronger leadership and joint strategic working
- Joint Health and Wellbeing Strategies should include clearer priorities about homelessness prevention. Each local JSNA should clearly identify who is at risk of and experiencing homelessness in the local area; and the impacts on health and wellbeing for these groups.
- Basic health and housing literacy is essential for everybody working in a health and housing setting. Local leaders should provide clear and co-ordinated direction to all agencies and individuals to ensure that ‘every contact counts’, and equip the workforce to do this.
- Local leaders should help embed a ‘prevention first’ approach, identifying opportunities to prevent and intervene earlier for ‘at risk’ communities. This should consider the role of communities, the voluntary sector, and any workforce that comes into contact with ‘at risk’ groups, including, primary and secondary health care, allied health professionals, social care, housing and homelessness, criminal justice, employment and education.

Access to advice and early intervention
- Extend availability of primary homelessness prevention in primary and secondary health care settings. The Care Act’s requirements for information, advice and guidance provide renewed opportunity for Health and Wellbeing Boards to review and extend this provision, working with local and national voluntary sector advice agencies.
- There needs to be greater engagement with schools, educational establishments and early year’s services by housing and health professionals to raise awareness and share effective practice in identifying children and young people at risk of homelessness. This should include training for school nurses, health visitors and staff that make home visits to households prior to starting school.
- Public Health and NHS managers should ensure frontline health professionals can identify appropriate services in their area to refer people at risk of homelessness to - e.g. through provision of online resources and stronger partnerships with local voluntary sector providers.

Improve data collection and evaluation
- Improve the recording and sharing of data to enable services to target interventions at those at risk of homelessness, and evidence what works. The housing status of those accessing health services should be routinely measured, alongside the health and accommodation outcomes of interventions.
- Local public health teams should help develop and promote ways for services to evaluate cost effectiveness and show return on investment for interventions. The development of effective prevention ‘metrics’ would help demonstrate how prevention activity achieves improvements across shared outcomes in a locality.
- At a national level, the partners to the housing and health memorandum of understanding (MOU) have an opportunity to continue to support health, social care, housing and homelessness sectors to address gaps in evidence to inform new ways of working.
REFERENCES


Department of Communities and Local Government (2012a) *Making Every Contact Count, a joint approach to preventing homelessness*, London: DCLG.


Preventing homelessness to improve health and wellbeing, Homeless Link, 2015


APPENDICES

Appendix 1: Search Strategy

A search was carried out using Scopus, Homeless Hub Database, Social Care Online, ISI Web of Science, Jstor, Psychinfo, Medline, NHS evidence, Google Scholar, Centre for Welfare Reform and Royal Society for Public Health. The search was initially restricted to publications published since 2004 within the UK. It was then extended to a wider geographical search area to include Western Europe, Canada, United States and Australia.

The following search terms were used which retrieved relevant articles. The search terms were chosen to reflect the wide definition of homelessness being used in the review and the different populations and settings in which homelessness prevention interventions may take place.

<table>
<thead>
<tr>
<th>Search terms</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>TITLE-ABS-KEY(homelessness) AND TITLE-ABS-KEY(prevention) AND TITLE-ABS-KEY(United Kingdom)</td>
<td></td>
</tr>
<tr>
<td>(TITLE-ABS-KEY(temporary accommodation) OR TITLE-ABS-KEY(homelessness) OR TITLE-ABS-KEY(bed and breakfast) AND TITLE-ABS-KEY(United Kingdom) OR TITLE-ABS-KEY(England) AND TITLE-ABS-KEY(prevention)) AND SUBJAREA(multi OR medi OR nur OR vete OR dent OR heal OR multi OR arts OR busi OR decl OR econ OR psyc OR soc)</td>
<td></td>
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<tr>
<td>MeSH: Adolescent; Adult; Diagnosis, Dual (Psychiatry); Female; Homeless Persons; Housing; Humans; Income; Male; Middle Aged; Netherlands; Public Health Practice; Questionnaires; Risk Factors; Single Person; Social Problems; Socioeconomic Factors; Substance-Related Disorders; Urban Population; Young Adult</td>
<td></td>
</tr>
<tr>
<td>&quot;homelessness prevention&quot; AND &quot;health&quot;</td>
<td></td>
</tr>
<tr>
<td>(&quot;homeless&quot;* OR &quot;bed and breakfast&quot;* OR &quot;squat&quot;* OR overcrowded OR &quot;sofa surfing&quot;) AND &quot;at risk&quot; and &quot;prevent&quot;*</td>
<td></td>
</tr>
<tr>
<td>hospital and homeless* and prevent*; &quot;mental health&quot; and homeless* and prevent*</td>
<td></td>
</tr>
<tr>
<td>&quot;homeless&quot;* and prevent*</td>
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</tbody>
</table>
In addition the following terms were used which did not provide relevant articles:

- Floating support
- Unsafe housing
- LGBT
- Substance misuse
- Ex-service or veteran
- Hidden homeless
- At risk
- Poor conditions
- Damp
- Migrant
- Asylum
- Sex work
- Thermal comfort
- Non decent home
- Disabled or disability
### Appendix 2: Call for evidence submissions

<table>
<thead>
<tr>
<th>Source</th>
<th>Summary of model</th>
<th>How is it funded?</th>
<th>Has it been formally evaluated?</th>
<th>Model it fits into</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smartmoves, Brighter futures</td>
<td>Smartmoves provides housing related support to people who are struggling to maintain their home or tenancy. Support is generally delivered in people’s homes. Activities include helping people to get support from health services; getting involved in positive activities during the day such as learning, recreation, volunteering or paid work; managing their money better.</td>
<td>Stoke on Trent City Council through the Accommodation Commissioning Team (formerly Supporting People)</td>
<td>No</td>
<td>Holistic in-tenancy support/ community outreach health support</td>
</tr>
<tr>
<td>Brighter Futures and Community Matron Partnership</td>
<td>The community matron, and multiagency staff (including workers at the hostel and support staff from Brighter Futures, the street sex workers team and the rough sleepers outreach team) direct homeless people to further services to help their wider physical, mental and social health including the alcohol liaison team at University Hospital of North Staffordshire.</td>
<td>Brighter Futures provide premises. The Community Matron is employed by Staffordshire and Stoke-on-Trent Partnership NHS Trust</td>
<td>Yes</td>
<td>Critical time identification targeted at groups in the community/ Secondary healthcare</td>
</tr>
<tr>
<td>Brighter Futures A &amp; E Community Support Team</td>
<td>Provides intensive, outcome focussed support to people with complex needs. The service helps people plan a journey of change that assists in solving the underlying problems that lead to their drinking.</td>
<td>North Staffordshire CCG</td>
<td>Yes</td>
<td>Targeted support and advocacy for people leaving institutions/ Secondary healthcare</td>
</tr>
<tr>
<td>Framework</td>
<td>This service works with high volume alcohol users who are either street homeless or living in homeless accommodation services in hospital settings (those with more than 3 alcohol related admissions within a month). The service works proactively to seek out these patients wherever they are in the hospital system. Once referred in to the service the patients work with multi-disciplinary teams to address their homelessness. This includes nurses with specific knowledge of housing options and staff from the Homeless Street Outreach Team who are housing specialists work alongside the service.</td>
<td></td>
<td>Targeted support and advocacy for people leaving institutions/ Secondary healthcare</td>
<td></td>
</tr>
<tr>
<td><strong>Framework</strong></td>
<td>The street outreach team (SOT) proactively work with patients discharged as “NFA” or to a temporary address. Once discharge the SOT work with hospital staff and meet the patient at the LA Housing Aid Centre and ensure the patient is linked to a “8 till late” Walk In Medical Centre where GP registration can occur if necessary. A hospital discharge specialist works with social workers to identify appropriate accommodation and support options for homeless people who are referred to the service. Priority is given to those who have been admitted into hospital who have completed their treatment and are ready for discharge.</td>
<td>short term funding for a Hospital Discharge specialist</td>
<td>Targeted support and advocacy for people leaving institutions/Secondary healthcare and community outreach health support</td>
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</tr>
<tr>
<td><strong>Petrus Green Gym</strong></td>
<td>The service works with people in the local community who present with enduring mental health issues, substance misuse and dependency problems, histories of offending and homelessness. The project involves people in horticultural and literary activities which include helping older people who are less able to look after their gardens and helping people to eat healthily and cook on a limited budget. The outcomes of the project are increased self-esteem, confidence and improved behaviour which leads to overall better wellbeing, improved mental health and a reduction in behaviours that can lead to homelessness.</td>
<td>NHS CCG currently in progress</td>
<td>Critical time identification targeted at groups in the community/Community outreach health support</td>
<td></td>
</tr>
<tr>
<td><strong>Blackburn with Darwen &amp; District Without Abuse: Refuge Accommodation</strong></td>
<td>Provision of emergency accommodation to vulnerable women and children fleeing domestic abuse, ensuring safety and security to victims at risk of domestic abuse which prevents them from becoming homeless. The service provides 24 hour accommodation, support and recovery programmes, safety planning and risk management ensured to reduce risk to women and child/ren. Service user needs are addressed through Independent Living Plans to create independence promote empowerment.</td>
<td>Housing Benefit and Supporting People Yes</td>
<td>Critical time identification targeted at groups in the community/ non-health community outreach</td>
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</tr>
<tr>
<td>Scheme</td>
<td>Description</td>
<td>Supporting People</td>
<td>Critical Time Identification Targeted</td>
<td>Holistic In-Tenancy Support/ Community Outreach Support</td>
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<tr>
<td>Blackburn In Partnership Supported Housing Scheme</td>
<td>A supported housing scheme for women aged between 16 – 35 who have complex dependency issues or other complex support needs. The service offers harm reduction support to help clients to reduce or maintain their use and to improve their overall health and wellbeing. They also offer a safe supportive environment for homeless women to access training to enable them to move on into independent accommodation. The scheme works in partnership with alcohol and drug services, sexual health, mental health, housing, GPs and many other agencies in order to provide a multi team approach to support planning.</td>
<td>Supporting People</td>
<td>No</td>
<td>Critical time identification targeted at groups in the community and holistic in-tenancy support/ non-health community outreach</td>
</tr>
<tr>
<td>Stepping Stone Projects- Blackburn with Darwen Floating Support Service</td>
<td>Support for people who are homeless or at risk of homeless to gain a tenancy or sustain their current tenancy. The project work’s with a minimum of 39 people aged 16 and over and aims to empower people and increase independence. They support clients to access benefits, apply for grants and loans, report repairs, register with GP and/or dentist and access specialist services in relation to mental health, substance misuse and offending behaviour.</td>
<td>Supporting People</td>
<td>Yes</td>
<td>Holistic in-tenancy support/ Community outreach health support</td>
</tr>
<tr>
<td>Transforming Lives Programme (including Troubled families delivery)</td>
<td>A multi-agency Transforming Lives panel receive household referrals and examine these against their housing needs. Where referrals meet the Troubled Families criteria or where the concerns relate primarily to housing issues, housing needs support officers become lead professional for the family, coordinating the team around the family and managing the actions to address the causes of the concerns rather than just addressing the presenting symptoms in silo. Problems addressed include health issues, ASB and tenancy sustainment.</td>
<td>Troubled Families</td>
<td>Yes</td>
<td>Holistic in-tenancy support/ Community outreach health support</td>
</tr>
<tr>
<td>Mental Health Single Referral Scheme</td>
<td>The Scheme aims to enable people with Mental Health issues and complex support needs to access housing and housing support. The Scheme coordinator (Shropshire Council employee within the Housing Options Team) holds the scheme meeting on a three weekly basis bringing together representation of a wide range of agencies and acts as a platform for discussions about the appropriate accommodation type for individuals who are discussed. The project is aimed at individuals who are not capable of maintaining independent accommodation without support. By providing this support it helps prevent homelessness among individuals residing in independent accommodation.</td>
<td>Shropshire Council (Housing Options)</td>
<td>No</td>
<td>Holistic in-tenancy support/ Community outreach health support</td>
</tr>
<tr>
<td>Programme</td>
<td>Description</td>
<td>Funding Sources</td>
<td>Targeted support and advocacy for people leaving institutions/ Secondary healthcare</td>
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<tr>
<td><strong>Cornwall Homeless Hospital Discharge Project</strong></td>
<td>The project aims to reduce the amount of hospital beds blocked in Cornwall by single homeless people who were medically fit for discharge but have no address to be discharged to. The remit also included those patients discharged NFA after short stays in acute hospital beds. The project has: i) developed and implemented a county-wide multi-agency protocol; ii) delivered training and awareness events (e.g. inductions, team meetings) to help staff better understand the services available and the pathways for patients prior to discharge; and iii) recruited a Homeless Patient Advisor post providing a direct contact for staff and agencies to link into the service at the point of patient admission.</td>
<td>Department of Health</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>Young Mums Will Achieve</strong></td>
<td>YMWA’s primary objectives are to support mums back into mainstream education, employment and training whilst supporting the development of positive pathway and life skills. The groups offers: creche provision on site; transport support; the opportunity to develop employability skills; a peer supportive environment and an opportunity to meet the specific needs of the group; signposting to universal and specialist services.</td>
<td>Several funders including European Social Fund, Colleges, health and Local Government</td>
<td>No</td>
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<tr>
<td><strong>WILD's Independent Living Project</strong></td>
<td>WILD's Independent Living Worker offers advice and advocacy for young mums and young dads on: housing applications; homelessness; landlord relationships; rights and responsibilities; how to be a good tenant; poor housing conditions</td>
<td>Comic Relief</td>
<td>No</td>
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Preventing homelessness to improve health and wellbeing, Homeless Link, 2015
CALL FOR EVIDENCE: PREVENTING HOMELESSNESS TO IMPROVE HEALTH & WELLBEING

Public Health England (PHE) has commissioned Homeless Link to conduct a rapid review of effective homelessness prevention interventions that have been developed in response to identified health and wellbeing needs.

Preventing ill-health and reducing inequalities are key priorities for PHE. It is also concerned with the wider determinants of health, of which housing is one. There is a clear relationship between someone’s housing or homelessness situation and their health.

PHE would like to know if it is possible for local agencies to better identify a connection between a household’s health, wellbeing and housing circumstances before crisis e.g. homelessness, and what examples exist of responses that are effective in preventing homelessness, protecting and improving health and wellbeing.

The diagram below sets out the typical process this might take and one example of the type of intervention this might include:

As part of this review we are issuing a Call for Evidence of existing and emerging ‘prevention practice’ which tackles homelessness and leads to improvements in health and wellbeing from any organisation with experience in this area e.g., local authorities, the Voluntary and Community Sector, health agencies etc. We are interested in hearing about any examples where early intervention linked to health and wellbeing has prevented homelessness from occurring, or resolved a person’s housing need rather than models of practice which focus on tackling the health and wellbeing of people who are already homeless.

Please share are any examples of work being undertaken or have been undertaken using the template below. If the information in any of the sections is not available please leave them blank. These will be used to identify and highlight effective practice that could be replicated in other areas.

If you would rather tell us your example over the phone please contact us using the details below. Please return any examples by 17th September 2014.

<table>
<thead>
<tr>
<th>Name of Intervention/Project</th>
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<tbody>
<tr>
<td><strong>Summary:</strong> please tell us about your intervention, including</td>
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<tr>
<td><strong>Homeless Link</strong></td>
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<tr>
<td><strong>Aims</strong></td>
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<tr>
<td>Description of the homeless/housing problem it seeks to address</td>
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<tr>
<td>Activities delivered</td>
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<tr>
<td>Who delivers it</td>
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<tr>
<td>Where it is delivered (e.g., GP surgery, Job Centre, Community Hub etc)</td>
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<tr>
<td><strong>Target client group</strong> (e.g., families, young people, BME groups, ex-offenders – please include all who can use the service if more than one target group)</td>
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<tr>
<td><strong>Location</strong></td>
<td></td>
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<tr>
<td><strong>Date project started (and ended if applicable)</strong></td>
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<tr>
<td><strong>Partner organisations – who else is involved in delivering it?</strong></td>
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</tr>
<tr>
<td><strong>How is it funded?</strong></td>
<td></td>
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<tr>
<td><strong>How much does it cost to deliver?</strong></td>
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<tr>
<td><strong>Outcomes: what are the outcomes for the project and how are they measured?</strong></td>
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</tr>
<tr>
<td><strong>Has it ever been evaluated?</strong> Please provide more information about evidence of the intervention’s effectiveness in preventing/reducing homelessness and improving health &amp; wellbeing and the methodology used to show this. If you have data on cost effectiveness, please include this here. Or please provide the evaluation report if this is available.</td>
<td></td>
</tr>
<tr>
<td><strong>What would you say has been key to the project’s success and outcomes? Were there any barriers to implementation?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Would you be willing for this case study to be published in our review for PHE?</strong></td>
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</tr>
<tr>
<td><strong>Is it possible to have a photo from the project and a quote?</strong></td>
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</tr>
<tr>
<td><strong>Is there anything else about the project or intervention you think would be useful to share with us</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Please provide contact details for further information</strong></td>
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</tr>
</tbody>
</table>
FAQs

What do you mean by homelessness?  
For the purpose of this review, we are interested in all forms of homelessness, including statutory homelessness and single homelessness. It might also include hidden homelessness, those living in overcrowded or unsuitable accommodation, or those in particularly vulnerable housing situations.

Our intervention has not been evaluated – can we still include it?  
Yes, we are interested in emerging practice, as well as interventions which might have been formally evaluated.

Does it matter who commissions or delivers the interventions?  
We are interested in any homelessness prevention activity which has been developed in response to somebody’s health and wellbeing needs. This might be delivered in health settings (e.g. a housing advisor in a GP practice); another public service setting (e.g. school or JCP) or within a community environment (community hubs, day centres).

If you have any questions about the review please contact Francesca Albanese – francesca.albanese@homelesslink.org.uk or 020 7840 4422. Please return any examples by 17th September 2014.
What we do
Homeless Link is the national membership charity for organisations working directly with people who become homeless in England. We work to make services better and campaign for policy change that will help end homelessness.

Let’s end homelessness together
Homeless Link
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