Sheffield Homeless Health Needs Audit, 2015

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This report documents the health needs of homeless people in Sheffield. It was undertaken during August-September 2015 and involved providers of homeless services administering a questionnaire designed by Homeless Link and used on a national basis. The audit focussed on physical and mental health, social determinants and health behaviours. The results compare the Sheffield position with a national position.

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Acknowledgements:

Warm thanks are extended to all provider organisations who contributed to this audit through collecting data from their clients; commenting on the design of the audit and reviewing the quality of the data collected.

Our thanks also go to all members of the Project Steering Group for their input into the design and preparation for this audit, and to administrative staff in the Communities Commissioning Service who collated the manual returns and were responsible for data entry.

Sheffield
Homeless Health Needs Audit

Contents

Section 1: Purpose of the Homeless Health Needs Audit:

This audit is a snapshot of the needs of a sample of homeless people in Sheffield. For the purpose of this audit, the definition of "homeless" is that used in the national framework used by Homeless Link. That is single homeless people, generally understood to be those who do not have a secure or suitable place to live but do not meet the priority need criteria.[1]

The purpose of the Audit is three fold:

1. To provide an overview of the needs of homeless people in Sheffield to add to the Joint Strategic Needs Assessment.
2. To provide a summary of key findings that can be used by commissioners and service providers to inform their planning and priority setting.
3. To provide data about the needs of a sample of homeless people in Sheffield for use and analysis by partners working with homeless people.

In addition to this report, a file of data based on the responses to the Homeless Link Questionnaire is also available and held by the Public Health Research and Intelligence Team, Sheffield City Council. This report is an initial overview of the information. Additional analysis can be undertaken if required.

Section 2: Introduction:

Homelessness and rough sleeping have been increasing nationally[2] and health and wellbeing needs are high among rough sleepers and people living in insecure accommodation. In particular, there is a high prevalence of mental ill-health, drug and alcohol dependency and physical health needs[3].

The potential needs of the homeless are recognised in the Sheffield Health and Wellbeing Board Action Plan for tackling Health Inequalities in Sheffield[4]. In February 2015 the Board signed the Charter for Homeless Health[5] which includes a commitment to including single-person homelessness in the Joint Strategic Needs Assessment (JSNA).

[1] A Future Now, Homeless Health Matters: the case for change, October 2014

[2] Though rates of homelessness have risen across the country overall, conversely in Sheffield the number of homeless presentations has fallen. The reasons for this are not fully understood, but may in part be down to the range of housing-related support services on offer and the refocussing of these support services over the last three years towards targeting homeless prevention; and the Council's Homeless strategy and delivery with partners which has seen the refocus from statutory assessments to better prevention and redirection into supported housing.

[3] The homelessness monitor: England 2015Suzanne Fitzpatrick, Hal Pawson, Glen Bramley, Steve Wilcox and Beth Watts, Institute for Social Policy, Housing, Environment and Real Estate (I-SPHERE) February 2015

[4] https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/joint-health-and-wellbeing-strategy/tackling-health-inequalities.html

8. Develop a better understanding of health inequality by 'group': Whilst we have good data on inequality by geography, we do not have it by group. Groups such as BME communities, children with learning difficulties, homeless people, victims of domestic and sexual abuse and carers are all reported nationally to have below average health, but local data are lacking.

[5] http://www.mungosbroadway.org.uk/homelessness/publications/latest_publications_and_research/2069_charter-for-homeless-health

The Council is also preparing to re-commission some homeless services and is currently updating the Sheffield Homeless Strategy. The information from the Audit will inform both areas of work.

The findings from the Audit and key data will also be available to providers within the City to inform their own planning and delivery.

The Homeless Health Audit toolkit used for this report was originally developed by Homeless Link with funding from the Department of Health and includes a questionnaire designed to be completed by service users with help from a support worker. A number of local questionnaires were also added following consultation with stakeholders[6].The principal aim of conducting the audit is to increase local knowledge on the health needs of the homeless population.

The target population for this audit was people who were receiving Housing Independence Services (HIS), formally Supporting People (SP), many of whom the Council has no statutory responsibility to house. The questionnaire was completed during August and September 2015 using a non-random sampling strategy which aimed to include as many clients as possible. Approximately 3800 people received HIS services during 2014/15. In total there were 219 completed questionnaires included in the survey.

Data from the audit is compared with national homeless and general populations where available although caution should be taken when comparing many of these figures directly because different surveys often using very different methodologies. Nevertheless they often provide a useful point of reference for the size of the challenge facing services in meeting the needs of a group whose health is among the poorest in our communities.

Where possible, data from the Sheffield audit is also compared to data from the Homeless Link national aggregate based on a sample of around 3,355 people across 27 Local Authorities in England. This national aggregate is referred to as “HL27” throughout this report where comparison is made with the Sheffield data. However, due to variation in methodologies, timings of the audits and the profile of respondents, comparison between Sheffield and the national aggregate should be treated with some caution.

Section 3: Summary of findings:

In this section we have captured some of the key observations and reflections of the steering group and the findings from the report authors.

1. National Comparison: It is evident from the Sheffield Audit that the health needs of homeless people in Sheffield are similar to the national picture. This group of citizens have some of the worst health outcomes in the City. As such, the same national trends, pressures and challenges are likely to be seen here in Sheffield. How we respond to them locally will require a Sheffield leadership approach across partner organisations, not just a Council response.

[6] Local questions included: access to mobile phones, former armed forces, and use of food-banks.

2. **Local Partnership**: Recognition must go to the fifteen different provider organisations that supported the completion of this audit. Even within a climate of reduced public sector funds, the providers participated using their own resources, staffing and positive relationships with their clients. It is a reflection of the commitment of Sheffield providers to the needs of their clients and the positive partnership arrangements that exist across the sector. This is something that is a credit to the City and a solid foundation upon which a strong Sheffield leadership approach can be built.

3. Disability: Just under half of all respondents considered themselves to have a disability. This is greater than the national homeless audit of 36%. Most striking is that 70% of those who had a disability reported 'Mental Health' as being an element of their disability. The Equality Act 2010 places a legal duty on all agencies to eliminate discrimination and harassment of disabled people and to promote greater opportunities for disabled people. This also means making reasonable adjustments where necessary for those who have a disability. This does not just refer to the physical environment but includes enabling access to support for people with hidden disabilities such as learning disabilities and difficulties and mental illness as well as a physical disability. This is a legal responsibility that all providers should note when delivering/planning services.

4. Access to Services: The results of the Sheffield Audit for use of, and access to, health services closely mirrors that of the National Homeless Link report[7]. There was almost no difference in the rates of hospital admissions, A&E attendances, ambulance usage or GP contacts between the Sheffield and national populations.

5. Use of Health Services: Homeless people are frequent users of acute health services. This has significant cost implications for the local NHS. HM Treasury figures record the average cost of A&E attendance as £113 and £1,779 for an inpatient hospital episode[8]. The challenge for commissioners is to ensure there is an adequate and appropriate level of access to meet this need, whilst at the same time making additional and innovative interventions to minimise unnecessary or avoidable use of secondary care facilities amongst this population.

6. Mental Health: The data shows that homeless people experience high levels of stress, anxiety and other signs of poor mental health. The proportion of homeless people with diagnosed mental health problems (63%) is over double that of the general population (around 25%) and is higher than the national audit of homeless people(44%), particularly for depression. Of those with mental health issues, just under a third of those already receiving some form of support would like more help, and close to one in five do not receive any support but would like to. This suggests there are still significant gaps to address. It is recommended that providers and commissioners of services consider this information. The Sheffield 'Preventing and Responding to Homelessness[9]' call for evidence (2015) provides additional information on service options.

7. Substance Misuse: For substance misuse, we see a similar pattern as that reported nationally except for the percentage using crack/cocaine where the percentage is higher in Sheffield. This possibly reflects that historically Sheffield has always had high prevalence of crack use along with heroin, not necessarily as a sole drug of misuse. It is noted that people using heroin with crack or

[7] The Unhealthy State of Homelessness, Health Audit Results 2014, Homeless Link
[8] http://neweconomymanchester.com/our-work/research-evaluation-cost-benefit-analysis/cost-benefit-analysis/unit-cost-database
[9] Sheffield Call for Evidence – Responding to, and Preventing Homeless, 12th-20th August 2015 Final Report October 2015. V. Roberts, J. Skinner

cocaine will be treated through the Opiate Service as heroin is always treated as the primary drug due to the nature of the treatment. Cannabis users are the majority users of non-opiate services and some targeted work will be done in 16/17 about alcohol and cannabis use which is a common presentation into treatment.

8. Communicable Diseases: It should be noted that overall, 20% of respondents reported that they had been tested for TB. In comparison, the national audit found that 30% had been tested. Access to screening is therefore a key issue for Public Health and preventative services. Strategies to decrease TB incidence in homeless populations include increasing case detection, mandatory screening in shelters and using incentives to improve compliance to treatment. NICE (2013) recommends a "whole system approach" illustrating how local authorities should work with the NHS and Public Health England to support informed commissioning that meets the needs of homeless people[10,11]. NICE recommended active case finding in places where homeless people congregate and as part of cold weather initiatives. Combining active case finding with measures to improve treatment compliance was found to be cost effective.

9. Multiple-use of Services: A notable proportion of the group surveyed are in contact with two or more services. As such, there may be a need to look at how services are delivered to ensure compounding needs are effectively addressed and delivered in a complementary and efficient way. Crucial to this is the sharing of client information between providers in a way that is compliant with Information Governance requirements, is technically compatible with different information systems and has a common understanding of providers' categorisations.

10. Health Behaviours: Supporting homeless people to change risky health behaviours and support recovery is clearly a need. Consideration could be given as to how existing successful public health interventions in Sheffield could be further extended or tailored to meet the needs of the homeless in Sheffield. Linkages should also be made to the 'Recovery Communities' supported by the DACT. Possible other areas for development (taken from the Sheffield Homeless Call for Evidence) include the role of the Health Champions and Trainers, Peer Support and recovery community approaches.

11. Multiple-Disadvantage: It is clear from the audit that many of those surveyed in the Audit face multiple-disadvantage. The positive relationship between employment, education and training and health are well known. It is recommended that City Region and Sheffield specific approaches to supporting people furthest from the job market due to illness and disability positively target the cohort surveyed.

12. Debt: The survey found a clear relationship between debt and health. We know from other evidence that there is a strong causal relationship between debt and ill health[12], including poor mental health. We can therefore conclude that debt has a negative impact on the health and wellbeing of homeless people. It is recommended that this issue is explored in more depth and

[10] NICE (2013), Tuberculosis in vulnerable groups, http://www.nice.org.uk/advice/lgb11/chapter/Introduction, (accessed 19/01/2016)

[11] NICE (2013) Press release: 'Providing shelter for homeless people with tuberculosis: just one way local government can help tackle TB' https://www.nice.org.uk/news/press-and-media/providing-shelter-for-homeless-people-with-tuberculosis-just-one-way-local-government-can-help-tackle-tb-says-nice
(accessed 19/01/2016)

[12] Debt and Health: A Briefing, December 2015, Author: Giuseppe Paparella, Policy Officer www.pickereurope.org

discussions are held with Sheffield Citizen Advice Service about the evidence they are gathering about need, for example through their lottery funded work with food banks, and about the scope for action to ensure that homeless people can access help and advice about debt.

Section 4: Demographic Information

This section describes the demographic characteristics of the 219 responses as reported by homeless people to their support worker. Where data is available, these characteristics are compared with the characteristics of the 3,355 responses aggregated by Homeless Link from the 27 other local authorities who have completed the audit ("HL27"). There are some strong similarities between the Sheffield demographic profile and that of the other 27 authorities; the greatest difference being the larger proportion of women in the Sheffield audit.

One factor to be taken into consideration in interpreting the demographic profiles is that of selection bias. For example, the extent to which clients with more complex needs (such as those poor language skills or low concentration) may not have been approached to complete the audit because of time pressure is a possibility, but will be unknown.

Providers

The results are based on responses from a non-random sample of 219 clients who were selected by their support worker.

These responses came from 15 different organisations as shown in the table opposite.

Provider	Responses
South Yorkshire HA	37
Roundabout	28
DEPAUL	19
Salvation Army	18
Shelter	18
St Anne's	16
Big Issue	15
Young Women's Housing Project	13
Cluster Project	11
Rough Sleepers	11
Support55	10
SCC Supported Housing Office	9
911Project	8
SCC	6
Grand Total	**219**

Age/sex profile of the sample

The total of 219 responses fell short of the 300 target (described in the Method" section below). Nevertheless, the age/sex profile of the Sheffield audit broadly reflected the client base of the Housing Independence Survey described above, although 26-35 year olds were slightly underrepresented in the audit respondents, and 18-25 year olds slightly overrepresented.

55% of the responses were from men. One third from 18-25 year olds and a further fifth from those aged 36-45.

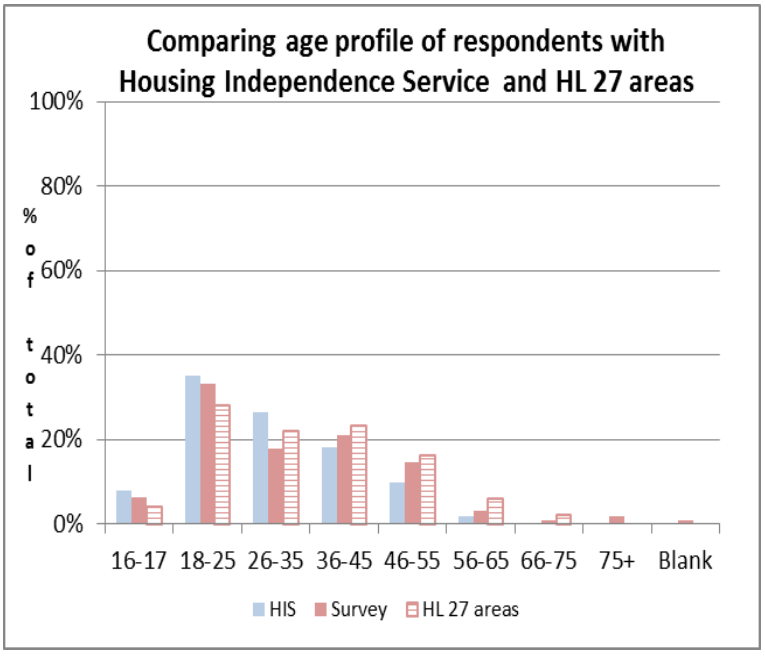
When compared with Homeless Link's aggregate of 27 Local Authorities (HL27), the Sheffield audit had a notably greater proportion of women respondents, although the audit figure was similar to the HIS figure.

Number of actual responses received

Age Range	Female	Male	missing	Total
16-17	8	6		14
18-25	36	37		73
26-35	22	17		39
36-45	15	31		46
46-55	11	21		32
56-65	5	2		7
66-75		2		2
Over 75	1	3		4
missing		1	1	2
Total	**98**	**120**	**1**	**219**

Profile of responses received

	Female	Male	Total
16-17	4%	3%	6%
18-25	16%	17%	33%
26-35	10%	8%	18%
36-45	7%	14%	21%
46-55	5%	10%	15%
56-65	2%	1%	3%
66-75	0%	1%	1%
Over 75	0%	1%	2%
(blank)	0%	0%	1%
Total	**45%**	**55%**	**100%**



	Sheffield	HIS	HL27
Male (all age)	54%	54%	71%
Female (all age)	46%	46%	29%

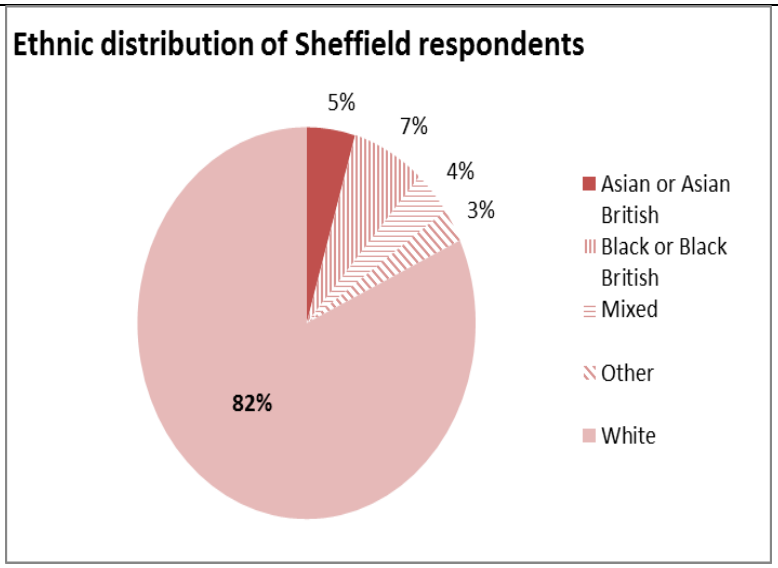
Ethnicity

82% of the sample described themselves as "white" (compared with 89% in the national survey).

5% and 7% described themselves as Asian/Asian British or Black or Black British respectively.

The ethnicity profile of respondents was somewhat different from that of the HIS which had a notably smaller proportion of white clients (68%).

Therefore we note that the sample did not reflect the ethnic profile of HIS users.



Ethnic distribution of Housing Independence Service clients

Asian/Asian British	8%
Black/Black British	11%
Gypsy/Romany/traveller	1%
Mixed/Other	13%
White	68%

Sleeping arrangements

When asked where they were currently sleeping, a large proportion said they were in 2nd stage / supported accommodation[13]. However, it was interesting to note that a notable proportion of the 'other' category included people who perceived themselves to be living in their "own home" when this was found to be some form of supported temporary tenancy when respondents were prompted further.

Self-reported sleeping status

2nd stage/supported accommodation	44%
Hostel	22%
Sleeping on somebody's sofa/floor	2%
Sleeping rough on streets/parks	3%
Squatting	0%
Other	28%

[13] The definition used in the prompt cards was 'Supported accommodation is often used by those moving on from 'first stage' direct access hostels. These projects vary in length of stay and levels of support provided'.

Disability

Just under half of all respondents considered themselves to have a disability. In the national homeless audit, 36% reported any kind of disability.

It is worthy to note that the highest disclosed 'disability' was Mental Health.

In Sheffield the reported type(s) of disability were as shown opposite.

Type of disability	n	% of all respondents (n=219)	% of those reporting a disability (n=101)
Mental Health	71	32%	70%
Mobility	29	13%	29%
Learning Disability	17	8%	17%
Long term condition	15	7%	15%
Sensory	6	3%	6%

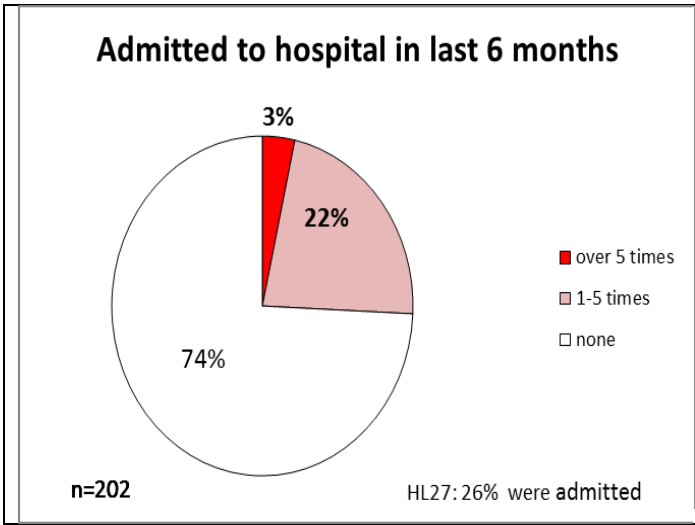
*respondents may have reported more than one disability

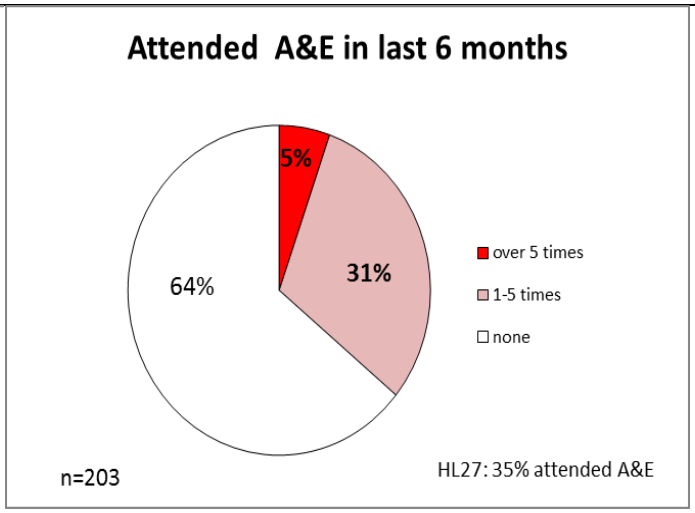
Section 5: Access to health services

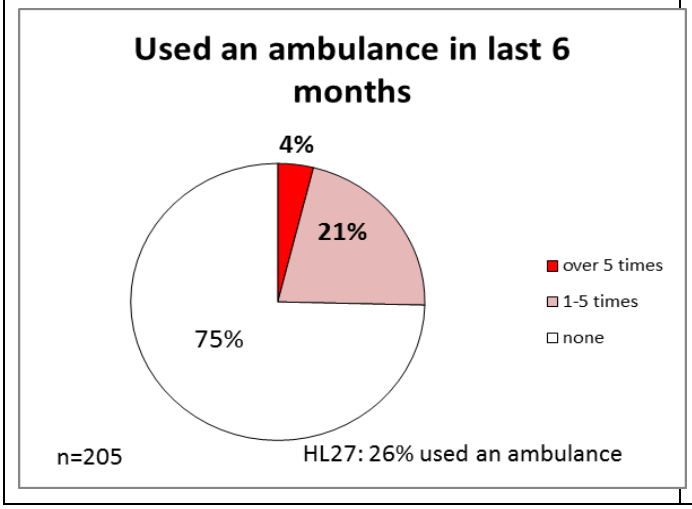
Nationally, homeless people are heavy users of health services, with the number of A&E visits and hospital admissions per homeless person four times higher than for the general public[14].

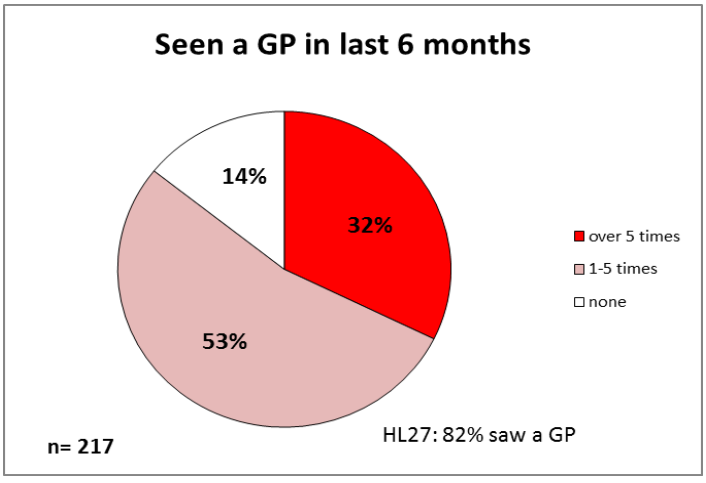
In Sheffield, individuals experiencing homelessness are heavy users of acute health services, a situation that has significant cost implications for the NHS. The latest data indicates that the number of A&E visits and hospital admissions per homeless person is also four times higher than for the general public. It is clear that this will have direct costs and implications for the NHS and the Sheffield Clinical Commissioning Group.

The results of the Sheffield audit for use of, and access to, health services closely mirrors that of the National Homeless Link report[15]. There was almost no difference in the number of hospital admissions, A&E attendances, ambulance usage or GP contacts between the Sheffield and national populations.









[14] See Department of Health, 'Healthcare for single homeless people', (2010): 'http://www.dhcarenetworks.org.uk/_library/Resources/Housing/Support_materials/Other_reports_and_guidance/Healthcare_for_single_homeless_people.pdf

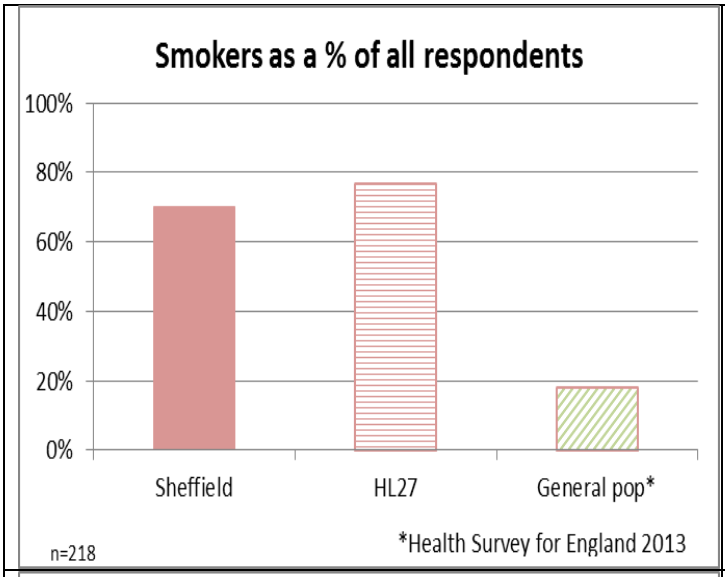
[15] The Unhealthy State of Homelessness, Health Audit Results 2014, Homeless Link

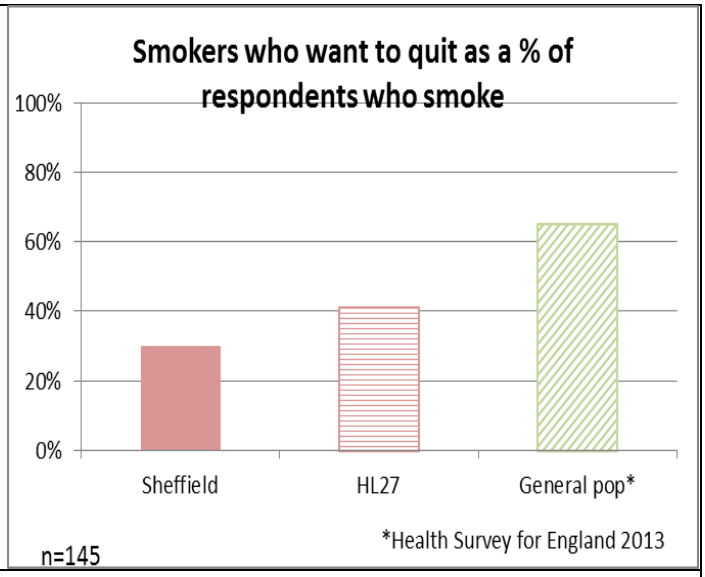
Section 5: Health behaviours

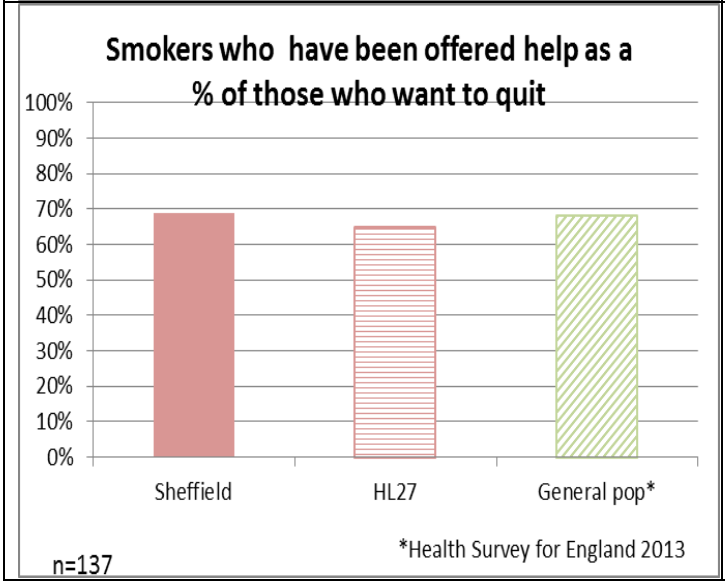
Our local data also supports national evidence that being homeless can make it much harder to have a healthy lifestyle. High levels of smoking and poor diets are likely to make existing physical and mental health more difficult to overcome and could lead to health issues in later life and contribute to preventative early mortality. Supporting homeless people to change risky health behaviours and support recovery is clearly a need. Addressing this need should take into account the relationship between the wider determinants of health (housing, education, employment, poverty etc.) and health choices.

Smoking

Prevalence of smoking is over 3 times that of the general population with the numbers who want to quit half that of the general smoking population.





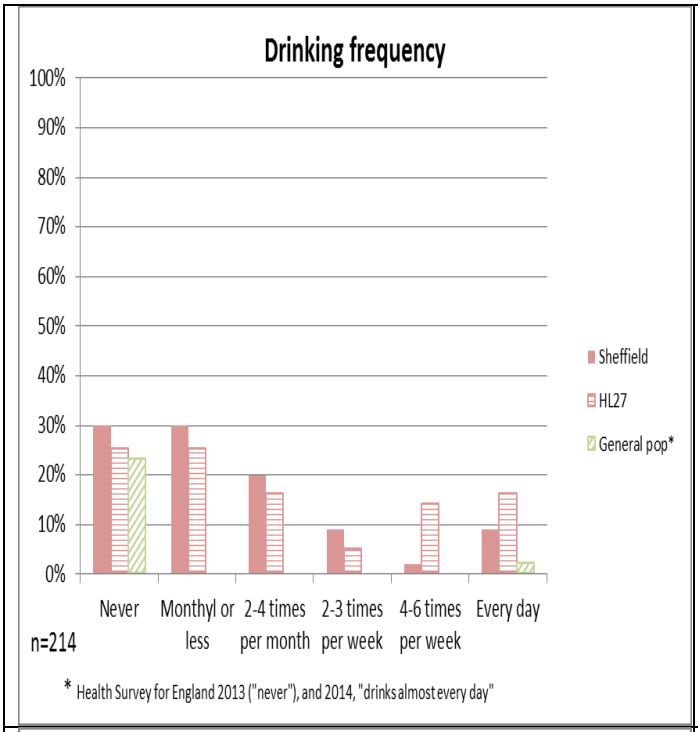


Whilst self-reported smoking prevalence is considerably higher amongst the homeless population when compared with the general population, homeless smokers are less likely to want to quit.

However, there appears to be an equitable level of support given to those who smoke, regardless of their homeless status.

Alcohol

Self-reported alcohol use is less than that reported nationally and the percentage in recovery from an alcohol problem is also less.

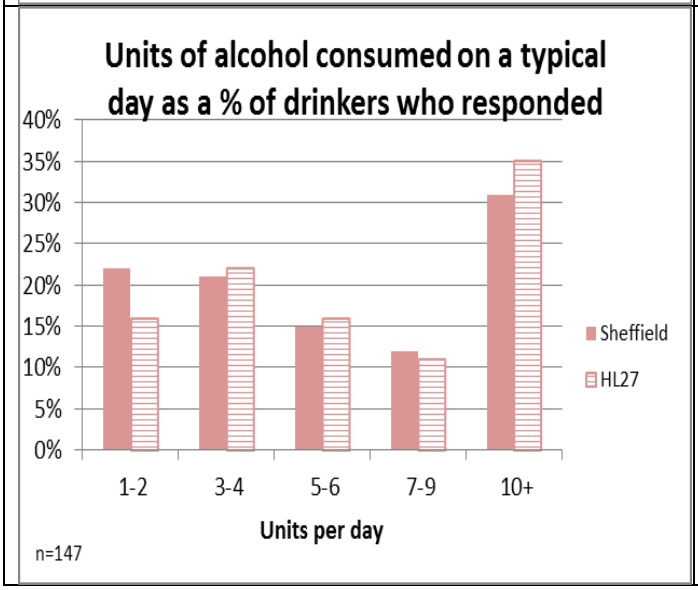


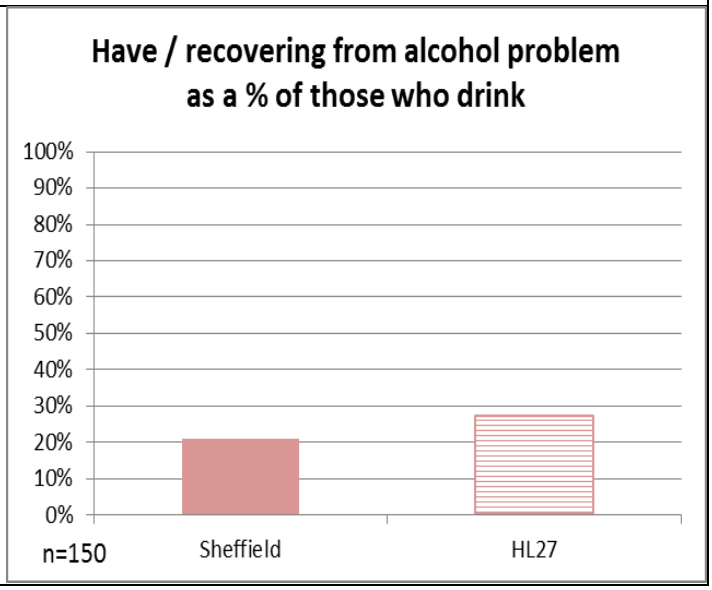
Use of alcohol

Almost one third of the Sheffield sample said that they never drink alcohol. Whilst this figure appears surprising, it is only slightly higher than the national audit.

Amongst those who do drink, around one third can be classed as “high risk drinkers”, consuming at least 10 units per day. When looking at the units of alcohol consumed on a typical day (as a percentage of drinkers who responded) we see that the level of consumption 10+ units per day is around 30% of those who responded (n=147).Overall, there appear to be fewer “high risk drinkers” in Sheffield compared to the national audit.

Around one fifth of drinkers report recovering from an alcohol problem. Again, this is similar to the national audit.



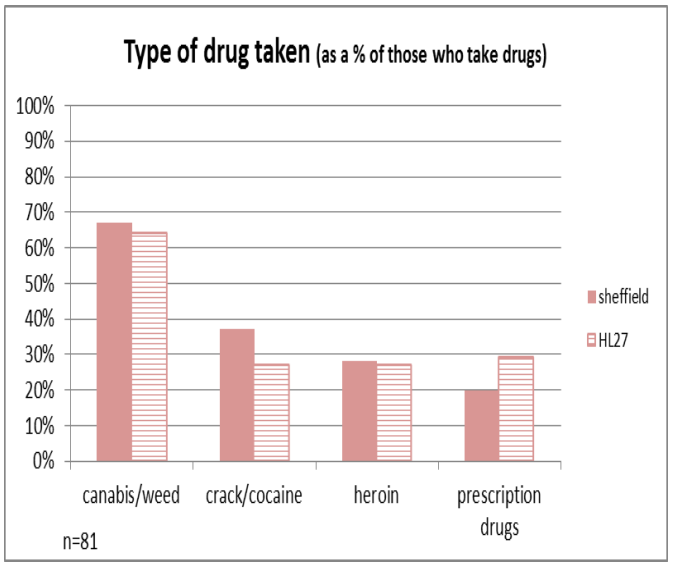


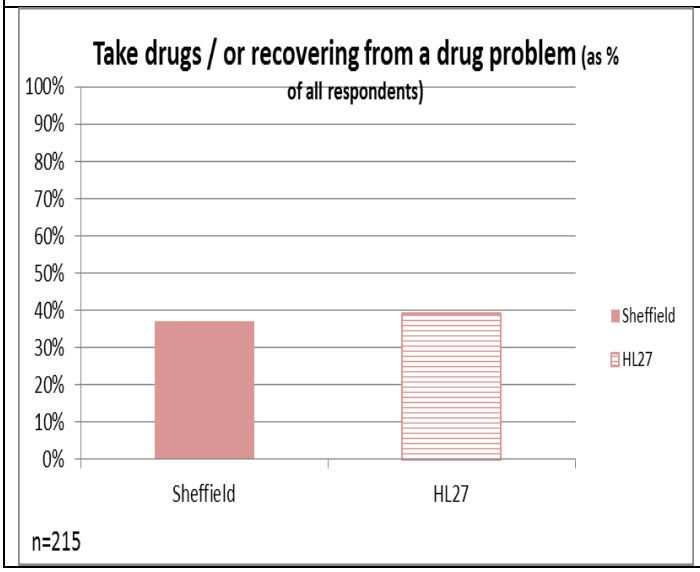
Sheffield’s draft alcohol strategy reflects on the fact that people from deprived socio economic groups (and particularly men) are more likely to experience ill health through alcohol use or misuse. This pattern in reflected and reinforced within this Health Needs Audit and links to the section on Social Determinants covered in Section 9.

Substance misuse

Drug use

For substance misuse, we see a similar pattern as that reported nationally except for the percentage using crack/cocaine where the Sheffield percentage is higher. It should also be noted that cannabis appears to be the most often used drug for many who participated in the survey.





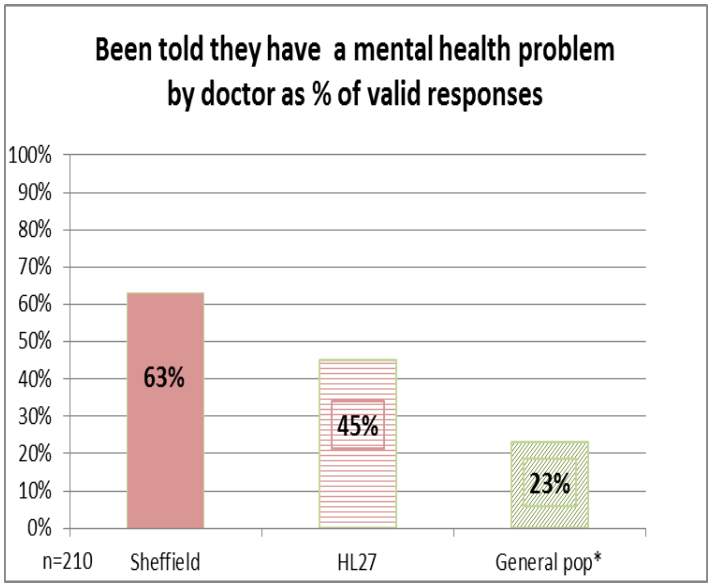
Around 38% of all respondents in both the Sheffield audit and in the national homeless audit said that they take drugs or were recovering from a drug problem.

Section 6: Health conditions

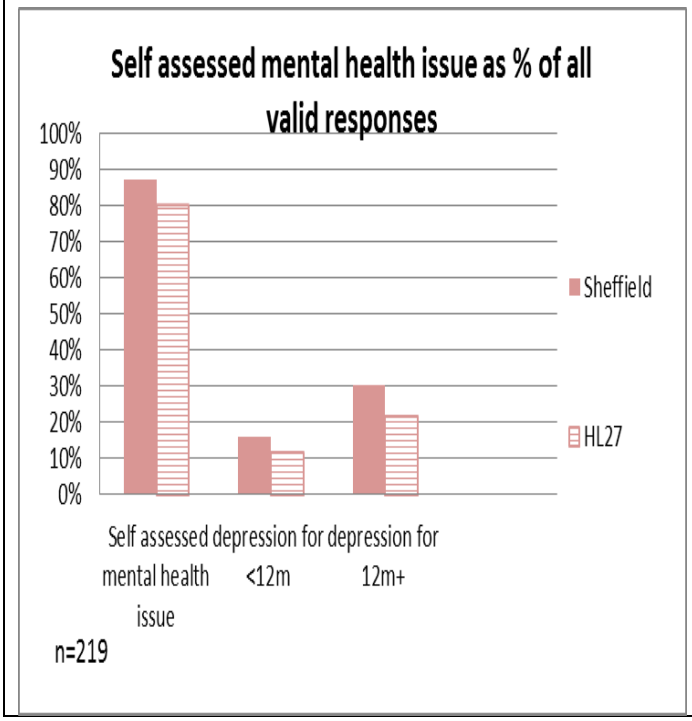
Our data shows that homeless people experience high levels of stress, anxiety and other signs of poor mental health. The proportion of homeless people with diagnosed mental health problems (63%) is over double that of the general population (around 25%) and is higher than the national audit of homeless people (44%), particularly for depression.

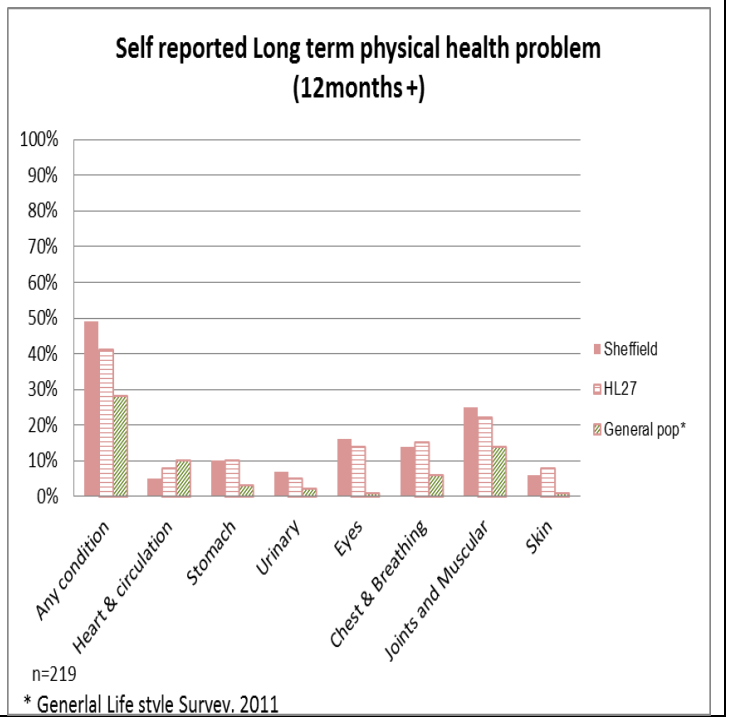
Long term conditions

Available comparable data shows that almost all long-term physical health problems are more prevalent in the homeless population than in the general public. An exception is heart and circulation issues. This could be because older people are more likely to develop heart problems, and the average age of people using homelessness services is much lower. If we include responses that cover short term health problems reported by homeless people, the prevalence of physical health problems is even greater.



*Adult Psychiatric Morbidity Survey 2007, at least 1 diagnosed psychiatric disorder in last year





Section 7: Screening and Immunisations

Homeless people are at greater risk of developing TB, HIV and Hepatitis C than the general population. A systematic review[16] (Beijer et al. 2012) showed that in the UK, the prevalence of TB was at least 34 times greater in the homeless population, and the prevalence of HepC was around 50 times greater.

The TB bacteria are more likely to spread in crowded hostel accommodation or settings where homeless people gather to sleep or socialise. Rough sleeping, cold, poor nutrition and drink or drug abuse place stress on the immune system that increase the likelihood that exposure to TB will go on to develop the illness. Homeless people may be less likely to access help through failing to recognise the seriousness of their symptoms, and because of difficulty in making contact with services. Ongoing transmission in shelters is a particular feature of TB amongst the homeless population. When detected, homeless TB cases tend to spend longer in hospital.

For those already diagnosed with HIV, the disruption to everyday routine brought about by homelessness makes adherence to a medication regime more difficult and therefore increases the likelihood of their condition worsening. Placing homeless people with HIV in shared accommodation brings about increased risk of discrimination by co-residents. This may increase the homeless person's feelings of isolation and stigmatisation, making storage of medication more difficult, self-management of their condition more difficult, with the result that they may attempt to conceal their health needs.

Access to screening is therefore a key issue for Public Health and preventative services. Strategies to decrease TB incidence in homeless populations include increasing case detection, mandatory screening in shelters and using incentives to improve compliance with treatment. Sheffield's substance misuse services offer full screening and vaccination for Hep B, screening for Hep C and referral for treatment, and also offer flu jabs for the vulnerable clients in their services through partnership with CCG. NICE (2013) recommends a "whole system approach" illustrating how local authorities should work with the NHS and Public Health England to support informed commissioning that meets the needs of homeless people[17,18] . NICE recommended active case finding in places where homeless people congregate and as part of cold weather initiatives. Combining active case finding with measures to improve treatment compliance was found to be cost effective.

[16] Beijer et al (2012), Prevalence of tuberculosis, hepatitis C virus, and HIV in homeless people: a systematic review and meta-analysis, Lancet Infect Dis. 2012 Nov;12(11):859-70. doi: 10.1016/S1473-3099(12)70177-9. Epub 2012 Aug 20.

[17] NICE (2013), Tuberculosis in vulnerable groups, http://www.nice.org.uk/advice/lgb11/chapter/Introduction, (accessed 19/01/2016)

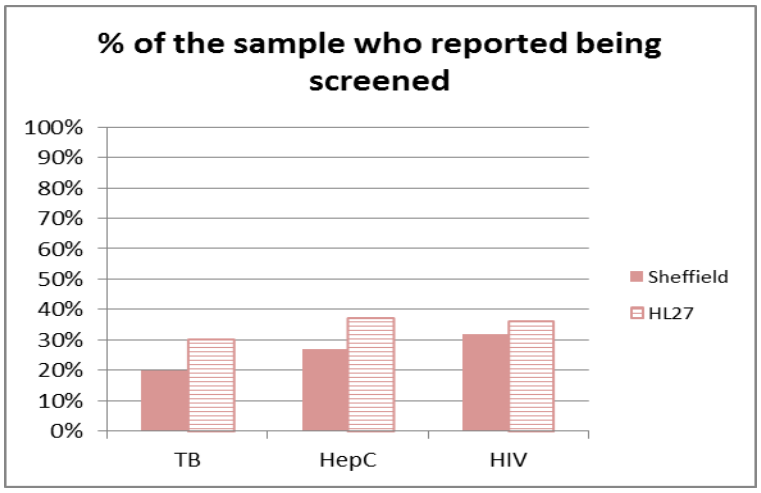
[18] NICE (2013) Press release: 'Providing shelter for homeless people with tuberculosis: just one way local government can help tackle TB' https://www.nice.org.uk/news/press-and-media/providing-shelter-for-homeless-people-with-tuberculosis-just-one-way-local-government-can-help-tackle-tb-says-nice
(accessed 19/01/2016)

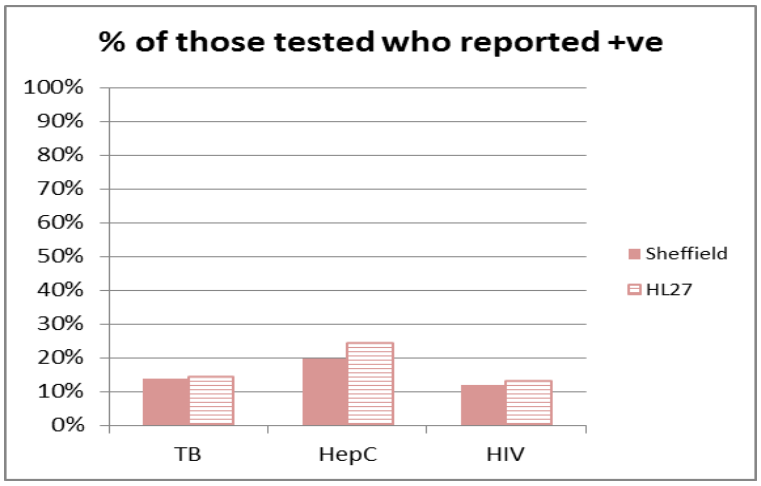
Screening

TB: Overall, 20% of respondents reported that they had been tested for TB. In comparison, the national audit found that 30% had been tested. In the Sheffield audit, 14% of those who were tested said that their test had been positive, indicating TB. This was the same as the national homeless audit.

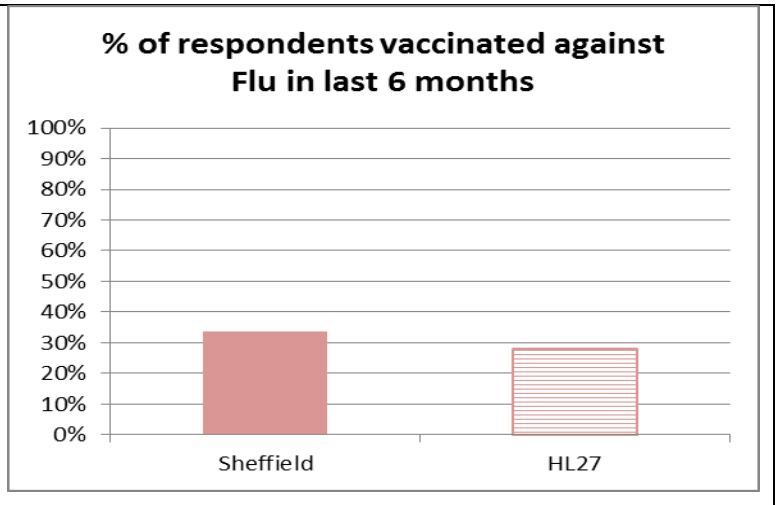
HepC: Just over a quarter of those who responded, said that they had been screened for HepC. This was slightly less than the national picture. In Sheffield, 20% of those screened were found to be positive, which was a slightly lower rate than the national audit

HIV: A slightly lower percentage of Sheffield homeless (32%) reported being screened than the national audit. Rates of positive detection were broadly similar at about 12% of those screened.





FLU: The self-reported rate of flu vaccination amongst Sheffield homeless (34%) was slightly higher than the national audit.



Section 8: Is more help needed?

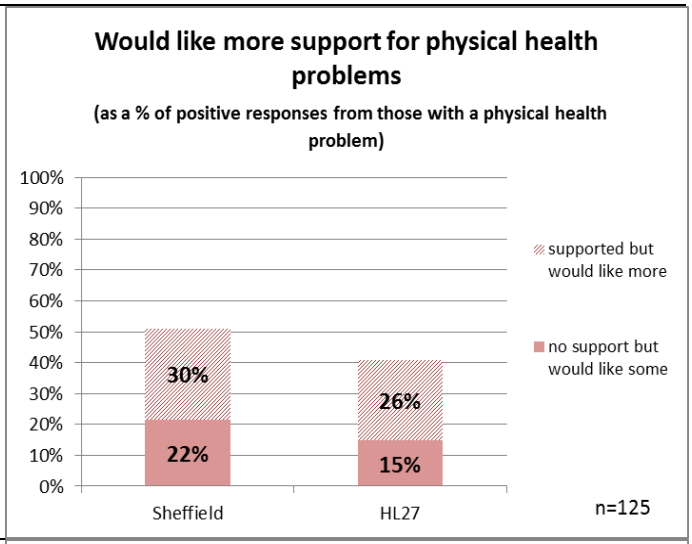
While many homeless people receive help, others do not. Some clients reported that they were receiving support for some of their health needs, but not for other conditions they experience.

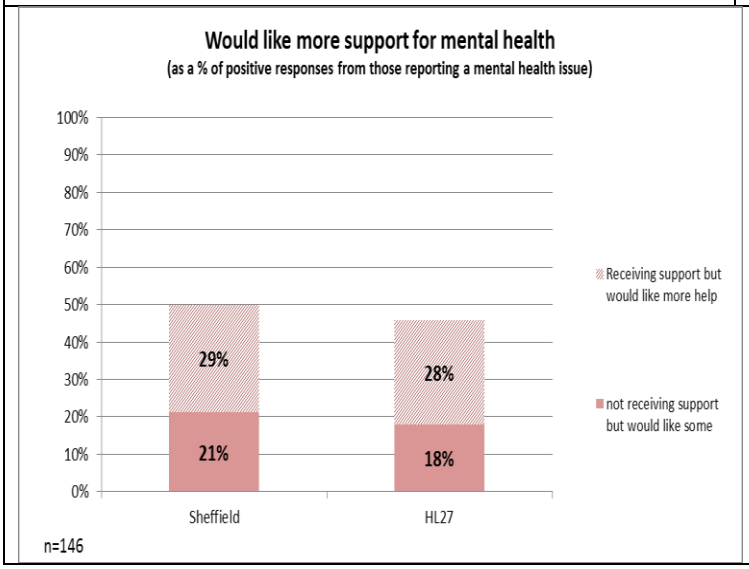
Support needs

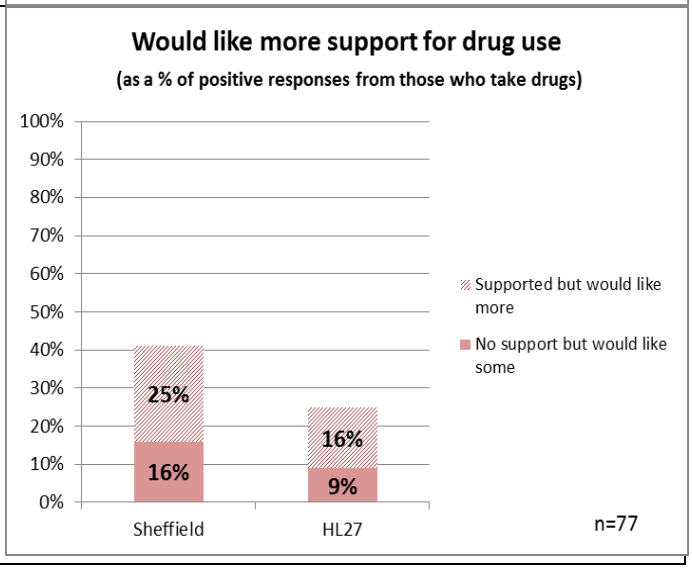
Around two-thirds of homeless people with physical health problems were receiving support, although many of these people said they needed more help. 22% of those surveyed were not receiving support but said they would like to.

Of those with mental health issues, just over a third of those already receiving some form of support would like more help, and close to one in five do not receive any support which suggests there are still significant gaps to address.

Most homeless people who have a drug use issue and would like support seem to be receiving it, and positively reported that it is meeting their needs. However, around a quarter of homeless people that receive support said they would like more.







Section 9: Severe and Multiple Disadvantage

For some homeless people, their homelessness is merely one indicator of the disadvantage they may face. Work by the Lankelly Chase Foundation, Mapping severe and Multiple Disadvantage (2015)[19] attempts to create the clearest possible quantitative picture possible nationally of the disadvantage that individuals and families can face.

In their Hard Edges report they looked at the prevalence of adults who are accessing Homeless, Offending and Substance Misuse services to help understand the complexity and 'compounding' of need faced by some adults and families. The data below gives an illustration of the number of people from the 219 individuals who completed the questionnaire who are accessing 2 (SMD2) or all 3 (SMD3) services.

Multiple disadvantage

When compared with Lankelly Chase national prevalence rates of 4.2 per hundred for SMD2 and 1.5 per hundred for SMD3 people who participated in the survey were around 10 times more likely to be within the potential cohorts of Sheffield adults who fall within the SMD2/3 categories.

This illustrates the effect of 'compounding' on the individuals and the multiple challenges and needs homeless people face.

Number of people accessing all three services (SMD3)

Homelessness & Substance misuse & offending	n	With diagnosed MH
Left prison within past 12 months	6	4
Left prison more than 12 months ago	24	15

Number of people accessing 2 services (SMD2)

Homeless and Offending	n	With diagnosed MH
Left prison within past 12 months	10	6
Left prison more than 12 months ago	30	19
Homelessness & Substance misuse		
*Take any drugs or recovering from a drug problem / have **or** recovering from an alcohol problem*	81	51

[19] Lankelly Chase Foundations, Hard Edges Mapping Severe and Multiple Disadvantage – England. G Bramley and S Patrick, 2015

Section 10: Social Determinants:

Health is determined by an interconnected and complex range of factors including biological, behavioural, and environmental factors. The general socio-economic, cultural and environmental conditions of society will have a profound impact on the living and working conditions experienced by particular groups of people in that society including the Homeless. Similarly, these broader 'social determinants' of health along with social and community networks will shape individual lifestyle factors that are important for health (e.g., exercise, nutrition, smoking and drug use)[20].

They influence the types and quantity of food we can access, our risk of exposure to infectious diseases, the education we receive, the type and quality of housing we can afford, the types of employment that may be available to us, our opportunities for leisure activities, our security and safety, our access to social networks and to timely and effective health care. There are, however, some stark inequalities within Sheffield with regard to the ability of different groups in society (e.g., people living in poverty, people from some minority ethnic communities, people with disabilities) to access the types of living conditions that promote positive health.

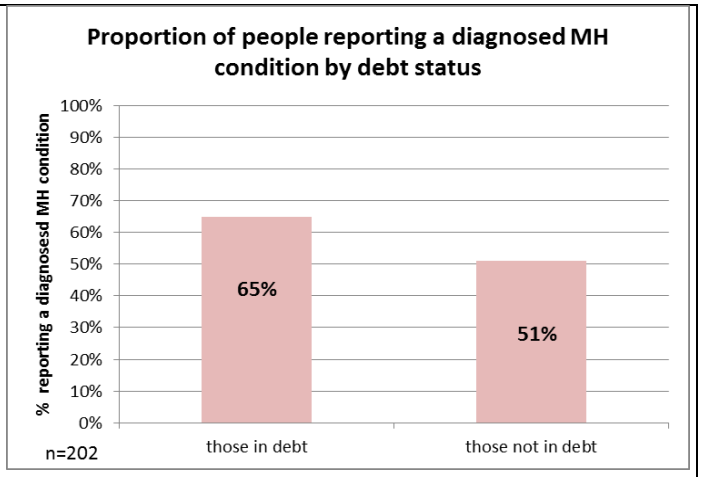
Of particular relevance to understanding the health inequalities experienced by people who are homeless is the role of social institutions in addressing discriminatory cultural and social attitude which in turn would improve the access of homeless people to living conditions that are associated with better health (e.g., better education; wealth; autonomy and power; better quality housing; secure and rewarding employment; access to timely and effective health care).

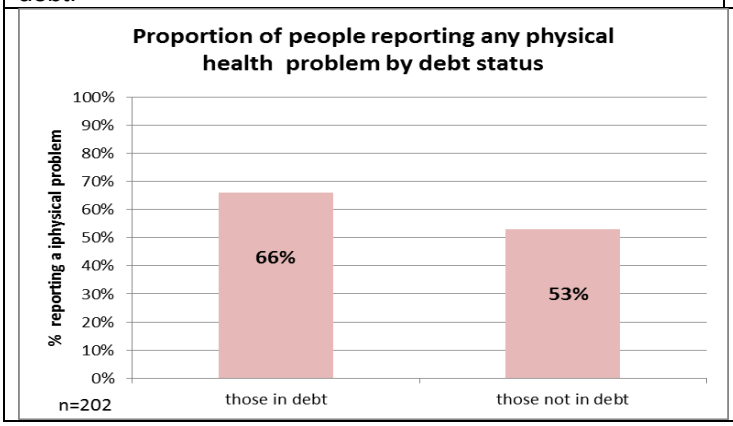
Debt

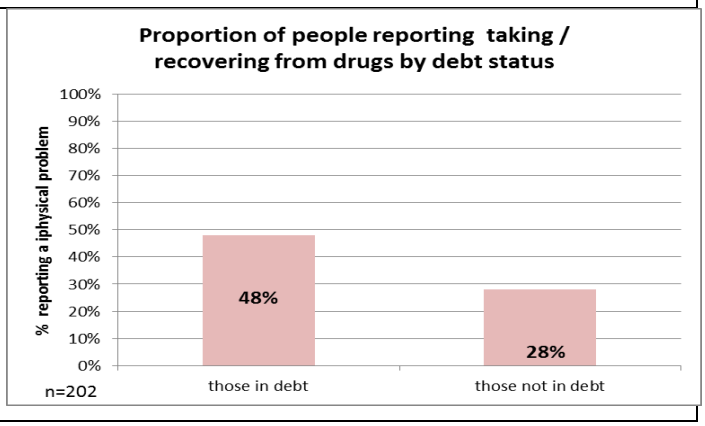
Just under half of all respondents reported that they were in debt. For this group, the types of debt are shown in the table below.

Rent	67%
Doorstep lending	16%
Friends, family, peers	12%
Dealers (mainly drugs)	9%

Those in debt reported a higher level of diagnosed mental health problems (65%) than those who were not in debt (51%). Those in debt also reported higher levels of physical health problems and drug use, than those not in debt.







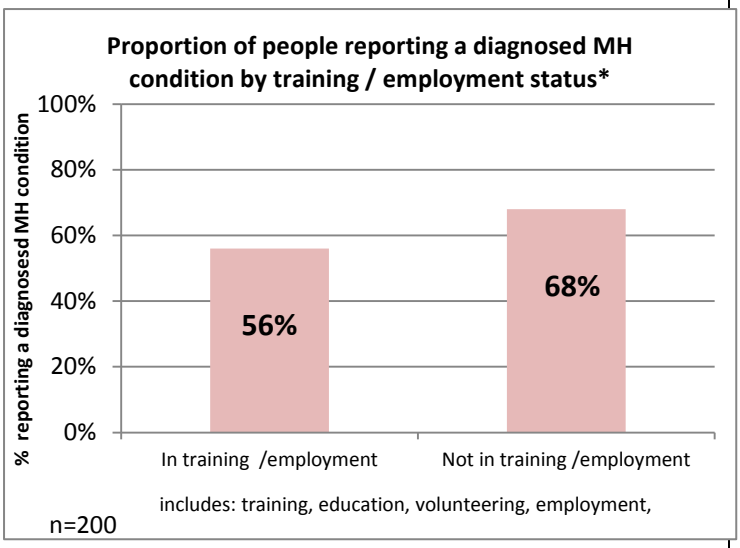
[20] Health Inequalities & People with Learning Disabilities in the UK: 2012 Eric Emerson, Susannah Baines, Lindsay Allerton and Vicki Welch

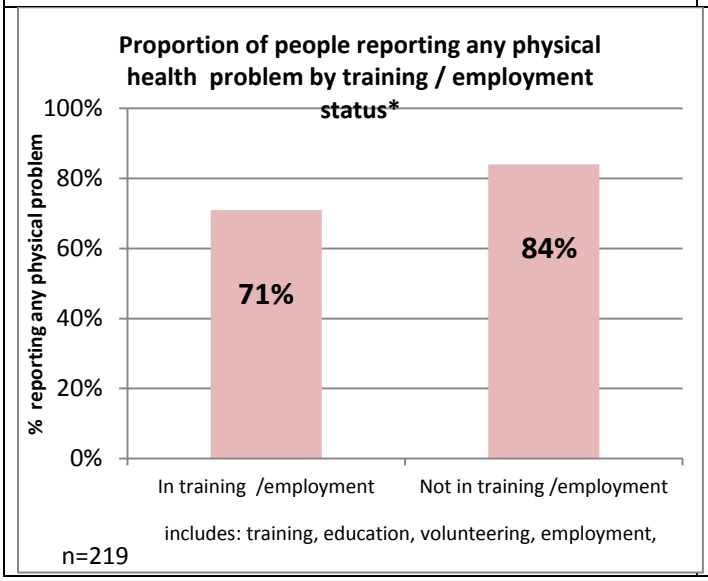
Background	Food Banks
21% said they have dependent children living with them (Over half of these were from 2 of the provider organisations). 5% had served in the armed forces 91% said their migration status was UK resident. (93% in the national survey)	46% of men and 39 % of women respondents had used a food bank in the last 6 months (local Question)

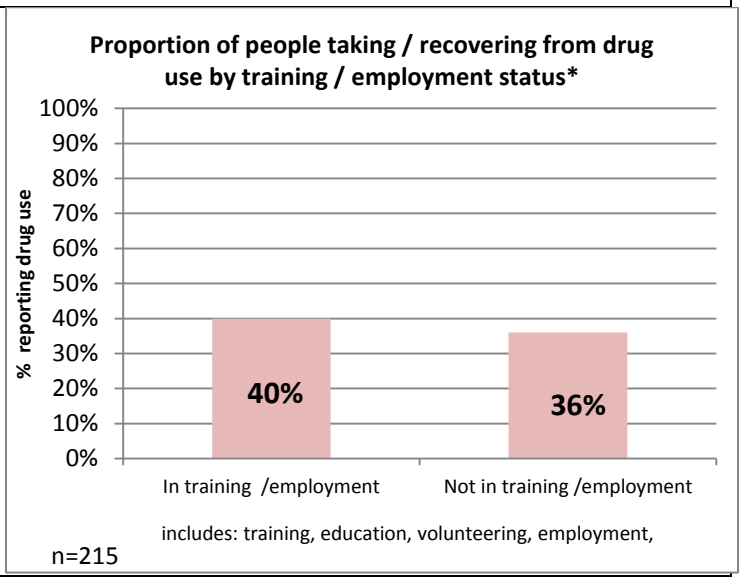
Training and Education

	Sheffield	HL27
In training or education	16%	17%
Volunteering	14%	13%
In employment	9%	6%
Accessing guidance around work or training	21%	30%

There is an association between those who are not involved in any training, education, volunteering or access to guidance around these and the prevalence of both mental health problems and physical problems. However drug use is slightly more prevalent amongst those who are engaged in these activities.

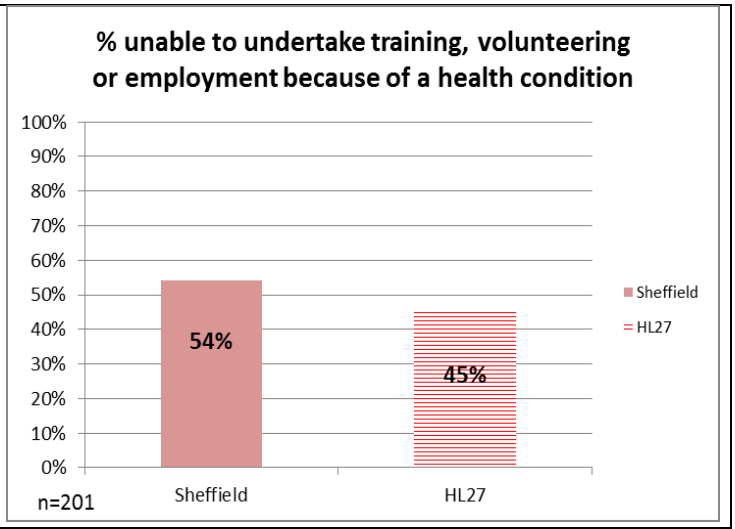






Access to Education, Employment and Training

A slightly greater proportion of the Sheffield homeless are unable to access training, employment or volunteering opportunities because of their health, in comparison with the national audit.



Offending

The percentage of people who took part in the audit who were currently working with probation services was half of that of the national response. This is not a surprise when considering that the number of people who have left prison in the last 12 months is also substantially lower than the national figure. This is probably a reflection that they access the Sheffield Offender Service who were not included in the survey.

It is interesting to note that the percentage who left prison more than 12 months ago is the same as the national picture.

	Sheffield	HL27
currently working with probation service	7%	15%
left prison in the last 12 months	5%	12%
left prison more than 12 months ago	14%	14%
left care services for young people within the last 5 years	5%	5%

Section 11: Method:

In May 2015 a steering group was established to oversee the delivery of a Health Needs Audit/Assessment. The members were Public Health (Communities, Commissioning and the Research and Intelligence Team), the Clinical Commissioning Group (CCG), the Drug and Alcohol Coordination Team, the Housing Independence Service and Housing Options Service

An event on the 19th June 2015 was held with key stakeholders and provider organisations (commissioned and non-commissioned) to test the feasibility of undertaking a questionnaire based approach using the Homeless Link Audit. There was general agreement to progress the proposed approach and services committed to undertaking the questionnaires with their clients. A number of Sheffield specific questions were also included in the Questionnaire[21] and it was agreed that people completing the questionnaire would be given a £10 voucher in recognition of their time and effort (though it was recognised that this could lead to selection bias).

During the latter part of August and during September 2015, 300 questionnaires were distributed to providers at their request. In all 219 completed questionnaires were returned and uploaded on the Homeless Link Data Set with 12 excluded due to a late return.

Following the data being uploaded, a 'Reality Checking Event' was held on November 20th 2015 to identify which data could be worked with and which data needed to be excluded on the grounds of bias. As a result a number of questions and responses were given a health warning, though no responses were excluded. Where appropriate this 'Health Warning' is flagged in the relevant sections of this report with an explanation of the concern.

In February 2016, a report alongside the data was presented to a range of stakeholders, service providers and interested parties for comment. Feedback from this event has been referenced within this report where appropriate.

Target of responses

The aim was to achieve a target of 300 responses and for the age / sex distribution of these responses to be as close as possible to the profile of the Housing Independence Service. This would have broadly represented a 10% sample of total annual HIS service users[22]. The 300 expected responses were therefore apportioned in accordance with the age/sex distribution of the HIS to arrive at an expected target. In total 300 questionnaires were distributed, with 219 being included in the survey.[23]

[21] Addition questions were agreed for: Access to screening, armed forces membership and use of mobile phones, debt and use of food banks
[22] Just over 3,800 people sought support in 2014-15 including single people and families. Source: Housing Independence Commissioning Strategy 2016 – 2020 'Supporting Independence'
[23] A number of completed questionnaires were not included due to late return.

Age sex profile of Housing Independence Service (His) clients

	Female	Male	Total
16-17	5%	3%	8%
18-25	18%	17%	35%
26-35	12%	14%	27%
36-45	6%	12%	18%
46-55	4%	6%	10%
56-65	1%	1%	2%
66-75	0%	0%	0%
75+	0%	0%	0%
Total	**46%**	**54%**	**100%**

Target profile of respondents (based on apportioning a target of 300 according to HIS profile)

Target responses = 300

	Female	Male	Total
16-17	14	10	24
18-25	54	51	105
26-35	37	43	80
36-45	19	35	54
46-55	12	18	30
56-65	2	4	6
66-75	0	1	1
Over 75	0	0	0
Total	**138**	**162**	**300**