Homelessness: *Factsheet*

Tower Hamlets Joint Strategic Needs Assessment 2010-2011

Executive Summary

Homelessness has historically been and continues to be a problem in Tower Hamlets. In 2008 the Tower Hamlets Homelessness Strategy was launched to combat the issue on a partnership basis. The work plan associated with this strategy is currently being refreshed in light of likely future developments in funding and benefits rules. There is a continuing need for partnership working to address homelessness and the effective working of the Homeless Partnership Board remains of importance. The three key strands of the strategy remain critical;

- Prevent homelessness
- Provide accommodation for those who are homeless
- Support those who are homeless or at risk of homelessness.

Within the work plan there are several actions to better link health services with homeless services, and it is anticipated the refresh of the work plan will continue and refine this theme.

Recommendations

- Continue to contribute fully to the Homeless Partnership Board;
- For rough sleepers support the pilot of the London Pathway model at the Royal London in Whitechapel in Autumn 2011 and its implementation;
- Support the Tower Hamlets hostel needs assessment process;
- Support the provision of primary healthcare to homeless patients via a homeless practice such as Health E1.

1. What is homelessness?

Homelessness is often the end point and consequence of multiple disadvantages. In trying to avoid narrow definitions of homelessness this fact sheet includes hostel dwellers and the insecurely housed as well as rough sleepers.

The term 'insecurely housed' includes:

- Single homeless – people who are not part of a family or do not have dependent children;
- 'Hidden Homeless' – e.g. people staying with extended family in overcrowded conditions that meet the legal definition of homelessness, and have not been provided with accommodation by their local authority.

The broad legal definition of homeless under which Local Authorities have a duty to act is that either there is: no accommodation someone is entitled to occupy or it is not reasonable for people to continue to occupy their accommodation and are judged to be in priority need.

It is important to note that for homeless groups health outcomes are poor; for example the average age of death of a homeless person is between 40 and 42 years[1], and a homeless drug user admitted to hospital is seven times more likely to die over the next five years than a housed drug user admitted with the same medical problem[2]. Homeless children and young people are likely to enter such a cycle without early intervention.

2. What is the local picture?

At the November 2009 street count, the number of rough sleepers recorded in Tower Hamlets was 7. This was the 12th highest figure nationally[3]. However, this may not be the best estimate due to a much more complex local situation with transient populations sleeping rough for short periods of time.

The Combined Homeless and Information Network (CHAIN) is a database for people who work with rough sleepers and the street population in London[4]. 279 verified rough sleepers were contacted by services in Tower Hamlets during the year 2009/2010. This was an increase from 230 the previous year and continues a consistent increased trend over the last 3 years (see below).

[1] DH Office of the Chief Analyst (March 2010) *Healthcare for Single Homeless People* Department of Health

[2] Morrison DS. *Homelessness as an independent risk factor for mortality: results from a retrospective cohort study*. International Journal of Epidemiology 2009; 38:877–883

[3] http://www.communities.gov.uk/

[4] CHAIN is a database for people who work with rough sleepers and the street population in London. The system is used to help workers share information to ensure that they act as quickly and effectively as possible to help those they encounter. Reports based on information held in CHAIN help decision-makers monitor the needs of rough sleepers in London.

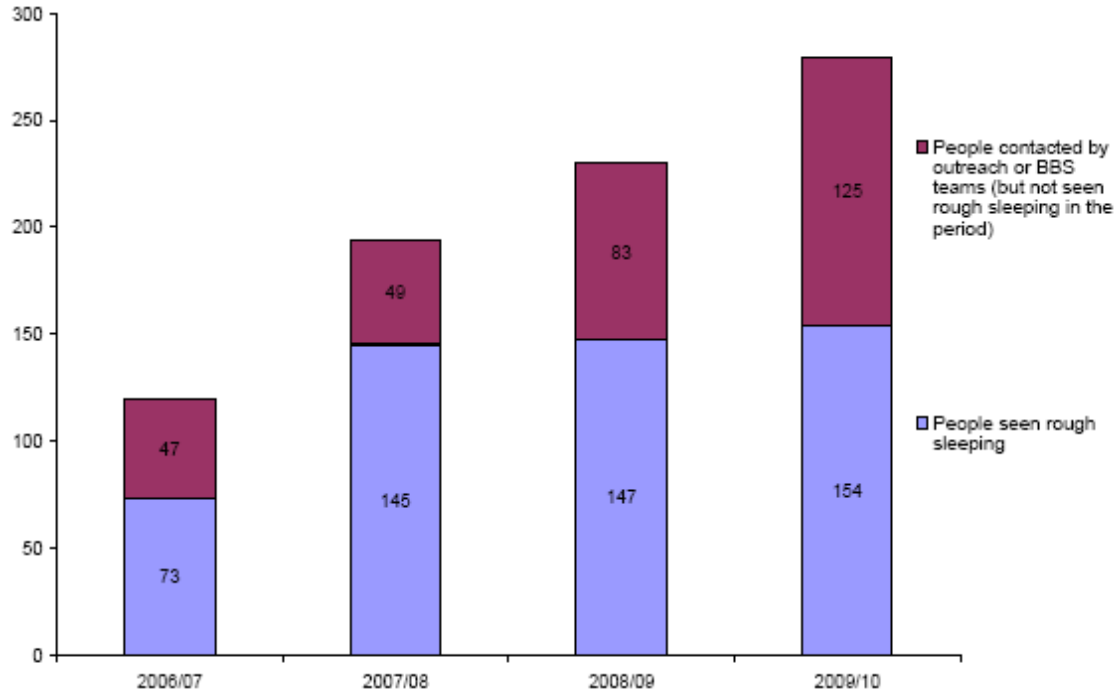

Figure 1 - People seen by outreach or building based (BBS) teams in the year - rough sleeping or contacted either on the streets or in services

Source: CHAIN Annual Report for Tower Hamlets April 2009-March 2010

Profiling of rough sleeping in Tower Hamlets

The majority of people contacted in Tower Hamlets in 2009/10 are White (75%), most of who are White British. 12% of people contacted are Black and 4% are Asian. The ethnic origin of those contacted in Tower Hamlets in 2009/10 is consistent with the previous three years.

Of the 84 people contacted in 2009/10 with an ethnic origin of White - Other, 53 are CEE nationals[5].

[5] CHAIN Annual Report for Tower Hamlets April 2009-March 2010

[6] CHAIN Annual Report for Tower Hamlets April 2009-March 2010
[7] Cited in The Pathfinder Needs Assessment, 2011
[8] Pathway Needs Assessment, 2011
[9] Data taken from:
http://www.communities.gov.uk/housing/housingresearch/housingstatistics/housingstatisticsby/homelessnessstatistics/livetables/
[10] Report of Corporate Director Development & Renewal, June 2010
[11] This is particularly common amongst BME households, with the South Asian community having the greatest number of three generations living in one household amongst all ethnic groups. ODPM, Homelessness and Housing
[12] Reaching Out: Think Family (2007), Social Exclusion Task Force, Cabinet Office, p1

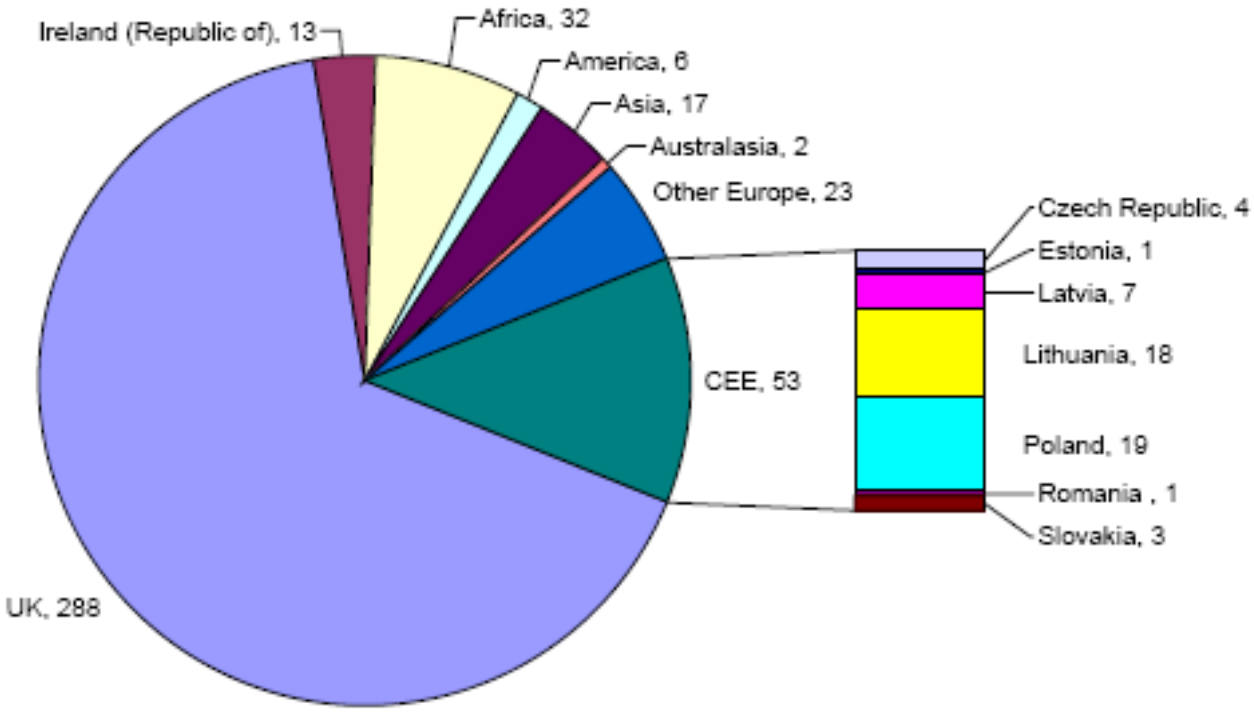

Figure 2 - People contacted by outreach and/or arriving in or departing from accommodation in the year by nationality

Source: CHAIN Annual Report for Tower Hamlets April 2009-March 2010

Base: 434. *Note that the base figure for this graph excludes clients where the nationality is missing or not known (51).*

The complex needs and co-morbidities of rough sleeping homeless groups are also identified in the CHAIN report for Tower Hamlets:

Support Needs	No. of people	%
Alcohol only	63	13%
Drugs only	80	16%
Mental health only	24	5%
Alcohol and drugs	53	11%
Alcohol and mental health	36	7%
Drugs and mental health	23	5%
Alcohol, drugs and mental health	43	9%
All 3 no	42	9%
All 3 not known or not assessed	116	24%
All 3 no, not known or not assessed	5	1%
Total	**485**	**100%**

Figure 3 - Identified client support needs

Source: CHAIN Annual Report for Tower Hamlets April 2009-March 2010

The proportion of people contacted in Tower Hamlets with an alcohol (53%) and drugs (54%) problems is noticeably higher than the proportion across all boroughs in London (alcohol 26%, drugs 36%). Tower Hamlets has a total of 149 rough sleepers recorded in 2009-2010, with 75 of these being new people (flow). In a similar period City saw 338 (145 new), Newham had a total of 18 (16 new) and Hackney a total of 63 with 48 new rough sleepers recorded[6] .

Royal London admissions and A&E attendances for homeless patients

Homeless people attend A&E six times as often as the housed population, are admitted four times as often and stay three times as long. This results in secondary care costs that are eight times higher than average, largely consisting of unscheduled emergency admissions. The Nuffield Trust recently reported an overall increase of 11.8% in emergency admissions in England over the past five years at a cost of £330 million per year[7].

During 2010, 660 homeless patients were admitted on 955 occasions, 524 (79.4%) were admitted only once 78 (11.8%) were admitted twice and 58 (8.8%) more than twice. Of the 295 repeat admissions, 150 were within 28 days of the previous admission. The average number of admissions per patient was 1.45[8] .

As a basic snapshot of demand on homelessness services in 2007, over 4,000 people/households approached the homeless service for assistance, including:

- About 1500 single homeless people (70% male, 30% female) who received advice from Housing Options;
- Over 1000 who received advice about private sector tenancies and legal issues;
- About 300 16-17 year olds;

- Over 400 women with needs around domestic violence.

The number of applicants in 2009/10 making a homeless application remains comparable with previous years. However, local implementation of prevention methods and finding alternatives such as the rent deposit scheme have reduced the number where a full homeless duty was accepted from 850 in 2008/09 to 690 in 2009/10.

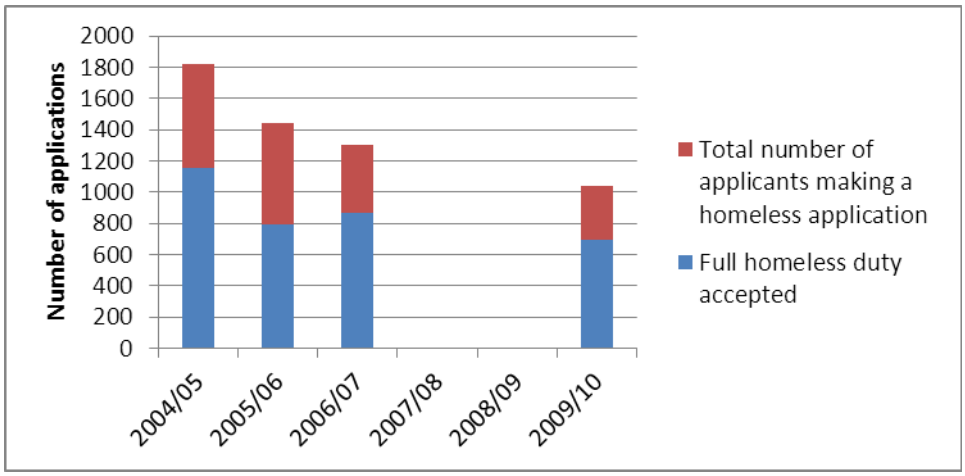

Figure 4: Numbers accepted as being homeless and in priority need[9]

The number of lets to homeless applicants was 899 for 2009/10 compared with 810 in 2008/09. However, this was a lower proportion of all lets (35%) compared with 39% of all lets in 2008/09 and the average of 39% over the previous 5 years.[10]

In 2006-7, 70% of clients accepted for re-housing in Tower Hamlets were from BME groups (Asian 49%, Black 19%) although they make up 49% of the boroughs population. In 2009-10 this was a similar case, with 65% being from Asian or Black backgrounds (Asian 48%, Black 17%). This concurs with trends across London and nationally, with ethnic minorities being over-represented in homeless acceptances. In many ways, the disproportionate number of those from BME communities amongst homeless households in Tower Hamlets could be explained by age, as homeless people are also disproportionately young.

Parental ejection and ejection by friends or relatives represented 60% of all homeless acceptances between 2005 and 2007. Whilst this is the main reason nationally also, representing 37%, it is a much more significant factor in Tower Hamlets. This is attributable partly to the very high levels of overcrowding in the borough and the number of three generation families living in one household[11].

1 in 12 children in Tower Hamlets live in homeless households, young people leaving home feature disproportionately highly amongst homeless presentations. Homelessness increases child vulnerability and it increases the risk of a child being on the Child Protection Register from 1% to 12%.[12] Approximately 60% of 16-17 year olds in housing need are not in education, training or employment, compared to 8% in Tower Hamlets as a whole.

3. What are the effective interventions?

The 'Standards for commissioners and service providers', Faculty of Homeless Health sets out to define the essential qualities required for effective health services for homeless people[13].

[13] Faculty of Homeless Health, 2011

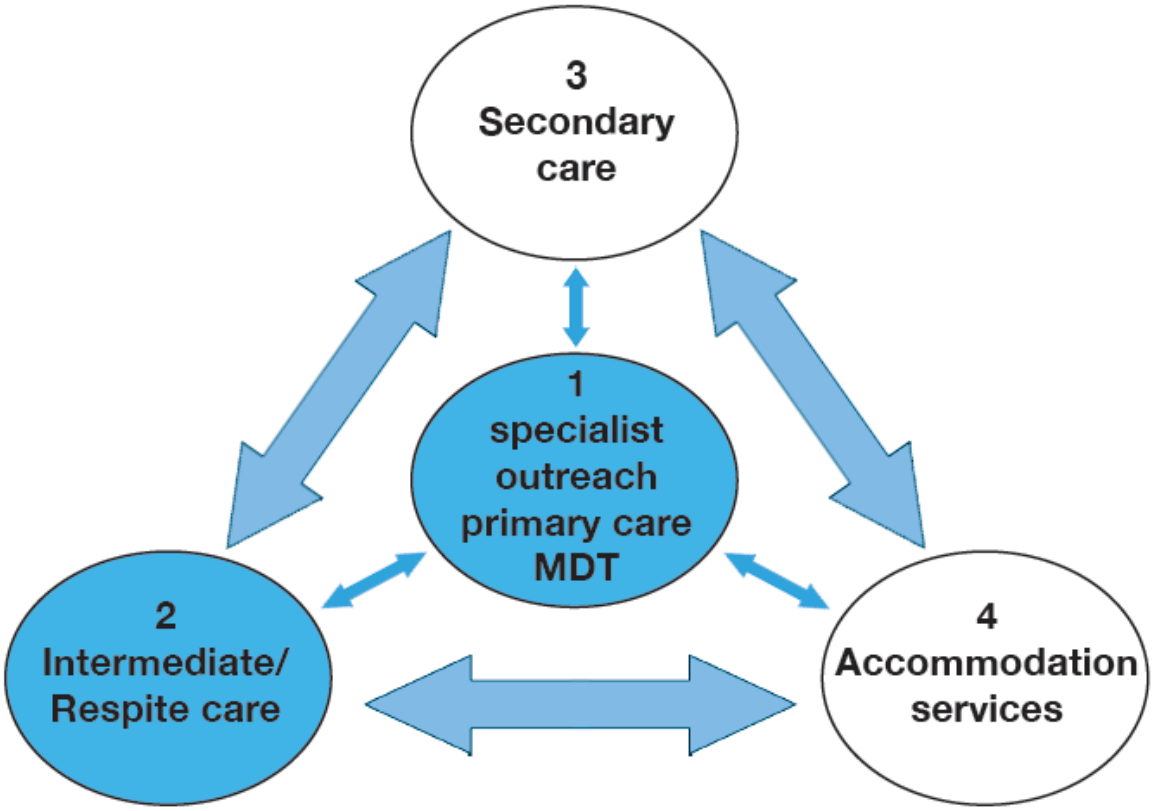

Figure 5 - Integrated approach to commissioning of homeless health services.

Source: Faculty of Homeless Health, 2011.

This highlights the importance of both the multi-disciplinary and the integrated approach required for homeless health services to be effective in meeting needs.

Homeless Prevention
Effective working of partners and the Housing Options and Support Team are required to minimise the numbers of people who become homeless.

Effective partnerships with services
Homeless populations are a vulnerable 'marker' group in several respects; they have poorer health status and some homeless people are at greater risk of harm caused through their addictions, for example, needle sharing. As well as communicable diseases such as TB. It is imperative to ensure that integration between housing and other services is made including mental health and substance misuse services and adult social care which are of particular relevance and importance to this population; other important agencies include enforcement, outreach and discharge from institutions[14]. Effective access to primary care to ensure early treatment is particularly emphasised[15].

Proactive engagement with outreach services
There is a requirement for the need for services to go to clients. This includes embedding services (primary and

[14] HL City Bridge Project, Mungo's D&O, Mungo's HM, DOH GT, CLG
[15] Mungo's D&O, CLG, DOH GT
[16] Mungo's D&O, Mungo's HM, DOH GT

secondary care for mental health and substance misuse) into venues used by clients, including a "housing first" approach; as well as street outreach (both to engage clients and to facilitate assessments)[16].

4. What is being done locally to address this issue?

Locally there is a Tower Hamlets Homelessness strategy[17] and 5 identified central themes; Children, Young People and Families; Supporting vulnerable people; Access to housing; Employment and economic well-being; Excellent public services. This strategy is currently being reviewed and refreshed in light of changes to the financial envelope and changes to housing benefits. The strategy supports early intervention, preventing overcrowding and homelessness by providing access to the right housing options at the right time, methods to support and tackle exclusion. The aims of the strategy are being addressed through the on-going work of the homelessness partnership board which is currently refreshing the homelessness strategy action plan.

To support the rough sleeping populations in Tower Hamlets outlines the outreach teams provided by the local authority, as well as the importance of re-integration. The NHS supports this through the Health E1 practice allowing easy access for homeless populations to register with a GP and the provision of Blood Borne Virus (BBV) and TB outreach services.

The Tower Hamlets Common Housing Register lettings policy was changed in 2010 to give greater priority for overcrowding to reduce the perverse incentive for overcrowded households to present as homeless. The creation of the Housing Options and Support Team in 2008 was intended to improve access to support services and longer term accommodation for homeless people on the basis of need.

In May 2011 a charity called Pathway developed a needs assessment with the aim of exploring the impact of homelessness on the Royal London hospital. Funding for a pilot project has been secured through a NIHR research grant and should commence in the Autumn of 2011. It is important to acknowledge the raft of local voluntary sector organisations, including hostels that work with homeless groups in Tower Hamlets. These include, but are not exclusive to, Look Ahead, Providence Row and The Salvation Army.

5. What evidence is there that we are making a difference?

In 2003, the borough's first homelessness strategy set the two main aims of preventing homelessness and improving services. Prevention services in place now include tenancy support, rent deposit schemes, housing advice and options, mediation and a sanctuary scheme for women at risk of domestic violence. Consequently the number of statutory homeless applications fell by approximately 50% between 2003-2008. There have also been advances in service improvement over the past few years and the homeless service has received accreditation for the Charter Mark standard for excellent customer service.[18]

The number of households in temporary accommodation continues to fall steadily.[19] Numbers in temporary accommodation are mainly a function of the numbers being admitted and the numbers permanently re housed. The reduced acceptances and number of lets to the homeless in 2009/10 has resulted in a steady reduction in overall numbers from 2423 in April 2009 to less than 1900 in April 2010 (see below). However the reduced supply position for 2010/11 may reduce the lettings available to the homeless.

6. What more do we need to know?

- The effect on rates of homeless presentation after the recent lettings policy changes, need to be carefully

[17] http://www.towerhamlets.gov.uk/lgsl/851-900/868_housing_strategy_and_polic/homelessness_strategy.aspx
[18] Homelessness Strategy, Tower Hamlets 2008-2013
[19] Homelessness Strategy, Tower Hamlets 2008-2013

monitored;

- The potential effects of the proposed changes to housing benefit and the funding rules for social housing will need careful consideration once the changes are finalised and the timescales for implementation settled;
- The evaluation results of the Pathway pilot once this work has begun will need to be analysed.

7. What are the priorities for improvement over the next 5 years?

The Tower Hamlets Homelessness Strategy (2008-13) work plan is currently being refreshed in light of likely future developments in funding and benefits rules.

There is a continuing need for partnership working to address homeless and the effective working of the Homeless Partnership board is important. The three key strands of the strategy remain critical;

- Prevent homelessness
- Provide accommodation for those who are homeless
- Support those who are homeless or at risk of homelessness

Improve health care services for homeless patients by adopting the Pathway model if the pilot proves it to be effective and by adoption of the Standards for Homeless health advocated by the Faculty of Homeless Health.

8. Key Contacts

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Date updated:	*December 2011*	**Updated by:**	*Rakhee Lahiri – Public Health Strategist* *Tim Madelin – Senior Public Health Strategist*	**Next Update Due:**	*December 2012*

Date signed off by Senior JSNA Leads:	*Date factsheet signed off by senior JSNA leads from Public Health and LBTH*	**Signed off by (Public Health Lead):**		**Date signed off by Strategic Group:**	*Date factsheet signed off by Strategic Group*	**Sign off by Strategic Group:**	*Name the relevant Strategic Group*
		Signed off by (LBTH Lead):					