



Public Health
England

Protecting and improving the nation's health

Evidence review:

Adults with complex needs (with a particular focus on street begging and street sleeping)

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-leading science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health, and are a distinct delivery organisation with operational autonomy to advise and support government, local authorities and the NHS in a professionally independent manner.

Public Health England
Wellington House
133-155 Waterloo Road
London SE1 8UG
Tel: 020 7654 8000
www.gov.uk/phe
Twitter: [@PHE_uk](https://twitter.com/PHE_uk)
Facebook: www.facebook.com/PublicHealthEngland

Prepared by: Emma Seria-Walker. For queries relating to this document, please contact Emma Seria-Walker: emma.seria-walker@phe.gov.uk



© Crown copyright 2018

You may re-use this information (excluding logos) free of charge in any format or medium, under the terms of the Open Government Licence v3.0. To view this licence, visit [OGL](https://www.ogil.io). Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

Published: January 2018
PHE publications
gateway number: 2017683

PHE supports the UN
Sustainable Development Goals



Contents

About Public Health England	2
Acknowledgements	5
Executive summary	6
1.0 Introduction	8
2.0 Context	8
3.0 Literature review methodology and scope	12
4.0 Definitions	13
Homeless	13
Hidden homeless	13
Multiple Exclusion Homelessness (MEH)	14
Rough sleepers	14
Street homeless	14
Begging	14
5.0 National profile of people who street beg and/or street sleep	15
Street begging	15
Rough sleepers	17
Homelessness more generally	23
Gender, age, ethnicity and learning difficulties	25
Geographic spread	27
Length of time spent on the streets and/or homeless	27
The overlap between street begging and street sleeping	28
6.0 What factors may be driving increases in homelessness?	30
7.0 Why do people street beg and/or street sleep?	32
8.0 The impact of street begging and/or street sleeping	40
The impact on individuals	40
Impact of homelessness on health	40
Impact on children and families	42
Impact on communities	42
9.0 Interventions – what works to prevent/ reduce street begging and street sleeping?	43
Early intervention in the context of homelessness	43
Integrated working and system wide approaches	44
Interventionist approaches Vs non-interventionist approaches	44
Promising interventions	45
Inclusion health	56
Models of homelessness provision	60
Street begging evidence	60
10.0 Impact of enforcement on street begging/street sleeping	62

11.0	Financial costs of homelessness – what is the return on investment?	65	
12.0	Conclusion	68	
	Recommendations		69
	Appendix A:	70	
	Literature search – scope and results	70	
	Appendix B:	72	
	Trends in Rough Sleeping by Local Authority in the South East, 2010-2016	72	
	Appendix C:	77	
	Toolkits, guides and strategies that may be useful	77	
	Westminster Begging Strategy		77
	Westminster Rough Sleeping Strategy		77
	Prevention Opportunities Mapping and Planning Toolkit (PrOMPT)		77
	Psychologically informed services for homeless people – Good Practice Guide		77
	Meeting the psychological and emotional needs of homeless people. Mental Health Good Practice Guide		77
	What it's worth? Guidance on using financial savings analysis in the homeless sector		77
	The impact on health of homelessness: A guide for local authorities		77
	No excuses: under the youth accommodation pathway section		77

Acknowledgements

Thank you very much to all those who provided advice, evidence, support and guidance throughout the development of this piece of work.

In particular, Barbara Norrey from PHE Library Services for undertaking the initial literature search.

Charlotte Matthews, Lisa Wills, Sandra Jerrim, Colin McAllister, Liz Slater, Jason Horsley, Felicity Ridgway, Mark Pirnie, Briony Tatum, Amy McCullough, Alan Knoble, Katy Bartolomeo, Jackie Hall, Cassandra Powers and Martin Buckmaster from Portsmouth and Southampton City Councils for your help in scoping and steering this work.

The Safer Portsmouth Partnership for providing us with access to the work you are doing on those with complex needs.

Dr Nick Maguire from Southampton University for providing your time, knowledge, expertise and research on this topic.

Executive summary

Public Health England South East Centre was asked by Portsmouth and Southampton City Councils to provide an independent review of the literature around homelessness. With particular reference to those who are street homeless and those who street beg to support efforts to prevent and reduce homelessness and the adverse outcomes associated with this.

The purpose of this document is, therefore, to provide an overview of the national picture in relation to homelessness and provide insights into the current evidence base to support action in preventing and reducing homelessness, particularly with those who are street sleeping and street begging.

Homelessness in the UK is increasing and projections indicate that it is set to continue to rise over the coming years, with significant numbers affected by the lack of availability and affordability of housing; changes to the benefits system; and a range of risk factors, which have been identified that mean that individuals have an increased likelihood of becoming homeless.

Sections 2, 5, 6 and 7 explore the data, risk factors and reasons why people street beg, street sleep and/or experience homelessness and indicate that it is a highly complex mix of issues that combine, stemming from early childhood experiences through to the development of substance misuse and mental health problems. This, coupled with the significant social exclusion faced by these adults with complex needs, serves to make the provision of interventions and services to reduce and prevent homelessness incredibly difficult.

Section 9 explores promising interventions from the literature that may support efforts to prevent and reduce homelessness. Some of the key interventions include:

- No Second Night Out
- Housing First
- Psychologically Informed Environments
- Personalised Services
- MEAM

There was little primary research looking at interventions specifically to prevent or reduce street begging or street sleeping. Much of the literature relating to this is found in grey literature, policy or strategy papers, or informal news pieces. However, there are some key themes that have emerged, including:

- early intervention in the context of homelessness

- integrated working
- interventionist approaches Vs non-interventionist approaches

In addition, there has been a recent review of the evidence in relation to interventions for inclusion health, which highlight a number of areas where there is good evidence to support intervention, including:

- pharmacological interventions
- psychosocial interventions
- case management
- disease prevention
- housing and social determinants
- other interventions
- interventions tailored to women
- interventions tailored to young people

What is clear is that no one single intervention on its own will reduce or prevent homelessness. A system wide, integrated approach is needed to ensure that there a range of linked services available to meet the needs of those with highly complex needs. A home is one of the key things required to support this group. Evidence suggests that simply having appropriate long-term accommodation can have a significant impact on those with complex needs, who are often the most socially isolated and excluded people within our communities.

Sections 8, 10 and 11 explore some of the impacts associated with homelessness and particularly street begging and street sleeping, where evidence exists and highlights some of the potential savings that could be made through tackling this complex issue. There are a lack of return on investment tools to provide a robust judgement on the extent of those savings, but there is likely to be substantial gains to health and social services as well as benefits to the criminal justice system of addressing this issue.

This review highlights some of the gaps in data, research and evidence that exist and recommends that:

- local authorities consider the findings of this review and how they may be able to utilise it in the context of their local situations (some toolkits, guides and strategies that may be useful can be found in Appendix C)
- PHE considers the research/evidence/data gaps in this area and how we may be able to overcome some of these and support the development of the evidence base for this highly complex and vulnerable group

1.0 Introduction

Public Health England South East Centre was asked by Portsmouth and Southampton City Councils to provide an independent review of the literature around homelessness. With particular reference to those who are street homeless and those who street beg to support efforts to prevent and reduce homelessness and the adverse outcomes associated with this.

The purpose of this document is, therefore, to provide an overview of the national picture in relation to homelessness and provide insights into the current evidence base to support action in preventing and reducing homelessness, particularly with those who are street sleeping and street begging.

2.0 Context

Homelessness in England is increasing, with data on statutory homelessness, prevention and relief and rough sleeping all showing an increasing trend year on year, particularly since 2010. However, the scale of homelessness is even larger when you consider the number of people who are not captured in national statistics. For example, those staying with friends and family on a temporary basis.

The outcomes associated with homelessness and particularly rough sleeping or street sleeping, the most visible form of homelessness, are poor with many experiencing mental health problems, substance misuse problems and a range of physical health problems as a result of the conditions in which they live. Life expectancy in those sleeping on our streets was found to be as low as 47 years on average for men living on the streets and was even lower for women.¹

Whilst there are a range of services in place to meet the needs of those sleeping on the streets, they are often geared towards specific issues like drugs and alcohol or mental health. As a result, people find themselves falling between services or not having high enough needs to meet thresholds and, thus, continue to struggle with the increasing complexity of being homeless and having a number of needs to address.

The Department for Communities and Local Government is the government department with responsibility for developing policy and strategy to tackle homelessness and have a

¹ Thomas, B. (2012) Homelessness kills: An analysis of the mortality of homeless people in early twenty-first century England. London: Crisis.

responsibility to support local authorities in their statutory duties under the Housing Act 1996 (as amended).²

Local authorities have a statutory duty to provide accommodation to those who fall within certain categories of 'priority need' and who are not deemed intentionally homeless. These categories are specified in the Housing Act 1996, section 189 and include:

- people with dependent children who are residing or might reasonably be expected to reside with them
- people who are homeless or threatened with homelessness as a result of any emergency such as a flood, fire or any other disaster
- where any person who resides or who might reasonably be expected to reside with them, is vulnerable because of old age, mental illness, handicap or physical disability or other special reason
- pregnant women, or a person who resides or might reasonably be expected to reside with a pregnant woman

If an applicant does not qualify for accommodation under one of these categories, the council has a lesser duty to provide 'advice and assistance' to help them find accommodation.

The above categories make it very difficult for single homeless people and those couples without children to qualify for housing under the Act.

The Homelessness Act 2002³ introduced the power for local authorities to take reasonable steps to prevent homelessness for those households that do not meet any of the categories for priority need and where their homelessness would be unintentional. The National Audit Office (2017)⁴ in their recent report on homelessness indicate that local authorities with high applications for assistance, used these new powers to provide 'housing options' services and used this approach to assess a household's housing needs and attempt to prevent homelessness before it happens.

This focus on preventing homelessness has been further cemented through the new Homelessness Reduction Act 2017⁵. The Homelessness Reduction Bill was introduced in the House of Commons on 29 June 2016, with legislation completing its passage through Parliament on 23 March 2017, receiving Royal Assent on 27 April 2017. It is expected to come into force in April 2018.

2 Housing Act (1996). The Stationary Office. <https://www.legislation.gov.uk/ukpga/1996/52/contents>

3 Homelessness Act (2002). <https://www.legislation.gov.uk/ukpga/2002/7/crossheading/homelessness-reviews-and-strategies>

4 National Audit Office (2017). Report by the Comptroller and Auditor General. Department for Communities and Local Government. Homelessness. HC 308 SESSION 2017-19; NAO September 2017.

5 Homelessness Reduction Act (2017). http://www.legislation.gov.uk/ukpga/2017/13/pdfs/ukpga_20170013_en.pdf

An article in Housing Matters⁶, in August 2017 states that *'The Homelessness Reduction Act 2017 will make the most far-reaching changes to homelessness legislation since the original Housing (Homeless Persons) Act was enacted forty years ago'*

The new Act seeks to address some of the problems with the current Acts, particularly in relation to single homelessness, by tackling it more effectively through earlier intervention, prevention, appropriate assessment of needs and the development of individualised plans. Key elements include:⁷

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

Where the local authority is unable to relieve or prevent the applicant's homelessness by providing or assisting them to obtain suitable accommodation within 56 days, then further action will be dependent on whether or not the applicant is found to be in priority

6 Gallagher, John (2017). Homelessness Reduction Act 2017. Housing Matters; Issue 119, p4-5; August 2017.

7 Chartered Institute of Housing (2017). What you need to know about the Homelessness Reduction Act 2017.

<http://www.cih.org/resources/PDF/Policy%20free%20download%20pdfs/What%20you%20need%20to%20know%20Homelessness%20Reduction%20Act%202017.pdf>

need. If there is no priority need, then the authority will have no further duty, if there is a priority need, then they would then fall under the main housing duty in the Housing Act 1996.⁶

In relation to street begging specifically, one of the key pieces of legislation that remains in force today is the Vagrancy Act 1824 (as amended). Begging is an offence under section 3 of the Act and is a recordable offence, with the maximum sentence being a fine at level 3 on the standard scale (currently £1000).⁸

There are other provisions that also criminalise begging behaviour, including:

- wilfully blocking free passage along a highway is an offence contrary to section 137 of the Highways Act 1980 (as amended), punishable by a level 3 fine
- using threatening or abusive words or behaviour is an offence under section 5 of the Public Order Act 1986, which also carries a level 3 fine

In addition to the legislative framework, there have been significant changes to the benefit system over recent years, particularly in relation to housing benefit, which appears to be having an impact on the extent of homelessness in the UK. These changes are reflected on through the later sections in this review.

⁸ Cromarty, H and McGuinness, T (2016). Rough sleepers and anti-social behaviour (England) Briefing paper number 07836, 13 December 2016. House of Commons Library.

3.0 Literature review methodology and scope

See Appendix A for the full review scope, methodology and results. The key lines of enquiry for the review were:

- who street begs and/or is street sleeping?
- what needs do they have?
- what works to meet those needs?
- what works to reduce the number of people street begging and/or street sleeping?
- what is the return on investment?

A literature search was undertaken looking at primary research, systematic reviews, grey literature, evaluations, national guidance and policies over the last 5 years (2012-2017). However, older work was identified through looking at references within texts.

Summary of results:

- MEDLINE: 104
- PSYCINFO: 4
- SCOPUS SOCIAL SCIENCE: 3
- GOOGLE: 21

One person looked through the abstracts and resources identified and full articles were selected to look at in more detail based on relevance to the scope outlined in Appendix A and with the definitions outlined below in mind.

The majority of the literature was from the US, Canada and the UK, with some limited research from Europe and other countries.

Further literature was identified through looking at the references within the resources identified.

4.0 Definitions

For the purposes of this review, the following definitions have been used when searching through the literature identified.

Homeless

Homelessness means not having a home. A home is a place that provides security and links to a community and support network. It needs to be decent and affordable. Under the law, even if someone has a roof over their head they can still be homeless. This is because they may not have the right to stay where they live or their home may be unsuitable to live in.⁹ The statutory definition of a homeless person, as set out in Part VII of the Housing Act 1996, is:

- (1) A person is homeless if he has no accommodation available for his occupation, in the United Kingdom or elsewhere, which he -
 - (a) is entitled to occupy by virtue of an interest in it or by virtue of an order of a court,
 - (b) has an express or implied licence to occupy, or
 - (c) occupies as a residence by virtue of any enactment or rule of law giving him the right to remain in occupation or restricting the right of another person to recover possession

- (2) A person is also homeless if he has accommodation but -
 - (a) he cannot secure entry to it, or
 - (b) it consists of a moveable structure, vehicle or vessel designed or adapted for human habitation and there is no place where he is entitled or permitted both to place it and to reside in it

- (3) A person shall not be treated as having accommodation unless it is accommodation which it would be reasonable for him to continue to occupy¹⁰

Hidden homeless

Many people who become homeless do not show up in official figures. This is known as hidden homelessness. This includes people who become homeless but find a temporary solution by staying with family members or friends, living in squats or other insecure accommodation.¹¹

9 Street Homelessness Factsheet. This factsheet was produced by Shelter. Written by Rita Diaz 2006.

10 House of Commons ODPM: Housing, Planning, Local Government and the Regions Committee. Homelessness. Third Report of Session 2004-05, Volume 1 – Report. <https://publications.parliament.uk/pa/cm200405/cmselect/cmodpm/61/61i.pdf>

11 <http://www.homeless.org.uk/facts/homelessness-in-numbers/hidden-homelessness>.

Multiple Exclusion Homelessness (MEH)

Fitzpatrick, S et al¹² describe MEH as; 'People have experienced MEH if they have been 'homeless' (including experience of temporary/unsuitable accommodation as well as sleeping rough) and have also experienced one or more of the following other domains of 'deep social exclusion': 'institutional care' (prison, local authority care, mental health hospitals or wards); 'substance misuse' (drug, alcohol, solvent or gas misuse); or participation in 'street culture activities' (begging, street drinking, 'survival' shoplifting or sex work)'.

Rough sleepers

The Department for Communities and Local Government (DCLG) defines rough sleeping as 'People sleeping, about to bed down (sitting on/in or standing next to their bedding) or actually bedded down in the open air (such as on the streets, in tents, doorways, parks, bus shelters or encampments). People in buildings or other places not designed for habitation (such as stairwells, barns, sheds, car parks, cars, derelict boats, stations or 'bashes'.'

The definition does not include people in hostel or shelters, people in campsites or other sites used for recreational purposes or organised protest, squatters or travellers. Bedded down is taken to mean either lying down or sleeping. About to bed down includes those who are sitting in/on or near a sleeping bag or other bedding.

Street homeless

Street homelessness is a much wider term than rough sleeping, taking into account the street lifestyles of some people who may not actually sleep on the streets. Street homeless people are those who routinely find themselves on the streets during the day with nowhere to go at night. Some will end up sleeping outside, or in a derelict or other building not designed for human habitation, perhaps for long periods. Others will sleep at a friend's for a very short time, or stay in a hostel, night-shelter or squat, or spend nights in prison or hospital.⁹

Begging

Begging is defined in the dictionary as the solicitation of money or food, especially in the street.

¹² Fitzpatrick, S; Bramely, G and Johnson, S (2012). Multiple Exclusion Homelessness in the UK: An overview of key findings. Institute of Housing, Urban and Real Estate Research, Heriot-Watt University, 2012.

5.0 National profile of people who street beg and/or street sleep

Much of the literature focuses on rough sleepers as a cohort of the homeless population. There is little data specifically on those who are purely street sleepers.

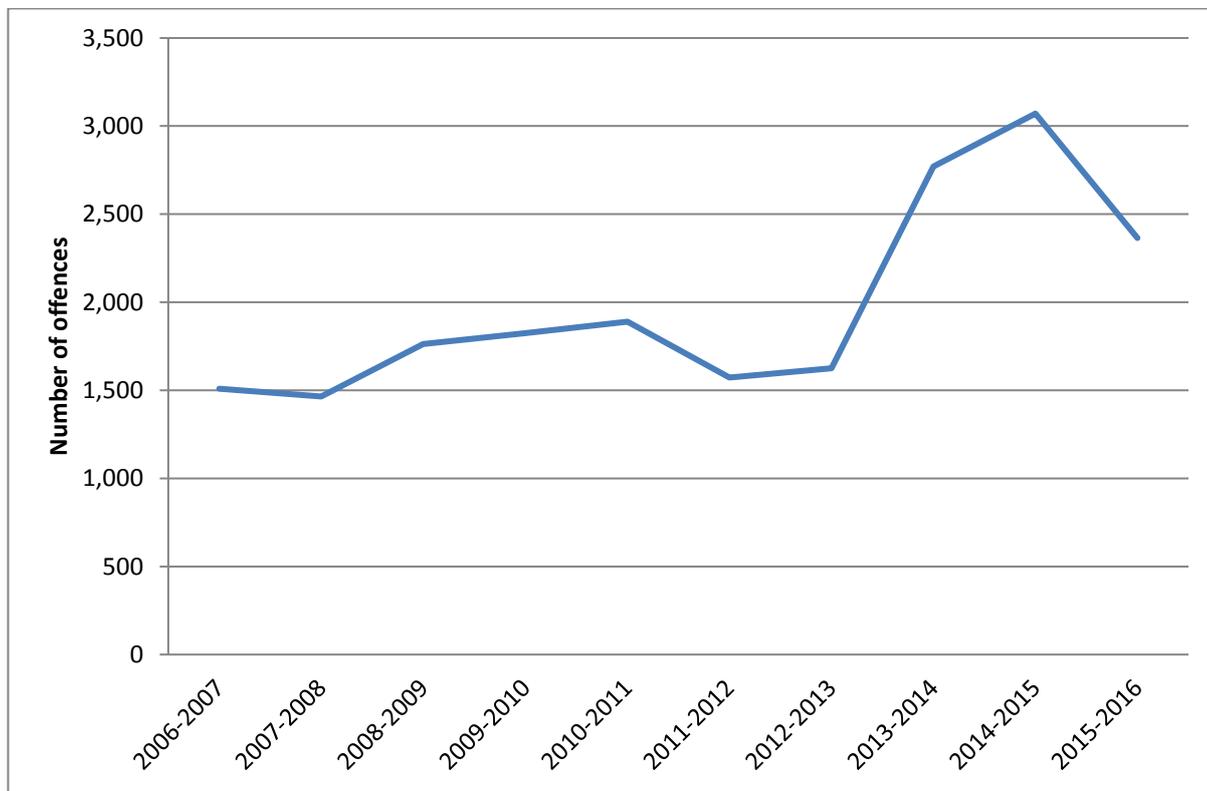
There is a lack of literature focusing on street beggars, as there are no national databases or regular reports published on the subject. Much of the information outlined below is taken from charity websites and news articles. There are a small number of reports based on freedom of information requests, which give an indication of the scale of begging based on the number of arrests under the Vagrancy Act (1824).

Street begging

Begging is an offence under Section 3 of the Vagrancy Act (1824). According to a Freedom of Information request response in July 2016 from the Crown Prosecution Service, there were 2,365 arrests under Section 3 of the Vagrancy Act (1824) in England in 2015/16.¹³ There has been a 36% increase in arrests since 2006/07, peaking at 3,071 arrests in 2014/15 (Chart 1).

¹³ This response to the Freedom of Information request is published online at: https://www.whatdotheyknow.com/request/being_an_incorrigible_rogue (accessed 19 September 2017).

Chart 1: Number of Offences under the Vagrancy Act 1824, section 3, which reached a hearing in the UK from 2006/07 - 2015/16



Source: Crown Prosecution Service, Freedom of Information Release, 6 July 2016.

Unlike rough sleeping, there are no national counts or estimates on the number of street beggars in the UK. Therefore, the data on arrests as a result of police action is likely to underestimate the true extent of begging.

There is little data from studies or other analyses that provide us with much information on demographic features of this population in terms of age, gender, ethnicity, geography and the like. Much of the literature focuses on street begging in developing countries and those which do focus on developed countries have tended to focus on a specific sub set of this population. For example, beggars from the Roma community.¹⁴

What is evident from the literature that does exist is that street begging, as one might expect, is usually focused around popular tourist destinations¹⁵ and other urban areas, where the opportunities are likely to be greater.

¹⁴ Carlqvist, I (2016). Sweden: A Beggar on Every Corner. Gatestone Institute, 9th April, 2016
<https://www.gatestoneinstitute.org/7782/sweden-roma-beggars>

¹⁵ Andriotis, K (2016). Beggars – tourist's interactions: An unobtrusive typological approach. *Tourism Management* 52 (2016) 64-73.

Rough sleepers

The Department for Communities and Local Government publishes an annual count and estimates of rough sleeping in England every autumn. The rough sleeping counts and estimates are single night snapshots of the number of people sleeping rough in local authority areas.¹⁶ Local authorities decide whether they are going to carry out a count or do an estimate each year. In 2016, 14% (47) of local authorities conducted a count and 86% (279) provided an estimate based on local intelligence gathered from local services.

The 2016 publication includes demographic information about those sleeping rough for the first time.

In the autumn of 2016, the total number of rough sleepers counted and estimated was 4,134 this was an increase of 16% (565 people) from the autumn of 2015.

London has the greatest number of rough sleepers in England, 964, which makes up 23% of the total number of rough sleepers. This is down from 26% of the total number in 2015. The rest of England has seen a 21% increase in the number of rough sleepers between 2015 and 2016, from 2,629 to 3,170.

When we look at the 10 local authorities with the highest number of rough sleepers in 2016, we see that Brighton and Hove is the only local authority in the South East that features and has the second highest number of rough sleepers at 144. Westminster has the highest at 260.

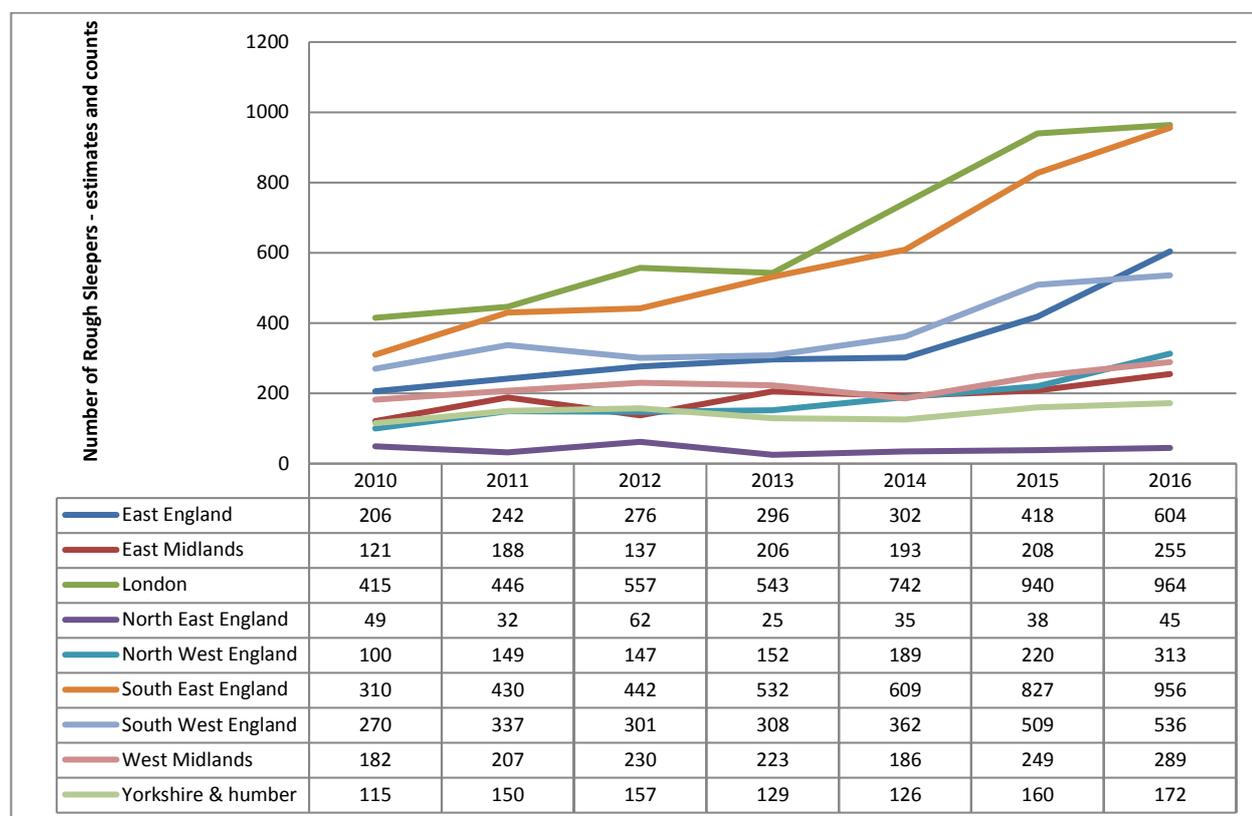
Of the 4,134 people sleeping rough in 2016:

- 12% (509) were women
- 7% (288) were under 25 years old
- 17% (714) were EU nationals from outside the UK
- 5% (194) were from outside the EU

An upward trend in rough sleeping can be seen over the period 2010-2016 in almost all regions, particularly London, the South East, the South West and the North West (Chart 2).

¹⁶ Department for Communities and Local Government, 2016: Rough Sleeping Statistics Autumn 2016, England.

Chart 2: Rough sleeping by region 2010-2016



Source: DCLG.

2 Local Authorities (Brighton and Hove 85% increase – 78 to 144 and Portsmouth 147% increase – 15 to 37) in the South East are in the top 10 local authorities with the largest increases in the number of rough sleepers between 2015 and 2016 (Table 1).

Table 1: Top 10 local authorities with largest increase in the number of rough sleepers, 2016

Local Authority	Region	2015	2016	Change from 2015	% change on 2015
Brighton and Hove	South East	78	144	66	85%
King's Lynn and West Norfolk	East	5	42	37	740%
Cornwall	South West	65	99	34	52%
Wigan	North West	3	28	25	833%
Luton	East	53	76	23	43%
Portsmouth	South East	15	37	22	147%
Cambridge	East	18	40	22	122%
Norwich	East Midlands	13	34	21	162%
Nottingham	East Midlands	14	35	21	150%
Walsall	West Midlands	7	26	19	271%

Source: DCLG.

When you look at the snapshots for some of the local authorities in the South, we can see that there has been a huge rise in the numbers of rough sleepers between 2010 and 2016 (Table 2). Whilst the numbers are small and numbers are largely based on estimates, figures indicate that there has been a step change in the number of rough sleepers since 2010. Trends in rough sleeping for all local authorities (upper and lower tier) in the South East can be found in Appendix B.

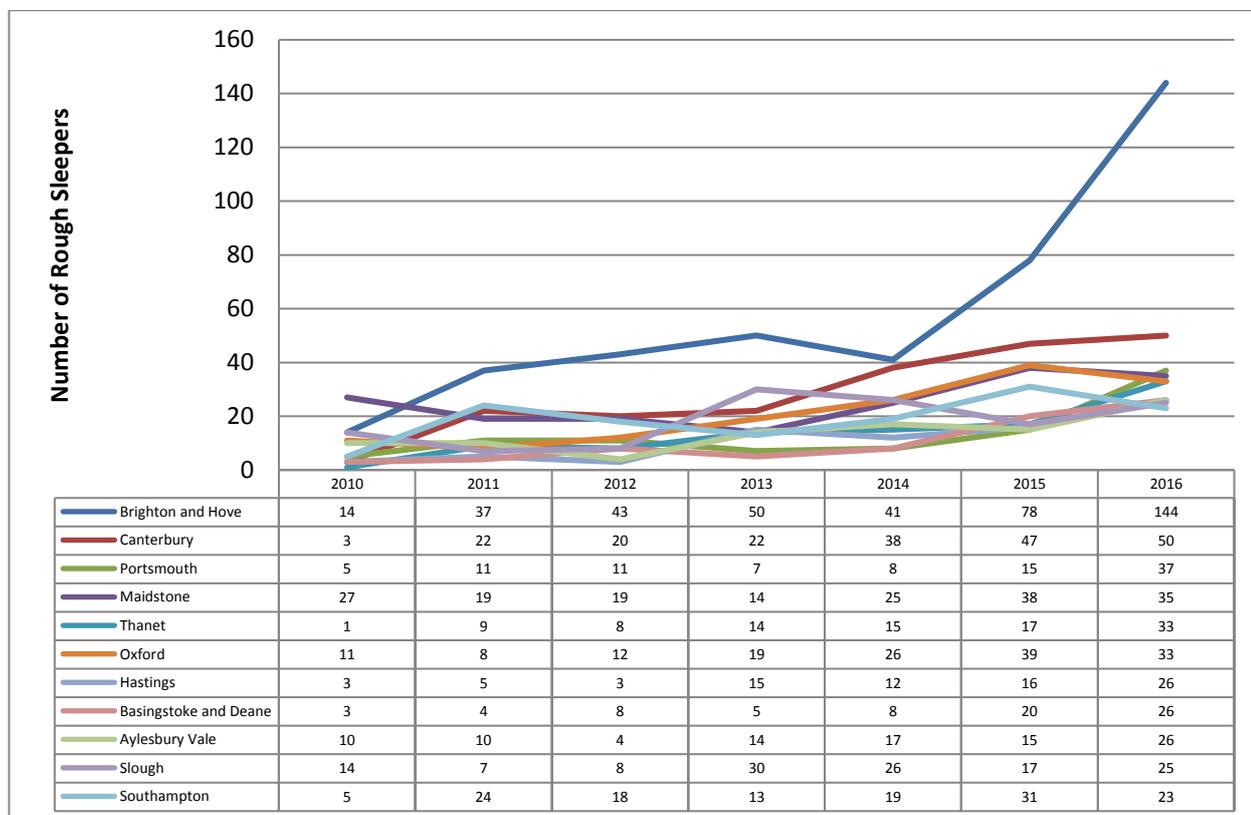
Table 2: Rough Sleeping in Top 11 Local Authorities for Number of Rough Sleepers in the South East of England, 2010 compared to 2016

Local Authority	Number of Rough Sleepers in 2010	Number of Rough Sleepers in 2016	% Change 2010-2016
Brighton and Hove	14	144	929
Canterbury	3	50	1567
Portsmouth	5	37	640
Maidstone	27	35	30
Thanet	1	33	3200
Oxford	11	33	200
Hastings	3	26	767
Basingstoke and Deane	3	26	767
Aylesbury Vale	10	26	160
Slough	14	25	79
Southampton	5	23	360

Source: DCLG.

Chart 3 shows the trend by year for the 11 local authorities in the South East with the highest estimated number of rough sleepers in 2016.

Chart 3: Trend in the Number of Rough Sleepers by Local Authority in the South East, based on the 11 Local Authorities with the Highest Number of Rough Sleepers in 2016, 2010-2016



Source: DCLG.

The Combined Homelessness and Information Network (CHAIN) database provides further data on rough sleeping in London and is published by the Greater London Authority on a quarterly basis.¹⁷

In April – June 2017, outreach teams recorded:

- 2,584 people sleeping rough across London, a 4% decrease on the 2016 figure of 2,689
- Of the 2,584 people sleeping rough, 362 (14%) were living on the streets, 1,206 (47%) were new rough sleepers (sleeping rough for the first time) and 1030 (40%) were intermittent rough sleepers
- 1,352 (56%) rough sleepers were of UK origin; 522 (21%) were of Central and east European origin, with those from Poland and Romania being the majority within this group (168 - 7% and 198 - 8% respectively)
- 1,374 (76% – base no. 1,808) reported one or more support need (ie alcohol, drugs and/or mental health) – excludes those that were not assessed

¹⁷ Greater London Authority (July 2017). CHAIN quarterly Report, Greater London, April 2017 – June 2017.

- 797 (44%) had support needs for alcohol; 730 (40%) had support needs for drugs; 887 (49%) had support needs for mental health – base no. 1,808
- 936 (54% - base no. 1,733) reported experiences of the armed forces (8%), care (12%) or prison (37%)

The homeless monitor: England 2017¹⁸ is a longitudinal study, which provides an independent analysis of the impact of policy and economic developments on homelessness in England and other parts of the UK. The monitor is published annually, with this latest report being the 6th edition.

Table 3 below outlines some of the key trends in homelessness over the period 2009/10 – 2015/16 and indicates that:

- rough sleeping in England has increased by 134% over the period and by 120% in London
- the number of statutory cases of homelessness and acceptances of such cases has increased by 29% and 44% respectively over the period

Table 3: Summary of homelessness statistics

Summary of Homelessness Statistics	2009/10	2014/15	2015/16	% change 2014-15 - 2015-16	% change 2009/10 - 2015/16
Rough sleeping in England – snapshot ^a	1,768	3,569	4,134	16%	134%
Rough sleeping in London - annual ^b	3,673	7,581	8,096	7%	120%
Local authority statutory homelessness cases - annual ^c	89,120	112,350	114,780	2%	29%
Local authority homelessness acceptances - annual ^d	40,020	54,430	57,740	6%	44%
Local authority homelessness prevention and relief cases ^e	165,200	220,800	213,300	-3%	29%
Total local authority homelessness case actions	205,220	275,230	271,050	-2%	32%

Source: Taken from the Homeless Monitor: England 2017.

a = Numbers estimated by local authorities on given date (based on counts in a minority of local authorities).

b = Numbers recorded as sleeping rough at least once during financial year.

c = Homelessness applications processed under statutory procedures.

d = Households formally assessed as 'unintentionally homeless and in priority need'.

e = Instances involving non-statutory assistance provided to homelessness applicants in retaining existing accommodation or securing a new tenancy.

Using data contained within the homeless monitor, CHAIN and rough sleeping counts and estimates data, Crisis have published projections in relation to 'core homelessness',¹⁹ which includes:

- rough sleeping
- sleeping in tents, cars, public transport
- squatting (unlicensed, insecure)
- unsuitable non-residential accommodation eg 'beds in sheds'
- hostel residents
- users of night/winter shelters
- DV victim in refuge
- unsuitable temporary accommodation (which includes bed and breakfast accommodation, hotel etc)
- sofa surfing

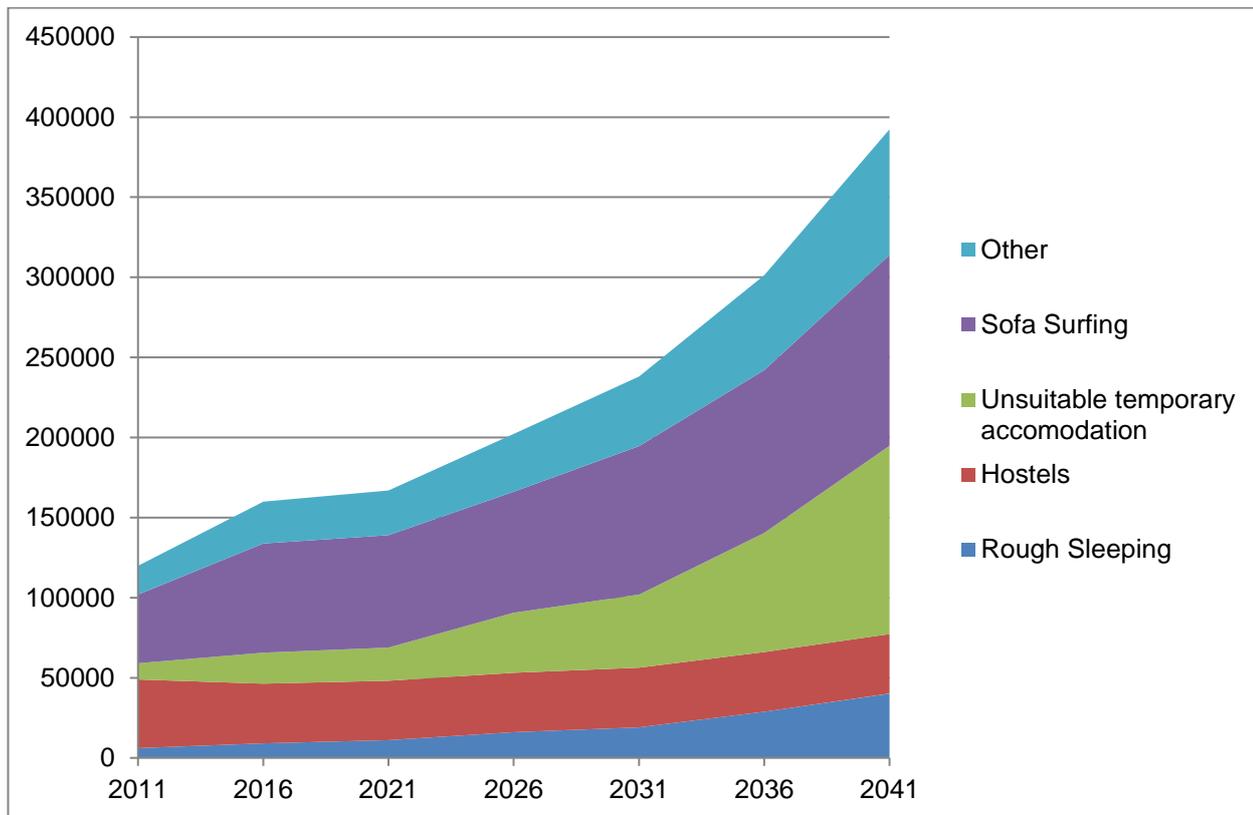
They indicate that between 2011 and 2016, core homelessness has increased by 33.4% in Great Britain, with rough sleeping increasing by 49.2% from 6,100 to 9,100. They used a sub-regional housing market model²⁰ and adapted it to forecast future levels of homelessness.

Chart 4 indicates that levels of core homelessness are projected to rise over the coming years. Rough sleeping in particular is projected to increase from 6,100 in 2011 to 40,100 in 2041 in Great Britain and within this a rise from 5,000 in 2011 to 38,000 in England.

19 Bramley, G (August, 2017). Homelessness Projections: Core Homelessness in Great Britain - Summary Report. Crisis, 2017.

20 Bramley, G., Leishman, C., Cosgrove, P. and Watkins, D. (2016), What Would Make a Difference? Modelling Policy Scenarios for Tackling Poverty in the UK: Heriot Watt University, Joseph Rowntree Foundation.

Chart 4: Forecast of Core Homelessness, Great Britain, 2011-2041



Source: Crisis Core Homelessness Projections, 2017.

Homelessness more generally

There are a couple of studies from the US that have used data from a more representative sample of the population. So that they could compare experiences of those who have had periods of homelessness with those who have not.^{21,22}

These studies give us an indication of how prevalent homelessness is in the context of a generic population. Roos et al²¹ found that in their study population of 34,653 non-institutionalised people aged 20 years or older in the US, 3.1% (1,103) reported lifetime homelessness. In this study, lifetime homelessness was determined based on 2 questions: in wave 1 of the study they were asked *'In your entire life, did you ever have a time that lasted at least 1 month when you had no regular place to live – like living on the street or in a car?.'* In wave 2, respondents were asked the same question and were also asked whether homelessness had occurred since the last interview.

21 Roos, L.E et al (2013). Relationship Between Adverse Childhood Experiences and Homelessness and the Impact of Axis I and II Disorders. *American Journal of Public Health, Supplement 2, 2013, Vol 103, No S2, p.S275-S281.*

22 Shelton, K.H et al (2009). Risk Factors for Homelessness: Evidence From a Population Based Study. *Psychiatric Services, ps.psychiatryonline.org – April 2009, Vol 60, No.4, p.465-472.*

Of the 1,103 people experiencing lifetime homelessness, 44.6% (493) were women and 55% (610) were men. This equated to 2.3% and 4% of the total sample respectively.

If we extrapolate this to the general population of England and Wales, using ONS mid-year population estimates (2016), there would be an estimated 1,381,625 people aged 20+ years that have experienced lifetime homelessness.

Shelton et al²² focused on a cohort of young adults (18-28 years) and analysed data for 14,888 young adults (mean age 22) who participated in a longitudinal study of adolescent health and was a nationally representative, population based sample in the US. They found that 4.6% (682) of the sample were classified as ever being homeless. Inclusion as homeless was based on responses to 3 questions, *'Have you ever been homeless for a week or longer – that is, you slept in a place where people weren't meant to sleep, or slept in a homeless shelter, or didn't have a regular residence in which to sleep'*, *'Have you stayed in a homeless shelter?'* and *'Where do you live now?'*

Of the 682 young adults that were ever homeless, 48% (328) were women and 52% (354) were men. This equated to 2.2% and 2.3% of the total sample respectively.

If we extrapolate this to the general population of England and Wales using ONS mid-year population estimates (2016), there would be an estimated 240,548 people aged 18-28 years that have ever been homeless.

Hard Edges²³, a study that looked at the overlap between problems such as homelessness, drug and alcohol misuse, poor mental health and offending behaviours, also gives us an indication of the scale of the issue in relation to homelessness. They sought to understand the extent and nature of this form of severe and multiple disadvantage (SMD) and developed a statistical profile through an integrated analysis of specific 'administrative' datasets. These datasets were the Offender Assessment System (OASys), the National Drug Treatment Monitoring System (NDTMS) and the Supporting People (Client Record and Outcomes Short-Term Services). They complemented these with the MEH Survey 2013 and the ESRC Poverty and Social Exclusion Survey 2012.

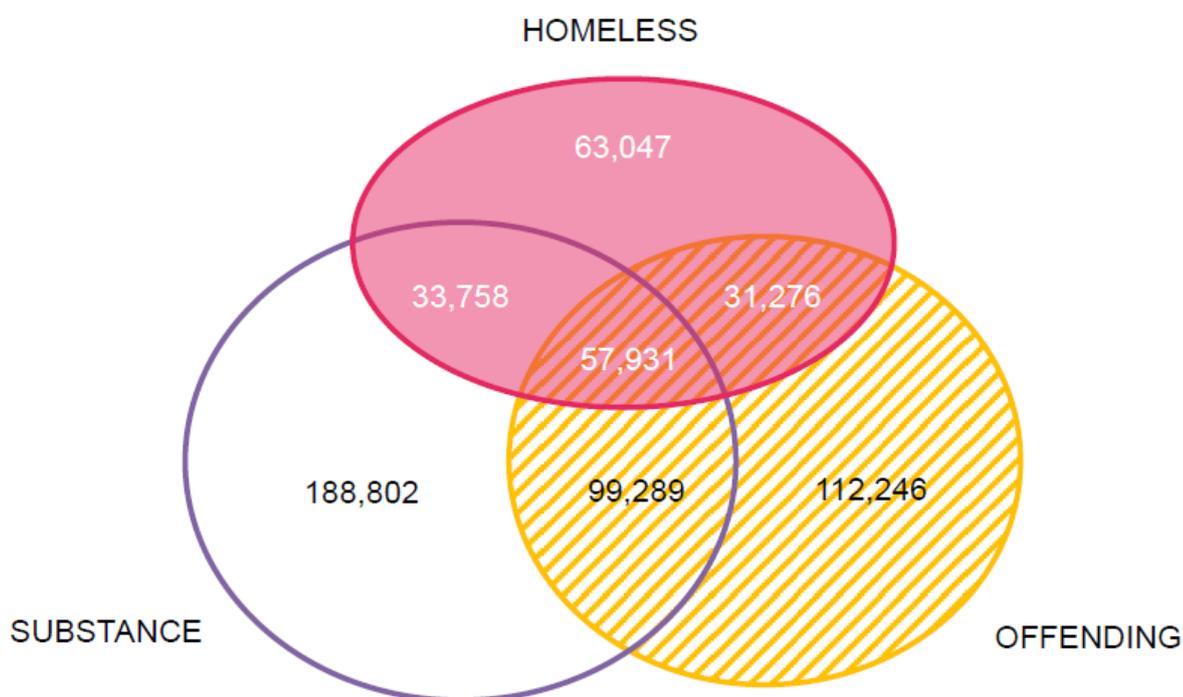
They found that 63,047 people in England in 2010/11 experienced homelessness only based on the data analysed. Using this, they suggested a national prevalence rate for SMD 1 (experiencing one disadvantage domain only – homelessness only, substance misuse only or offending only) of 9.3 people per 1,000.

23 Bramley, G; Fitzpatrick, S et al (2015). Hard edges. Mapping severe and multiple disadvantage. The LankellyChase Foundation, 2015.

If we extrapolate this to the general population of England and Wales using ONS mid-year population estimates (2016), there would be an estimated 188,895 people aged 18-28 years that have ever been homeless.

Whilst the above prevalence estimates are based on figures from American literature and, therefore, provide a crude estimate of the likely numbers of people having ever experienced homelessness. They do help to provide an indication of potential scale. Given the difference in demography, levels of deprivation and the like between the US and parts of the UK; figures are likely to be an underestimation, particularly in areas where levels of deprivation are high.

Figure 1: Overlap of SMD disadvantage domains, England, 2010/11



Source: Hard Edges, 2015.

Gender, age, ethnicity and learning difficulties

In their annual review 2016²⁴, Homeless Link report the findings of their annual review, which is based on surveys with 394 accommodation projects and 53 day centres; analysis of Homeless UK secondary data sources; and case studies collated through telephone interviews with staff working in homelessness services.

²⁴ Homeless Link (2016). Support for single homeless people in England. Annual Review 2016. Homeless Link, 2016.

They found that in a 'snapshot' of who was resident 'last night' in 1 of the accommodation projects (Base number = 312):

- 72% were male and 28% were female
- 45% were young people aged 16-24 years
- 12% were older people aged over 50 years
- 23% were prison leavers/ex-offenders
- 15% were from black or minority ethnic groups
- 9% were EEA nationals
- 7% were care leavers
- 4% were LGBT
- 3% were ex-service personnel
- 6% had learning difficulties

Hard Edges²³ looked at SMD domains in relation to gender, age, ethnicity and family status and found that:

- 78% of men experience all 3 SMD domains (homelessness, offending and substance misuse) compared to 22% for women
- when you look at homelessness only, around 41% of men experience homelessness only compared to 59% for women, suggesting that men face more significant levels of SMD
- 36% of those experiencing all 3 SMD domains are aged 25-34 years, with 23% being aged 35-44 years. Only 2% were aged 65+ years
- when you look at homelessness only, over 40% were aged under 25 years and there were none aged 65+ years, suggesting that the homelessness only cohort is younger, perhaps indicating that they have not yet been impacted by other SMD domains
- 85% of those experiencing all 3 SMD domains are white, which is in line with the working age population of England as a whole
- for those who were homeless only, there was more diversity with 74% being white. Black and mixed race clients were over represented in the homeless only domain
- 90% of those experiencing all 3 SMD domains were single homeless. However, they found that almost 60% either lived with children or had ongoing contact with their children
- nearly a third of homeless only clients were living as part of families with children

Geographic spread

Hard Edges²³ also looked at geographic spread in relation to SMD and found that there was a pattern of SMD concentration in specific types of locales:

- northern urban areas
- both 'core' cities and former manufacturing towns
- some coastal areas, including major seaside resorts and former port cities, particularly Bournemouth and Plymouth who feature in the top 24 local authorities
- certain London authorities, particularly the central borough eg Westminster, Islington, Camden and Tower Hamlets

They state that the mapping exercise suggests that there is an association between SMD prevalence rates and areas of the country where poverty tends to be concentrated, and that all other things being equal, the factors most associated with higher levels of SMD include:

- **demographic factors:** having a high proportion of the population aged 16-24 years and/or large numbers of single person households
- **economic factors:** high rates of unemployment and/or poverty
- **housing factors:** housing markets with concentrations of smaller properties (eg bedsits and small flats) – although indicators of housing pressure (overcrowding) or low quality (lack of central heating) were not associated with areas of high SMD
- **health factors:** a poor health profile amongst the local population
- **institutional factors:** concentrations of institutional populations, especially those living in mental health hospital or units, or in homeless hostels. There was also an association with local concentrations of holiday accommodation, tying in with the overrepresentation of seaside towns

Length of time spent on the streets and/or homeless

Reaching Out²⁵, in their consultation with those who are street homeless, found that amongst the 257 people they interviewed:

- 32% had not had a permanent place to stay for more than 3 years
- 11% had not had a permanent place to stay for more than 10 years
- 10% had had a permanent place to stay within the last 6 months
- 44% had occupied permanent accommodation in the last year

²⁵ Rice, B; Hough, J; Smith, J; and Francis, M (2007). Reaching Out. A consultation with street homeless people 10 years after the launch of the Rough Sleepers Unit. Shelter in partnership with Broadway, 2007.

http://england.shelter.org.uk/professional_resources/policy_and_research/policy_library/policy_library_folder/reaching_out

They indicate that this suggests that many have lost their homes only recently and are not long-term rough sleepers.

There is nothing in the literature about how long people street beg for.

The overlap between street begging and street sleeping

The extent to which street begging and street sleeping overlap is difficult to quantify. There are mixed findings in the literature, ranging from a statement from Crisis in 2005 as part of written evidence they submitted to the House of Commons, which suggested that 'the vast majority of people who beg are street homeless'.²⁶ They go on to say that 'begging and street homelessness constitute overlapping parts of a broader homelessness problem....a Crisis survey found that 58% of people who begged had slept rough the night before and a report by Fitzpatrick and Kennedy on *behalf of the Joseph Rowntree Foundation* came to similar conclusions. *The research identified a high degree of overlap between begging, rough sleeping and Big Issue vending and found that people's experiences of rough sleeping invariably preceded their involvement in begging*'.

In a factsheet on Street Homelessness produced by Shelter, the charity states that '*there is a lack of clarity about the relationship and crossover between rough sleepers and other people who participate in street-based activities, but who have accommodation. A street lifestyle can precede, accompany or follow periods of street homelessness, or be maintained while a person has long-term accommodation. Street lifestyles can also encourage rough sleeping and provide a route into sleeping on the streets*'.⁹

Within this factsheet, Shelter cites research from 2001,²⁷ which suggests that only 6 individuals out of a sample of 260 people who beg were living in their own home. They state that whilst begging and homelessness are inextricably linked, not all rough sleepers beg and not all beggars are rough sleepers, but the vast majority of those who beg are in unstable accommodation of one kind or another.

However, there have been a number of more recent reports and news articles, which suggest that the majority of those who beg are not homeless. For example, a BBC News article in July 2015 stated that '*fewer than one in five people arrested for begging in England and Wales last year were homeless....Freedom of Information figures from 34 out of 43 police forces showed 1,002 people arrested for street begging in 2014 – of whom 199 were **legally defined*** as homeless*'.²⁸

26 publications.parliament.uk/pa/cm200405/cmselect/cmhaff/80ii/80we15htm. Prepared January 2005. Accessed 1 September 2017.

27 Department for Transport, Local Government and the Regions, *Looking for a change: The role and impact of begging on the lives of people who beg*, 2001.

28 www.bbc.co.uk/news/uk-33729766. 31 July 2015. Accessed 1 September 2017.

(*The legal definition of homelessness, used by the police, says someone is homeless if they have no accommodation they are entitled to occupy - or if the standard of their accommodation is so bad they cannot reasonably be expected to occupy it).

The homelessness charity, Thames Reach, have also provided evidence to suggest that a large proportion of those who beg are not homeless and state that *'only 40% of people arrested for begging in a Metropolitan Police operation claimed to be homeless....An operation in Birmingham in autumn 2013 showed that 6 out of 10 people arrested for begging had a home....Most people begging have accommodation of sorts, either a hostel place or a flat or bed-sit'*.²⁹

The relationship between street begging and street sleeping is a complex one, but what is clear from the literature is that those who street beg and/or are street sleepers are some of our most vulnerable individuals. They have a range of complex needs and experience severe and multiple deprivation over long periods of time. Further discussion on why people street beg and/or street sleep can be found in the following section.

29 www.thamesreach.org.uk/news-and-views/campaigns/giving-to-beggars/faq/?locale=en.

6.0 What factors may be driving increases in homelessness?

Section 5 clearly highlights that homelessness in all its forms has increased over the last few years and particularly from around 2010. In a Briefing Paper for the House of Commons, the authors state that *‘the increase in statutory homelessness since 2009/10 is attributed to a number of factors, of which the most important is identified as the continuing shortfall in levels of new house building relative to levels of household formation. Housing benefit reforms are also viewed as a significant contributory factor...’*³⁰

Furthermore, The National Audit Office (NAO) in their recent report state that *‘it appears likely that the decrease in affordability of properties in the private rented sector, of which welfare reforms such as capping of Local Housing Allowance are an element, have driven this increase in homelessness...the government has not evaluated the impact of its welfare reforms on homelessness, or the impact of the mitigations that it has put in place’*.⁴

The Institute for Fiscal Studies has also recently published a report on housing and have looked at the cost of housing for low income renters.³¹ They estimate that benefit reforms since 2011 have cut the housing benefit entitlements of 1.9 million privately renting households, which contain 4.8 million people and 600,000 social-renting households, which contain 1.3 million people. This includes two thirds of low income private renters and one sixth of low income social renters.

They indicate that the shortfall between housing benefit entitlement and the cost of renting a property for low income renters is much higher than it would have been without the reductions made since 2011. Low income renters spend a higher proportion of their income on rent than higher income renters, even after accounting for any help they may get through housing benefit entitlements and this differential has risen over time. The proportion of low income renters who do not have all their rent covered by housing benefit has risen from 74% in the mid 1990s to 90% in the mid 2010s.

For example, the market median rate for Southampton is:

- a room is £390 per calendar month

³⁰ Wilson, W and Barton, C (2017). Statutory Homelessness in England. Briefing Paper Number 01164, 9 October 2017. House of Commons Library.

³¹ Joyce, R; Mitchell, M; and Norris Keiller, A (2017). The cost of housing for low income renters. The Institute of Fiscal Studies, 2017.

Adults with complex needs (with a particular focus on street begging and street sleeping)

- a studio is £495 per calendar month
- a one bedroom flat is £595 per calendar month

Housing Benefit (where the LA can assure the landlord payment direct) or Universal Credit (where the LA cannot assure payment direct to the landlord) will pay a 'maxima' of £294.91 per calendar month for a room.

For a studio or one bedroom flat, Housing Benefit or Universal Credit will pay a 'maxima' of £294.91 for those aged under 35, or £506.35 for those aged over 35 years of age.

This means that there is very little incentive for landlords to let their properties to those who are homeless, unless they are over 35, but even then, the gains for them from a commercial perspective are limited. The lack of affordable housing coupled with the benefit gap has had a significant impact on those who were already vulnerable.

7.0 Why do people street beg and/or street sleep?

Whilst the issues discussed in section 6 go a long way to explain why people are increasingly becoming homeless, this section explores some of the reasons why people become homeless in the first place and/or have an increased likelihood of experiencing homelessness throughout their lifetime.

The reasons why people street beg and/or street sleep are many and the way in which these interact is complex. What is clear from the literature is that many of those who find themselves engulfed within a life on the streets, do so as a result of early exposure to significant trauma/adverse experiences in early childhood^{21,22, 32,33}. Such childhood trauma/adverse experiences include:

- physical abuse
- neglect
- there sometimes not being enough food to eat at home
- homelessness
- domestic violence in the household
- parental substance misuse
- parental mental health issues
- poor family functioning
- socio-economic disadvantage/poverty
- separation from parents or care givers

Evidence suggests that this early trauma/adverse childhood experiences result in an increased likelihood of being homeless in the future. 98% of those who experienced such events, also had experience of being homeless at some point in their adult life and/or were currently homeless.³²

Fitzpatrick et al (2013) sought to identify the pattern and nature of multiple exclusion homelessness (MEH) across the UK. *'People have experienced MEH if they have been 'homeless' (including experience of temporary/unsuitable accommodation as well as sleeping rough) and have also experienced one or more of the following other domains of 'deep social exclusion: 'substance misuse (drug, alcohol or solvent misuse);*

32 Fitzpatrick, S; Bramely, G; Johnsen, S (2013). Pathways into multiple exclusion homelessness in seven UK cities. *Urban Studies*, 50(1),148-168.

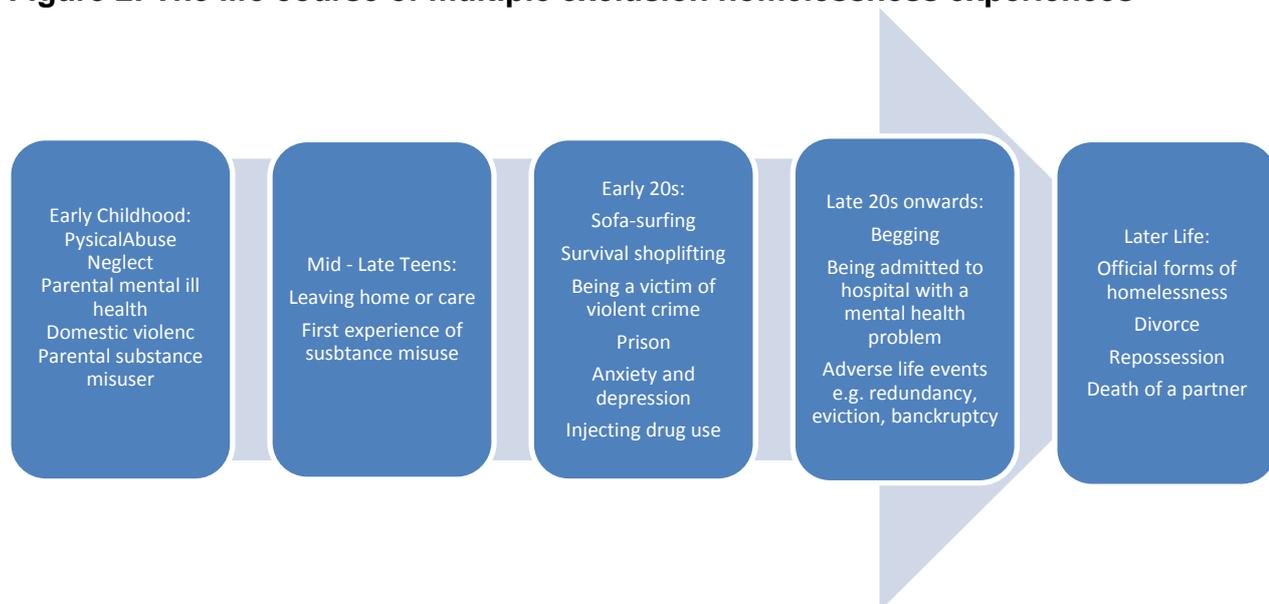
33 Fitzpatrick, S; Bramely, G; Johnsen, S (2012). Multiple Exclusion Homelessness in the UK. Heriot Watt University and ESRC, Institute for Housing, Urban & Real Estate Research, 2012.

participation in 'street culture activities'(begging, street drinking, survival shoplifting or sex work)'.

Whilst this is wider than street sleepers and street begging; it helps to understand the circumstances, experiences and severe and multiple deprivation/social exclusion, which have impacted significantly on those individuals who have found themselves on the streets.

Fitzpatrick et al^{32,33} describe these pathways into MEH almost as a life course, with particular MEH experiences happening through our lives, which then increase the likelihood of us experiencing homelessness and other complex issues such as mental ill health and substance misuse (figure 2). Through their work, they were also able to 'cluster' MEH experiences and identify sub groups within the MEH population with similar sets of experiences.

Figure 2: The life course of multiple exclusion homelessness experiences



Source: Fitzpatrick, S, 2013.

They found that experiences that happened earliest in individual's pathways were:

- abusing solvents, glue or gas
- being thrown out by parents or carers
- using hard drugs
- developing a problematic relationship with alcohol and/or street drinking

They suggested that this implies that these factors, when they apply, may often be contributory factors in the commencement of an MEH pathway.

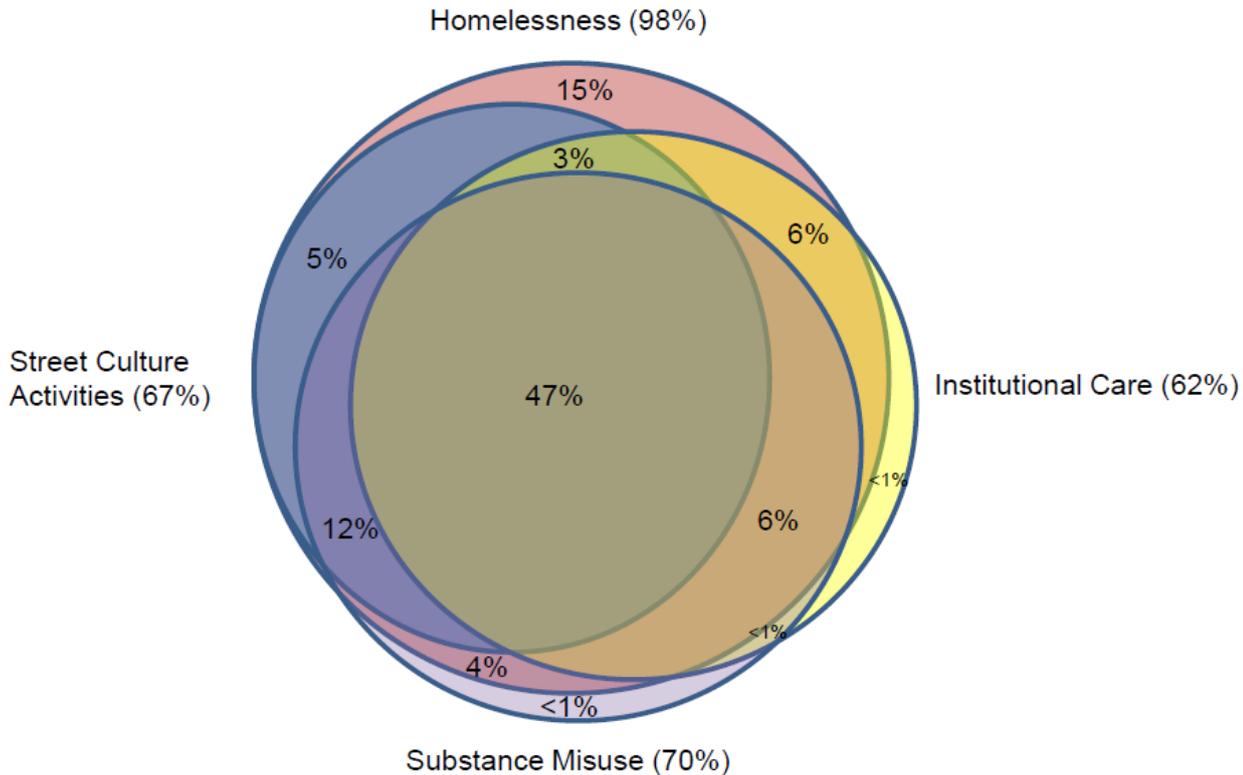
Fitzpatrick et al (2013)³² found that the set of experiences that occurred in the middle – later phases of an MEH individual's pathway seemed to confirm a transition to street

lifestyles and those occurring in the late phase of the pathway eg official forms of homelessness (repossession, partner death etc) were not part of the initial set of originating causes, but are often outcomes of a sequence of events, which are more likely to have started with combinations of the kinds of factors that occur in the earlier phases of the pathway.

As part of their study, Fitzpatrick et al (2012)³³ undertook a Census Questionnaire Survey of low-threshold service users (those services that make relatively few 'demands' of service users, such as day centres, soup runs, direct access accommodation, street outreach teams, drop in services, needle exchange etc).

They used the results from this to demonstrate that the experience of specific domains of deep social exclusion (homelessness, institutional care, substance misuse and street culture activities) was extremely widespread amongst this population. Figure 2 below shows the complex nature of the interactions between the domains and indicates that almost all had experienced homelessness (98%); 70% had experienced substance misuse; 67% had experienced street culture activities and 62% had experienced institutional care. The degree of overlap is huge and some 47% of people have experienced all 4 domains (Figure 3).

Figure 3: The Overlap Between the Domains of Deep Social Exclusion



Source: Fitzpatrick, 2012.

The census survey also demonstrated that homelessness was a particularly prevalent form of exclusion.

Through the census survey and extended interviews, they were able to identify what predicts whether an individual within the MEH population has had a more or less complex set of MEH experiences. Factors associated with more complex MEH experiences (with other being equal), included:

- being male
- being aged between 20-49 years old (especially 30s)
- having experienced any of the following as a child: physical abuse or neglect, there sometimes not being enough to eat at home, or homelessness
- having parents with problems such as domestic violence, substance misuse or mental health issues
- having had poor experiences of school ie truancy, exclusion, victim of bullying etc
- being brought up in a household with at least 1 adult in paid work all or most of the time
- having lived on welfare benefits for most of your adult life
- being recruited to the study from a 'non-homelessness' service

Roos et al²¹ looked at the relationship between adverse childhood experiences and homelessness and the impact of Axis I and II disorders³⁴. They state that *'childhood adversities are found to be substantially overrepresented in homeless samples and a history of childhood adversity has been related to particularly poor outcomes among the homeless'*. They used the National Epidemiologic Survey of Alcohol and Related Conditions (NESRAC) to investigate whether a history of different childhood adversities were associated with increased odds of developing lifetime homelessness and whether Axis I and II mental disorders mediated these relationships.

They found that in the entire sample of 33,728, a very small proportion reported lifetime homelessness – 3.1% (1,103). Of these, 4% (610) were men and 2.3% (493) were women. Those with lifetime homelessness experienced higher rates of all childhood adversities compared to those without lifetime homelessness (85% of women lifetime homeless compared to 49.8% of those without lifetime homelessness, and 77.1% of men with lifetime homelessness compared to 50.3% of those without lifetime homelessness).

The most prevalent childhood adversities for both men and women experiencing lifetime homelessness were:

- physical abuse
- physical neglect

³⁴ Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). Washington DC; American Psychiatric Association, 1994.

- general household dysfunction

Nearly half of women with a history of lifetime homelessness experienced childhood sexual abuse.

Odds ratios (OR) were calculated for each type of childhood adversity, they found that the ORs for each childhood adversity was significantly ($P < .001$) associated with an increased likelihood of lifetime homelessness in both men and women. Those most strongly associated with lifetime homelessness and/or Axis I and II disorders were:

For women:

- childhood emotional abuse (OR = 4.24) was most strongly associated with both lifetime homelessness and any Axis I or II disorder (OR = 4.04)

For men:

- emotional abuse and sexual abuse (OR for both = 3.25) related to highest likelihood of experiencing lifetime homelessness
- whereas emotional abuse was most strongly related to any Axis I or II disorder (OR = 4.54)

They also adjusted for Axis I and II disorders and estimated the extent to which lifetime homelessness could be attributed to adverse childhood experiences, and found that the attributable fraction for men and women were 45% and 61% respectively.

Shelton et al²² similarly looked at the factors associated with lifetime experience of homelessness and used a representative sample who participated in the National Longitudinal Study of Adolescent Health. They collected data from 14,888 young adults who were involved in the study, 6 years after they enrolled in the study as adolescents.

4.6% (682) of the respondents were classified as ever being homeless (610 had been homeless for a week or more; 199 had stayed in a homeless shelter and 6 were currently homeless during the interview period).

They found that several factors were uniquely associated with homelessness:

- ever having run away from home (OR = 4.03)
- ever having been ordered out of the home by parents (OR = 3.16)
- placement in foster care (OR = 2.15)
- incarceration of the biological father (OR = 1.45)
- parental-caregiver neglect (OR = 1.47)
- duration of welfare assistance to the family before age 18 (OR = 1.14)

- economic difficulty in the last 12 months (OR = 1.23)
- a diagnosis of depression (OR = 1.61)
- having had a psychiatric hospitalisation in the past 5 years (OR = 1.82)
- problems with drugs in the last 12 months (OR = 1.16)

Interestingly, they found that parental physical aggression and sexual abuse; investigation of the family by social services; expulsion from school; current recipient of welfare benefits; prescription medication for antidepressants; suicidal ideation; problems with alcohol and gambling; and none of the indicators of criminal behaviour or violence were independently associated with homelessness.

Shelter²⁵ undertook a consultation with rough sleepers in 2007. They found that the key factors contributing to homelessness in that population were:

- relationship breakdown (41%)
- being asked to leave the family home (28%)
- drug problems (31%)
- alcohol problems (28%)
- leaving prison (25%)
- mental health problems (19%)

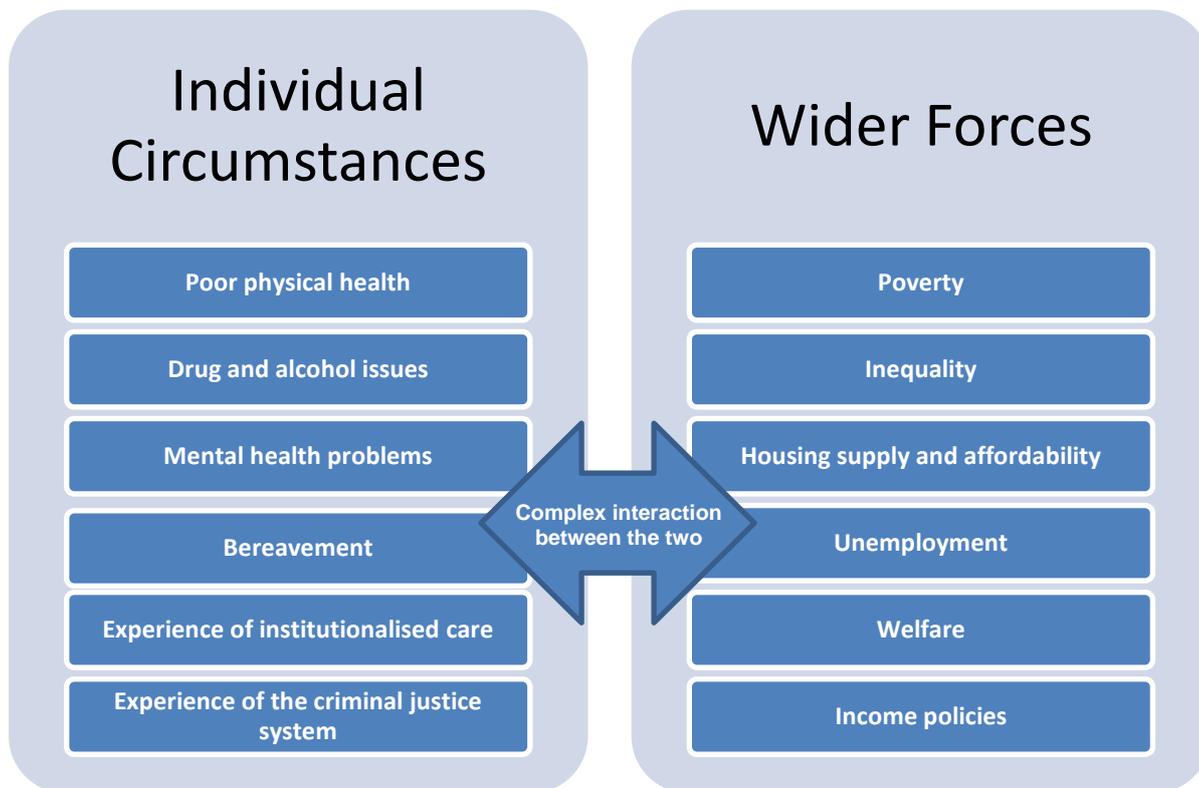
On average the interviewers found that the majority of those interviewed had 2 or 3 factors that contributed to their homelessness and 30% identified 4 or more factors that contributed, which again supports the issues raised above in terms of multiple exclusion homelessness and the complex needs of this group.

Respondents talked about how drug problems can lead to homelessness and make it more difficult for people to get off the streets. They also talked about how the lack of pathways into housing/suitable accommodation from institutional care (hospital or prison, for example) can lead to homelessness and often relapse into drug use. However, where there were such pathways in place, those interviewed felt that they were effective when used.

Homeless.org.uk indicate that the most common reasons people give for losing their accommodation is that a friend or relatives are no longer able to provide support, or because of relationship breakdown.³⁵ However, they also recognise that there are a number of factors in play that can impact on an individual and mean that they arrive at a point where they become homeless. They indicate that such factors include (Figure 4):

³⁵ Pasted from: <http://www.homeless.org.uk/facts/understanding-homelessness/causes-of-homelessness>

Figure 4: Factors Impacting on the Likelihood of Becoming Homeless



In relation to begging specifically, Thames Reach, through evidence gathered by their outreach teams and others state that one of the key drivers is drugs and alcohol and indicate that *'overwhelming evidence shows that people who beg on the streets of England do so in order to buy hard drugs, particularly crack cocaine and heroin and super-strength alcoholic beers and ciders....the evidence comes from a number of sources. Firstly, Thames Reach's outreach teams....they estimate that 80% of people begging do so to support a drug habit...secondly, when the Metropolitan Police did some drug testing of people arrested for begging, the figures indicated that between 70 and 80% tested positive for Class A drugs....most recently, in a police crackdown in Birmingham on begging in autumn 2013, every single one of the 40 people arrested failed a drug test'*.²⁹

A number of other homeless charities echo these findings and similarly state that drugs and alcohol are often the key drivers for street begging.^{28,35}

Those experiencing complex problems and who are homeless are at increased risk of sleeping rough, being involved in street drinking, begging and becoming involved in prostitution. One study on the experiences of homeless individuals found that there is a:³⁶

³⁶ Taken from Homelessness.org.uk: www.homeless.org.uk/facts/understanding-homelessness/impact-of-homelessness

Adults with complex needs (with a particular focus on street begging and street sleeping)

- 77% chance that someone could sleep rough
- 53% chance that someone could be involved in street drinking
- 32% chance that someone could beg
- 10% chance that someone could be involved in prostitution

8.0 The impact of street begging and/or street sleeping

Homelessness has a significant impact on the individuals themselves, their families and the communities in which they participate in street culture/lifestyles or utilise services to support their needs.

The impact on individuals

Figure 5 below, highlights the impact of homelessness on the individual experiencing it.³⁶ Those who are homeless are significantly more likely to be unemployed, have poor mental health, have long-term physical health issues and use drugs compared to the general population.

Figure 5: The Impact of Homelessness on the Individual



Source: homeless.org.uk.

Impact of homelessness on health

The Local Government Association has recently published a guide for local authorities aimed at addressing the health needs of those who are homeless.³⁷ The document states that a recent audit found that:

- 41% of homeless people reported a long-term physical health problem, compared to 28% in the general population

³⁷ Leng, G (2017). The Impact on Health of Homelessness. A Guide for Local Authorities. LGA, September 2017.

- 45% had a diagnosed mental health problem, compared to 25% in the general population
- co-morbidity amongst the longer-term homeless population is not unusual; the average age of death of a homeless person is 47 (and is lower for women at 43)

As part of the interviews for the Hard Edges research, they asked about health problems or disabilities and found that those in all SMD domains had significant health problems, with alcohol and drug misuse being the main issue, followed by 'problems/disability with arms, legs, hands, feet, back or neck' (Table 4). Issues relating to respiratory conditions and heart conditions were also high.

Table 4: Health problems reported (prompted) by MEH sample, by SMD category

Do you have any of the health problems or disabilities listed on this card?					
Illness/Health problem	SMD1	SMD2	SMD3	All MEH	Wkg Age
Alcohol or drug related problems	30%	60%	78%	43%	1%
Problems/disability with: arms, legs, hands, feet, back or neck	27%	23%	30%	27%	20%
Chest/breathing, asthma, bronchitis	24%	26%	25%	24%	12%
Stomach/liver/kidneys/digestive	14%	19%	32%	19%	6%
Heart/high blood pressure or circulation	21%	10%	13%	16%	12%
Skin conditions/allergies	15%	12%	13%	14%	14%
Migraine or frequent headaches	10%	10%	18%	12%	7%
Difficulty in seeing (excl normal glasses)	11%	13%	17%	12%	7%
Difficulty in hearing	7%	7%	17%	8%	5.2%
Epilepsy	6%	7%	0%	5%	1%
Diabetes	4%	0%	1%	2%	3.2%
Other health problems	4%	0%	3%	2%	5%
Cancer	1.6%	2.5%	0%	1.6%	0.8%
Hepatitis	1.7%	0.7%	2.2%	1.2%	
Stroke	1.6%	0.9%	1.9%	1.2%	0.5%
ADHD	1.4%	0%	3.8%	1%	
HIV positive	1.7%	0%	0%	0.8%	
Chronic fatigue/tiredness	1%	0.4%	0%	0.6%	
OCD	0.4%	0%	1.9%	0.4%	
Autism	0.0%	0%	0.6%	0.1%	
None					

Source: Hard Edges, 2016.

Montgomery et al³⁸ in their study, compared the characteristics of people experiencing homelessness who were sleeping primarily in unsheltered situations with those who were accessing homeless shelters and other sheltered situations. They were looking at the correlated between unsheltered status and increased risk of mortality and found that:

- those sleeping in unsheltered situations had 12% higher adjusted odds of having at least 1 risk factor for mortality compared to those sleeping in sheltered situations

Impact on children and families

LGA document

Children who start life in an environment where housing is insecure eg temporary accommodation, have an increased risk of poor access to universal healthcare such as immunisations and associated with an increase in accidents and greater rates of infection.³⁷ Homeless children are at greater risk of:

- stress and anxiety, resulting in depression and behavioral issues
- lower educational attainment – accessing school places may be difficult
- absenteeism from school
- bullying
- isolation

Parents are also at greater risk of suffering from anxiety, depression and isolation and as a result may neglect the needs of their child(ren).

Impact on communities

Rough sleeping is often associated with nuisance activities such as begging, street drinking and anti-social behaviour and can have a negative impact on communities.⁸ The literature does not go into this in much detail, but talks about things in relation to the legal framework underpinning this and the extent of the use of civil measures.

³⁸ Montgomery, AE et al (2016). *Homelessness, Unsheltered Status and Risk Factors for Mortality: Findings from the 100,000 Homes Campaign*. Public Health Reports 2016, Vol. 13(6) p765-772. Association of Schools and Programs of Public Health, 2016.

9.0 Interventions – what works to prevent/ reduce street begging and street sleeping?

Much of the evidence around interventions found relates to homelessness in its broadest sense; particular aspects of homelessness. For example, homeless veterans or institutional homelessness; or some specific issues, including drugs and alcohol or mental health.

There was little primary research looking at interventions specifically to prevent or reduce street begging or street sleeping. Much of the literature relating to this is found in grey literature, policy or strategy papers, or informal news pieces.

As discussed in earlier sections, the reasons why people become embroiled in a life on the streets or homeless more generally are wide and the interactions between them are complex. However, there are some key themes that have emerged, including:

- early intervention
- integrated working
- interventionist approaches Vs non-interventionist approaches

Early intervention in the context of homelessness

A number of studies discussed earlier highlight the way in which the risk of becoming homeless in the future is increased significantly if there are particular experiences in early childhood and that as a result, one of the key ways to prevent or reduce such outcomes would be to identify and intervene at the earliest opportunity. Preventing childhood adversity and/or finding ways of mitigating against the negative outcomes associated with such experiences is crucial.²¹

Similarly, Shelton et al²² believe that young people at the greatest risk of becoming homeless should be identified early through schools, paediatric services, social services and other similar types of contact points with children and families. They went on to say that prevention efforts should also be directed towards other factors that appear to predispose young people to homelessness such as a diagnosis of depression and receiving psychiatric care in the past 5 years (mid to late teens).

Fitzpatrick et al³² again reiterate the importance of intervening at the earliest opportunity. They suggest that the current preventative focus in the UK on the provision of housing options services, at the point of homelessness applications to local

authorities, is far too late for those with multiple exclusion homelessness. They believe that preventative interventions should focus on earlier signs of distress wherever possible. For example, with schools, drug and alcohol services, and the criminal justice service who are likely to come into contact with those vulnerable to MEH well before housing and homelessness agencies do.

Integrated working and system wide approaches

This theme came up particularly in the studies and commentaries relating to enforcement, where Johnsen et al³⁹ found that enforcement could result in positive outcomes for those who are homeless if there is also strong integrated working practices in place. This integration leads to less opportunities for vulnerable people to fall through the gaps between services and professionals and enables strong and coherent pathways for people.

One of the key examples of where integrated working and a system wide approach is vital is at the points in time when a person is leaving some form of institutionalised care be that a hospital, prison or mental health facility, for example. The point of discharge from an institution is a particularly challenging time for any individual, but again having strong integrated pathways within a system wide framework of care and support would reduce the impact of such experiences in relation to homelessness.

Interventionist approaches Vs non-interventionist approaches

Again, this theme arose primarily in the work looking at enforcement, where the researchers looked at interventionist approaches (enforcement and/or services that impose criteria or certain conditions to be met) and non-interventionist approaches (services like 'soup runs' that impose no criteria or conditions for access).

Johnsen et al⁴⁰ talk about the fact that 'conditionality' has become more apparent, where eligibility for support is more explicitly tied to service user compliance. They cite No Second Night Out (NSNO) as an example of where this is clear. It requires 'new' rough sleepers to engage with a 'single service offer' developed by homelessness agency staff, and failure to do so renders them ineligible for support from participating agencies in that area.

They felt that stakeholder opinion on interventionist approached vs non-interventionist approaches was divided currently.

39 Johnsen, S and Fitzpatrick, S (2008). The Use of Enforcement to Combat Begging and Street Drinking in England: A High Risk Strategy? *European Journal of Homelessness*, Volume 2, p.191- 204, December 2008.

40 Johnsen, S et al (2016). *First Wave Findings: Homelessness*. Economic and Social Research Council, 2016. www.welfareconditionality.ac.uk

Promising interventions

There are a range of interventions discussed in the literature, most of which are focused on homelessness in its wider form, rather than street sleeping or street begging. Table 5 outlines some of the literature in relation to interventions linked to homelessness and rough sleeping. Although, by tackling some of the issues linked to homelessness, street begging is likely to be reduced. Key interventions include:

- No Second Night Out
- Housing First
- Psychologically Informed Environments
- Personalised Services
- MEAM

Table 5: Promising Interventions for Street Sleeping/Homelessness

Intervention	Description of the intervention/ Summary of the report	Type of evidence/ Methodology	Sample Size/ Participant Characteristics/ Population aimed at	Results	Conclusions
No Second Night Out ^{41, 42}	<p>24 hour helpline and website so that members of the public can report and refer rough sleepers.</p> <p>Outreach worker dispatched to contact the person as quickly as possible.</p> <p>An assessment hub staffed by a professional team.</p> <p>Piloted in London until the end of September 2011.</p> <p>Principles:</p> <ul style="list-style-type: none"> • new rough sleepers should be identified and helped off the streets immediately so that they do not fall into a dangerous rough sleeping lifestyle • members of the public should be able to play an active role by reporting and referring people sleeping rough • rough sleepers should be helped to access a place of safety where their needs can be quickly assessed and they can receive advice on their options • they should be able to access emergency accommodation and 	Policy document.	Aimed at rough sleepers/street sleepers.		It needs to sit alongside efforts to tackle the multiple needs of the most entrenched rough sleepers through personalised approaches.

41 Department for Communities and Local Government (2011). Vision to end rough sleeping: No Second Night Out nationwide. Crown Copyright, April 2011.

42 Homeless Link (2014). No Second Night Out Across England. Homeless Link, 2014.

Adults with complex needs (with a particular focus on street begging and street sleeping)

	<p>other services, such as healthcare, if needed</p> <ul style="list-style-type: none"> • if people have come from another area or country and find themselves sleeping rough, the aim should be to reconnect them back to their local community unless there is a good reason why they cannot return. There, they will be able to access housing and recovery services, and have support from family and friends 				
	<p>The longer someone sleeps rough, the greater the risk that they will become trapped on the streets and vulnerable to becoming a victim of crime, developing drug or alcohol problems, or experiencing problems with their physical or mental health.</p> <p>In response to this, the concept of No Second Night Out (NSNO) was developed. The idea behind NSNO is to ensure rough sleepers are helped off the streets as quickly as possible, that nobody lives on the streets, and that once helped, people do not return to the streets.</p>	<p>Evaluation report – analysis of Homelessness Transition Fund data and follow up surveys with local authorities and charities.</p>	<p>Sample of 20 areas in the England with higher levels of rough sleeping as measured by the annual rough sleeper counts and estimates.</p> <p>These 20 areas represent 69 local authorities, covering a mixture of major cities, smaller towns and rural areas.</p> <p>These areas have all had funding from the Homelessness Transition Fund.</p>	<ul style="list-style-type: none"> • across the 20 areas, they worked with 2,546 rough sleepers • 67% of rough sleepers worked with were taken off the streets after the first night that they were found to be sleeping rough • 78% of this group did not return to the streets once helped 	<p>The most important outcomes of NSNO, according to respondents, were:</p> <ul style="list-style-type: none"> • improved services for rough sleepers • strengthened or improved partnership working between local authorities and voluntary sector providers <p>Most services catered for ‘new’ rough sleepers, rather than entrenched rough sleepers and there was concern raised about this group.</p> <p>The biggest challenge in implementing NSNO services was getting buy-in and agreement from all partners.</p> <p>The second biggest challenge was finding</p>

Adults with complex needs (with a particular focus on street begging and street sleeping)

					sufficient resources to provide the services, including staffing, physical and financial resources.
Housing First ^{43, 44, 45, 46}	<p>Housing First is designed to provide open-ended support to long-term and recurrently homeless people who have high support needs.</p> <p>People using Housing First services are much more likely to have complex needs including severe mental illness, poor physical health, long-term limiting illness, physical disabilities and learning difficulties compared to the general population.</p> <p>Clients do not have to be abstinent from drugs or alcohol to access services.</p> <p>Getting housing or remaining in housing is not conditional on accepting support or treatment.</p> <p>It operates within a harm reduction framework.</p>	Observational study of 9 services in the UK.	<p>143 service users across the 9 services.</p> <p>Data was collected from 60 (42%) service users.</p> <p>23 service users agreed to in depth interviews.</p> <p>Focus groups were held with staff from all 9 services.</p> <p>5 services operated in London, 2 on the south coast, one in the midlands and one in the north east.</p> <p>27% of all service users were female.</p>	<p>78% of service users were housed, as at December 2014.</p> <p>59 service users had been housed for a year or more by 5 of the services, representing 74% of their clients.</p> <p>There was evidence of improved mental and physical health – 43% reported ‘bad or very bad’ physical health a year before Housing First, reducing to 28% when about current health.</p> <p>52% reported ‘bad or very bad’ mental health a year before Housing First, reducing to 18% when asked about current health.</p>	<p>Housing First services that offer security of tenure, are client-led, use harm reduction, offer open ended support and do not make access to, or retention of, housing conditional on compliance with treatment or modification of behaviour, all appear to be effective.</p> <p>Gains in health, mental health, social integration, drug and alcohol use and levels of anti-social behaviour were not uniform. There was also the possibility of deterioration in mental and physical health. However, there was no evidence of increases in drug or alcohol use, or anti-social behaviour, since engaging with Housing First.</p> <p>Housing First is not a panacea and it is not the</p>

43 Bretherton, J; Pleace, N (2015). Housing First in England, An Evaluation of 9 Services. Centre for Housing Policy, University of York, February 2015.

44 Homeless Link Policy and Research Team (June 2015). ‘Housing First’ or ‘Housing Led?’ The current picture of Housing First in England. Homeless Link, 2014.

45 Collins, S et al (2012). Project-Based Housing First for Chronically Homeless Individuals With Alcohol Problems: Within-Subjects Analyses of 2-Year Alcohol Trajectories. American Journal of Public Health, March 2012, Vol. 102, No.3 p.511-519.

46 Kirst, M et al (2015). The impact of a Housing First randomized controlled trial on substance use problems among homeless individuals with mental illness. Drug and Alcohol Dependence, 146 (2015) 24-29.

Adults with complex needs (with a particular focus on street begging and street sleeping)

				<p>There was some evidence of reduced drug and alcohol use – 71% reported that they would ‘drink until they felt drunk’ a year before Housing First, reducing to 56% when asked about current behaviour.</p> <p>66% reported drug use a year before Housing First, reducing to 53% when asked about current use.</p> <p>There was positive evidence around social integration within communities and reconnecting with family and in reductions in anti-social behaviour.</p>	<p>case that Housing First should simply replace existing homelessness services.</p>
	<p>While Housing First offers a long-term accommodation solution, the evidence base on the scale of Housing First in England and the extent to which the principles of the model are being used in practice, is limited.</p> <p>Whilst there is a large body of research and evaluation on the effectiveness of the model in the US, Canada and some European countries, less exists in the English context.</p> <p>This report summarises evidence about the scale of the current use of</p>	<p>Review</p>	<p>Target clients for Housing First were rough sleepers (71%) and those with multiple and complex needs (70%).</p> <p>17% target their service to women only and young people aged 16-25 years.</p>	<p>There is strong evidence that Housing First provides strong and consistent outcomes for tenancy sustainment of between 70 to 90%.</p> <p>Outcomes in relation to mental and physical health, substance misuse and social integration are more mixed but are generally positive.</p>	<p>There is no single definition of Housing First, but there some core principles from the original Pathways model in the US:</p> <ul style="list-style-type: none"> • housing is a human basic right • immediate provision of permanent scattered site housing • respect, warmth and compassion for all clients

	<p>Housing First in England, how it is funded, and the challenges and opportunities for rolling it out on a national scale.</p> <p>It examines the gaps in current evidence, policy and practice that could be addressed to help Housing First be a credible housing solution to people experiencing multiple disadvantage across England.</p>				<ul style="list-style-type: none"> • no requirement regarding housing readiness • a commitment to working with clients for as long as they need • separation of housing and services • use of an assertive case management (ACM) and an intensive case management team (ICM)³ • consumer choice and self-determination • a recovery orientation; harm reduction rather than abstinence with regards to substance misuse <p>They suggest that through their scoping research, Housing First would be targeted at between 10-20% of people currently in contact with homelessness services.</p> <p>Whilst some services are adhering to the principles of Housing First, others have moved to what they call 'Housing Led' services, which they describe as lower intensity support, range and duration.</p>
--	--	--	--	--	---

Adults with complex needs (with a particular focus on street begging and street sleeping)

					<p>Funding sources were insecure, relying on charitable funds, LA grants and housing related support funds.</p> <p>By far the biggest barrier to setting up a Housing First project was reported as access to suitable and affordable accommodation in both the social and private rented sectors.</p>
	<p>Looked at alcohol use over 2 years among residents in a project based Housing First project in the US.</p> <p>Project-based Housing First provides immediate, low-barrier, non abstinence-based, permanent supportive housing to chronically homeless individuals within a single housing project. The study aim was to address concerns that non abstinence based housing may enable alcohol use.</p>	<p>This was a follow up study of 2 year alcohol use expanding on findings from an earlier publication.</p> <p>Data were collected in the context of a non randomised controlled trial comparing the effects of project-based Housing First and a wait list control condition on public system use and associated costs.</p> <p>Participants were followed up at 3, 6, 9, 12, 18 and 24 months. Response rates went from 100% at baseline to 61% at 24 months.</p>	<p>Participants were chronically homeless individuals with alcohol problems who had been allocated to the project-based Housing First condition in the parent study.</p> <p>Sample size = 95 participants.</p> <p>Participants were predominantly male (93.7%) and ethnically diverse.</p>	<p>Multilevel growth models indicated significant within subjects decreases across alcohol use outcomes over the study period. Intervention exposure, represented by months spent in housing, consistently predicted additional decreases in alcohol use outcomes</p>	<p>Although the project-based Housing First program did not require abstinence or treatment attendance, participants decreased their alcohol use and alcohol-related problems as a function of time and intervention exposure.</p>

Adults with complex needs (with a particular focus on street begging and street sleeping)

	<p>There is strong evidence that Housing First interventions are effective in improving housing stability and quality of life among homeless people with mental illness and addictions. However, there is very little evidence on the effectiveness of Housing First in improving substance use-related outcomes in this population.</p>	<p>Randomised Control Trial - Substance use outcomes were compared between a Housing First intervention and treatment as usual group in a sample of 575 individuals experiencing homelessness and mental illness, with or without a co-occurring substance use problem, in the AtHome/ChezSoi trial in Toronto, Canada.</p> <p>Generalised linear models were used to compare study arms with respect to change in substance use outcomes over time (baseline, 6, 12, 18 and 24 month).</p>	<p>575 participants – 301 in the intervention arm and 274 in the treatment as usual arm.</p> <p>Participants were mostly male (68%).</p>	<p>At 24 months, participants in the Housing First intervention had significantly greater reductions in number of days experiencing alcohol problems and amount of money spent on alcohol than participants in the Treatment as Usual group. No differences between the study arms in illicit drug outcomes were found at 24 months.</p>	<p>These findings show that a Housing First intervention can contribute to reductions in alcohol problems over time. However, the lack of effect of the intervention on illicit drug problems suggests that individuals experiencing homelessness, mental illness and drug problems may need additional supports to reduce use.</p>
<p>Psychologically Informed Environments⁴⁷</p>	<p>The concept of a Psychologically Informed Environment was originally developed by Robin Johnson and Rex Haigh as part of the Royal College of Psychiatrists' Enabling Environments initiative.</p>				

⁴⁷ Psychologically Informed Services for Homeless People, Good Practice Guide (2012).

	<p>The purpose of a PIE is to enable clients to make changes in their lives. Usually this would be changes in behaviour and/or emotions.</p> <p>There are a number of psychological frameworks that can be used Including:</p> <ul style="list-style-type: none"> • Humanistic • Psychodynamic • Cognitive Behavioural Therapy (CBT) • Dialectical Behaviour Therapy (DBT) <p>There is no single right approach to addressing someone’s emotional and psychological needs and organisations may decide to use more than one framework.</p>				
<p>Personalised Services⁴⁸</p>	<p>Homeless Link was commissioned by Broadway to carry out a review of services, which aim to deliver personalised responses to rough sleeping and entrenched homelessness.</p> <p>They examined how 5 projects working with long-term rough sleepers and people with complex needs who had often been sleeping rough for some time, were using personalised approaches to support people sleeping on the streets.</p> <p>Personalisation means recognising people as individuals who have strengths and preferences and putting</p>	<p>Review</p>			<p>Their key findings were that:</p> <p>Personalised approaches were effective in supporting rough sleepers who had previously not engaged with services to move off the streets; that they put homeless people at the centre of their support; building trusting relationships with project workers are essential; being given a choice was central to engaging rough sleepers; flexible approaches of staff,</p>

48 Homeless Watch (2013). Personally Speaking. A review of personalised services for rough sleepers. Homeless Link, December 2013.

Adults with complex needs (with a particular focus on street begging and street sleeping)

	<p>them at the centre of their own care and support. Central to personalisation are personal budgets in social care and personal health budgets in the NHS.</p>				<p>enabling them to be responsive were important; can enable rough sleepers to engage with other local support services.</p> <p>However, there was sometimes a lack of mutual understanding between existing services and personalised services; there was no clear evidence about the cost-effectiveness of personalised services; there is more to be done to support them better through existing local services.</p>
MEAM⁴⁹	<p>3 pilots in Cambridgeshire, Derby and Somerset. The purpose of the pilots was to coordinate existing local services to provide better support to individuals suffering from multiple needs and exclusions.</p> <p>This report is an updated evaluation of the pilots after 2 years since inception. Their first evaluation report was after 1 year.</p>	<p>Evaluation - The pilot areas started to work with clients in late 2010 and early 2011. The pilot areas collected data on client wellbeing and service use, which they gave to the evaluation team.</p> <p>They requested the same set of data from the pilot areas for Year 2 as</p>	<p>In Year 1, each area established a caseload of up to 15 clients and in total the pilots worked with 69 people in the first 12 months.</p> <p>They compared the wellbeing and service use of 39 clients after participating in the pilot with their wellbeing and</p>	<ul style="list-style-type: none"> • In Year 1 nearly all clients showed significant improvements in wellbeing across 3 quantitative measures (The NDT Assessment, The Warwick Edinburgh Mental Well Being Scale and the Outcome Star) • Year 1 improvements in wellbeing were maintained in 	<p>Survivorship bias.</p> <p>It was difficult for them to evaluate Year 2 effectively as they were unable to get any data from Somerset on the sample used in Year 1 and the data from Derby was incomplete.</p> <p>The authors acknowledge that the sample size is too small to draw any significant conclusions and that 'Survivorship bias' may have had an effect on the Derby data.</p>

49 Battrick et al (2014). Evaluation of the MEAM pilots - Update on our findings. A report by FTI Consulting and Compass Lexecon for Making Every Adult Matter, February 2014.

Adults with complex needs (with a particular focus on street begging and street sleeping)

		collected during Year 1.	service use before enrolling.	<p>Cambridgeshire and improved between Year 1 and 2 in Derby</p> <ul style="list-style-type: none"> • The Year 1 cost reduction increased in Year 2 in Cambridgeshire (26.4% against the baseline) • In Derby, costs increased in Year 1 and decreased (by 15.8%) in Year 2 	Survivorship bias would arise if those participants for whom we could not collect data had different characteristics from those for whom data was collected. That would lead to a bias in the observed results, with the programme appearing more or less successful than it actually was.
--	--	--------------------------	-------------------------------	---	--

Other promising evidence and interventions

A rapid systematic review of interventions to improve health and housing status in homeless people⁵⁰ found that:

- concurrent issues of substance abuse, mental illness and infectious disease make designing interventions to improve health and housing status of homeless individuals challenging – less than 1% of the research they found met the inclusion criteria for their systematic review. None of the evidence was found to be strong methodologically and only 10 were found to be of moderate quality
- provision of housing is associated with decreased substance use, relapses from periods of substance abstinence, health service utilisation and increased housing tenure
- abstinent-contingent housing appears to provide greater impact on sustained abstinence than non-abstinent-contingent housing
- interventions that included post-detoxification stabilisation, abstinent-contingent work therapy or an intensive residential treatment programme all showed significantly greater reductions in substance use than the usual care groups
- for homeless people living with mental health illness, provision of housing during discharge planning from hospital is associated with maintaining stable housing

Inclusion health

Inclusion health seeks to address the health and social inequities faced by some of our most vulnerable and excluded populations.⁵¹ Risk factors and the subsequent complexity inherent within these vulnerable populations are discussed in section 7. However, The Lancet have recently published a paper online, which looks at 'What works in inclusion health'⁵² in terms of effective interventions and looks at these under the following categories:

- pharmacological interventions
- psychosocial interventions
- case management
- disease prevention
- housing and social determinants
- other interventions
- interventions tailored to women
- interventions tailored to young people

50 Fitzpatrick-Lewis, D et al (2011). Effectiveness of interventions to improve the health and housing status of homeless people: a rapid systematic review. BMC public health, 2011; Vol.11, p.638.

51 Luchenski, S et al (2017). What works in inclusion health: overview of effective interventions for marginalised and excluded populations. Published online 11 November 2017. [http://dx.doi.org/10.1016/S0140-6736\(17\)31959-1](http://dx.doi.org/10.1016/S0140-6736(17)31959-1).

Key messages from their research were:

- people who are excluded from mainstream society, such as those experiencing homelessness, imprisonment, drug addiction and sex work, have considerably higher rates of disease, injury and premature mortality than the general public. Services need to tackle the so-called tri-morbidity of physical illness, mental illness and addiction
- multiple evidence based individual and structural interventions are available to prevent and address the excess burden of disease in these populations, but the need to translate and scale effective practice into action is crucial
- removal of barriers to access and uptake of services can be accelerated by involving people who have experience of social exclusion
- extreme exclusion is associated with frequent use of acute services, providing a strong economic case for preventive action
- the most effective upstream prevention policy is likely to be reduction of material poverty and deprivation, especially among families with children who are high risk of maltreatment
- gaps in knowledge remain, particularly around interventions to improve upstream determinants of social inclusion, such as employment and education, which are also instrumental to long-term recovery from social exclusion
- people who have experienced exclusion have identified appropriate housing as the most important intervention and systematic reviews have established the effectiveness of this intervention for improving health and social outcomes

Table 6 below provides a summary of the effective interventions by category as described in the paper.

Table 6: Effective interventions for inclusion health populations

Category	Effective Interventions
Pharmacological interventions	<ul style="list-style-type: none"> • methadone and buprenorphine are effective for treating opioid dependency; however methadone is more effective at retaining people in treatment • supervised injectable heroin might also be indicated for people resistant to standard treatment • no other effective treatments for substance use disorders only were identified • long acting injectable antipsychotics are effective for people with schizophrenia and substance use disorders • hepatitis C treatment is as effective among people who inject drugs as the general population. Retention in treatment

	<p>is improved when treatment of substance use disorders is provided simultaneously</p> <ul style="list-style-type: none"> • new short-term antiviral drugs are highly promising for inclusion health target populations • HIV treatment outcomes are improved by directly observed therapy, medication assisted therapy, contingency management and multi-component nurse-delivered interventions • adherence to tuberculosis treatment is improved in the short-term by incentives, but stand-alone directly observed therapy is ineffective without case management
<p>Psychosocial interventions</p>	<ul style="list-style-type: none"> • psychosocial interventions are most effective when provided in combination, although no clear evidence indicates the optimum intervention • contingency management (ie vouchers or incentives), motivational interviewing and cognitive behavioural therapy have shown some benefits for substance use disorders and in therapeutic communities for reincarceration • mental health and drug treatment services might be more effective when provided in an integrated setting
<p>Case management</p>	<ul style="list-style-type: none"> • case management can improve and enhance links with services and improve mental health symptoms • evidence is mixed as to whether or not this approach improves outcomes in substance use disorders and other health related outcomes • when used with assertive community treatment, case management might also help to reduce homelessness
<p>Disease prevention</p>	<ul style="list-style-type: none"> • harm reduction schemes including needle and syringe programmes, substitution programmes and safe injecting site programmes can reduce risk behaviour, risk of blood borne viruses and overdose risk • generally, multicomponent interventions are more effective than stand-alone interventions • interventions in community and criminal justice settings are effective

	<ul style="list-style-type: none"> • out reaching interventions can reach younger users and individuals with greater risk taking behaviours • training drug users to recognise opiate overdose and administer naloxone can reduce risk of fatal overdose • uptake of screening for hepatitis C can be increased through targeted screening in primary care, use of dried blood spots instead of venous blood samples and outreach • in criminal justice settings, HIV risk reduction interventions and hepatitis B vaccination are beneficial
<p>Housing and social determinants</p>	<ul style="list-style-type: none"> • provision of housing improves a range of health and social outcomes for homeless populations, particularly among those experiencing mental illness and substance use disorders • occupational therapy might increase education, employment and life skills among homeless populations • supported work placements, which are effective for individuals with severe, long-term mental illness, might also help other socially excluded populations to secure employment
<p>Other interventions</p>	<ul style="list-style-type: none"> • medical respite can reduce the number of future hospital admissions and use of emergency departments in homeless populations • computer based interventions and physical exercise interventions might improve outcomes for substance use disorders • complementary and alternative therapies and spirituality or religion might also have potentially positive effects, but more rigorous evidence is needed
<p>Interventions tailored to women</p>	<ul style="list-style-type: none"> • a variety of sex sensitive interventions can improve the health and social outcomes of women, including structured counselling and social support, therapeutic communities, case management and integrated programmes and advocacy and empowerment • effective interventions for excluded women address the role of motherhood, trauma and violence, substance use

	<p>disorders and education and empowerment as key aspects for recovery</p> <ul style="list-style-type: none"> • interventions can be delivered in community and institutional settings to support women
Interventions tailored to young people	<ul style="list-style-type: none"> • generally, evidence about young people who are excluded is scarce, but potentially promising results have been reported for family based therapy, cognitive behavioural interventions and brief interventions for a range of outcomes • foster care might help to reduce criminal activity and improve mental health; however, no evidence based transition support services are available for looked after young people approaching the end of care

Source: Luchenski et al, 2017.

Models of homelessness provision

In their Annual Review 2016²⁴, Homeless Link look at emerging models of homelessness provision and suggest that there are signs of innovation within the homelessness sector. Key approaches include:

- shared accommodation schemes – 70% of accommodation projects reported using (49%) or exploring (21%) this approach
- rent deposit and bond schemes – 65% are using (50%) or exploring (15%) such schemes
- Housing First schemes – 39% are using (21%) or exploring (18%)
- floating support – 87% are using (74%) or exploring (13%)
- homelessness prevention – 81% are using (70%) or exploring (11%)
- independent lodgings for move on – 38% are using (19%) or exploring (19%)
- social investment methods, such as social bonds – 17% are using (5%) or exploring (15%)
- peer landlord schemes – 23% are using (6%) or exploring (17%)
- private sector leasing schemes – 48% are using (33%) or exploring (15%)

Street begging evidence

Much of the evidence in relation to reducing and preventing street begging is linked to enforcement, which is discussed in section 10. There are a number of case studies or examples of areas that have taken enforcement approaches, which are largely media or news items discussing the pros and cons of giving money to street beggars and local responses to such issues. Homeless Link have published a document, which pulls

together some of these case studies and sets it out in the context of what the local issues are; what steps they've already taken; what the outcomes have been; and any learning to share.⁵²

Oxford City Council carried out an evaluation of a begging initiative 'Your Kindness Could Kill'⁵³ which was launched in mid - July 2012 and focused on the prevalence of drug and alcohol use amongst beggars. They carried out 35 in depth interviews with service providers, beggars and Big Issue Vendors and a sample of 120 surveys was carried out with members of the public. They found that:

- campaign awareness amongst the general public was quite low at 27% and no tourists could recall the campaign
- the campaign was generally well received by the public, although there questions about how to help, concerns about stereotyping and concerns that the information was inaccurate
- giving to beggars reduced – survey results show that 30% changed their giving, but the researcher indicates that in the interviews this was anywhere between 0% and 70%
- although had not significantly increased the enforcement of begging legislation since the campaign, the perception of the begging population was that it had increased
- little evidence was found that service usage had increased since the campaign
- no reliable data was found to support a hypothesis that giving to homeless charities had actually increased

⁵² Homeless Link (2016). Responses to begging. Case Studies of Local Responses. Homeless Link, December 2016.

⁵³ Wahlstedt, E (Date unclear). Evaluation Study for the Oxford Begging Initiative. Oxford City Council.

10.0 Impact of enforcement on street begging/street sleeping

Evidence around the impact of enforcement on street begging and/or street sleeping is lacking. There are differing views on whether or not enforcement should play any part in addressing the issue of street begging/street sleeping, with charities like Crisis who strongly feel that there is *'little evidence to show that the use of enforcement measures, such as banning beggars from public spaces or fining them are effective means of tackling the underlying causes of begging and homelessness...not only are such methods ineffective, but they are extremely expensive with the average cost of securing anti-social behaviour order reported to be as high as £5,000.'*¹⁰

Similarly, Cromarty and McGuiness in their briefing paper for the House of Commons also highlight that voluntary sector organisations have voiced concerns about the increased use of legal powers as they feel it criminalises homelessness and leaves these vulnerable people in an even more marginalised position.⁸

Their briefing paper highlights the concerns of a number of voluntary sector organisations, for example Liberty, a Human Rights charity, state that *"PSPOs don't alleviate hardship on any level. They are blunt instruments which fast-track so-called 'offenders' into the criminal justice system...handing hefty fines to homeless people ... is obviously absurd, counterproductive and downright cruel"*.

They also discuss concerns that enforcement activity in one area simply shifts the activity to another area and forces these vulnerable people further away from the services they need.

It is not only the use of anti-social behaviour powers that has caused concern amongst voluntary sector organisations. The use of physical measures by planners, businesses and security companies to stop people resting or sleeping outdoors also appear to be on the increase.

Cromarty and McGuiness cite a survey by Crisis, which suggests that there has been an increase in 'street cleansing' tactics intended to deter rough sleeping. They describe such measures as the use of spikes; curved or segregated benches; gated doorways; wardens and night security guards in public spaces; noise pollution (such as loud music); and the use of sprinklers or hose pipes.

Johnsen and Fitzpatrick⁵⁴ undertook a research project to evaluate the impact of enforcement interventions on street users in England. They undertook in depth interviews and focus groups with 66 current or ex street users; service providers; and enforcement agencies in 5 case study areas, Westminster, Southwark, Birmingham, Leeds and Brighton. They found that:

- it was mainly local rather than national pressures that led a shift towards the use of enforcement
- begging and street drinking in large groups were perceived by local residents and businesses to have had a very negative impact within concentrated areas
- members of the public and enforcement agencies were not unsympathetic to the vulnerability of street users, but their top priority was a reduction in the negative impact of street culture on their daily lives
- 'harder' forms of enforcement (particularly ASBOs) had a deterrent effect and were key to reducing street activities in a targeted area. Even the threat of an ASBO could bring about substantial changes in street behaviour because of the possibility of long prison sentences for breaches of conditions
- when preceded by warning stages (such as Acceptable Behaviour Contracts) and integrated with intensive supportive interventions, ASBOs could lead to positive benefits for some street users – enforcement in these cases acted as a 'crisis point' prompting reflection and change
- 'softer' forms of enforcement (especially controlled drinking zones and environmental designing out measures) were highly effective in reducing the visibility of street activities, but there were no benefits for street users
- both soft and hard enforcement measures clearly led to geographical displacement and there was also consistent evidence of activity displacement (street users turned to things such as shoplifting, for example)

They were clear that where enforcement 'worked' was in those situations where measures were integrated with intensive support and where there was appropriate interagency working in place. Those street users who were most likely to respond positively to such measures, when these support services are in place, were those that had something positive to return or aspire to and/or had experienced other recent 'crisis points' that had sought them to think about their lifestyle. Unsurprisingly perhaps, those that were less likely to respond positively to enforcement measures had a long history of street living and/or substance misuse, had inadequately treated mental health problems, already had a criminal record, or considered themselves to be a 'hopeless case'.

They describe the use of enforcement as a 'high risk strategy' due to the unpredictability of the outcomes for specific street users.

⁵⁴ Johnsen, S and Fitzpatrick, S (2007). *The Impact of enforcement on street users in England*. Published for the Joseph Rowntree Foundation by The Policy Press, 2007.

In 2016, Johnsen, Watts and Fitzpatrick published a briefing paper on the issue, essentially updating some of their findings from 2007 and adding additional insights from their in depth interviews. Their key findings were that:

- there has been an increasing (but not unanimous) consensus amongst homelessness service providers in England that enforcement has a role to play in combatting rough sleeping and street culture
- homeless people support the use of enforcement in some circumstances, but resent measures that are implemented in an obviously discriminatory manner
- enforcement does prompt some homeless people to discontinue harmful behaviours and/or engage with support, but it also sometimes displaces the problem
- many rough sleepers are also subject to benefit conditionality, this can lead to increased compliance with Claimant Commitments, but there is little evidence that the current regime is effective in helping homeless people into paid work
- while rough sleepers in Scotland are affected by benefit conditionality in a similar way to those elsewhere in the UK, there is less appetite to use enforcement to address street culture and interventionist approaches to support are present, but less fully developed

They continue to stress that the use of enforcement is a high-risk strategy.

11.0 Financial costs of homelessness – what is the return on investment?

Literature on the return on investment for street begging and or street sleeping specifically is very limited. One systematic review on public health measures in general and the return on investment of such approaches is positive.⁵⁵

Masters et al⁵⁵ sought to determine the return on investment from a range of public health interventions through undertaking a systematic review of the literature. They found that the median return on investment for public health interventions was 14.3 to 1, meaning that every £1 invested yields a return of £14.30 plus the original investment. They looked at specialisms within this and in particular, 'wider determinant.'

There were 12 studies in this specialism, which focused primarily on the effectiveness of early years interventions, particularly those targeted at young offenders, or those deemed at risk of offending. These studies looked at factors beyond health with participants reporting improvements literacy, job prospects and earnings, thereby showing a return on investment to society and the wider economy. The median ROI for the studies in the wider determinants specialism was 5.6 to 1.

Through their work on ending homelessness, Crisis has developed a knowledge hub, which looks at this aspect. They estimate that:

- if 40,000 people were prevented from experiencing 1 year of homelessness, public spending would fall by £370 million⁵⁶
- the cost of rough sleeping for 12 months is £20,128 compared to the cost of a successful intervention (£1,426)⁵⁷
- 30 people sleeping rough would cost an additional £600,000 in public expenditure, rising to £1.2m if the situation continued for 2 years⁵⁷
- the longer someone is homeless, or the more frequently they experience homelessness, the more they will cost the taxpayer⁵⁷

Hard Edges²³ also gives some estimates about the financial costs of homelessness or multiple exclusion homelessness. They estimate that:

55 Masters, R et al (2017). Return on investment of public health interventions: a systematic review. *Epidemiology & Community Health Online* First, 29 March 2017.

56 www.crisis.org.uk/ending-homelessness/homelessness-knowledge-hub/cost-of-homelessness/

57 Pleace, N (July 2015). At what cost? An estimation of the financial costs of single homelessness in the UK. Centre for Housing Policy, University of Leeds, July 2015. Published by Crisis 2015.

- the cost of an individual with multiple needs including homelessness costs around £19,000 per annum (including benefits). This is 4-5 times the cost of an average person (£4,600)

In addition, Battrick et al⁵⁸ in their study of the MEAM pilots found that better co-ordinated interventions can reduce the cost of wider service use for people with multiple needs by up to 26.4%. They found that the average service use costs per individual prior to intervention (excluding benefits) were between £36,696 and £43,400 per year.

The Calouste Gulbenkian Foundation and MEAM⁵⁹ have used the Hard Edges and Battrick et al data to make the case for investment in meeting the needs of those with multiple needs. They go on to state that if you take the 58,000 people identified in Hard Edges with overlapping needs (see Figure 1) then the costs of this cohort per annum is likely to be in the region of £1.1b-£2.1b per annum.

They then look at this in terms of the level of investment that may be needed to ensure there is a focus on this particular cohort of people and use The Troubled Families Programme as an example. They state that *'The Troubled Families programme cost £448m over three years for 120,000 families. If we assume a national focus for the 58,000 individuals identified to date with multiple needs could be delivered at the same proportional cost, it would require an investment of £216m over three years. This represents a proactive investment of between 3.4% and 6.5% of total current annual costs [of this cohort]'*.

In terms of the return on investment of the MEAM approach, The Calouste Gulbenkian Foundation and MEAM⁵⁹ indicate that total service costs were either flat or had increased in the first year. As people got access to the services they needed and it took until the end of the second year for overall costs to be reduced. The fall in costs, they say, was primarily driven by a reduction in criminal justice costs and a rise in what they call 'good' costs (such as housing, health and treatment costs) that did not offset the criminal justice savings.

There is evidence that Housing First services have the potential to save money. Housing First services across 9 services in England were estimated to cost in the region £26 - £40 per hour. If one assumes that someone using Housing First would normally access high intensity supported housing, potential savings could be between £3,048 and £4,794 per person in support costs. They state that there is the potential for further savings for the NHS through reduced emergency medical services and the criminal justice system through reduced anti-social behaviour and crime. They estimate that

58 Battrick et al (2014). Evaluation of the MEAM pilots – update on our findings. London, FTI/PBE.

59 Calouste Gulbenkian Foundation and MEAM (2015). Individuals with multiple needs: the case for a national focus. The Calouste and Gulbenkian Foundation and MEAM, April 2015.

Housing First could, therefore, deliver potential savings in excess of £15,000 per person per annum.

The Department for Communities and Local Government undertook an evidence review of the costs of homelessness in 2012 and found that there were a number of research studies that have tried to calculate the total costs to government of homelessness. From these studies estimates of the annual costs to government range from £24,000 - £30,000 (gross) per person, anything up to £1bn (gross) annually.⁶⁰ They indicate that it is very difficult to extract solely the cost of homelessness.

They outline 4 main areas for government spend:

- Department of Work and Pensions
- Department of Health
- Ministry of Justice
- English Local Authorities

Evidence also shows that people who experience homelessness for 3 months or longer cost on average:⁶¹

- £4,298 per person to NHS services
- £2,099 per person for mental health services
- £11,991 per person in contact with the criminal justice system

Homelessness, particularly the more extreme forms like street sleeping are estimated to cost society significant amounts of money across health, social care, criminal justice system and local communities. There is a lack of return on investment evidence and/or tools available to accurately quantify the extent of savings that could be made through responding early to the needs of this complex group of individuals. However, the evidence does suggest that early signs from the MEAM pilots and other research are positive and that following a relatively small investment, significant savings can be made.

⁶⁰ Department for Communities and Local Government (August 2012). Evidence review of the costs of homelessness. Crown Copyright, 2012.

⁶¹ Pleace, N. & Culhane, D.P. (2016). Better than Cure? Testing the case for Enhancing Prevention of Single Homelessness in England. London: Crisis.

12.0 Conclusion

This review highlights the complexities associated with homelessness in terms of the risk factors for becoming homeless, the level of vulnerability of individuals experiencing homelessness, the range of health and social needs of those experiencing homelessness, the challenging housing market and changes to the benefits system, which are increasingly making it very difficult for local authorities to support those with complex needs including homelessness.

There is a great deal of information and research now about why people are homeless or experience homelessness. There is increasing evidence around interventions to support those with complex needs, including substance misuse, mental health problems and other physical conditions. Much of the evidence relates to homelessness in general, rather than specifically aimed at those who street sleep and/or street beg. Indeed, there is very little evidence around interventions to prevent street begging as a particular subset of this vulnerable group.

In terms of the return on investment of tackling homelessness and particularly street sleeping and street begging, there is very little literature on this. Dealing with the health and social outcomes associated with these vulnerable groups is highly expensive and there is likely to be a financial benefit in preventing such poor outcomes, but these have not been quantified robustly.

Whilst there is a plethora of data on the number of those who are homeless, much of this relates solely to those that are known to services because they have made an application to their local authority for assistance. As a result, much of the information on the numbers of people/households that are homeless, is likely to be an underestimation of the true scale of the issue as it does not capture those 'hidden homeless' who sofa surf and the like.

In addition, the data on rough sleepers is largely based on estimates from local authorities. Whilst around a third of local authorities provide a number based on a count of actual rough sleepers on a given day, two thirds are estimates based on local intelligence from service providers. Again, this means that there is likely to be an underestimation of the number of rough sleepers across the country.

Despite the limitations in terms of data; it is clear that homelessness, both in terms of statutory homelessness and rough sleeping, is increasing year on year and has done so since around 2010. Projections indicate that this is set to increase further over the coming years.

The new Homelessness Reduction Act 2017 places further duties on local authorities to prevent homelessness and support all those requesting help irrespective of whether or not they meet the criteria in relation to priority need through assessing their needs and developing a plan with them to meet those needs. With the lack of housing/affordable housing currently in the market and changes to the benefits system, this will be extremely challenging.

There are a number of interventions outlined in the review, which are promising in terms of reducing and preventing homelessness (section 9), but no single intervention will solve the complex issues surrounding homelessness. There needs to be a whole system, integrated approach to tackling homelessness, which needs to include all stakeholders both statutory and non statutory, including those with lived experience in order to ensure that services developed meet the needs of those who require them.

Recommendations

The purpose of this review was to highlight some of the key issues from a national perspective in relation to homelessness and identify any interventions that may be effective in relation to this, with a particular focus on street begging and street sleeping. It is therefore not appropriate for PHE to give any formal recommendations as such, but we would:

- encourage local authorities to consider the findings of this review and how they may be able to utilise it in the context of their local situations (some toolkits, guides and strategies that may be useful can be found in Appendix C)
- encourage PHE to consider the research/evidence/data gaps in this area and how we may be able to overcome some of these and support the development of the evidence base for this highly complex and vulnerable group

Appendix A:

Literature search – scope and results

Full results from the literature search are available on request.

Searcher: Barbara Norrey. **Person requesting search:** Emma Seria-Walker.

Date of request: 10/08/17. **Date results sent:** 22/08/17.

Search question

Questions in summary:

1. Who street begs and/or is street sleeping?
2. What needs do they have?
3. What works to meet those needs?
4. What works to reduce the number of people street begging and/or street sleeping?
5. What is the return on investment?

In more detail, we would benefit from understanding the following, priorities highlighted:

1. The national profile of people who street beg and/or street sleep:
 - a. To what extent do these two groups overlap?
 - b. Brief description of both
 - i. Person – demographics including sexuality plus housing status, eligibility for benefits and whether receiving them, relationship and family status
 - ii. Place – where – patterns nationally, in urban areas, in port and coastal towns, movement, nationality, citizenship status.
 - iii. Time – seasonal, trends over time
 - c. Risk factors and complexity. Percentage of people who street beg who:
 - i. Are homeless
 - ii. Lived in care
 - iii. Veterans
 - iv. Are ex-offenders
 - v. Have a drugs problem
 - vi. Have an alcohol problem
 - vii. Have a mental health condition (diagnosed and undiagnosed; chronic but stable/acute or unwell; mood disorders, PTSD, psychosis, personality disorders; dementias)
 - viii. Have a learning disability including autism
 - ix. Have a long-term physical health condition
 - x. Have a physical disability or sensory impairment
 - xi. Are sex workers
 - xii. Had ACE – child abuse or neglect, domestic abuse, parental substance misuse, parental offending
 - xiii. Have children – with them, in care
2. The impact of street begging - costs and harms for:
 - i. Those who beg
 - ii. Their families (including children)
 - iii. Public services
 - iv. Wider society

3. The trajectory of street begging
 - a. What brings people to street beg? Eg including benefits (not claiming, sanctions, not eligible), exploitation and people trafficking, exacerbation of mental health, drug and/or alcohol use, housing.
 - b. How long do people street beg for? Is there any relation to access to services?
 - c. What happens to people who street beg to end their street begging?
 - d. What is the relationship between street begging and drug use? Eg, does reducing street begging divert people into other criminal behaviour? Temporal relationship.

4. The trajectory of street sleeping
 - a. What triggers people to sleep on the streets?
 - b. How long do people street sleep for? What is the relation to access to services?
 - c. What happens to people who street sleep to end their street sleeping?
 - d. What is the relationship between street sleeping and mental health? Eg What are the key 'tipping points' which mean that people go from having mental health needs with a home to having mental health needs and street sleeping.

5. Interventions
 - a. What works to reduce street begging and street sleeping?
 - i. Including, but not limited to, public education to reduce people donating
 - b. What works to meet the needs of people with multiple complex needs, including dual diagnosis? Including psychologically informed approaches.
 - c. Where are the opportunities for prevention, early intervention, support and enforcement? Both for those at risk of street begging and/or sleeping, and also those already street begging and/or sleeping.
 - d. Does enforcement cause problems for other parts of the system?
 - e. Do any other interventions have negative impacts on other parts of the support system?
 - f. How long does it take to have a measurable impact?
 - g. How much does it cost?
 - h. What is the return on investment?
 - i. What has been tried but does not seem to work?

6. Tools
 - a. Frameworks
 - b. Self-assessment tools
 - c. To evaluate our strategies and interventions
 - d. Any further research due?
 - e. Any further policies due? Eg Government Green Paper on Supported Housing due?
 - f. Any further tools due?
 - g. Literature search terms and strategies

NOT for PHE August 2017 review - Additional, related issues:

1. How much drug litter do other areas have? What works to reduce drug litter? What is the cost-effectiveness?
2. The impacts of Diamorphine prescribing and supervised consumption rooms on anti-social behaviour. Eg <https://www.jrf.org.uk/report/prescribing-heroin-what-evidence>:
<http://www.actiononaddiction.org.uk/Documents/Community-Impact-Study.aspx>

Summary of resources searched and results:

Source	Results
MEDLINE	104
EMBASE	0
PSYCINFO	4
SCOPUS SOCIAL SCIENCE	3
GOOGLE	21

Appendix B:

Trends in Rough Sleeping by Local Authority in the South East, 2010-2016

Table: Trends in Rough Sleeping by Local Authority (Upper and Lower Tier) in the South East, 2010-2016

Local Authority	2010	2011	2012	2013	2014	2015	2016
Brighton and Hove	14	37	43	50	41	78	144
Canterbury	3	22	20	22	38	47	50
Portsmouth	5	11	11	7	8	15	37
Maidstone	27	19	19	14	25	38	35
Thanet	1	9	8	14	15	17	33
Oxford	11	8	12	19	26	39	33
Hastings	3	5	3	15	12	16	26
Basingstoke and Deane	3	4	8	5	8	20	26
Aylesbury Vale	10	10	4	14	17	15	26
Slough	14	7	8	30	26	17	25
Southampton	5	24	18	13	19	31	23
Reading	6	5	4	8	12	16	22
Eastbourne	6	3	11	6	11	10	19
Chichester	15	15	26	19	14	17	19
Arun	25	10	26	18	13	15	19
Spelthorne	1	2	3	7	5	12	18
Fareham	6	3	1	8	8	6	18
Cherwell	0	0	2	14	14	21	17
Isle of Wight	1	9	2	9	4	4	16

Adults with complex needs (with a particular focus on street begging and street sleeping)

Crawley		16	11	17	17	21	33	15
Tunbridge Wells		9	13	10	12	15	15	15
West Berkshire		5	6	11	8	23	15	14
Medway		7	12	17	6	2	14	14
Guildford		6	4	10	8	10	14	13
Wycombe		15	14	1	9	9	11	13
Surrey Heath		0	2	1	0	4	18	12
Woking		2	2	2	8	9	12	12
Gravesham		1	8	10	8	3	6	12
Worthing		5	7	8	17	17	19	11
Wokingham		1	2	2	3	2	14	11
Bracknell Forest		1	1	1	2	4	5	10
Rushmoor		0	3	4	7	11	15	9
Dartford		0	15	16	12	19	10	9
Shepway		9	12	5	4	4	13	9
Dover		8	14	5	5	4	9	9
Ashford		2	7	4	1	5	5	8
Vale of White Horse		0	0	0	5	5	5	8
Havant		5	3	3	0	3	10	8
Windsor and Maidenhead		6	7	4	7	6	35	8
South Oxfordshire		1	0	0	5	3	5	7
Mid Sussex		3	5	6	6	11	6	7
Wealden		0	0	0	0	1	0	7
Gosport		4	2	1	6	1	4	6
Horsham		6	2	2	5	2	3	6
Swale		0	2	6	5	2	6	6
Runnymede		1	8	6	2	13	3	5
Test Valley		2	7	6	6	7	3	5
South Bucks		0	0	0	2	0	0	4
Winchester		5	9	7	11	14	5	4

Adults with complex needs (with a particular focus on street begging and street sleeping)

Waverley		0	2	0	3	0	2	4
Tonbridge and Malling		1	4	3	4	7	0	4
Elmbridge		4	1	3	3	2	7	4
New Forest		1	4	4	3	9	2	4
Adur		0	0	0	1	2	0	3
Epsom and Ewell		1	3	4	4	7	6	3
Lewes		4	3	0	0	0	9	3
Oldham		1	0	1	2	0	2	3
Tandridge		1	2	1	1	2	2	2
East Hampshire		3	2	2	2	1	1	2
Sevenoaks		0	1	2	2	0	6	2
Mole Valley		0	0	2	2	4	3	1
Chiltern		0	0	2	4	3	1	1
Rother		6	5	5	5	0	5	1
Reigate and Banstead		4	5	6	6	7	3	1
Eastleigh		2	3	2	2	1	0	0
Hart		0	1	1	1	1	1	0
West Oxfordshire		1	5	5	2	3	3	0

Source: DCLG.

Table: Rate or Rough Sleepers per 1,000 Households by Local Authority (Upper and Lower Tier) in the South East, 2016

Local Authority	2016 Rough Sleeping Rate per 1,000 households
Brighton and Hove	1.12
Canterbury	0.77
Hastings	0.61
Oxford	0.56
Thanet	0.52
Maidstone	0.51
Slough	0.46
Spelthorne	0.43
Portsmouth	0.41
Eastbourne	0.40
Fareham	0.37
Chichester	0.37
Basingstoke and Deane	0.35
Surrey Heath	0.34
Aylesbury Vale	0.34
Reading	0.33
Crawley	0.33
Tunbridge Wells	0.30
Woking	0.30
Cherwell	0.28
Gravesham	0.28
Arun	0.27
Isle of Wight	0.25
Rushmoor	0.24
Guildford	0.23
Southampton	0.22
Worthing	0.22
West Berkshire	0.22
Dartford	0.21
Bracknell Forest	0.20
Wycombe	0.18
Shepway	0.18
Dover	0.18
Wokingham	0.17
Gosport	0.16
Ashford	0.15
Vale of White Horse	0.15
Havant	0.15
South Bucks	0.14
Runnymede	0.14

Adults with complex needs (with a particular focus on street begging and street sleeping)

Windsor and Maidenhead	0.13
South Oxfordshire	0.12
Medway	0.12
Mid Sussex	0.11
Adur	0.11
Wealden	0.10
Horsham	0.10
Swale	0.10
Test Valley	0.10
Epsom and Ewell	0.09
Winchester	0.08
Waverley	0.08
Tonbridge and Malling	0.08
Elmbridge	0.07
Lewes	0.07
Tandridge	0.06
New Forest	0.05
East Hampshire	0.04
Sevenoaks	0.04
Oldham	0.03
Mole Valley	0.03
Chiltern	0.03
Rother	0.02
Reigate and Banstead	0.02
Eastleigh	0.00
Hart	0.00
West Oxfordshire	0.00

Source: DCLG.

Appendix C:

Toolkits, guides and strategies that may be useful

Westminster Begging Strategy

Westminster Rough Sleeping Strategy

Prevention Opportunities Mapping and Planning Toolkit (PrOMPT)

This is a practical resource to help to identify opportunities to prevent rough sleeping locally. It guides you through 4 stages:

- **building partnerships** – including securing the involvement of clients locally
- **audit and analysis** – mapping routes into rough sleeping, identifying opportunities for early intervention and rapid preventative action, and identifying gaps in local services and safety nets
- **action planning** – identifying key steps needed to remodel services, commission new services and ensure prevention
- **review** – monitoring progress and updating the audit and analysis

Importantly it involves people who have direct experience of sleeping rough as experts.

Psychologically informed services for homeless people – Good Practice Guide

Meeting the psychological and emotional needs of homeless people. Mental Health Good Practice Guide

What it's worth? Guidance on using financial savings analysis in the homeless sector

The impact on health of homelessness: A guide for local authorities

No excuses: under the youth accommodation pathway section

Homeless Link developed a model to support young people at risk of homelessness, or who are already homeless. There are 4 key steps:

Adults with complex needs (with a particular focus on street begging and street sleeping)

- prevention
- assessment
- housing
- support

The document below provides some of the key statistics around young people and homelessness and provides an outline of the model with some case study examples from other areas as part of their description of the model.