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Homelessness and housing support needs in West Sussex

Local data & intelligence briefing

West Sussex Public Health | April 2025

Purpose of briefing & contents

This Public Health briefing draws together data and information on homelessness and housing support needs in West Sussex, including two recently published reports that explore 1) the risk factors and vulnerabilities of people who died whilst known to homelessness or housing support services, and 2) the experiences of people living in temporary accommodation who use drugs and/or alcohol.

Additional national and local data are presented, alongside next steps for West Sussex Public Health to improve the health and care of this vulnerable population in West Sussex.

Contents

Contributors & contact details

This briefing draws together data and information from several documents, with authors from West Sussex County Council (WSCC) and partners.

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Local context

Homelessness and insecure housing is an increasingly pressing issue across the West Sussex Health and Care system.

A range of forums and partnership groups in West Sussex are leading work in this area, including:

West Sussex Health and Wellbeing Board – one of five priorities in the draft West Sussex Joint Local Health and Wellbeing Strategy focuses on health and wellbeing in temporary accommodation

West Sussex Drug and Alcohol Partnership – wider determinants of health, including suitable housing, is one of four main priorities

West Sussex Multiple Compound Needs Board – currently in development

West Sussex Strategic Housing Group

West Sussex Temporary Accommodation Action Group

Sussex Mental Health and Housing Programme meeting

District and borough councils – some are currently developing new housing and homelessness strategies and plans

Local Community Networks – some are focusing on health and wellbeing in temporary accommodation as a priority in 2024/25

It is intended that this data and intelligence briefing supports the work of these groups.

Homelessness – a national issue

Defining homelessness

Homelessness is not one single situation, nor are all types of homelessness alike. Homelessness includes those who are:

- **'roofless'** – e.g., **people sleeping rough**
- **'houseless'** – e.g., living in **hostels** or statutorily-provided **temporary accommodation**; or
- in **'insecure'** accommodation – e.g., **sofa-surfers**[1].

Local authority statutory duties[2]

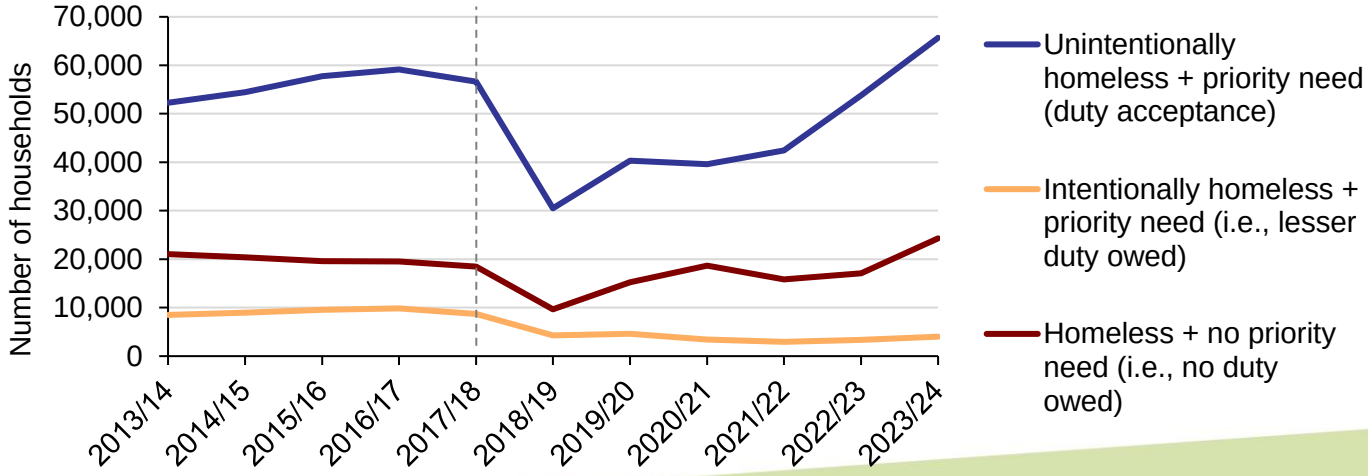
Local authorities have three statutory duties relating to homelessness:

1. The **'prevention duty'** for those threatened with homelessness
2. The **'relief duty'** for those already homeless to support securing accommodation
3. The **'main housing duty'** to secure accommodation for those in priority need and unintentionally homeless (if the prevention and relief duties are unsuccessful).

Scale of homelessness in England

- Over the last decade, **homelessness has been rising** in England.
- In 2023/24, around 65,670 people were accepted by local authorities in England as being eligible for the statutory 'main housing duty'. An additional 24,300 were recorded as homeless but ineligible for support[3].
- **The number of people sleeping rough has also been rising** in recent years. Nearly 4,670 people were recorded as sleeping rough in England in 2024, up from 3,900 people in 2023[4].
- Not included in these official statistics are many **more "hidden homeless"**, including people staying with friends or family or sofa-surfing.

Number of households owed a 'main housing duty' by local authorities in England, 2013/14 –2023/24. Dashed line shows introduction of prevention and relief duties.



All data from the Ministry for Housing, Communities and Local Government[3,4].

Homelessness and health

Housing as a wider determinant of health

Safe, secure and good quality housing is well documented as a wider determinant of health[5].

Homelessness is an experience that can drive **social exclusion** and **inequalities** in outcomes[6,7].

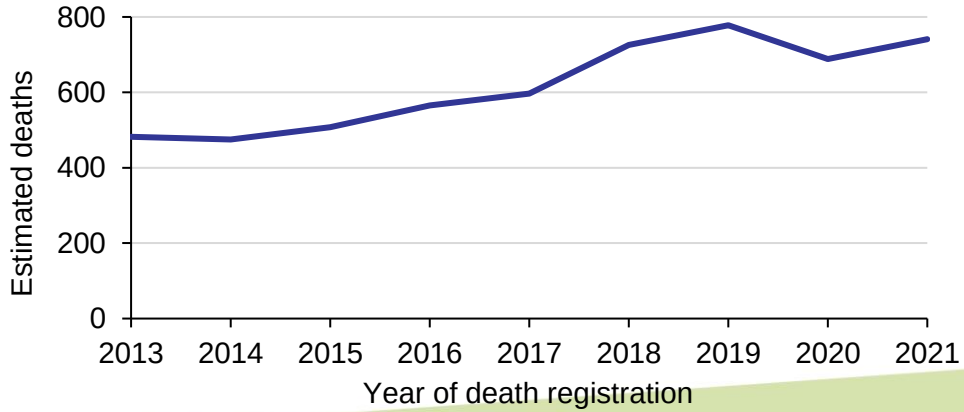
Co-occurring health and care needs are common amongst people experiencing, or at risk of, homelessness, as are overlapping or prior experiences of social exclusion and **disadvantage**, such as substance misuse, mental ill-health, time spent in prison and domestic abuse[6,8-10].

Many of these needs and disadvantages may have a **bi-directional relationship** with homelessness, meaning that these issues can increase the risk of becoming or remaining homeless, whilst homelessness can increase the risk of, or exacerbate, these issues[11,12].

Health inequalities and homelessness

- Health amongst people experiencing homelessness is far poorer than the general population, with **increased rates of morbidity, multi-morbidity, premature ageing and frailty**[7,11,13].
- In England and Wales, people experiencing homelessness die far younger than the general population: the **average age of death is estimated at around 43-45 years**.
- Over the last decade, the **estimated number of deaths amongst people experiencing homelessness increased by around 50%** in England and Wales. The death rate also increased, reaching **16.8 deaths per million general population** in England and Wales in 2021[14].

Estimated number of deaths of homeless people in England and Wales, registered between 2013-2021. This includes those recorded at death as: rough sleeping, no fixed abode or in emergency accommodation, night shelters and hostels.



All deaths data from the Office for National Statistics[14].

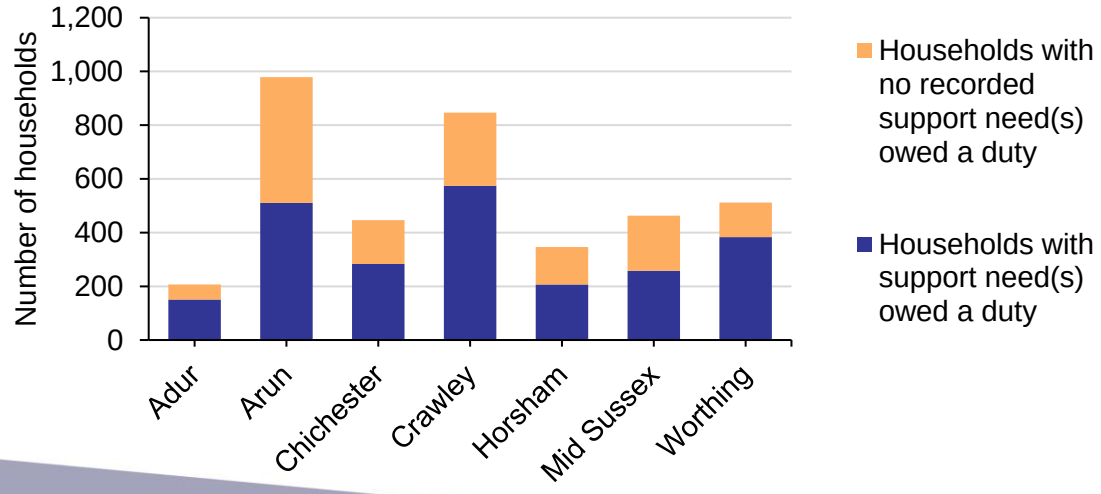
Homelessness – the West Sussex picture

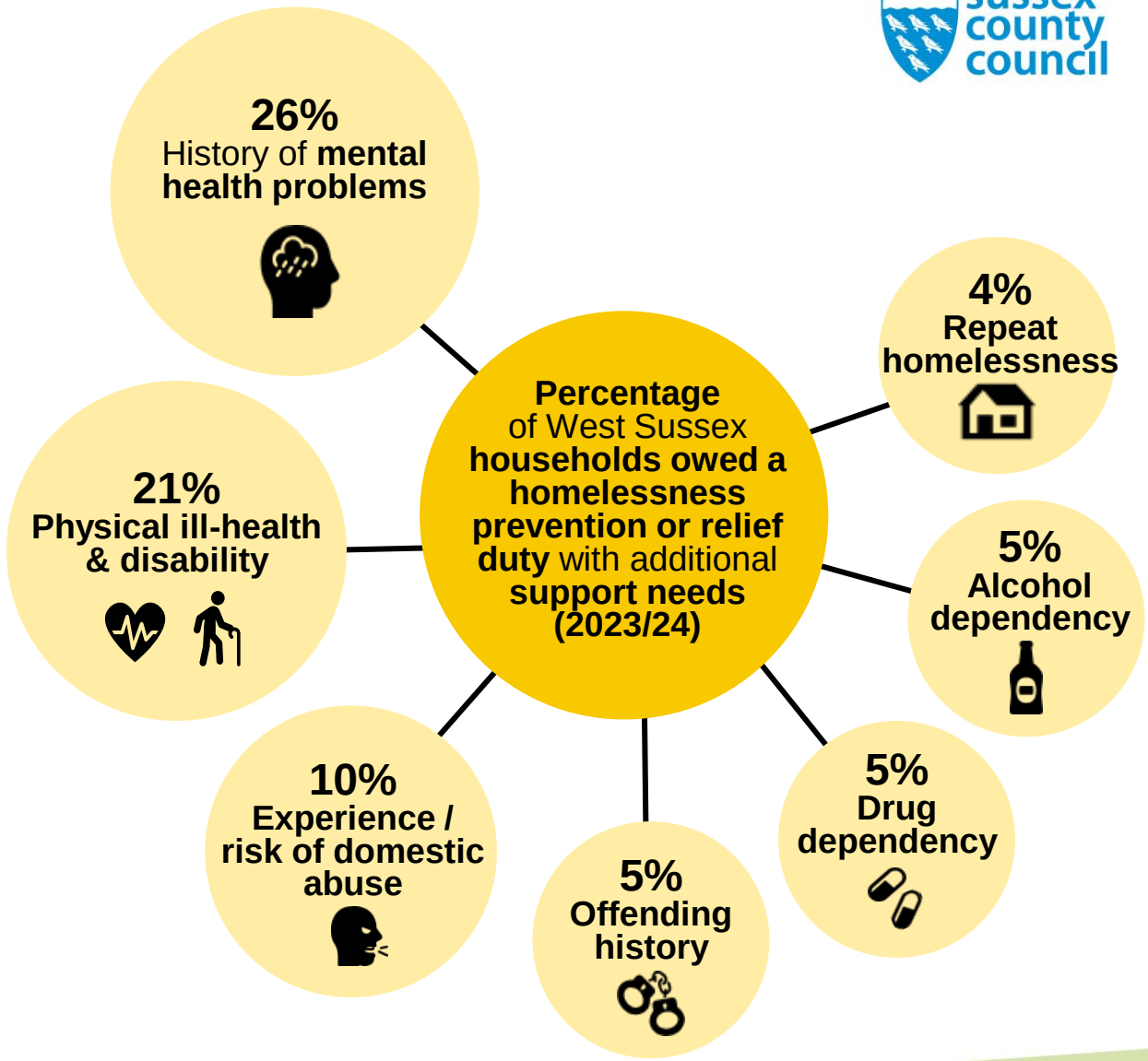
Statutory homelessness in West Sussex

3,800 households in West Sussex were owed a **homelessness prevention or relief duty** in 2023/24, and **900 households** were owed the **'main housing duty'**.

Additional support needs were highly prevalent in households who were owed a homelessness prevention or relief duty in West Sussex – ranging from 52% of households owed a duty in Arun to 75% of households owed a duty in Worthing.

Number of households owed a prevention or relief duty by local authorities in West Sussex with and without additional support needs, 2023/24.





All data from the Ministry for Housing, Communities and Local Government[15].

Homelessness – the West Sussex picture

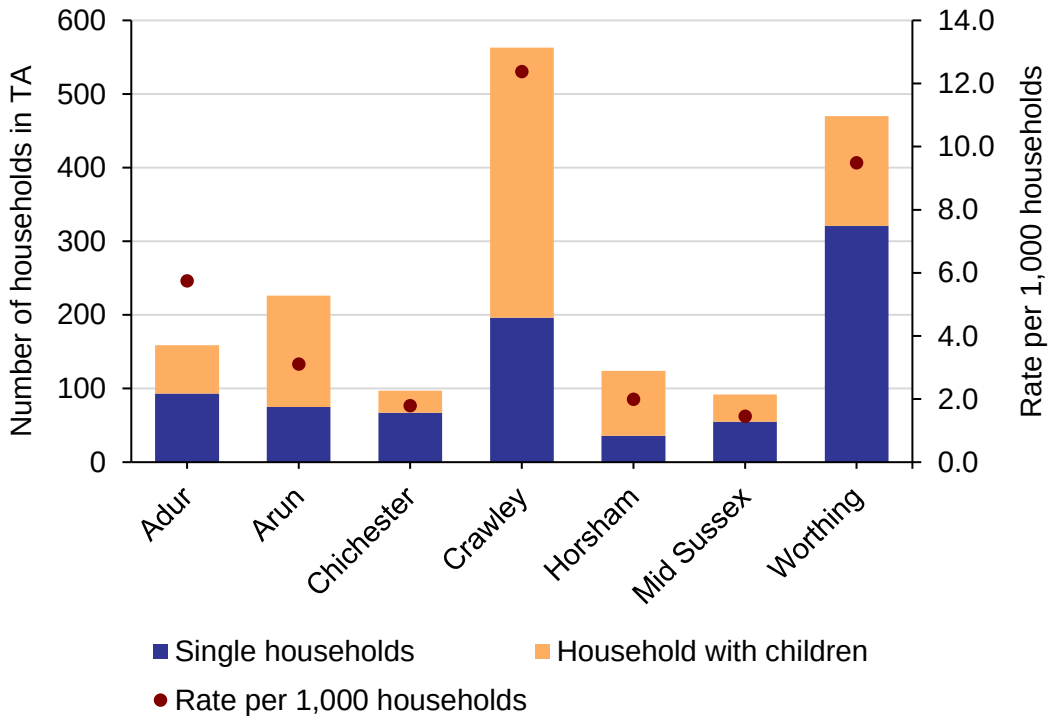
Statutory temporary accommodation in West Sussex

- As of September 2024, there were **1,731 households in temporary accommodation** (TA) arranged by local authorities (LAs) in West Sussex.
- The **Crawley and Worthing LAs accounted for over half of households in TA** and had the **highest rates of households in TA in West Sussex.**
- The rates of households in TA per 1,000 households in **Crawley (12.4 per 1,000) and Worthing (9.5 per 1,000) were more than double the rates in West Sussex** overall (4.6 per 1,000) and the South East (4.0 per 1,000).

Households with dependent children in temporary accommodation

- **Around half of West Sussex households in TA had dependent children** (888 households).
- Proportionally, there were **more households with dependent children living in TA in Crawley (65.2% of households in TA), Arun (66.8%) and Horsham (71.0%)**.

Number of single households and households with children, and rate per 1,000 households, in temporary accommodation (TA) arranged by local authorities in West Sussex, as at the end of September 2024. NB: 'single households' refers to households without children and may be comprised of one or more adults (e.g., couples without children).



TA data from the Ministry for Housing, Communities and Local Government[16]. Rates calculated using Census 2021 households data from the ONS[17].

Homelessness – the West Sussex picture

Types of statutory temporary accommodation[18]

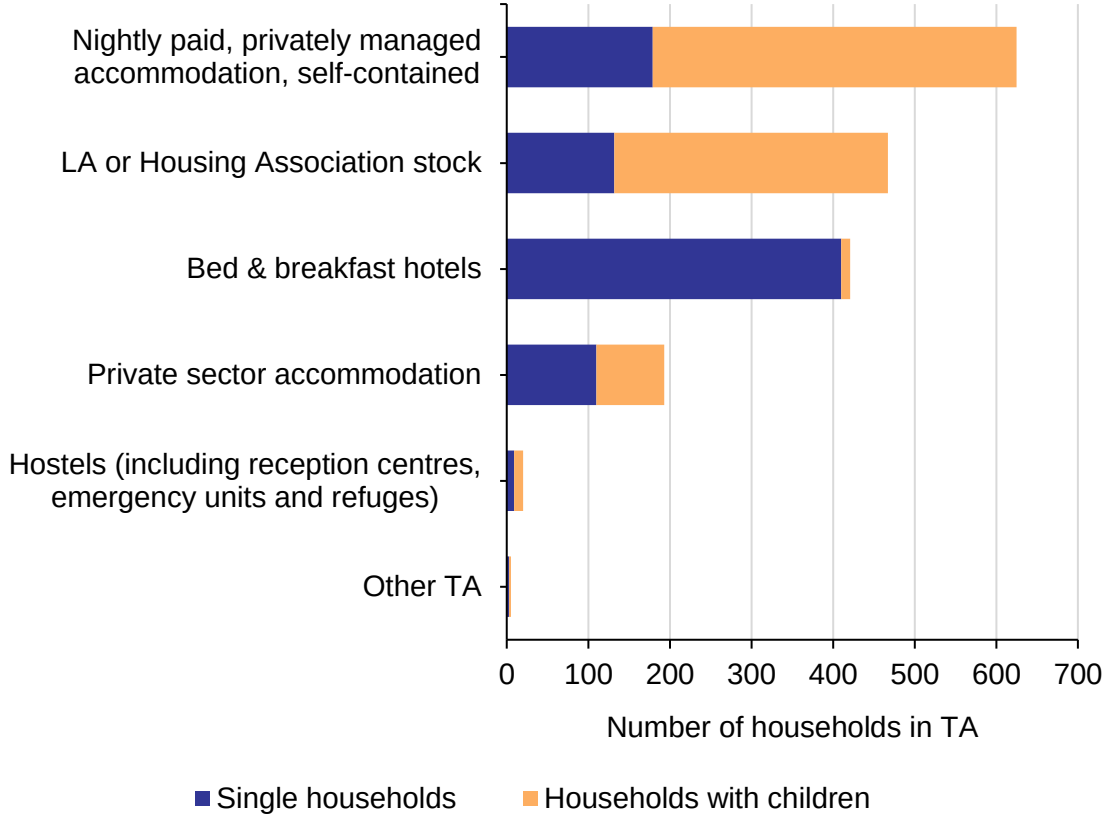
Under the umbrella of 'temporary accommodation' (TA) are different types of accommodation, which can vary in the facilities available – e.g., whether accommodation is self-contained or facilities are shared. TA includes emergency accommodation, such as bed & breakfast hotels, and longer-term temporary accommodation, such as local authority (LA) or housing association stock.

Statutory temporary accommodation placements in West Sussex

Of the 1,731 households in TA arranged by LAs in West Sussex (as of September 2024), **nightly paid self-contained accommodation, LA or Housing Association accommodation, and bed & breakfasts were the most common** placements.

Most West Sussex households with dependent children were placed in self-contained TA, whilst **2.5% of households with dependent children were placed into TA with shared facilities** (e.g., B&Bs and hostels). This was similar to the South East proportion (3.4%).

Type of temporary accommodation (TA) for households placed in TA by local authorities (LA) in West Sussex, as at the end of September 2024.



All data from the Ministry for Housing, Communities and Local Government[16]

Housing needs of those in substance misuse treatment in West Sussex – from the West Sussex Drug and Alcohol Partnership Needs Analysis 2024

Robert Whitehead | West Sussex Public Health and Social Research Unit

Further data & information available from:
https://jsna.westsussex.gov.uk/updates/west-sussex-drug-demand-analysis/

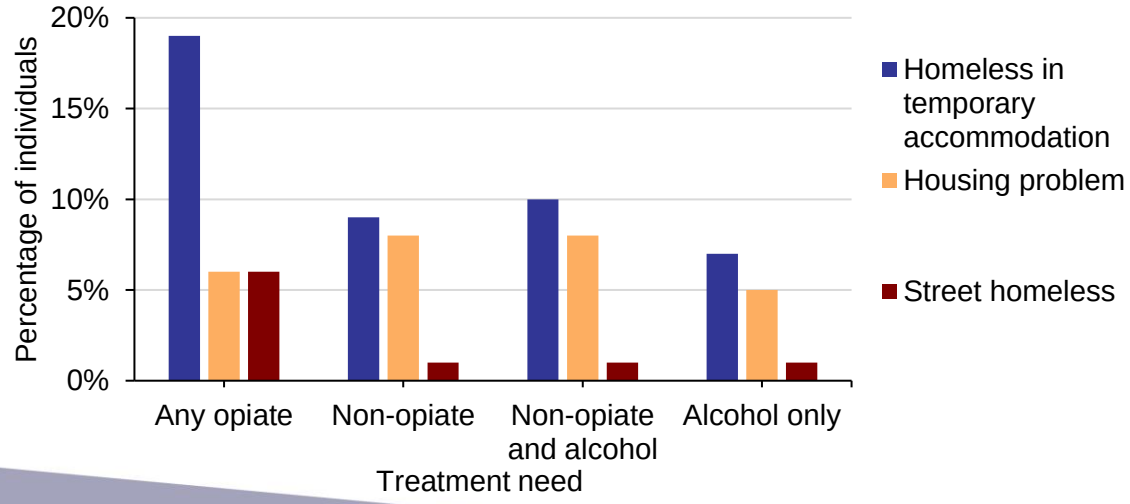
Housing needs of those in substance misuse treatment (Change, Grow, Live) in West Sussex

Housing needs at the start of treatment

Over recent years, around 20% of the nearly 11,000 people who have been in treatment for substance misuse in West Sussex have had a homelessness or housing need at the start of their treatment.

Around half of these were in temporary accommodation (TA; 11%), whilst around a quarter had a housing problem (6%). A smaller number were street homeless (2%).

Housing needs of those in treatment for substance misuse, at the start of treatment, in West Sussex, 2016 – 2023.

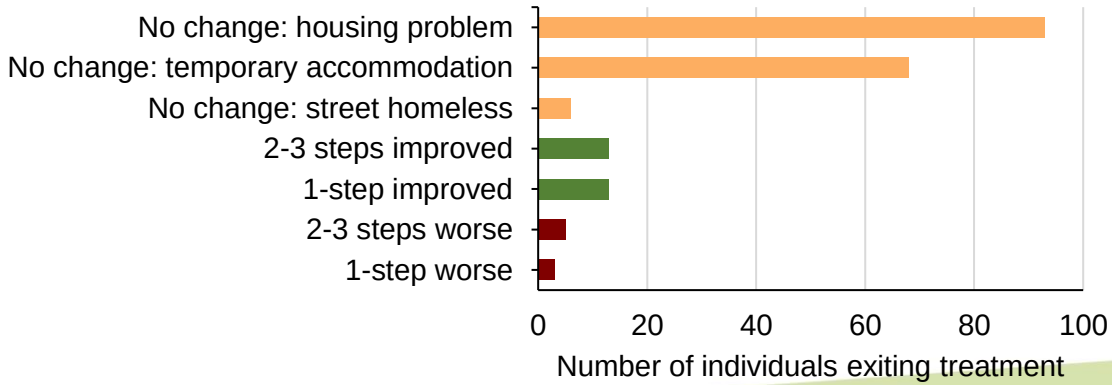


Change in housing status during treatment

Of those who finished substance misuse treatment (or had an otherwise closed record) in West Sussex between 2016 – 2023:

- Most began and ended treatment in settled accommodation.
- Around three-times as many reported an improvement in their housing status by treatment exit than those reporting a worsening situation.
- However, most who started treatment as street homeless, in TA or with housing problems remained in the same situation at treatment exit.

Change in housing status during treatment, West Sussex, 2016 – 2023.



All data provided by Change, Grow, Live (CGL).

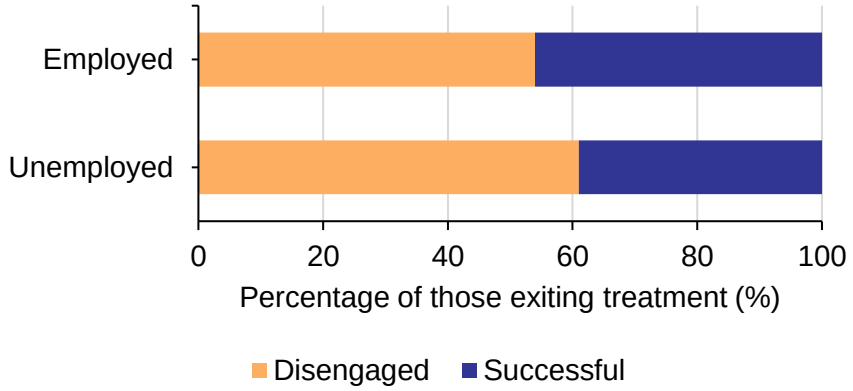
Housing and other factors linked to successful substance misuse treatment outcomes in West Sussex

Of the 8,379 treatment cases closed between 2016 – 2023 in West Sussex, 90% either successfully completed their treatment or disengaged from the service (n=7,586).

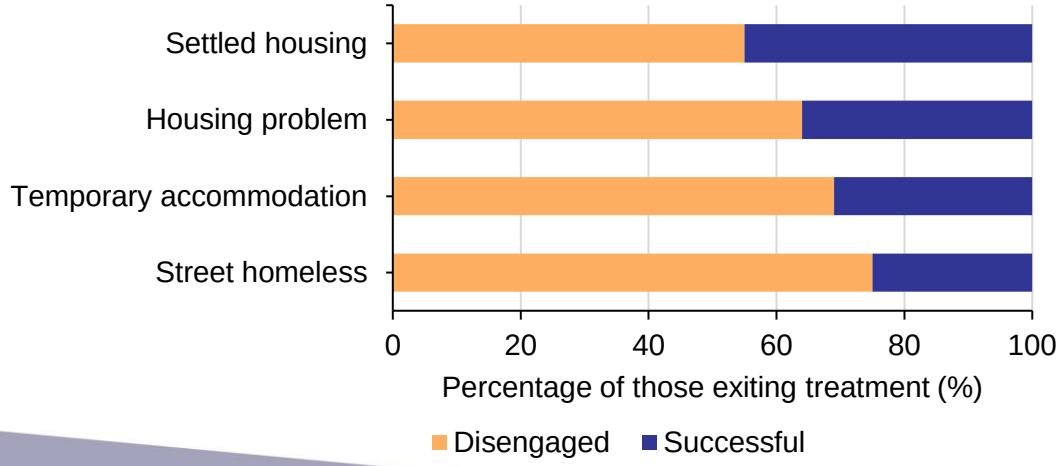
Of these, there were notable **differences in treatment outcomes** depending on housing, employment or mental health status (as recorded at the start of treatment).

Where people had a **homelessness or housing support need**, **mental health issues** or were **unemployed**, unsuccessful treatment outcomes were more likely (i.e., disengagement from treatment).

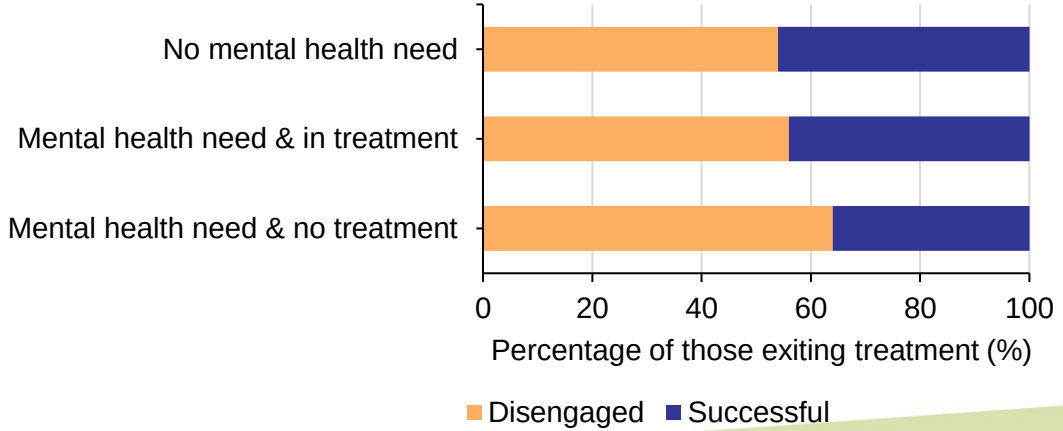
Treatment outcome by employment status



Treatment outcome by housing status



Treatment outcome by mental health need



All data provided by Change, Grow, Live (CGL).

Deaths of people with a homelessness or housing support need in West Sussex: 2020/21–2022/23 review

Catherine Wells | West Sussex Public Health and Social Research Unit

Full report available from:
https://jsna.westsussex.gov.uk/updates/homelessness-deaths-review-2024/

Background

Aims & objectives

To contribute to the local evidence base around the issues faced by people experiencing, or at risk of, homelessness, the WSCC Public Health team used a **novel approach**…

- working in **partnership with homelessness and housing support services** in West Sussex…
- to **review a sample of the case histories and fatality reports, held by these services, of deceased clients** who had died whilst known to these organisations…
- with the **aim of better understanding the histories, risk factors and vulnerabilities driving early mortality** in this vulnerable population**,** at a local level.

Homelessness and housing support organisations

These services provide a wide range of support for a variety of people, including:

- statutory and non-statutory temporary accommodation,
- day-centres and community hubs, and
- community outreach, including support for those at risk of homelessness and those who have previously been homeless.

Good to know

This review does <u>not</u>:

- Present data on the official causes of deaths of people in this group.
- Describe increases or decreases in the number or rates of death (mortality trends) in this group.
- Triangulate information contained in the case histories, provided by the participating homelessness and housing support organisations, with other sources.
- Contain recommendations for activity or action.

Scope and methodology

Working in partnership with local homelessness services (LHS)

Project **scoped** with LHS and local authority commissioners

Database co-designed with LHS

LHS **identified & shared** deceased client case histories for review

Sample of **clients who died in a 3-year period** (April 2020 - March 2023). Including:

Single people and **childless couples** in 5 categories:

- People sleeping rough
- Sofa surfers
- In unsupported temporary accommodation
- In supported temporary accommodation
- In 'move-on' or permanent accommodation with multiple needs

Data fields of interest:

- Demographics
- Circumstances of death
- Health - physical, mental and substance misuse
- Service histories
- Risk factors and vulnerabilities

Reviewing & analysing the client case histories

Data collected as **categorical** variables & **descriptive stats** produced

Narrative summaries produced for each case & analysed for **themes**

Report **shared with LHS partnership** for feedback

Key findings – number of deaths and demographics

Number of deaths

- **60 deaths** between April 2020 and March 2023.
- Cumulatively over the three years, there was a **higher frequency of deaths in the autumn and winter period** (September to February), with a peak in January of each year.

Demographics

- Around 9 in 10 were **male** (n=53).
- Most were aged **35-64 years** (ranging from 26-87 years).
- 4 in 5 were of **White British or Irish** ethnicity (n=48).

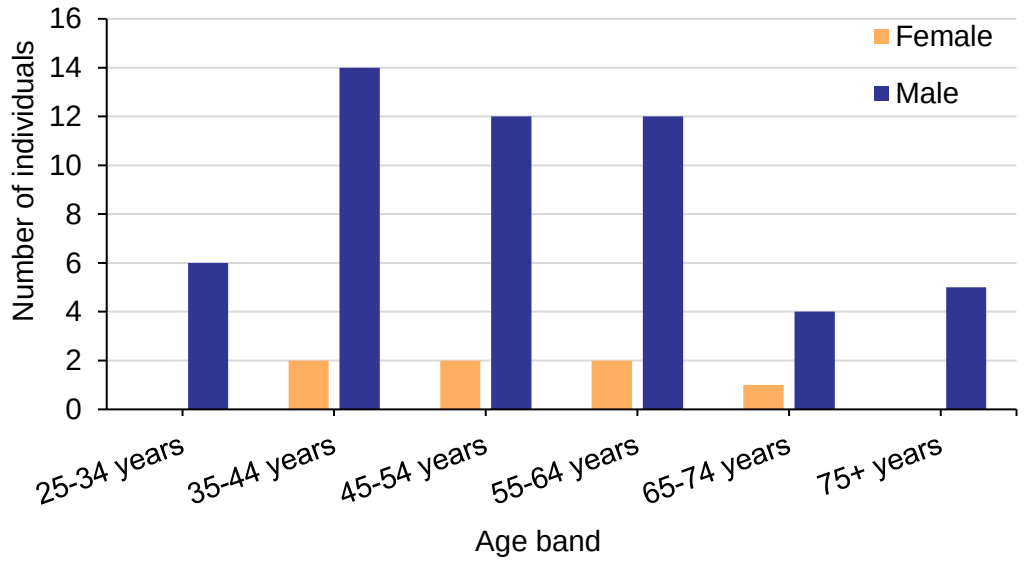
Good to know

Not all of the homelessness and housing support providers who were invited to participate in the review did so. There **may have been additional deaths** that would have fit the inclusion criteria that are not included in this review.

Additionally, deaths of **people with a housing support need who were not known to the participating services** in West Sussex are not included.

This review presents a **snapshot of the risk factors and vulnerabilities** experienced amongst this cohort, rather than a definitive enumeration of these issues.

Number of individuals who died by sex and age-band.



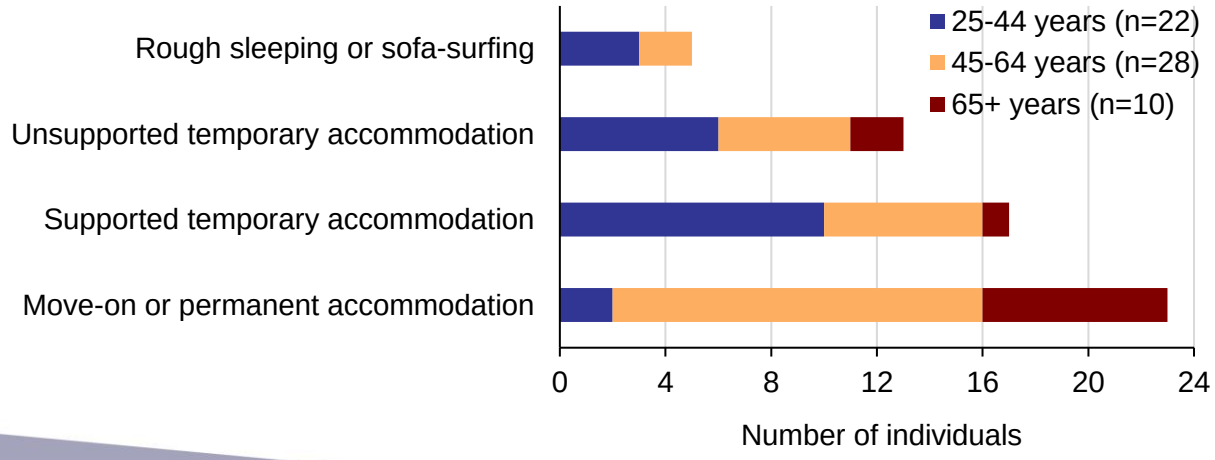
Key findings – housing situation around time of death

Housing situation around the time of death

- Around 1 in 3 were living in move-on or permanent accommodation (n=23).
- Half were living in temporary accommodation (TA). Of those in TA, slightly more than half were in supported TA (mostly high support settings, i.e., 24/7 staffing).
- Only a handful were sleeping rough or sofa-surfing (n=5).

NB: many individuals were recorded as having moved in and out of different accommodation types throughout their lives.

Number of individuals who died by last known housing status and age-band.



Good to know

This sample included people who were known to homelessness services but who were **not necessarily sleeping rough or living in unstable accommodation around the time of death**.

Whilst all of the deaths related to vulnerable individuals, many with multiple and compounding needs, this is **not a homogeneous group**.

Key findings – circumstances of death

Suspected cause of death

Information on suspected cause of death was available for three-quarters of individuals.

Physical health issues and illnesses (n=29)

Physical health issues and illnesses were the most common broad cause of death, where information was available.

Many of these physical health deaths involved **chronic conditions**, such as cardiovascular issues, cancers, COPD and liver issues.

External causes (n=16)

Around 1 in 4 deaths were due to **external causes**. **Suspected drug overdoses** were the most common external cause of death (n=9) and mostly in younger males (aged 25-44 years).

Not known (n=15)

Two deaths were suspected to be **suicides**. Both involved younger males.

Location of death

Of the 50 individuals where location of death was known:

- 22 died at home
- 17 died in a hospital or a hospice
- 10 died outdoors or in a public place

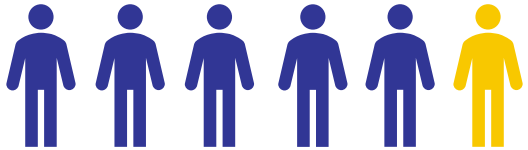
Good to know

The organisations who provided the case histories for this review are not routinely informed of the official cause of death and the level of detail provided was variable. Data was not triangulated against other sources.

All causes should be treated as **suspected** causes of death.

Key findings – health issues

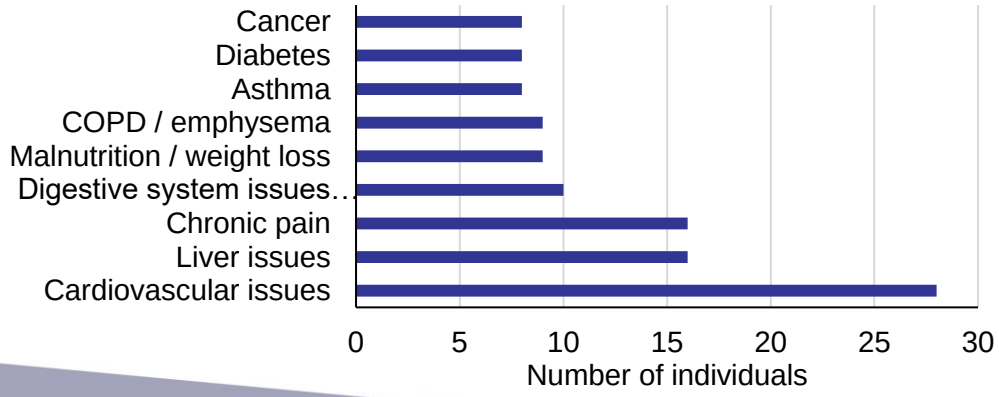
Physical health conditions



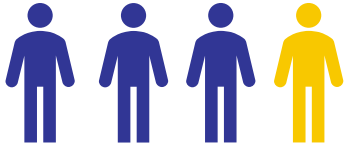
5 in 6 had at least one **physical health issue** ongoing around the time of death

- Many of these were **long-term and chronic conditions**.
- Physical health issues often related to **harmful lifestyles**, including the effects of long-term alcohol dependence.
- **Multi-morbidity** was common – at least half had ≥1 long-term physical health condition.

Most common physical health issues (reported in at least 10% of all individuals). NB: digestive system issues excludes liver issues.



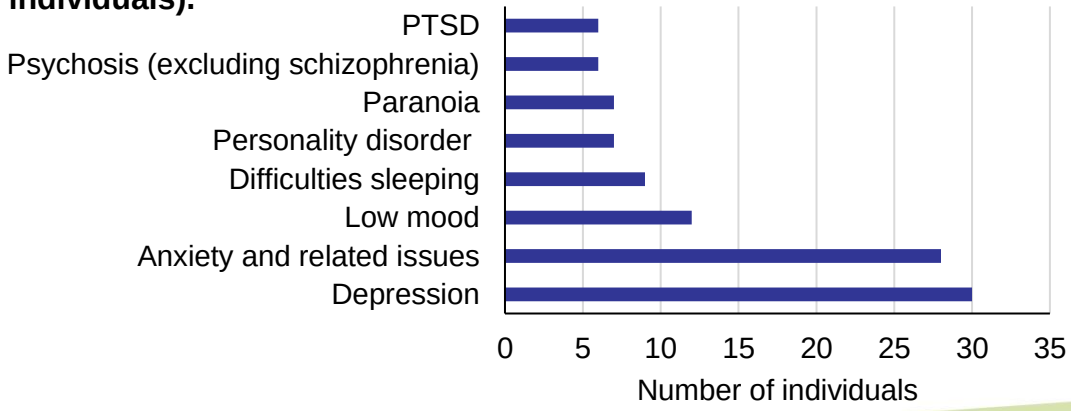
Mental health conditions



3 in 4 had at least one **mental health issue** ongoing around the time of death

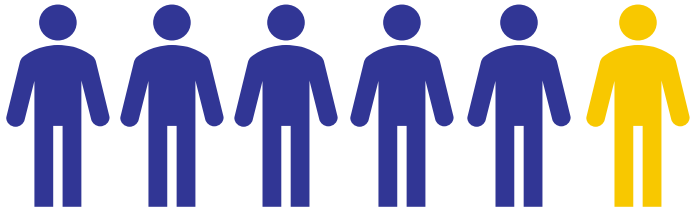
- **Depression** and **anxiety** were common.
- Several individuals were recorded as having **serious mental illnesses**, such as bipolar disorder, schizophrenia and psychosis.
- NB: In many cases, it was not recorded whether these were clinical diagnoses.

Most common mental health issues (reported in at least 10% of all individuals).



Key findings – substance misuse issues

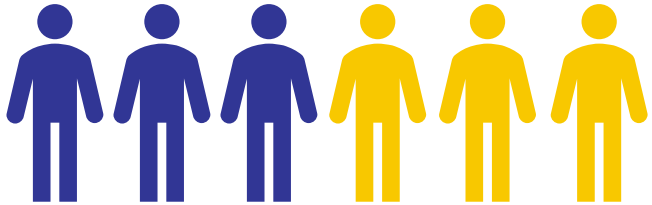
Alcohol misuse



5 in 6 with any history of **alcohol misuse**

- Of those with any history of alcohol misuse, most were stated or suspected to have been **alcohol dependent** at some point in their lives (n=40).
- Around the time of death, ongoing alcohol misuse remained highly prevalent (n=40).
- In many cases, **long-term alcohol misuse** was thought to be a **risk factor** leading to the individual's death.

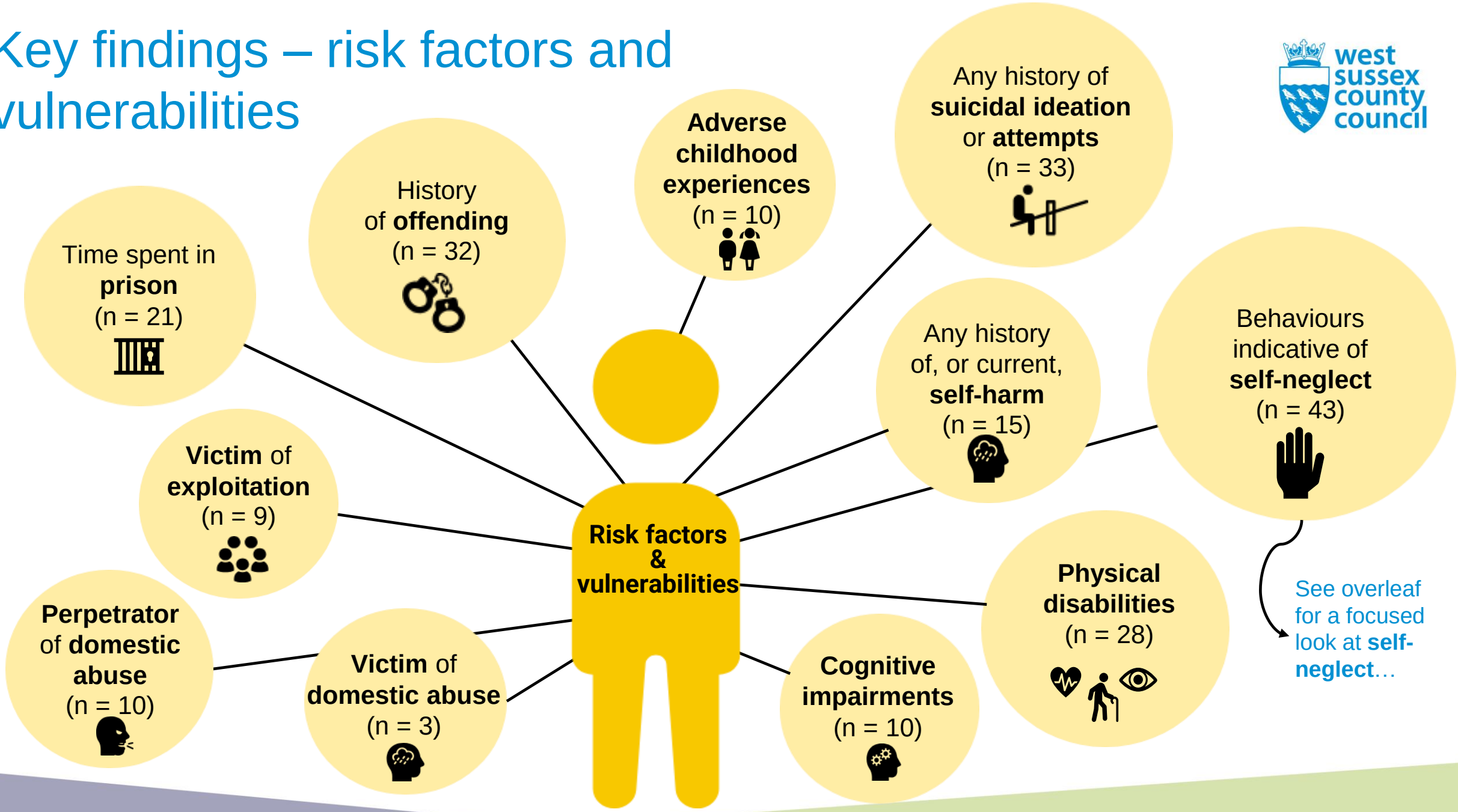
Drug misuse



(Nearly) **3 in 6** with any history of **drug misuse**

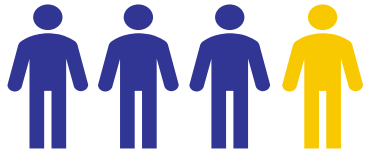
- Drug misuse was common – although to a lesser extent than alcohol misuse.
- 1 in 4 individuals were identified as having ongoing drug misuse problems around the time of death (n=15).
- Of those with any history of drug misuse, around half were described as having misused **heroin** (n=15). Misuse of **crack cocaine** and **cocaine** were also common, as was **cannabis** misuse.

Key findings – risk factors and vulnerabilities



Key findings – risk factors and vulnerabilities

Self-neglect



3 in 4 showed at least one **behaviour indicative of self-neglect**

- **Failing to access or refusing assistance** from services were the most common types of self-neglect, followed by **poor personal hygiene and health**.
- Around 1 in 4 individuals displayed **three or more behaviours indicative of self-neglect**.
- Self-neglect was the most common reason for a **safeguarding** referral.

Good to know

To identify and categorise behaviours that were indicative of self-neglect, the statutory guidance for the Care Act 2014 and guidance from the Sussex Safeguarding Adults Board and Social Care Institute of Excellence was used[19-21].

Type of self-neglect	Total
Failing to access / refusing assistance or services: health services	29
Failing to access / refusing assistance or services: alcohol or drug treatment	27
Poor personal hygiene and health	23
Neglecting personal affairs	8
Neglecting their environment/home (including hoarding, squalor, lack of household maintenance)	6
Failing to access / refusing assistance or services: social services	3
Ongoing misuse of own medication	2
Total number of individuals with known self-neglecting behaviours	**43**

Key findings – thematic analysis

Common factors affecting health, wellbeing and resilience over time…

Information collected from the case histories was reviewed to identify common themes regarding **issues and experiences which acted to decrease the health, wellbeing or resilience** of this group over time.

NB: Many of these issues did not directly cause or contribute to death – but were thought to be significant contributing factors to their deterioration over time or which inhibited their ability to access and maintain support.

A selection of these themes is presented overleaf, with more detail available in the full report…

Theme	Total number of individuals (n=60)	Proportion of all individuals (%)
History of alcohol and/or drug misuse or dependency	54	90%
Difficulties in independent living	52	87%
Compounding issues needing holistic support	51	85%
Physical health problems	50	83%
Mental health problems	48	80%
Poor engagement or disengagement with support services	48	80%
Current support not working for them or needs not being fully met	45	75%
Gaps, barriers and access to services	35	58%
Self-harm and suicidal behaviour	33	55%
Unstable (or chaotic) lifestyles	33	55%
Family and relationship breakdown	26	43%
Behaviours affecting eligibility to access support	25	42%
Access to employment, training or volunteering	22	37%
Vulnerable to peer influence or cultures of substance misuse	18	30%
Risks attached to a large inheritance/benefit payment	2	3%

Key findings – thematic analysis

History of alcohol and/or drug misuse or dependency

The harmful effects of substance misuse, often continued over long periods, were evident in most, if not all, aspects of this group's lives. This included effects on individuals' behaviour, relationships, ability to maintain their tenancy, employment and personal admin, alongside poor and worsening physical health.

Difficulties in independent living

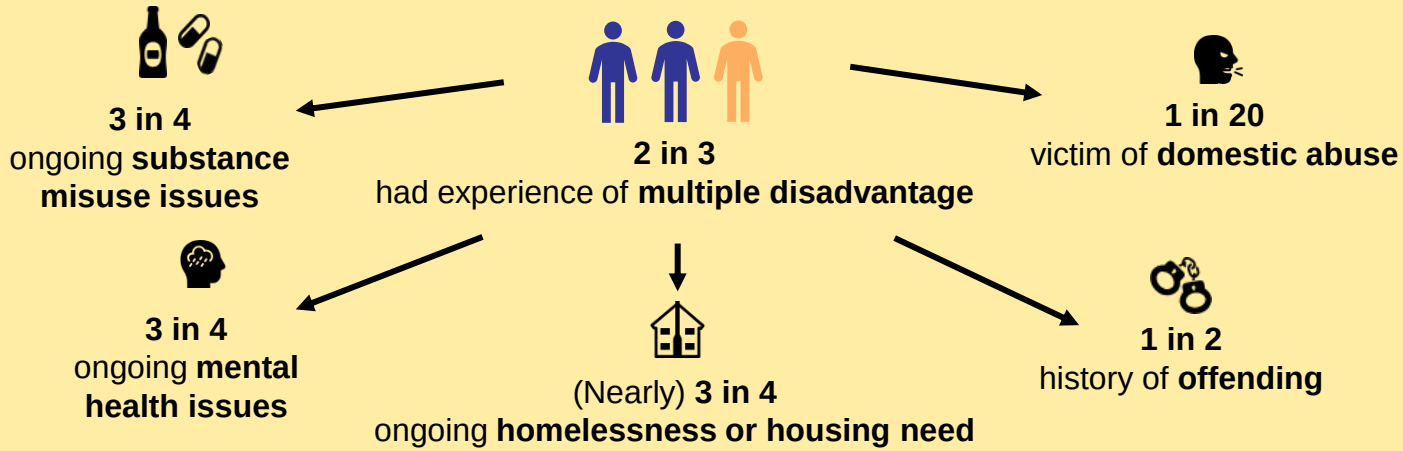
Many people lacked the personal skills, mental or physical capacity, or resilience needed to live independently. People struggled to manage their own health and personal care, and needed support to access and engage with services.

Compounding issues needing holistic support

Having multiple compounding needs acted to increase individuals' vulnerabilities and the risk of poor outcomes. This included the co-occurrence of physical and mental health issues, substance misuse issues, social care needs, housing problems, employment difficulties, offending behaviours and other issues. The accumulation of needs could create barriers to accessing support.

Multiple Disadvantage

Using the *Changing Futures* programme's definition of 'multiple disadvantage' – i.e., to have ≥3 of the below issues[22] – most individuals in this group had experience of multi-disadvantage (n=40).



Key findings – thematic analysis

Poor engagement or disengagement with support services

Not being engaged with support services, disengaging from one or more of these services, or engaging only at the point of crisis, meant that many individuals did not receive the longer-term care and support that they needed or sufficient consistency in this support. These behaviours were often indicative of self-neglect or part of a wider pattern of poor self-care.

Current support not working for them or needs not being fully met

Many people had significant or compounding needs that were not able to be fully met in their current placement. In some cases, this posed a risk to individuals' continuing abstinence, health or safety.

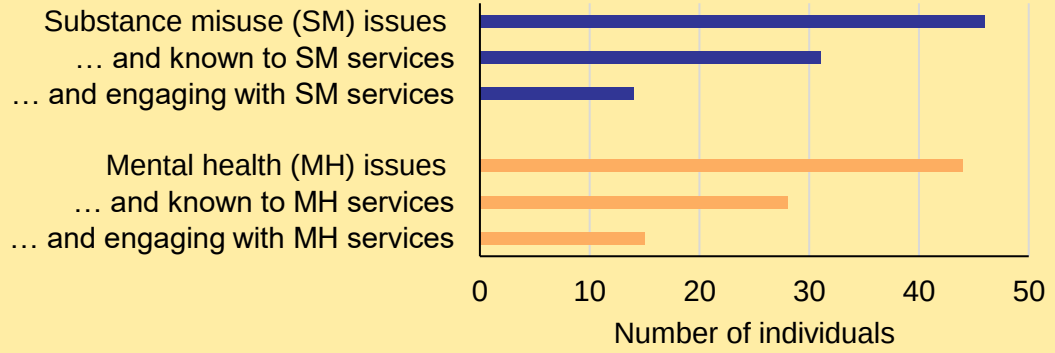
Several individuals inconsistently engaged or stopped engaging with their existing care, potentially putting their health at risk, because they didn't feel that this provision worked for them.

Gaps, barriers and access to services

Some individuals faced barriers which affected their ability to access services. Some of these were personal, such as discomfort or reluctance in disclosing health needs, and others practical, such as mobility issues and a need for translation support.

Service histories – individuals with ongoing mental health or substance misuse issues who were known to, or engaging with, services

The themes described here may be apparent in the service histories of those with substance misuse and/or mental health issues. Despite high levels of these issues in this group, relatively few were known to, or engaging with, relevant services.



In summary…

Amongst this group of people who died whilst experiencing, or at risk of, homelessness…

Multiple and compounding needs were common

High level of **health and substance misuse** issues – including a high prevalence of **long-term and chronic conditions**

Numerous risk factors and vulnerabilities, including **self-neglecting behaviours** and **social care needs**, **self-harming** and **suicidal** behaviours, **offending** behaviours, **employment** difficulties, and other issues

Most had **difficulties living independently**, **poor engagement or disengagement** with services, and experience of **gaps, barriers** or instances where **existing service provision was not working** for them

Challenges in providing support were identified – individuals' **circumstances, needs, and ability or willingness to engage with services fluctuated**

The health and care of homeless people is a **system issue** → i.e., it requires attention across the health, care and social support system

Moving forwards…

Whilst this review does not make recommendations for any specific actions, its findings can be used:

to support the work of organisations and services working with people experiencing, or at risk of, homelessness …

… both **singly…**

… and **in partnership** as a joined-up **health, care and social support system**.

Consideration of the report's findings by **system leaders**, via relevant **governance structures**, will support systems to improve the health and care of this vulnerable population.

Understanding the experiences and impact of temporary accommodation on adults who use drugs and/or alcohol

Dan Barritt | West Sussex Public Health Lead
Sara Shepherd | CAPITAL
Duncan Marshall | CAPITAL

Full report available from: https://www.capitalcharity.org/drug-alcohol-partnership

Background & Objectives

Background

Having a housing problem is associated with poorer treatment outcomes: people are less likely to stop using drugs and/or alcohol and engage in treatment or other support.

Dame Carol Black's 2021 report recognised the **important role that housing and housing support play in recovery** and called for a greater understanding of what is needed for this population[23].

In June 2024, WSCC Public Health commissioned CAPITAL, a local **lived experience** organisation, to conduct **focus groups** with people to gather their views and experiences.

Objectives

1. Understand people's **experiences of temporary accommodation** (TA), and the extent to which it **supports or challenges their engagement in treatment and supports their recovery** (including individual physical, social, and mental wellbeing).

2. Identify, from the perspective of people with lived and living experience, **what 'good' looks like** in terms of TA conditions and **what additional support could benefit recovery**.

The focus groups

Between July-October 2024, CAPITAL hosted **seven focus groups** in six locations across the county, with **thirty-eight people who use drugs and alcohol**. Most attendees were:

- Male
- Aged 35-44
- White/English/Scottish/British.
- Mental ill-health was the leading disability reported.
- Lived in temporary accommodation for up to two years and had changed temporary accommodation 1-2 times in the past year.
- Experienced periods of homelessness (living in caravans, cars, and tents) between temporary accommodation placements.

Contributing factors for needing temporary accommodation

Co-occurring mental health and substance use conditions (over two thirds).

Poor mental health.

Relationship breakdowns, family issues, and domestic abuse.

Engagement with the criminal justice system.

Eviction from family, friends, and partners.

Permanent accommodation

The importance of permanent accommodation

Many said stable accommodation would enable them to get back to normality, be autonomous, and would reinstate their dignity.

"…a foundation for building a good life, a future", and "growth".

Many described the importance to them as parents, and to help improve and manage their mental and physical well-being.

"…it's the ultimate – having somewhere I can have my kids."

Challenges with transition into permanent accommodation

Many were nervous of moving into permanent accommodation before they were ready.

"I don't think I could live on my own. I need to be with others and supported…",

Some said that being in supported TA was a way for them to learn to live independently, reduce loneliness, and have someone on hand for support.

"I needed some kind of transitioning period and a support worker to help me prepare for the responsibility of running a home and paying bills etc..."

Being in temporary accommodation

Impact of temporary accommodation on recovery

Many said that they feel positive in their current TA, and that it has helped with their recovery and mental health.

"…it has made me feel more stable and helped me stay away from drinking – I'm 4 months sober."

"It has opened more doors for other services and has had a big improvement on my mental health."

But challenges were also described.

Challenges with current environment

Being triggered by people still using substances when moving into shared TA.

"…other people having relapses hasn't helped me. We all need the same rules and support, and people who relapse need more support, not punishment."

Rules / boundaries around drug and/or alcohol use not being applied consistently.

Location and isolation.

Costs associated with service charges, and unfair rules and restrictions.

Access to specialist treatment services, health, and wider support

Two thirds described facilitating factors that enabled them to access specialist treatment and support.

"I can't fault the help."

"Services come to us once a week, including the Job Centre, Housing, Salvation Army, and CGL. There's a board outside our rooms with everything that is happening that day, so that we can get involved."

But others described challenges involving cost and the location.

"…there is support in Brighton, but I have to pay to travel there".

"Moving to a different location away from my GP, who I have had for many years, has been inconvenient and I don't want to change GP as I have a good relationship with the one, I already have".

Other challenges were access to oral healthcare and not receiving routine letters for appointments.

Impact on mental health and well-being

Many described difficulties of moving away from their existing social support networks and in accessing mental health treatment.

"…the isolation living in an area away from family and friends has been really hard for my mental health."

Lack of safe spaces for children to visit, living with others who were still using and/or drinking, frequent changing of staff and negative interactions, and living outside before being housed in TA and in-between stays.

"…places where dads can have kids… where I am I wouldn't bring them here to see neighbours doing drugs."

What would ‘good’ look like?

Improvements in the environment (including cleanliness and decoration) and conditions of living within the TA.

“…more privacy”**, and **“remove audio and video surveillance.”

“…the temporary housing I was in before had good quality rooms, and we were treated like humans.”

The location of the TA in relation to transport links and other vital services.

“…needs to be near to services, for example food banks and other supporting organisations.”

Separate accommodation for users and non-users (including age and sex considerations), and easy to access help and support from people with lived experience.

“We need someone here to signpost us to where to go to get proper help.”

“It would help getting things like paperwork sorted.”

Consistent support with finances and transitioning into permanent accommodation.

“…support workers to help with finances and budgeting while in temporary housing.”

Conclusions

1. **Shared TA environments with people who are still using drugs and/or alcohol**, compounded by **inconsistency of common rules, expectations, and boundaries of the TA provider**, including substance use, can be detrimental to recovery.
2. A **lack of trust by TA staff**, **poor understanding of difficulties**, and **no safe or suitable areas for children** to play or stay are detrimental to recovery, and broader emotional, social, and physical health.
3. **Ongoing support and education** around **managing finances**, developing **skills for living independently**, and **preparation for transitioning from temporary to permanent accommodation** is essential to build and sustain recovery.
4. Access to **peer support networks** and **specialist support within TA** settings supports recovery. **Training for staff** would help them to understand people's difficulties with drugs and alcohol, trauma, and stigma, and enable them to access relevant support services when needed.

Recommendations from this report

1. Ensure that all **TA staff are trained in trauma informed approaches**, that relate specifically to drug and/or alcohol dependence and associated stigma.
2. **Upskill staff** in TA and associated settings in having **short, initial conversations that enable a better understanding of individual need**.
3. **Suitable family areas or arrangements** should be considered in TA settings, as early as possible.
4. Immediate **guidance should be given around house or common rules**, and **staff should be aware of local support services and how to refer**. House rules and up-to-date information about local services should be clearly displayed.
5. **Practical budgeting tools and financial management support** should be scoped locally and made visible and available to all residents in TA settings, including resettlement support.
6. **Alternative TA solutions**, which could be more sustainable, cost friendly, and community focused should be explored and considered (e.g., modular home solutions).

Next steps for West Sussex Public Health…

Next steps for West Sussex Public Health…

To improve the health and care of people experiencing homelessness in West Sussex, we, as a Public Health team, will work towards five strategic ambitions:

1

Data and intelligence

We will improve our **understanding of the health and wellbeing needs and experiences** of individuals and families experiencing homelessness, including exploring the impact of different forms of homelessness and across different sub-groups.

A homelessness **needs assessment** will be undertaken to support this ambition, in partnership with a wide range of professionals and people with lived or living experience.

We will set out plans to develop **data sharing** ambitions with partnership stakeholders to have an **up-to-date understanding of priority outcomes**.

2

Strengthening partnership working

We will promote a **system wide approach** to health and wellbeing of people experiencing homelessness through establishing or enhancing **robust governance** and **strong multi-agency partnerships**.

We will **capitalise on existing partnerships and boards**, by linking in with existing programmes and providing **leadership from a public health context**, i.e., West Sussex Drug and Alcohol Partnership, West Sussex Health and Wellbeing Board, Safer West Sussex Partnership and Community Safety Partnerships, West Sussex Multiple Compound Needs Board, and Local Community Networks.

We will also explore the **role of anchor institutions** in supporting the health and wellbeing of this group.

Next steps for West Sussex Public Health…

To improve the health and care of people experiencing homelessness in West Sussex, we, as a Public Health team, will work towards five strategic ambitions:

3

Supporting the workforce

We will support the **development of the workforce** to improve confidence and ability to support people experiencing homelessness who may have multiple and compounding needs. For instance, through providing substance use, mental health and trauma-informed approaches **training to staff** across the system who support people experiencing homelessness.

4

Co-production

We will work in **partnership with people with lived or living experience** to design and deliver workstreams aimed at improving the health and wellbeing of people experiencing homelessness.

5

Access to services and support

We will work with partners to **improve access to services and support** through accessible and up to date information, including around housing pathways and healthcare, and exploring the **role of peer support** to enhance access to services. This will also include improving support to increase readiness to transition to move-on or permanent accommodation.

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