

# Sick and tired

The impact of temporary  
accommodation on the health  
of homeless families



# Shelter

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To protect the identity of individuals mentioned in this report, models have been used in photographs and case history names have been changed.

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# Contents

Summary and main recommendations	4
About the research	6
Introduction	8
How families' health suffers	11
<b>Case history – Zoë: mental health</b>	15
Access to information	18
<b>Case history – Sabah: mobility problems</b>	21
Needs assessments	22
<b>Case history – Sofia: managing special needs</b>	24
Access to primary care	27
<b>Case history – Jo: depression and anxiety</b>	30
Co-ordination of services	31
<b>Case history – Amir: complex health needs</b>	35
Conclusions and recommendations	37
Appendix one: details of sample group and methodology	45
Appendix two: topic guide for case history interviews	47

# Summary

When people are forced to move into temporary accommodation, their health suffers.

The uncertainty of their situation, often combined with poor living conditions, impacts both physically and mentally on homeless individuals and families.

In Britain, nearly 100,000 households, many of them families with children, are living in this state of limbo.

Depression, an increase in visits to doctors or hospitals, and falling levels of self-esteem and activity, are not uncommon.

People housed in temporary accommodation are vulnerable to diseases such as bronchitis and tuberculosis, and existing physical health conditions such as asthma, are often exacerbated.

The problems are frequently compounded because families are placed in inappropriate accommodation for their health and social needs; co-ordination of services fails; and/or basic information that could assist them to plan and exercise choice over their situation is not forthcoming.

Addressing these issues will significantly improve the lives of homeless families, reducing pressure on health and social services in the long term. Additionally, short-term action could help local authorities and agencies fulfil their Supporting People and Homelessness Act obligations.





# About the research

This research follows on from a 2003 survey on the impact of temporary accommodation, which formed the basis for Shelter's *Living in limbo* report. One of its key findings was the impact of homelessness on health, and this report is based on further analysis of almost half of the original questionnaires that were returned.

All the findings in this report relate to the sample of 194 families with dependant children (47 per cent of the original survey respondents), who reported having a range of specific health problems. All these families were living in types of temporary accommodation other than bed and breakfast hotels. In-depth case history interviews, which appear throughout this report, were conducted with five individuals from families in the sample group. Details of the composition of the sample group and research methodology can be found in Appendix one. A topic guide for the case history interviews can be found in Appendix two.

The research sought to:

- explore how and why families felt living in temporary accommodation affected their health, and the factors they felt caused this
- establish the extent to which specific health and other support needs appeared to have been assessed in homelessness interviews or through subsequent contact with local authorities
- identify specific issues that remain to be addressed in the placement of families with health problems in temporary accommodation.

The intention of the research was to examine the impact that living in temporary accommodation had on families' health, from their own perspective. It did not examine whether or not living in temporary accommodation caused health problems, and it must be recognised that many of the families who participated had existing health

problems at the time they became homeless.

## Key findings of this research

More than half (58 per cent) of the families said that their health or their family's health had suffered as a result of living in temporary accommodation. Nearly all of the families felt that their children's health had suffered through living in temporary accommodation.

Almost half (47 per cent) of the families reported that their health had become worse since they moved into temporary accommodation. Among those suffering depression, 63 per cent said this had worsened and 60 per cent of those with asthma or other chest and breathing problems said their condition had deteriorated.

The longer families lived in temporary accommodation, the more likely they were to attribute their worsening health to their housing situation.

A total of 45 per cent of the families reported visiting their doctor or hospital more frequently since becoming homeless.

More than half of people in the survey stated that they were depressed. This figure was even higher (64 per cent) for people living in workless households. The case histories show how depression impacts on people's levels of motivation; in some cases, people found it difficult to perform even basic tasks, such as cooking.

The case histories contrast some respondents' levels of self-esteem and activity before they moved into temporary accommodation with their situation now, showing huge differences.

Parents experienced considerable anxiety because they were unable to plan for their children's future, especially for their education. This was compounded when families had been moved several times before receiving an offer of permanent accommodation.

The case histories suggested that local authorities were not forthcoming with basic information, such as the progress of a family's housing application. Lack of control over, or knowledge about what would happen was causing very high levels of distress amongst some applicants.

Half of the families with health problems were living in neighbourhoods where they said they were worried about crime; more than a third said they felt isolated. Almost half of the families were not able to call on help and support from friends.

Families were not accessing specialist support services in cases where these may have been necessary. More than two thirds of people suffering from mental health problems were not using any support services and over three quarters of families with children aged four or under were not accessing Sure Start schemes.

### **Key recommendations**

On the basis of the research findings, Shelter makes the following recommendations:

- 1 The Office of the Deputy Prime Minister (ODPM) should develop a national strategy containing measures to make life better for people living in temporary accommodation in the short term and to reduce the need for its use in the longer term. As part of their regional housing strategies, Regional Housing Boards should set out how they will allocate capital and revenue funding to achieve these aims.
- 2 Every local authority should review its homelessness strategy and use the deferred completion date for Supporting People strategies<sup>1</sup>, to ensure that they collect accurate information on the levels and types of needs among all groups of homeless people in their district. This data should be used to inform future commissioning of Supporting People services.
- 3 Local authorities should develop policies and procedures to ensure that all homeless families have their health and other support needs assessed thoroughly. Assessment should first take place when families initially apply as homeless to the local authority, and should be reviewed at regular intervals as long as the families are living in temporary accommodation. This would ensure that changing health and social care needs are monitored and that these needs are adequately met.
- 4 Primary Care Trusts (PCTs) should work closely with local authorities to identify where there is a need for greater provision of specialist health care for homeless people. PCTs should consider increasing current funding levels for Personal Medical Services schemes, especially for projects that work with homeless families.
- 5 The ODPM should ensure that the revised Homelessness Code of Guidance clarifies the functions of health services in relation to housing and homelessness, and establishes robust procedures to ensure that health and social care services are informed when homeless families are placed in temporary accommodation.
- 6 The Department for Education and Skills (DfES) should ensure that the role of housing is fully integrated with the new arrangements for children's services set out in the Children Act 2004 and currently being piloted in Children's Trust pathfinder areas.
- 7 The Department for Education and Skills (DfES) should provide funding to expand Sure Start services or create new mobile services to meet the needs of homeless families.

1. Local authorities are now expected to produce full five-year Supporting People strategies by March 2005

# Introduction

Having access to good housing is vital to people's physical and mental well-being. Good housing alleviates health problems, enhances access to care, and improves people's quality of life.<sup>2</sup> Being homeless or living in bad housing can damage people's health, their education, and their future. People who are homeless or living in bad housing are more likely to:

- develop diseases, such as bronchitis, TB or asthma
- suffer from depression, low self-esteem, and be less able to maintain relationships or seek work
- suffer from bad health later in life, even when their housing circumstances have ceased to be poor.<sup>3</sup>

Record numbers of people accepted as homeless are currently living in temporary accommodation. At the end of June 2004, this totalled 99,380 households, a high proportion of which were families with children.

Temporary accommodation is typically not secure or affordable for homeless families. Some of it is in bad condition; most of it is provided at high rents, creating dependency on housing benefit to meet the costs. Increasingly, in some areas of high housing demand, homeless families are placed outside the district they apply to be housed in and find themselves therefore cut off from social and support networks.

Also, homeless families may have to move several times between temporary placements before the local authority offers them permanent accommodation. In addition, local authorities often do not fully assess the support needs of homeless families. This means that families can be placed in accommodation that is inappropriate and inadequate for them.

The Government's target to eliminate the use of bed and breakfast accommodation for homeless families has been met. From April 2004, regulations ban the use of bed and breakfast accommodation for homeless families, for periods of more than six weeks. Local authorities will have to use other types of accommodation to accommodate these households temporarily. This will include their own and housing association stock, hostels, and accommodation leased from private landlords.

Living in temporary accommodation is already known to have a number of negative impacts on people's physical and mental health. Homeless children are particularly in danger from fires and accidents.<sup>4</sup> Their long-term physical and social development is also placed at risk because they lack access to education and support services. Poor health outcomes are now recognised to be the result of a number of factors: not only the quality of the accommodation in which people live, but also the degree of access they have to support services and to social networks.

Within central government, there is an increasing awareness of the need to tackle poor health outcomes through joint work between departments, such as health, housing and education. A number of government departments have now committed themselves to specific targets and action.<sup>5</sup> Strategic initiatives, such as the Homelessness Act 2002 and the Children Act 2004, also stress the importance of joint working between services and departments, as a means of providing people with stable, secure housing and giving them the support they need to enable them to stay in their current accommodation.

The 2004 Spending Review emphasises the links between bad housing, homelessness, and child poverty, and the need to

2. For example, Smith, J D, Alexander, A et al, (1997), *Rehousing as a health intervention: miracle or mirage?* *Health and Place*, Vol 3 (4)  
3. Shelter (2004), *Toying with their future*, London: Shelter  
4. For example, Roberts, I and Power, C (1996), Does the decline in child injury death rates vary by social class? *British Medical Journal* 313: 784-6  
5. Department of Health (2003), *Tackling Health Inequalities: Priorities for Action*, London: Department of Health



reduce numbers of families with children in temporary accommodation. Recent government policy has also been positive in improving physical standards in temporary accommodation and reducing the long-term use of bed and breakfast hotels for homeless families.<sup>6</sup> However, whilst welcome, these measures are not sufficient to redress the full range of physical and mental health impacts of living in temporary accommodation.

In April 2004, Shelter launched its million children campaign, aimed at ending the devastating impact of the housing crisis on over one million children in Britain. The campaign was launched with the publication of *Toying with their future*,<sup>7</sup> a report revealing that over a million children are growing up in overcrowded, unfit, or emergency housing, and suffer from serious health and education problems that put their future at risk.

Shelter's 2004 report, *Living in limbo*,<sup>8</sup> illustrates and provides costings of the wider impacts of housing homeless families in temporary accommodation.

One of the key findings of the survey behind that report was the impact of homelessness on health, a finding that Shelter considered required further scrutiny.

This report looks in more detail at the impact of temporary accommodation on the physical and mental health of homeless families. It calls for an increase in help available to families in this situation, and action to limit the need for temporary accommodation when families find themselves without a home. It makes recommendations both to the Government and local authorities on how they can tackle this situation, as well as helping them to achieve targets on preventing homelessness and reducing health inequalities.

6. The latter measure has been incorporated into legislation via the Homelessness (Suitability of Accommodation) (England) Order 2003.

7. Shelter (2004), *Toying with their future*, London: Shelter

8. Mitchell et al (2004), *Living in limbo*, London: Shelter



# How families' health suffers

Families in this study felt their health had suffered in a number of ways since they became homeless and were placed in temporary accommodation. This included both the development of mental health problems, such as depression, and physical health problems resulting from housing conditions. Families also discussed how and why existing physical and mental health problems had worsened, often as a result of them having no control over their circumstances and no knowledge of what was going to happen to them, or when. There were specific examples of households struggling to care for family members with chronic health problems or conditions, in unsuitable and unfamiliar surroundings and without access to necessary health care and support services.

## State of health and use of health services

Almost all the families (98 per cent) reported being registered with a GP. A total of 45 per cent of these reported visiting their doctor or hospital more frequently since they had become homeless. However, several families reported difficulties in

travelling long distances to keep their existing GP, whilst others had difficulty registering at a new practice.

When the families were asked specifically about their health now compared to how it was before they were homeless, almost half (47 per cent) reported that their health had got much worse since they moved into temporary accommodation. Families were also asked to state whether any member of their household had a specific health problem; in all cases where a specific problem was mentioned, the family said it had become worse since they had been housed in temporary accommodation (see Chart 1). A total of 63 per cent of those with depression said it had become worse and 60 per cent of those with asthma, and other chest or breathing problems, felt their condition had worsened.

**Chart 1:** Since you have been housed in temporary accommodation, how does your health compare to how it was before?

	Total number answering	better	same	worse
Asthma	48	4	20	24
Other chest/breathing problems	38	2	8	28
Skin problems/eczema	56	11	16	29
Depression	104	11	27	66
Other mental health problems	24	5	3	16

Participants in the study specified ways in which their health and that of their families had suffered. These included:

- taking antidepressants
- developing colds and flu
- isolation and loneliness
- being unsettled
- anxiety and stress
- disability.

Specific comments included:

‘I have more viral infections and my depression has increased and I do not feel secure here.’

‘No stability, increased depression and anxiety, relapsing on drugs due to eviction.’

The case histories provided examples of why people felt their conditions had worsened. Zoë spoke very clearly of how she and her son became depressed and suicidal after moving into temporary

accommodation because she felt there was ‘nothing to live for’. Her dealings with the council resulted in total frustration and caused her to feel she had no control over what was going to happen to her family, or when, if ever, they might be moved.

**Length of stay and health problems**

Over half (58 per cent) of the families said that their health had suffered ‘due to living in temporary accommodation’. The longer families had lived in temporary accommodation, the more likely they were to attribute worsening health to their housing situation, as shown in Chart 2, below.

**Chart 2:** Number of families reporting that their health had suffered due to living in temporary accommodation

Length of time in temporary accommodation	Number of households in temporary accommodation for this time-period	Number stating their health had worsened due to living in temporary accommodation	Percentage of households reporting health had worsened by time spent in temporary accommodation
Less than three months	23	6	26%
Three to 12 months	46	25	54%
More than 12 months	124	77	63%

Families with existing health problems clearly found it difficult to manage the health needs of those members of the family with chronic problems or specific conditions, while they were in temporary accommodation. In one case, Sofia, a single mother, was trying to care for her teenage son who was severely autistic. She had been forced to move boroughs, had no information about specialist health or support services, and was isolated from her friends. The accommodation they were living in was further exacerbating her son's condition.

### **Housing conditions and location, and their impact on health**

Most families were housed in self-contained accommodation and only ten per cent were sharing facilities. Despite this, a total of 42 per cent of families that responded, agreed with the statement that the accommodation they were living in was 'damp and mouldy'. A total of 27 per cent of those that replied, agreed with the statement that 'the cooking facilities are poor and unhygienic'.

Damp and dusty accommodation caused additional problems for families with members suffering asthma and other breathing problems. Both Sabah and his wife suffered serious asthma, but were housed on the upper floor of a block with unreliable lifts. The accommodation was damp and there was dust from building work. There was also no parking for their car, despite family members being registered as disabled.

Many families also had concerns about the location of their accommodation, or the area they were living in:

- half of the families (50 per cent) said they were 'worried about crime in the area' in which they were living
- a total of 44 per cent felt 'isolated from family and friends'

- more than half (56 per cent) were 'worried about the number of people taking drugs' where they lived.

### **Children's health and education**

Ninety per cent of the parents said their children had suffered as a result of living in temporary accommodation. More than a tenth reported that their children found it difficult to make friends and more than a fifth (21 per cent) reported that their children were often unhappy and depressed.

A total of 18 per cent of parents said that their children had missed school whilst living in temporary accommodation.

Reasons given included:

- tiredness
- problems with the parent's health and mobility
- the child's own health problems
- depression on the part of parents and children
- being unsettled and having to move.

'Emotional instability', children regularly feeling ill, and 'psychological problems' were among the various ways in which parents specified that their children's education had suffered through living in temporary accommodation.

Parents found it difficult to plan for their children's education if they were at an age when they needed to move to another school. Jo, who suffered from anxiety, found this an additional stress. For parents of children with special needs, living in temporary accommodation exacerbated an already difficult situation. Sofia reported that her son received no education for 12 months whilst a suitable school place and transport was arranged, following their move to temporary accommodation outside their borough.



## Health and workless households

More than half (98 families) of the sample were not in work or training. Over a quarter of these families specified that physical health and/or mobility problems prevented them from working. A further quarter were not at work due to mental health problems. Other significant reasons for not being able to work were:

- lack of childcare
- high rents make working unaffordable
- not knowing how long the family would be living at the current address.

## Access to services

Few families had access to relevant health-support services or were making use of them.

- More than half of the respondents suffered from depression, but only a fifth (22 per cent) were making use of social-support services such as mental health care. The majority said they were either not using such services or did not need them.
- More than two thirds (70 per cent) of people suffering with mental health problems were not using any mental health or other support services; only 30 per cent said they had access to such services.

There were suggestions from the case histories that services were not always appropriate, even when they were offered. Both Zoë and her son suffered severe depression and had been suicidal, but found the mental health support services they were offered to be totally inadequate. Two of the other case histories mentioned family members with mental health problems refusing or discontinuing services they had been offered.

There were also problems with family support services.

- Less than a quarter (22 per cent) of families with children aged four or under were using Sure Start, whilst the great majority were not.
- Only 27 per cent of families with children aged between five and 11 were using youth services, and more than two thirds (73 per cent) were not. Less than a third (28 per cent) of parents with 11- to 16-year-olds said their children were using youth clubs.

Sofia's case history shows additional problems in accessing specialist youth services for her autistic son. She had been left to find information and apply for a placement herself. Both Sofia and her son were likely to benefit from the extra support and input from a specialist youth service, and it is worrying that no assistance had been given to her to achieve this.

Additionally, almost half (49 per cent) of the families were not able to call on help and support from friends. Again, this is likely to cause additional strains for families managing chronic health problems and conditions whilst in unsuitable and unfamiliar locations.

# Case history

## Zoë: mental health

Zoë is a single parent, living with her 17-year-old son. They became homeless as a result of domestic violence, living in a women's refuge and then a bed and breakfast hotel. They have since lived in two privately rented properties, leased by the council as temporary accommodation. The contract is due to expire again in a couple of months and they expect to have to move again, to further temporary accommodation.

Although there are no specific problems with the physical condition of the property they live in, it is on the fourth floor and Zoë can't use the lift because she has panic attacks. She has to walk up the stairs, which affects her asthma. However, Zoë's main problems are with depression, which she and her son have experienced since they first moved into temporary accommodation. Both Zoë and her son have attempted suicide since becoming homeless.

'There was nothing to live for, that's how I felt, there's nothing to live for and the council was really, really, really getting to me because like I said whenever you ring you never, ever, ever get a question answered and I just felt what's the point, so I decided to commit suicide and the police were called and I was taken into psychiatric hospital.'

Zoë was discharged the next day and was told to get in touch if she needed more help:

'They told me to join things like coffee mornings and go and talk to people, and I told them to get stuffed because I found that very insulting.'

She did not receive any other follow-up. Her son was advised to see a psychiatrist, and they were both given medication. Zoë sees her GP regularly for medication for depression and asthma:

'I've lost count of how many times I've been to my GP. More than I can remember. I never used to go to the doctor's.'

Zoë says her depression is caused by their homelessness, lack of security, and the way they have been treated by the local authority. Zoë feels unable to relax because her landlady has the keys to her property and makes her feel like she's 'being watched'. She insists on being able to visit the property regularly and sends Zoë text messages telling her things she has to do:

'You know a lot of people like to relax in the bath, I can't do that. How can I do that because I am constantly in fear of her coming in the property? It demoralises you, it makes you feel like a trapped animal, you can't get out, but you can't do anything living in the property you are in . . . that's what it's like living in temporary accommodation, it's like being in prison. You are controlled by other people and you've done nothing wrong.'

In common with the other case studies, Zoë has found the lack of information and communication from the council especially difficult:

'When you question things, you are classed as a nuisance. You are made to feel bad about yourself, that you shouldn't be complaining because when you do complain you are told that there are people in worse situations than you, so it's like you are meant to feel grateful that you are in temporary accommodation. Well, I am not grateful. I am not grateful at all.'

Zoë felt the worst aspect was the total lack of control she felt over her circumstances:

'It's torture, absolute torture, not knowing when you are going to be rehoused and where you are going to be rehoused. They are the two worst things I think. You are just constantly worried. When and where.'

For Zoë and her son, the impact of their situation was devastating. Before becoming homeless she had a good job, working as a home carer for social services:



‘I went from looking after other people to existing in a poxy two-bedroom flat, taking antidepressants so that I don’t kill myself. And that should pretty much sum up what it’s like. That’s what temporary accommodation does for you. It destroys you.’

**Her son had been:**

‘A very, very confident boy, knew exactly what he wanted in life, where he wanted to go and everything. So he went, basically like me, from an outgoing person that was happy and who worked and appreciated their life to someone who wasn’t even interested in... getting out of bed in the morning.’

Zoë was clear that the problems she and her son were experiencing resulted solely from their being homeless and in temporary accommodation. It was the simple resolution of this that would make a difference:

‘Put it this way, what can the doctor do? I go to my doctor and I say I feel suicidal. “Why do you feel suicidal?” “Because basically I live in the present.” “Why are you basically living in the present?” “Because I live in temporary accommodation.” “Oh, I see, I understand. Take these tablets.” That’s it. What else can a doctor do? What can a doctor do for me whilst I am living in temporary accommodation? He can’t pick the phone up and say, “I suggest you rehouse this person immediately.” He hasn’t got that power. What else can he do except say, “Swallow these tablets.”’

**Being permanently housed would enable Zoë to restart her life:**

‘I don’t think, I know that I would be able to get my life back, being placed in permanent [accommodation].’

‘I’d be paying them rent because I wouldn’t be ill and I would be able to work. So rather than withdrawing from the system I would be putting in to the system.’

# Access to information

Providing information and advice is increasingly recognised as a vital tool, both in preventing homelessness and ensuring that the experience of homelessness is less costly in human and financial terms. *More than a Roof*,<sup>9</sup> the Government's strategy document on homelessness, recognises that the sharing of information about clients is vital in order to address their needs. The Children Act 2004 also views effective information sharing as the essential starting-point in providing co-ordinated services – setting out an expectation for local authorities to produce protocols to enable information sharing across a wide range of departments, including housing.

All the individuals interviewed for their case histories had lived in temporary accommodation for at least two years. Their information needs ranged from a basic explanation of what was happening with their housing application, and what they could expect, to specific signposting or referral information about how to access health services, schools and other facilities. In general, there was a very low level of contact between the families living in temporary accommodation and local authority housing department staff. Many families felt it was difficult to access even basic information from the local authority, such as updates on the progress of their housing application. When families did approach the local authority pro-actively for information about their housing, they often perceived the response from staff to be rude and unhelpful. For some people, this lack of information was extremely stressful.

## The impact of poor information

'There is no one to turn to and there is nowhere for you to go. You just have to sit in somebody else's property and wait until the council can be bothered to offer you permanent accommodation. That's the worst part, not knowing... So you go from ... [a flat on the] 4<sup>th</sup> floor to 10<sup>th</sup> floor ... you just don't know and they won't tell you.' (Zoë)

'Nobody explains to you anything, the staff [are] very rude, they treat you not as a human being... Families should be provided with more information from day one. They need to know what's ahead of them. Someone should explain the procedure.' (Jo)

Lack of information about the housing process was particularly stressful to families asked to move at short notice. Families were required to move to another temporary placement for a number of reasons, such as the landlords of accommodation privately leased to the council wishing to sell. This information was often not passed on, nor the implications of it fully explained. This exacerbated the feelings of insecurity and anxiety that families already felt through living in temporary accommodation.

## Practical difficulties

'Nobody told me that I had to go from bed and breakfast to temporary accommodation. Then I was moved into a temporary property. I was given six days to move, paint, and clean the house. I had to get rid of my furnishings. The council was supposed to set up storage, but they never did. It created stress.' (Jo)

One of the families with mobility needs was given insufficient time to view and assess a property being offered to them as settled accommodation. The property was allocated to someone else, and the family remained in temporary accommodation.

9. DTLR (2002), *More than a Roof*, London: DTLR



### **Lack of access to other crucial information**

In some cases, families needed to access other, specific information, but experienced similar problems in doing this:

- Jo was not being provided with information necessary to plan for the change of her nine-year-old son's school, increasing her stress and anxiety
- Zoë was not given information about where to access appropriate, specialist health care and support for her autistic son, when she was moved to temporary accommodation in another area.

These factors had a number of effects. In some cases, the lack of information and the unhelpfulness of local authority staff deterred families from approaching them on subsequent occasions, either for information or for other assistance. Jo, in particular, stated that she no longer felt able to deal with the council herself because she had found the experience so stressful. In the longer term, this may mean that families are less likely to report new or worsening health problems, or circumstances where their health deteriorates further and impacts on the type of accommodation that they need.



CHILTERN 1-172

ENTRANCE TO  
PUBLIC LIFTS

NO PARKING  
AT ANY TIME

# Case history

## Sabah: mobility problems

Sabah arrived in Britain from Iraq in the early 1990s, with his wife and child. His wife's family had been killed and their child died soon after their arrival. They now have three other children, two sons aged six and ten, and a daughter aged eight.

Sabah's family lived in private rented accommodation, but became homeless when their landlord sold the house. For the last two years they have lived in temporary accommodation in a one-bed flat, on the third floor of a 'dilapidated' building.

Between them, Sabah's family suffer a number of serious health problems. Sabah suffers from asthma, depression, other mental health problems, chest and breathing problems, back problems, diabetes and rheumatism. He has had two heart attacks in the last four years. His wife has asthma, is disabled, and has been admitted to hospital on several occasions. Sabah and his wife are in receipt of Incapacity Benefit and Disability Living Allowance. Their eldest son has diabetes.

The family's temporary accommodation is overcrowded, unhealthy and unsuitable. It is damp and mouldy, and the heating and hot water systems are not effective. Building work is going on, causing noise and dust, which impacts on Sabah and his wife's asthma. The location of their flat is clearly unsuitable, considering the family's mobility problems. The lifts are sometimes defective, requiring Sabah to walk up the stairs, which has a serious impact on his heart condition and asthma. There are no parking spaces near the flats, even for disabled people, which means they can't make use of their car. This, in turn, impacts on the whole family. Because of both parents' mobility problems, the location and situation of their flat makes it almost impossible for them to take their young children out to places they can safely play. There is nowhere to play inside because

they are overcrowded. Sabah would like to be able to take his children to a park more often, as he also needs the fresh air.

'You cannot take a child to school, you cannot go shopping, you can't go.'

Sabah's wife used to receive counselling, but stopped using this service as she found it too distressing. A health worker visits their son every fortnight, but Sabah feels he also needs help from social services. Despite several approaches to social workers, Sabah feels that he has not been listened to:

'I go to the social worker, I tell him I need help, for [my] children, [my] family, nobody helped, nobody came, nobody listened to me.'

Sabah is concerned about his eldest son's well-being whilst he is at school. He had tried to get his son into the same school as his cousin, who understands his diabetes and would be able to keep an eye on him during the day, but this was not possible.

The local authority is aware of the family's health problems and their doctor has written letters on their behalf. About six months ago, Sabah was told that they had top priority on the council's waiting list, but the family is still awaiting their offer of permanent accommodation.

Sabah hopes that the family will be given some choice with their permanent location, as transport and accessibility are so important to them. Sabah was hoping that suitable, permanent accommodation would help the family better manage their health problems and have further positive effects:

'Of course, because it will make [the] children happy and you will be happy too. If you see your child sad, you are also sad.'

# Needs assessments

Recent government research states the need for homeless people's support needs to be addressed via a comprehensive assessment process, and for support to be delivered to meet these needs.<sup>10</sup> The Homelessness Act 2002 and *Every Child Matters*<sup>11</sup> also view good assessment as having an essential role in delivering good-quality services for children and other groups of homeless people.

Homeless families are usually recorded as being in priority need because they have dependent children, and any health needs are unlikely to be recorded at this point. Therefore, local authorities are not as likely to be aware of a family's specific health needs as they may be with an individual who was accepted as being in priority need for health reasons. It appears uncommon for authorities to conduct a thorough assessment of families' health and other support needs during the homeless application process. This can result in families being placed in accommodation that is inappropriate and inadequate for their needs,<sup>12</sup> often away from their support and social networks.

## Carrying out housing needs assessments

The case histories provide some evidence that needs assessments were carried out at the point the family was originally accepted as homeless, but there was virtually no evidence of assessment occurring when families were moved into subsequent placements. This is despite the fact that, in some cases, the family's health needs had clearly changed. The case histories illustrate that families may be moved between temporary accommodation placements without regard to their actual needs. For example:

- a large family were moved to a smaller temporary property, which meant they were overcrowded

- a family with members who had mobility and respiratory problems were moved from a ground-floor property to one on a higher floor, without access to a reliable lift service.

## Impacts of the lack of assessment of a family's needs and their placement in inappropriate accommodation

Both Sabah and his wife have heart and back problems, and asthma. The family was moved from its first temporary placement to a flat on the third floor of a block with an unreliable lift system. The flat has no access to parking, meaning that the family cannot use their car. This limits their ability to get out and take the children to school, the shops or to play facilities. The stress of their situation is affecting Sabah's heart problem and his asthma.

Sofia and her teenage son, who is severely autistic, were placed in accommodation that was noisy and unsuitable for his needs. Her son's health needs do not appear to have been properly assessed by any relevant agency:

'I don't know how long I can bear [it], his condition is getting worse because of this place . . . I have written to the person in charge . . . Nothing has been done and I'm very concerned about the condition of my son. He's been getting worse.' (Sofia)

Frequent change is also causing problems:

'Every time we move it is not good for my son, because we have moved about two or three times and it disturbs him, you know what I mean, because of the change . . . because he doesn't know what is going on, he doesn't know why this change, so I applied for permanent, I need permanent accommodation where he can get settled and stay for a long time. Cause every time changing him . . . his mental condition [worsens]'. (Sofia)

10. ODPM (2003), *The Support Needs of Homeless Households*, London: ODPM

11. DfES (2003), *Every Child Matters*, London: DfES

12. Gorton, S (forthcoming), *Guide to Addressing Family Homelessness for PCTs*

All of the individuals interviewed for their case histories had had to move several times and they lived in several different temporary placements. Not only was this disruptive to the families, but they often lost contact with their existing services and networks and felt isolated in their new neighbourhoods.



# Case history

## Sofia: managing special needs

Sofia and her 13-year-old son have lived in temporary accommodation for the last two years. When they first became homeless, they stayed with friends, but Sofia's son is severely autistic and his health problems meant this was very difficult. Her son requires constant care; Sofia has to help him with eating, bathing, and getting dressed:

'He has no sense of danger, and he needs assistance all the time, 24 hours . . .'

Sofia approached social services for help in finding accommodation when she came to Britain, after fleeing conflict in her home country. She feels that her son's condition was not taken into account when they were accommodated. They spent a year living in a one-bedroom flat but it was difficult for them to share a room and they were later allocated a two-bedroom, ground-floor flat. However, there is a lot of noise from the flat above which causes her son to become excited and 'run round all the time'. People living in the flats above have thrown things at him. Machines run all night in the factory behind the flat, and Sofia says the noise wakes her son, causing him to become agitated and to bang on the walls and doors. She believes her son's condition is getting worse because of where they live and says it is particularly difficult for him to cope with noise and change:

'I would like somewhere . . . calm, if they can take account of the condition of my son, [it] would be helpful . . . Where we live is noisy.'

Sofia's doctor has written to the council to say her son needs a better place to live. She would like help from health care professionals to assess her son's health and housing needs, but he is not

receiving any specific health care or support services, despite requests for assistance. Sofia worries about her son as he's getting older, and she needs advice about how to cope with him, but she has no information about where to go or who to talk to and has difficulty accessing relevant health care specialists. Her son was sent to a psychiatrist, but there seems to have been no follow-up.

Sofia is unemployed, as she has to be at home when her son comes back from school. He has no access to youth clubs, or other activities and support. Sofia has applied for her son to attend a specialist out-of-school project and hopes he may be able to use this in the future. She received no support from social services in accessing any appropriate services and had to find the details herself.

At least Sofia's son now attends school. Living in temporary accommodation made this very difficult to arrange. After they were previously moved, from one London borough to another, it took almost a year for the education authority to find him a place at a special needs school. He had to stay at home during this period, and Sofia had to give up the college course she'd enrolled in to look after him during the day. Her son was allocated a place at a special needs school in September, but it took them three months for the education authority to arrange appropriate transport to enable him to attend. He's not able to use public transport because of his condition. However, Sofia says she has since found out that the school is for children with physical disabilities and is not really suitable for her son's needs. She has asked the education authority to find a more appropriate school, but this is made more difficult by not knowing where they will be living in the future:



‘It has affected me because . . . this uncertainty, you don’t know what is happening tomorrow, and you are . . . upset . . . every time, maybe we will move. I am already in some uncertainty because of my son, and with temporary accommodation I don’t know what will happen tomorrow.’

Sofia felt a main impact of living in temporary accommodation was the lack of choice and control over what happened to her son:

‘Other people are deciding for me, for my son [we have] no choice.’

Being able to settle permanently is particularly important for families coping with special needs. For Sofia, obtaining settled accommodation and appropriate schooling for her son would allow her to continue with her education and have some life for herself:

‘I’m really looking forward to a permanent house so I can [do] something [for] myself, it’s really affecting me.’

# Access to primary care

Previous research has found that homeless people experience higher-than-average levels of health problems.<sup>13</sup> However, many of them face a range of barriers accessing appropriate health services. These range from institutional factors, such as opening times and location of services, to a lack of integration between primary care and other local services.<sup>14</sup> Barriers increase for homeless people who have multiple needs, such as mental health problems,<sup>15</sup> those who have been homeless for longer periods of time and those who live in areas of low homelessness. Homeless people are also likely to leave their existing health problems untreated until they reach a crisis point. They will then need to rely on treatment at A&E, or will present themselves at other primary health care services with multiple and more entrenched problems.<sup>16</sup>

A central aim of the Government's health inequalities agenda is to change the way in which health services are planned and delivered. The *NHS Plan* (2000)<sup>17</sup> aims to reduce inequalities through improving access to NHS services and promoting working in partnership to tackle the causes of ill-health, especially for hard to reach groups. A core responsibility of Primary Care Trusts (PCTs) is to ensure that mainstream health services meet the needs of their local population, including homeless people. PCTs have powers to commission and develop services through working in partnership with other agencies. The role and structure of PCTs also creates opportunities to link community care to social care and to deliver health improvement in a range of non-NHS settings, such as schools. *Tackling Health Inequalities: A Programme for Action* (2003)<sup>18</sup> highlights the central role that PCTs have in working together, in partnership with local

government, to reduce health inequalities. Local Delivery Plans, the main planning tool for PCTs, require PCTs to set out how they will address local health inequalities. There is scope to link in with local authority homelessness strategies and to examine available services to homeless people.

Some positive work has been carried out to improve access to primary health care over recent years (eg extending the services available in doctors' surgeries). Personal Medical Services have successfully expanded access to GP services for homeless people and, in some cases, improved joint working with other services such as mental health. National Enhanced Services for GPs also offer positive opportunities for homeless people, because they aim to promote greater integration between GPs and local homelessness agencies.

Despite such initiatives, gaps in specialist primary care services for homeless people are still substantial. Personal Medical Services operate in approximately one third of all PCT areas only. There is a particular lack of provision for homeless individuals and families in areas where there is a low incidence of homelessness.

In contrast to the findings of previous research on homeless people's access to health care<sup>19</sup>, this research found a high rate of registration with GPs. However, most of the families studied appeared to rely exclusively on them for health care, and there was no evidence that specialist primary health care services were available. Families also reported using their GPs much more frequently than they had done before they were homeless, and for a wider range of health needs.

13. For example, Bines, W (1994), *The Health of Homeless People*, Centre for Housing Policy Discussion Paper 9, York: Centre for Housing Policy

14. Griffiths, S (2002), *Addressing the health needs of rough sleepers*, London: ODPM

15. Croft-White, C and Parry-Crooke, G (2004), *Lost Voices*, London: Crisis

16. ODPM (2003), *Homelessness and Health Information Sheet No 1: Personal Medical Services*, London: ODPM

17. Department of Health (2000), *The NHS Plan: a plan for investment, a plan for reform*, London: Department of Health

18. Department of Health (2003), *Tackling Health Inequalities: Priorities for Action*, London: Department of Health

19. For example, Griffiths, S (2002), *Addressing the health needs of rough sleepers*, London: ODPM and Croft-White, C and Parry-Crooke, G (2004), *Lost Voices*, London: Crisis

## Increased attendance at doctor's surgeries

'I've lost count of how many times I've been to my GP. More than I can remember . . . Before I was in temporary [accommodation] I never used to go to the doctor's. I just used to [for] my asthma . . . so the only time I ever rung . . . was for a repeat prescription. Now I am always there for painkillers, more antidepressants, more Ventolin, more Becotide, more of everything.' (Zoë)

Families reported that GPs commonly prescribed medication as a response to most health problems. In some cases, both the GP and the patient were aware that a particular health problem was directly attributable to the patient's homelessness and that medication would not be able to address its root cause. Prescribing medication appeared to be a response resulting from a lack of more appropriate solutions, such as better housing, access to specialist services, and/or ongoing support.

## Increased use of medication

Zoë attempted suicide and was admitted to a psychiatric hospital. Following discharge, she was told to use her GP for medication. She told him about her attempted suicide and her belief that her depression resulted from living in temporary accommodation. However:

'The only thing he could offer me was more medication if I wanted it. That was it . . . I go to my doctor's and I say I feel suicidal . . . Why? Because I live in temporary accommodation. "Oh, I see, I understand. Take these tablets." That's it. What else can a doctor do? What can a doctor do for me whilst I am living in temporary accommodation? He can't pick up the phone and say "I suggest you house this person immediately." He hasn't got that power.'

Although GP registration levels were high, families also commented on the difficulty of registering with a GP if they had to move into a new area. In some cases, they had to travel long distances to reach their existing GP for appointments. This added to their levels of stress and incurred extra costs.

GPs are not able to address all the health issues that homeless families present, nor provide access to the full range of mental and physical health services that are needed. Some health problems may therefore remain untreated and become worse over time. This potentially increases the financial costs of treatment. A lack of available, alternative, primary health care services means that families often have no choice but to return to their GP for medication. The cost of GP use, in itself, is expensive for health services.

## Potential costs of increased GP use

Existing information indicates that the average cost of a GP consultation, including prescriptions, is £127.<sup>20</sup>

In *Living in limbo*<sup>21</sup>, Shelter made an estimate of the average cost of health services for a person with health problems, based on four additional consultations. The annual cost, based on this calculation, would be £508 per person, per annum.<sup>22</sup>

*Living in limbo* also calculated the costs incurred at a national level, based on an estimate of numbers of homeless households that were ill, or unemployed, due to living in temporary accommodation. On this basis, the additional annual costs can be estimated at £11.929 million per annum.

20. Netten, A and Curtis, L (2003), *Unit Costs of Health and Social Care 2003*, Canterbury: Personal Social Services Research Unit, University of Canterbury; costs based on an hour of patient contact including prescriptions.

21. Mitchell et al (2003), *Living in limbo*, London: Shelter

22. Shelter (2004), *Living in limbo*, London: Shelter. This figure is Shelter's estimate of the additional numbers of people ill or unemployed due to living in temporary accommodation, ie people who would have been better off had they been in stable accommodation. Shelter's research indicated that rates of ill-health within the temporary accommodation survey sample were approximately 25 per cent higher than in a survey of previously homeless people who were now renting from a local authority or housing association (the National Child Development Survey, 1999/2000). The figure quoted, here, is therefore calculated by multiplying the total number of households living in temporary accommodation provided by local authorities at that time (93,930 households) by this proportion.





# Case history

## Jo: depression and anxiety

Jo and her son became homeless after she was divorced. They rented privately for some time, but had to leave when their landlord wanted the property back. They stayed in a bed and breakfast hotel for a year, spent six months in private-rented accommodation and are now occupying a one-bedroom council flat, as temporary accommodation. It only has two rooms, a bedroom and a combined kitchen and living room. Jo's son, now aged nine, sleeps in the bedroom, whilst Jo sleeps in the living room/kitchen:

'It sometimes creates problems because I still store most of my stuff in the bedroom and then I have to go in and out . . . He has reached the stage where he will expect me to knock at the door before I come in.'

Their current flat is smaller than the bed and breakfast hotel:

'My son's friends often say to him "how come we live in a small place". He once had a secret book where he drew his dream home. It has two floors, two bedrooms upstairs and a dining room and kitchen on the ground floor.'

Jo has been on medication for anxiety for the last five years, and living in temporary accommodation has made her condition worse. She has found the lack of information or explanation and not knowing what to expect, to be very hard. Jo was made to wait for her original landlady to get a bailiff's warrant before the council would accept her homeless application, and she found this very stressful as she was not kept informed about what was happening. Jo was subsequently not told when she was to be moved from the bed and breakfast accommodation and was given very little time to move to their next home.

Jo and her son have to move again when the lease of the current property expires. She has not been told about where they will be moved to or whether this will be permanent or temporary. Jo has found her housing officers to be rude and can no longer deal with the council herself. She finds the situation stressful:

'Nobody explains to you anything, the staff [are] very rude, they treat you not as a human being.'

Jo is concerned about where her son will go to school if they move to yet another area, and finds it difficult to deal with the fact that they have no choice or control as to where they will go:

'Choices have been taken away from us. You don't have choice when you live in temporary accommodation.'

Jo has had to change their doctor each time she's moved. She sees her doctor more often, because she needs regular medication. Her doctor wrote to the council about her situation and she tried contacting her MP, without success. Jo was told that a lot of people suffer from anxiety and she feels it is not taken seriously. She feels that not knowing what's going to happen led her to put her life on hold, but she is no longer prepared to do this and has started a diploma in childcare:

'I will never be able to work or buy a house or afford a flat . . . if I start to work with children I might be a keyworker. This may be a way of getting housed.'

Jo was concerned about the availability of permanent housing options in the area. She feels very isolated and, as a single parent, her friends are important sources of support:

'The council now is asking people to move out of London. I have been told that there is accommodation in Luton but how can I go to Luton because I don't know anyone there.'

# Co-ordination of services

Current policy initiatives encourage a more strategic approach to addressing complex issues such as homelessness. This new approach promotes joint working between departments and services, such as health and housing, as a means of producing better outcomes for homeless people. This is intended to address situations that have occurred in the past – where vulnerable people have been put at risk because they have not received the full range of support they need.

*More than a Roof*<sup>23</sup> introduced the Government's new agenda on homelessness. It argued that homelessness was caused by complex personal and structural factors and that support, as well as housing, was needed to tackle the problem. The Homelessness Act 2002 introduced a duty on all local authorities to conduct a review of homelessness in their area and produce a homelessness strategy. Local authorities are expected to use homelessness strategies to address the causes and symptoms of homelessness. They should also develop better partnerships and information-sharing systems, including protocols between departments and services, and common assessment models. Health services (as represented by Primary Care Trusts) are a key partner in this new approach. There are opportunities to create jointly funded posts between health and housing, as well as to improve practice in specific areas where co-ordination has been weak in the past, such as hospital discharge.

In April 2003, the ODPM issued *Achieving Positive Outcomes on Homelessness*,<sup>24</sup> an advice note on outcomes that the Department would like to see local authorities achieve in relation to homelessness. Reducing inappropriate use of temporary accommodation other than bed and breakfast, is one of the note's key suggested outcomes. The note also suggests that action to strengthen

help to homeless people could be most usefully focused on families with children, because their support needs make life in temporary accommodation even more unsuitable. It proposes a range of measures to tackle this issue, including:

- reducing the total amount of time that homeless people spend in temporary accommodation before a settled solution is found
- reducing the number of moves between temporary accommodation placements
- increasing the percentage of households in temporary accommodation located close to people's existing support networks
- increasing the proportion of homeless households with access to health, school, and other support services.

The ODPM has subsequently issued an advice note<sup>25</sup> with the Department of Health, outlining joint actions that health and housing services might take to combat homelessness. The paper acknowledges that homeless households experience poorer physical and mental health than the general population, and that joint work will help to meet health and housing targets, for example, in relation to reducing health inequalities. It proposes the setting up of partnerships on health and homelessness, to involve local authorities, PCTs and others. These partnerships would work towards a series of outcomes, such as improving health care for homeless people, improving access to primary health care, improving substance misuse and mental health treatment, and preventing homelessness through appropriate, targeted support.

The Children Act 2004 builds on the measures set out in the Green Paper, *Every Child Matters* by establishing a framework for services for children up to the age of 19.

23. DTLR (2002), *More than a Roof*, London: DTLR

24. ODPM (2003), *Achieving Positive Outcomes on Homelessness*, London: ODPM

25. ODPM/DH (2004), *Achieving Positive Shared Outcomes in Health and Homelessness*, London: ODPM

This focuses on early intervention, better accountability, and improved co-ordination between services working with children and proposes to establish new structures and posts to facilitate this, including multi-disciplinary teams. In the short term, these will integrate education, social care and health services; in the longer term, there are plans to also include statutory and voluntary homelessness agencies. The Act specifically recognises that homeless families with children, including those in temporary accommodation, are not currently likely to receive the range of services they need, and that greater co-ordination is required between services in order to ensure that their health needs are met. However, it does not include housing and homelessness in the new structures.

### **Supporting People and tenancy support**

Tenancy support is now recognised as a major factor in preventing homelessness and repeat homelessness, both for homeless families and single homeless people.<sup>26</sup> Housing-related support can cover a range of interventions – practical and emotional support, assistance with applying for welfare benefits, and help accessing school places or specialist services. Workers with either a generic or specialised support role may carry out these interventions.

Supporting People (SP) is the integrated funding stream for housing-related support, combining money previously held within social service, health, probation and housing benefit budgets. It aims to promote independent living, social inclusion and better co-ordination between services. Homeless people, both single people and families, are one of the four main client groups for which the SP programme provides services. The funding totals £350 million, set aside to support approximately 45,000 single homeless and 14,500 homeless families.<sup>27</sup>

Each administering authority<sup>28</sup> must produce a Supporting People strategy by March 2005, indicating how they will allocate the Supporting People Grant in their district against the needs for services that they have identified. Health is a major strategic partner in the Supporting People programme, and this presents opportunities to commission and fund services to meet both health and housing needs. As the objectives of Supporting People overlap significantly with those of the Homelessness Act,<sup>29</sup> it is also envisaged that there will be many overlaps and common features in local authorities' homelessness strategies and Supporting People strategies.

There has also been considerable interest in developing tenancy support and sustainment schemes as part of local authorities' homelessness strategies.<sup>30</sup> However, the majority of tenancy sustainment schemes are for people living in permanent tenancies, not temporary accommodation. Local authority practice also remains very variable in this area. Therefore, where schemes are set up, they need to be evaluated and, if considered successful, promoted and replicated elsewhere.

### **Support needs identified by the research**

The health, housing, and other support needs of the families participating in this research meant that they needed access to a range of departments and services. At some point during their stay in temporary accommodation, members of the families were likely to come into contact with primary care, mental health, education, and social services.

### **Housing-related support**

The case histories indicate some positive examples of support being provided. The most common source of support was from GPs. Several of the families' GPs

26. For example, DTLR (2002), *More than a Roof*, London: DTLR; ODPM (2003), *Repeat homelessness: Policy briefing 6*, London: ODPM

27. ODPM (2004), *Addressing the health needs of homeless people*, Policy briefing 7, London: ODPM

28. This may be a county council, London borough council or district council, according to local government organisation

29. Randall, G and Brown, S (2002), *Homelessness strategies good practice handbook*, London: ODPM

30. Credland, S (2003), *Local Authority Progress and Practice: Local authorities and the Homelessness Act 2002 – the first year*, London: Shelter





attempted to liaise with their local authority on their behalf. This usually took the form of letters requesting that the families be moved from their current accommodation because of the negative health impact of their current housing circumstances. However, these attempts were not generally successful, often because of the perceived unresponsiveness of the local authority's housing department.

There was no evidence of tenancy support being provided to any of the families. It was clear from the case histories that many of the families involved would have benefited from such a service. A housing support worker could have helped them gain access to the information they needed; acted as an advocate or link with local authority housing and social services departments; put them in touch with local services, as well as being a point of social contact for the families. This would have produced clear health benefits.

### **Lack of co-ordination between health and housing**

Both Zoë and her son had become severely depressed since living in temporary accommodation. Zoë attempted suicide and was admitted to hospital. On discharge, she returned to her temporary accommodation but received no assessment or follow-up visit from mental health services.

Zoë's son also linked his deteriorating mental health and suicidal behaviour to living in temporary accommodation. He also received psychiatric care. However, there was no sharing of information between the mental health service and the local authority.

Amir was admitted to hospital suffering a heart attack. There was no evident hospital discharge policy, and no follow-up support appeared to have been given to him at all. In addition, despite living in temporary accommodation at the time of the heart attack, there appeared

to have been no reassessment of the family's housing needs by the housing department or health services.

As these case histories illustrate, services were often not provided in a co-ordinated way to meet the health and other support needs of the families. Several negative impacts for health arise from this. Firstly, the individual efforts of health and social care professionals are wasted. Secondly, vulnerable people are more likely to 'slip through the net' in terms of support services, with health problems worsening in the longer term if they do not receive the support they need. Finally, there are also indirect impacts for homeless people, in terms of the feelings of isolation and depression they experience.

### **Children and education**

The research also demonstrates how the housing, education, and health needs of children and young people are particularly closely linked. Lack of access to good-quality, permanent accommodation creates problems for children's health and education. This is even more problematic for children with special needs. For example:

Sofia's son has special educational needs but, as a result of having to move boroughs for temporary accommodation, there were lengthy delays in finding him an appropriate school place.

'Everything stops. I have to wait for [the education authority] to take everything in hand. I have to look for a school, I have to wait to find a place available in school, it takes a long time'.

During this period he received no education and Sofia had to care for him 24 hours a day. The situation also had an impact on Sofia's ability to take up training and find work, further increasing her levels of stress and anxiety.



# Case history

## Amir: complex health needs

Amir moved his family to London in 1994, and initially lived in private-rented accommodation. They became homeless and were housed in a bed and breakfast hotel for ten months. They were subsequently moved to two housing association properties, each of which they occupied for four years. Two weeks before he was interviewed, Amir's family was finally rehoused permanently.

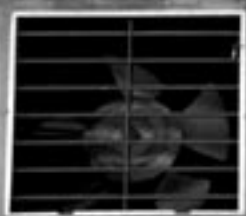
Amir and his wife live with their teenage son and adult daughter, and their daughter's husband and child, in a three-bedroom flat. They have another son who would like to move back home but is unable to do so because of the lack of space. Amir and his wife suffer from several health problems including asthma, mobility difficulties and diabetes. Amir's wife has mobility problems and has had numerous operations. Both Amir's wife and their son have mental health problems, for which their son is not accessing any medical, or other, support.

The family's health declined when they were placed in the hotel, which was in a 'terrible condition'. Amir's wife developed a mental health problem and Amir developed long-term back problems, exacerbated by having to use the stairs. The council had received several health reports on the family's health and mobility problems. Although Amir and his wife were admitted to hospital on a number of occasions, there was never any review or assessment of their condition on discharge. Amir found NHS staff to be unhelpful and not willing to listen or assist with their housing situation.

When Amir was first moved into temporary accommodation from the hotel, it was to a three-bedroom house that was overcrowded with his extended family. They had to leave most of their furniture in storage, and some of this was damaged or destroyed. The overcrowding made it particularly difficult for the family to deal appropriately with their mentally ill son:

'I am worried about [him], now we give him the best room in the house, [to] satisfy him, to make him happy, try to assist him.'

Amir has been engaged in a number of legal challenges against the council during the period they have lived in temporary accommodation. This exacerbates the ongoing stress the whole family have experienced. Amir's family has been offered permanent accommodation, but the first time this happened, Amir viewed a property and went to discuss it with his family, only to be told the next day that it had been offered to someone else. He was later offered an ex-hostel building that was in poor condition and was not accessible to them because of their mobility needs. The family finally had to accept a permanent flat in the same building that was the same size as their temporary accommodation. This means their mentally ill son and their grandchild will continue to share accommodation that is cramped, stressful and far from ideal.



NEAT



# Conclusions and recommendations: a strategy for temporary accommodation

Shelter believes that a range of short- and long-term measures is needed to address the problems associated with temporary accommodation. In the short term, it is crucial that people's experiences of living in temporary accommodation are improved, so as to minimise its negative impacts on health. We recommend a range of measures to raise standards of information sharing, assessment, joint working practice and support. In the longer term, we believe that a more strategic approach to dealing with temporary accommodation is needed, to better address issues of supply, support and management. Our recommendations on this approach are outlined below.

## Making life better for people in temporary accommodation

### 1 Information

Shelter believes it is crucial that agencies working with homeless families have access to comprehensive and up-to-date information on their health, and other support, needs. This will help ensure that homeless families remain in contact with services and get access to the support they need. Establishing systems that collect comprehensive and accurate information on the needs of homeless people also has benefits for local authorities in relation to their homelessness and Supporting People strategies, and for PCTs in terms of Local Delivery Plans. In both cases, this should have positive impacts on the future commissioning of services.

Shelter has supported several recent initiatives that aim to improve the collection and sharing of information.

- **Every Child Matters** proposes the creation on local authority responsibility to establish and maintain information 'hubs'. These databases would contain information on children, with input from a range of statutory

and voluntary agencies, including housing and homelessness.

- **Notify** is an information notification system developed jointly by the Association of Local Government/ Greater London Authority. Its primary role is to identify relevant services related to the placement or movement of statutorily homeless households living in temporary accommodation in London. The system notifies a selected range of services, including social services and PCTs. Each of these services, in turn, disseminates information within their department or PCT and makes contact with other departments and services. Shelter would like to see local authorities outside London establishing systems similar to Notify as soon as possible.
- **The Homelessness Act** introduced a new framework for housing allocations.<sup>31</sup> This new approach aims to establish a more customer-orientated system, offering housing applicants greater choice over where they are offered accommodation. Following the success of pilot projects in a number of local authority areas, the system is to be rolled out nationally. The guiding principles of the new allocation framework are that every allocations system should be simple for people to use, more transparent, and should enable applicants to easily access information both about the local authority's policies and procedures and their own housing application.

Shelter believes that adopting these principles in relation to people living in temporary accommodation would be beneficial. It would encourage people to consider themselves as active participants in the housing process, rather than passive recipients as is currently the case. It would also reduce the anxiety caused

31. This was implemented on 31 January 2003

by uncertainty over moves between temporary accommodation placements and into permanent accommodation.

The ODPM is currently preparing a revised Homelessness Code of Guidance. Shelter believes this is a further opportunity for the Government to clarify the types of information that should be shared between local authority departments and other services. We believe the revised guidance should establish robust procedures to ensure that health and social care services are informed when homeless families are placed in temporary accommodation. This would enable families to receive visits from professionals, such as health visitors.

## **2 Assessment**

In its response to the consultation on Standards in Temporary Accommodation, Shelter proposed that accommodation should not be regarded as suitable for an applicant, or applicants, unless the housing authority has made an assessment of their support needs. It should also assess the needs of the household in that accommodation and make arrangements for any support services, identified by the assessment, to be in place within a reasonable time.

To achieve this, housing authorities should incorporate assessments of support needs into their homelessness enquiries and assessments of housing needs, such as those carried out jointly with social services. Authorities should then provide written information to applicants indicating that an assessment of support needs has taken place and indicating what actions are to be taken to address identified needs. They should also specify when it will be reviewed, to take account of changing health and social care needs. These measures are essential to ensure that homeless families are placed in accommodation that is

suitable for the needs of all the household members. We propose that the ODPM incorporate this measure into a revised Order on the Suitability of Accommodation.

## **3 Joint working**

Whilst the strategic approach has brought some improvements, there are still significant problems in getting housing, homelessness, and health to work well together. This is hampering homeless people's access to services.

Policy and practice needs to improve in several areas. Firstly, there needs to be greater consistency within policy initiatives with regard to the role of housing and homelessness services in delivering integrated health and social care. Secondly, strategic partnerships are still not ensuring a sufficient degree of co-operation between housing and homelessness agencies that will enable delivery of joined-up services to homeless people.

### ***The Children Act 2004***

The Department for Education and Skills (DfES) should also ensure that the role of housing is fully integrated with the new arrangements for children's services set out in the Children Act 2004 and currently being piloted in Children's Trust pathfinder areas.

### ***Strategic partnerships***

As part of its work on the implementation of the Homelessness Act, Shelter carried out research with a sample of local authorities to monitor their progress in relation to the new legislation.<sup>32</sup> The research found that health services (as represented by Primary Care Trusts) had lower levels of involvement than other statutory partners in the development of homelessness strategies, and that their involvement produced comparatively less specific outcomes.

Both Shelter's research and the recent Government-funded review of Supporting

32. Credland, S (2003), *Local Authority Progress and Practice: Local authorities and the Homelessness Act 2002 – the first year*, London: Shelter

People also indicate problems with the involvement of health services. Health services have a poor attendance record on Supporting People Commissioning Bodies and Core Strategy Groups, and Supporting People and Homelessness Act strategies are not well co-ordinated. Lack of involvement on the part of health services is likely to limit their understanding of how they can improve health by preventing homelessness, and underestimate how joint working can reduce demand for health services. It also reduces the likelihood of services being commissioned and delivered in a cost-effective way. Both of these factors are likely to have negative impacts on health input into Supporting People services.

We welcome the approach to joint work set out in *Achieving Positive Shared Outcomes on Health and Homelessness*. However, its outcomes are advisory only and carry no statutory weight. At present, the suggested outcomes also do not address some of the underlying determinants of the health problems outlined in the document, such as the impacts on mental health that arise from living in temporary accommodation for long periods and the frequent moves between placements. We therefore recommend that the ODPM and Department of Health consider doing this.

We would also like to see Primary Care Trusts making greater use of their Local Delivery Plans, linking them with homelessness strategies and planning local health services for homeless people.

#### **4 Support**

Shelter believes that local authorities should use the opportunity presented by a deferred date for completion of Supporting People strategies to increase provision of support to homeless families in temporary accommodation.

Shelter runs five 'Homeless to Home' projects. These offer a possible good-practice model for local authorities looking to establish tenancy support services:

#### ***Homeless to Home services***

Shelter's Homeless to Home services have been working since 1998 to provide resettlement support to homeless families, with the aim of helping them sustain their accommodation and become established within the local neighbourhood. Homeless to Home teams now operate in five areas: Bristol, Birmingham, Herefordshire, Sheffield and Nottingham.

Apart from enabling people to sustain their tenancies, Homeless to Home workers provide support that helps homeless people improve their physical and mental health. This support includes helping users to access GP and other medical services; providing emotional support; dealing with quality-of-life issues, such as increasing social and community participation.

The recent evaluation of Supporting People states that Supporting People services can contribute significantly to achieving departmental objectives and recommends that, in the light of this, individual departments should make more resources available to fund services.<sup>33</sup>

Recent government research also highlights that homeless people are most likely to benefit from support delivered through multi-disciplinary teams.<sup>34</sup> In the light of these findings, Shelter would like to see central government departments, and the Department of Health in particular, provide more funding to establish multi-disciplinary teams. Multi-agency teams should include specialist workers, especially people with experience in dealing with mental health issues.

33. Sullivan, E/Robson Rhodes (2004), *Independent Review of the Supporting People Programme*, London: ODPM

34. Randall, G (2003), *The Support Needs of Homeless Households*, London: ODPM







### ***Specialist support for children***

Services for children are not eligible for Supporting People funding. The long-term future of the Children's Fund is also uncertain. Shelter therefore believes that new funding needs to be made available, to provide specialist children's support-worker posts in tenancy sustainment and support teams that work with homeless families. We propose that this funding should be made available via the Homelessness and Housing Support Directorate. In addition, we believe that the Department of Health should make a commitment to providing more help to homeless children via its budget for Children and Adolescent Mental Health Services.

Findings from our general survey on temporary accommodation indicate that Sure Start services are not accessible to many homeless families, with only a fifth of families using them. We believe it is essential that Sure Start is available to all homeless families, to ensure that the health and educational needs of homeless children are met and that data from Sure Start schemes is shared with housing, health and social services. We recommend that funding should be provided within the Sure Start programme to ensure that services are able to reach homeless families. This funding could be used either to modify existing services, or to set up mobile units to visit homeless families in locations such as day centres.

### ***Primary care***

Shelter would like to see an expansion of existing specialist primary care for homeless people, such as Personal Medical Services. We would especially like to see an increase in specialist services for homeless families, because of the particularly low levels of provision that exist for this group.

### ***Keeping rents affordable***

The use of Housing Benefit to fund temporary accommodation means that

market rents are often charged on privately owned temporary accommodation. In many cases, high rent levels are a deterrent against people seeking, or remaining in, work. However, being unemployed can further increase people's feelings of social exclusion and affect their mental health.

The current funding regime must change. Along with the Greater London Assembly, Association of London Government and National Housing Federation, we have previously campaigned for a block grant for local authorities for temporary accommodation. This would be a more effective means of funding temporary accommodation, allowing councils to sustain private-sector leasing of good-quality properties at affordable rents and thereby promoting access into work and training for people living in this accommodation.

### ***Moving people to more secure housing options***

Homeless families in the case studies contrasted their current situation and lifestyle, living in temporary accommodation, with aspirations for life once they were living in permanent accommodation. They were clear about the impact they felt that having a permanent home would have:

'because . . . so much pressure and stress and things like that would be lifted off of you . . . it's going to be such a release . . . to go . . . to your own place, where if you want to you can put a poster on the wall . . . Simple things like that . . . you can't do that when you live in somebody else's property.' (Zoë)

'Of course I would feel better . . . I think I would be able to relax . . . when I have a bath.' (Zoë)

'Mentally, I will be happier in my mind that I am now permanently housed.' (Sofia)

Ultimately, Shelter believes that there needs to be an end to the long-term

use of temporary accommodation for homeless households. Even temporary accommodation that is good quality, well-managed and accompanied by adequate support, is not able to address the emotional and psychological impacts of living in housing that is insecure and uncertain.

### **Measures to increase supply of housing**

If this aim is to be achieved, it is vital that there is an increase in the supply of affordable housing. The 2004 Spending Review announced a £1.3 billion increase in housing capital expenditure over the next three years.<sup>35</sup> We welcome this announcement and regard it as a significant boost for new affordable housing.

However, even if building were to begin immediately, the impacts on the supply of affordable housing from this amount of investment will not be felt for a significant period of time. In the shorter term, therefore, Shelter believes that a package of measures is needed to increase the number of lettings available, to both bring new units into the social-rented sector and free up units through encouraging mobility within or out of the sector. We would like to see consideration of the following:

- grant for local authorities or RSLs to purchase homes on the open market
- funding sponsored tenancy schemes with a grant to create affordable rents in the private-rented sector
- use of mobility schemes, to encourage under-occupiers in social housing to move to smaller properties and free up family-sized homes
- increasing the use of compulsory-purchase and management orders, to bring empty properties back into use.

### **A strategy for temporary accommodation**

Given the complexity of issues of supply, support and management, Shelter would also like to see the development of a strategic approach to the provision of temporary accommodation. This would enable the full range of issues to be addressed, including:

- matching the flow of homeless people to housing supply and/or increasing the available amount of temporary lets
- addressing the need for access to statutory services and other support services
- considering funding issues involved in supplying temporary accommodation, such as changes in Housing Benefit payments
- increasing opportunities for homeless people in temporary accommodation to become involved in training and employment.

We consider that this could be best achieved via developing strategies at two levels:

- nationally, with a lead from the ODPM
- regionally, via regional housing strategies published by Regional Housing Boards. This would address both capital and revenue funding issues and ensure that sufficient money was directed towards high need areas, as well as responding to overall levels of need.

The ODPM should consider providing additional funding to local authorities, for the purposes of setting up projects that increase the supply of lettings, or that take other innovative approaches to reducing the use of temporary accommodation.

35. 2004/05 expenditure = £5.9 billion, rising to £7.2 billion in 2007/08. This represents an annual increase of 4.1 per cent in real terms.

There is always likely to be a residual role for temporary accommodation, either as emergency accommodation for people who become homeless and need somewhere to sleep that same night, or as transitional accommodation, to provide people with time and space to review their options and exercise some choice about their permanent housing. The ODPM must also consider this issue.



# Appendix one

For this survey, Shelter conducted further analysis of a sample of 194 questionnaires that were returned by respondents in nine local authority areas. The authorities, on Shelter's behalf, had originally sent out the questionnaires to households placed in temporary accommodation in their district or borough. Shelter received 417 replies to the questionnaire and analyses of these are contained in the report *Living in limbo*.<sup>36</sup> The sample of 194 people for this research report was selected to include only families, with dependant children, who reported having a range of specific health problems. All these families were living in types of temporary accommodation other than bed and breakfast hotels.

## Details of sample group

### Location

Almost three quarters (73 per cent) of the sample were living in London boroughs with the rest living in other English local authority areas.

Selection of the sample concentrated on families, with reported health problems who were living in types of temporary accommodation other than bed and breakfast hotels. Two thirds of the sample were living in flats; just under one third lived in houses and a small number were occupying hostels and bedsits. The great majority of the sample (90 per cent) had self-contained facilities and were not sharing bathrooms and/or kitchen facilities with people other than members of their household.

### Age of respondents

- 29 per cent of respondents were aged between 16 and 25 years of age
- 60 per cent were aged between 25 and 44 years old
- 11 per cent were aged 45 and above.

### Base: 188 respondents.

### Ethnic origin

More than half of the families that replied described themselves as white, and over a quarter described themselves as black/black British. This is in line with homelessness statistics compiled by local authorities, which show that, on average, a quarter of households accepted as homeless and in priority need are from a minority ethnic group.<sup>37</sup> However, nationally, only nine per cent of the population is from ethnic minority groups.

### Ethnic origin of respondents

- |                            |     |
|----------------------------|-----|
| ■ White (100)              | 52% |
| ■ Black/black British (50) | 26% |
| ■ Mixed race (12)          | 6%  |
| ■ Asian (11)               | 6%  |
| ■ Other (17)               | 9%. |

### Base: 190 respondents.

### Family composition

Of the 194 families in the sample:

- 72 per cent were lone parents and 28 per cent were couples
- 62 per cent had a child/ children under the age of four living with them
- 38 per cent had a child/children aged between five and ten living with them
- 26 per cent had a child/children aged between 11 and 16 living with them
- nine per cent had a child/children aged between 17 and 18 living with them.

### Health problems

Families in the sample were suffering from a range of health problems. These included:

- over half, (58 per cent) reported that someone in their household suffered from depression
- one third (33 per cent) reported skin problems/eczema

36. Mitchell et al (2003), *Living in Limbo*, London: Shelter

37. Office of the Deputy Prime Minister (2003) *Statutory Homelessness: England Fourth Quarter 2002*, London: ODPM

- just under a third had asthma (27 per cent)
- a total of 23 per cent were suffering from other chest and breathing problems
- a total of 14 per cent reported having other mental health problems.

Other health problems experienced included migraines, stress, back problems, high/low blood pressure; anxiety or panic attacks; arthritis, heart problems and repeat vomiting or diarrhoea.

### **Experience of homelessness**

Forty-four per cent of the 179 families, who gave details of their 'homelessness history', said they had been homeless previously. Eighteen per cent of them (33 families) had experienced homelessness on two or more occasions before.

Most of the families had spent months or years in temporary accommodation. More than three quarters (79 per cent) had been living in temporary accommodation for a year or more.

### **Case history methodology**

Shelter undertook in-depth case history interviews with one individual from five of the sample group of families. The interviews aimed to explore health and homelessness issues in more detail, and to provide qualitative data to supplement the information on health available from the survey.

The sample of interviewees was not intended to be representative. It was based on those people who had indicated they were prepared to be contacted following the survey and who indicated they had a range of health problems. Household composition, ethnic background, and gender were taken into consideration in selecting the sample, as far as was possible from the biographical information available.

A topic guide of health-related questions was used as a basis for the interviews.

As Shelter was interested in learning more about the respondent's experiences of living in temporary accommodation, respondents were encouraged to provide as much information as they could.

Interviews took place at Shelter's premises and each interview was recorded and transcribed. Three women and two men were interviewed. The respondents were living in three London boroughs; Westminster, Croydon and Haringey.



# Appendix two

## Topic guide for case history interviews

All individuals interviewed were asked the questions listed below.

We would like to ask you the following health questions. We are also interested in your case history, and would like to give you the opportunity to talk about homelessness and how it affects your health and that of your family members.

- Did you or members of your family have any problems with your health before you became homeless?
- Were your family's health problems relevant to you becoming homeless? If so, how?
- What caused your family to become homeless on this occasion?
- Have the causes of homelessness contributed to your family's health problems. If so how?
- Was the council aware of your health problems when you were provided with temporary accommodation?
- Do you or anyone in your family receive any specific health care services? Has there been any difficulty in accessing these whilst you have been in temporary accommodation?
- Has the accommodation you have been housed in had any effects on your health? On the health of your children? If so, how?
- Do you have any specific concerns about the condition of your temporary accommodation? Dampness? Overcrowding? Accidents? Health and safety of children?
- Are there any other ways in which you feel that your family's health has been affected since you became homeless?
- Have you or any family members been admitted to hospital since you became homeless? If so, were your health needs assessed by the hospital staff before you were discharged or after you had been discharged?
- How often have you used health services, such as visits to your doctor, since you moved into temporary accommodation?
- If your use of any health services has increased since you became homeless, what has caused this?
- Have you had difficulties in accessing any health services since you became homeless? Why is this?
- Has anyone involved in your health care, eg your doctor or health visitor, helped you with your housing problem? Is there anything you would have liked them to have done to help?
- Do health problems prevent you or anyone in your household from working? Can you tell us a little about why this is?
- Are you, or anyone in your household, in receipt of Incapacity Benefit?
- Does your family make use of any children's services, such as Sure Start? If not, why is this?
- Do you know when you might be moved into permanent accommodation? If no, what effect is not knowing when you'll be moved having on your family?
- Do you have any concerns about where you will be housed permanently?
- Do you feel that you and your family have any choice(s) about your lifestyle that could make a difference to your health? If so, why? What could help to make healthier choices?
- What do you think could be done to help families deal with the stress of being homeless?
- Do you think your family's health will improve when you are housed permanently?
- Do you have any other comments?

## Bad housing wrecks lives

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We are the fourth richest country in the world, and yet millions of people in Britain wake up every day in housing that is run-down, overcrowded or dangerous. Many others have lost their home altogether. Bad housing robs us of security, health, and a fair chance in life.

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We can only do this with your help. Please support us.

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