



## **Housing as a Means, Not an End: The Health and Wellbeing of HMO Residents in Newcastle-upon-Tyne**

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February 2015

## **Acknowledgements**

Northumbria University would like to thank the Newcastle Inclusion Lab partners for their input and support with regards the development of the research project and application for funding.

Thank you to the Northern Rock Foundation for funding this research, which we hope will go some way in informing local policy and practice, for the benefit of HMO residents in the case study local authority and beyond.

Thank you to Sheila Spencer for her contribution to the stakeholder interviews and feedback on the report.

Finally, a big thank you to all of the interviewees for giving up their time to take part in the research.

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## **Executive Summary**

### **Project Overview**

Nationally, there is limited understanding of the lived experiences of residents of 'large' Houses in Multiple Occupation (HMOs), operating at the bottom end of the private rented market which cater for homeless people, and the inequalities associated with living in these properties. This research aims to address knowledge gaps regarding HMOs in Newcastle-upon-Tyne, with a particular focus on: entry routes, the demographics and service needs of residents, property conditions, management practices and the impacts of living in HMOs on health and wellbeing. The findings outlined in this report are underpinned by 19 stakeholder interviews, 12 interviews with HMO residents and 19 interviews with supported accommodation residents.

### **Research Findings**

The primary reasons for entry into HMOs include: homelessness following prison release, hospital discharge and relationship breakdown; being new to the area and requiring temporary accommodation until employment and settled accommodation can be secured; and eviction from supported accommodation and social/private tenancies. In all cases, residents felt they had little choice over their housing options at the point of entry. Stakeholder perceptions of HMOs as accommodation of 'last resort' for those unable to access settled accommodation, due to lack of income, not being considered to be in 'priority need' and complex needs were, therefore, largely accurate. To this end, however, HMOs can be argued to play an important role in the housing market.

The most common entry route appears to be self-referral. The local authority does not refer people into HMOs in Newcastle. Referrals – albeit somewhat reluctantly – are made, however, by housing and homelessness teams from other areas, as well as mental health, prison and probation teams operating both within and outside of Newcastle.

Residents are typically single adults, male and range from the ages of 18 to 65+. Almost all are reported to be White British and from the local or surrounding areas. They typically have multiple needs, with alcohol dependency and mental health problems being most prevalent, although physical health is also a concern. There were lower levels of drug use identified than expected, with several reports of 'snobbery' around this. Some men also have needs following serving in the Armed Forces.

Length of stay varies significantly. The data suggests on the one hand, a high turnover of short-term residents ranging from several days to months, and on the other, cohorts of long-term residents, lasting over twenty years in some cases. This reinforces the opinion of some stakeholders that large HMOs 'warehouse' people and offer little encouragement to residents to 'move on'.

Most of the short-term residents are understood to be engaging with services, including probation, health, crisis support and addictions, and are keen to progress their lives. None of the short-term residents interviewed regarded the HMOs as 'home' and just one had engaged in processes of 'home-making'. Conversely, long-term residents are typically thought to have little, if any, engagement with services and limited aspirations to move on. This suggests that engagement with services is a key variable likely to affect duration of stay.

All of the HMOs in the area are considered to be complying with minimum legal standards for rented housing. However, the physical quality of the buildings was typically described in negative terms, with interviewees commenting on the poor quality décor, state of disrepair and lack of cleanliness within the properties. There were complaints of insufficient heating and broken door locks. The bedrooms were described as 'basic'. Bedding is generally provided, but there were reports of mattresses and linen being old and stained, such that some residents provide their own. Some of the rooms are said to be in a state of disrepair and unclean, although this may well be due, in part, to the behaviour of some residents. One HMO appears to have an on-going infestation of bed bugs. Kitchens and bathrooms, on the whole, are said to be accessible and function as required, but also unclean, to the extent that some refuse to use them. Breakfast is typically provided in the properties, but the quality varies.

Preparing breakfast, along with other roles such as cleaning and security, seem to be frequently delegated to residents, who receive small cash-in-hand payments for this. In one HMO, residents discussed the abusive practices (violence and financial exploitation) of one resident acting as a 'security man' and the limited scope to complain about this. Residents were in agreement that landlords and managers are typically slow to undertake repairs. The local authority reported that all complaints made to regulatory services are investigated and the council has a range of powers to drive forward improvements. However, none of the residents interviewed had made a formal complaint about the quality of their accommodation, due to fear of eviction, hoping that living in the HMO was a short-term housing situation, or not knowing how/who to complain to or what action could be taken. This lack of knowledge was similarly

identified amongst stakeholders. It was also suggested that some residents do not complain because their expectations of what they can hope for themselves is low, as a result of their life course or because staying in a HMO is preferable to other options such as rough sleeping. Some residents may also lack the capacity needed to make a judgement about the quality of their housing.

The buildings are generally reported to be particularly noisy, sometimes creating a sense of chaos within the properties. Residents also spoke about feelings of insecurity and lack of comfort, privacy and control while living in the properties. Incidents of theft and violence were commonly reported. They discussed employing a range of strategies to cope with these conditions. While police call outs were said to be frequent, so too was reluctance by some managers and residents to co-operate with enquiries.

Residence in HMOs is typically detrimental to the health and wellbeing of residents – understood both objectively and subjectively across a range of domains – as a result of the physical, psychological and social conditions within the properties. It is difficult for the residents to maintain a healthy diet, due to the nature of the cooking facilities and thefts of food. Residents reported problems sleeping due to levels of noise. Some drew attention to chest problems as a result of indoor temperature, ventilation and damp. Others discussed skin irritations as a result of pests. Physical health complaints were more likely to be reported, however, as a result of drug and alcohol abuse, with problems of addictions almost universally reported to increase while living in the HMOs. Interestingly, not all considered this to represent a decrease in their wellbeing. Much more concerning, however, were the reported impacts of living in the properties on mental health, particularly linked to coping with the physical property conditions, the dependency-related behaviours of other residents and fears over personal safety. Several said it was difficult to maintain relationships with family and friends whilst living there, due to rules around visitors, lack of privacy and embarrassment over property conditions. Improvements in the health and wellbeing of some residents were reported following move on to other types of accommodation.

Interestingly, the majority of residents reported that the psychological and social property conditions were more detrimental to their wellbeing than the physical state. Stakeholders agreed that the effective management of these conditions is something which they strive for in the supported accommodation sector. Yet these aspects remain largely neglected in discussions of housing quality and associated policy and practice in respect of the private rented sector.

A small proportion of the residents interviewed have support workers, primarily from probation and mental health. Equally, stakeholders from probation, health and a homelessness organisation said they were supporting a small number of residents. It is thought that most of the residents of HMOs are registered with a GP, although the extent to which they are actively engaging with them is unknown. It is likely that few residents, however, are registered with a dentist. Some residents are known to attend crisis support services such as the People's Kitchen and food banks, for food supplies. None of the residents interviewed reported to be engaging with addictions services and just one was said to be actively looking for work with the support of a provider. The research was unable to identify any support services that provide formal in-reach within the HMOs. Those interviewed reported that no posters or information leaflets signposting individuals to relevant services are on display in the properties.

Stakeholders reported that it can be difficult to maintain contact with clients living in HMOs as it is difficult to know whether letters reach clients, there are no support workers present to encourage residents to attend appointments and residents often do not have mobile phones or frequently change their numbers. Stakeholders reported mixed receptions from managers when attending the properties and generally said that they do not feel safe visiting the properties, due in part to the difficulty of distinguishing between staff and residents. Some stakeholders have been asked to leave the properties after asking questions about the wellbeing of residents and as such, expressed concern that the primary motivation of landlords for running HMOs is financial gain. They stressed how this differs to the supported accommodation sector. A key matter of debate is the level of 'duty of care' towards residents that can be reasonably expected from private landlords. It is not reasonable to expect landlords to provide the same range of services to residents as in supported accommodation (despite providing accommodation to a potentially high volume of vulnerable people, many with complex needs), but what standard of accommodation can be expected? None of the services engaged with actively promote their services to HMO residents specifically, but said they would be happy to consider this in the future. The difficulty, however, is working out how to engage with long-term residents who are thought not to be engaging with services, or how to get services advertised in HMOs.

Please see 'Conclusion and Recommendations' for a full discussion of the recommendations to emerge from this research.

## Introduction

### **Overview of the Project**

In mid-2011, the Newcastle Inclusion Lab<sup>1</sup> formed, in response to a Cabinet Office call for the formation of ten local inclusion labs across the UK, with the purpose of exploring innovative solutions to problems of multiple disadvantages in their areas. In Newcastle-upon-Tyne, issues around Houses in Multiple Occupation (HMOs) were identified as key knowledge gaps. In England and Wales, the definition of HMOs is complicated, with four types of property failing with definitions and each subject to a different regulatory framework. However, an HMO is commonly defined as a building which is occupied by at least three tenants who form more than one household, with residents sharing toilet, bathroom and kitchen facilities. The focus of this research is 'large' HMOs, operating in the Housing Benefit sub-sector of the private rented market, which cater for homeless people.

Nationally, too, there is limited understanding of the number of people living in this type of accommodation, the demographics and service needs of residents, the lived experiences of residents and the inequalities associated with living in these properties. Evidence suggests that HMOs are loci of disadvantage, but the extent to which they reinforce, in addition to being products of, disadvantage and the reasons for this are unknown (for further discussion, see Rugg et al, 202; Rugg and Rhodes, 2008; Northern Ireland Housing Executive, 2009; Spencer and Corkhill, 2013; Crisis, 2014; Rose and Davies, 2014; Turley and Davies, 2014). Following a successful application to the Cabinet Office and a grant award from the Northern Rock Foundation, the project team have sought to develop an evidence base about a range of issues relating to privately-run HMOs in the area.

Specifically, the project looked at:

- Entry routes
- The demographics and service needs of residents
- Property conditions
- Management practices, and
- The relationship between living in HMOs and experiences of health and wellbeing.

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<sup>1</sup> Primarily made up of Newcastle City Council, Northumbria Police, Changing Lives and Northumbria University.



The research was led by Northumbria University, with partner agencies pledging a commitment to considering the implications of the findings for the regulation and management of the properties and the wellbeing of residents.

## **Methodology**

The research was designed collaboratively between the Inclusion Lab partners. It was originally underpinned by the principles of Participatory Action Research (PAR), with peer researchers playing a central role in the research process. A peer research methodology was chosen for this project as:

- peer researchers can use their direct experience of the issues being explored through the research to inform the research process;
- peer researchers are often well placed to contact potential research participants;
- participants are more likely to be comfortable discussing their experiences with people who have shared similar histories to them; and
- the methodology can be empowering for peer researchers and support their personal and professional development.

A detailed qualitative approach was employed, in response to calls for in-depth, context-specific studies in light of primarily quantitative approaches to the study of housing and wellbeing (Kearns et al, 2012).

Ethical approval for the research was granted by Northumbria University. Following this, potential peer researchers were identified through the Newcastle Users and Carers Forum. They were briefed on the research by the forum co-ordinator and given a research information sheet developed by the university. Those interested were invited to complete research methods training and feed into the development of the research process. In total, twelve people completed the training and were presented with a certificate in recognition of their achievements. They were also given research packs, containing all of the materials and equipment which they would require to undertake the interviews, as well as the contact details of the lead researcher. The intention was that the peer researchers, lead researcher and forum co-ordinator would have regular contact.

The peer researchers set about identifying participants and 19 interviews were completed. However, the majority of the participants interviewed were living in supported accommodation and so did not meet the project criteria (although these interviews are still drawn upon in the report). At this point, the lead researcher began regularly contacting stakeholders working in the areas of housing, homelessness, addictions, offending, advice, employment and crisis-support across the city, who may be coming into contact with HMO residents. 12 residents (11 male, one female) – drawn from four different hostels – were identified through this process, with the lead researcher undertaking the interviews as and when opportunities arose. Eight were current HMO residents and four had since moved on to other forms of accommodation. The residents interviewed had lived in a HMO for between two weeks and two years. No ‘long-term’ residents could be accessed through a ‘snowballing’ technique. It was more difficult to access HMO residents than anticipated, particularly as following several unsuccessful attempts to engage with landlords, it was not considered appropriate to try to make direct contact with potential participants via their accommodation. Several potential participants identified were also unwilling to talk about their experiences as part of the research.

19 interviews were completed with stakeholders from a range of sectors including housing, homelessness, regulation/enforcement, health, drugs and alcohol and criminal justice. This figure also includes one formal interview with the landlord of a large HMO in a north-east local authority. One private landlord was also engaged with informally.

All of the interviews were professionally transcribed and analysed, using codes generated from the interview schedules. Broader themes and sub-themes were then identified. Any information which was considered to be too historical to be substantiated was excluded from the report.

Although the focus of the report is a small number of HMOs in Newcastle-upon-Tyne, it is expected that the findings and recommendations will be applicable to other areas.

### **The Local Context**

Newcastle-upon-Tyne has one of the largest private rented sectors in the North East, accounting for approx. 27,000 properties, equivalent to 20% of the local housing market. This compares to nearly a decade ago, when the market accounted for just 12% of households. A local landlords survey conducted by the local authority in 2013 suggested that growth had occurred in all sub-sectors of the private market, although there has been a particular increase in respect of the supply of student housing. Currently, the market caters for a wide range of

social groups (families, students, professionals, housing benefit claimants and homeless people).

It is unknown how many HMOs there are in Newcastle or indeed, nationally. Only HMOs which meet particular criteria (i.e. are three or more storey high buildings and/or are occupied by five or more individuals from different households) are required to apply for a licence and thus make themselves known to the local authority. It is also likely that some HMOs which require a licence are operating without one. However, the large HMO accommodation, which is the focus of this research, is typically well-known to statutory and voluntary services across the city.

All residential accommodation, regardless of tenure, must comply with a range of legislation and regulation<sup>2</sup>. HMOs must also comply with an additional layer of regulation<sup>3</sup>. Licensing plays an important role in enabling local authorities to regulate and manage the sub-sector. Licences are granted on a five-year basis and properties must be inspected at least once during this period. HMO managers are also required to meet 'fit and proper' person criteria<sup>4</sup> (Wilson, 2013). Local authorities also have a range of powers to drive forward improvements within HMOs where complaints are made about property conditions and management practices. Powers include serving improvement notices, prohibition orders, hazard awareness notices, clearance orders, and even demolition orders (Rose and Davies, 2014). At the point of conducting the research, all of the large, licensed HMOs in the city were deemed to be meeting minimum property standards and fulfilling fit and proper management criteria. Despite this, research undertaken by Spencer and Corkhill (2013) into 'Bed and Breakfasts' and private hostels in the North East, identified 'unacceptable' property standards and widespread abusive management practices. In addition, a wave of recent reports looking into temporary accommodation suggest that residence in this type of housing is often a 'last resort' for a significant number of vulnerable, otherwise homeless individuals and is often detrimental to their health and wellbeing (see for example, Crisis, 2014; Rose and Davies, 2014).

The development of this project coincided with the introduction of changes to the welfare system (with the extension of the shared accommodation rate from 25 to 35 year olds being particularly

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<sup>2</sup> This includes Part 1 of the Housing Act 200 and the Environmental Protection Act 1990.

<sup>3</sup> This includes the Management of Houses in Multiple Occupation (England) Regulations 2006 and the Licensing and Management of Houses in Multiple Occupation (Additional Provisions) (England) Regulations 2007.

<sup>4</sup> This takes into account: whether the landlord has a criminal record for fraud, violence or drug related offences; evidence of discrimination in any business activity; compliance with housing laws; previous track record as a landlord; anti-social behaviour problems in any properties the landlord is responsible for; and any relationships the landlord has with letting agents.

relevant) and the introduction of the Localism Act 2011, which gave local authorities powers to discharge their homelessness duty to the private rented sector. There was speculation amongst stakeholders that these changes, coupled with a fragile local labour market, may result in an increase in demand for shared accommodation at the bottom end of the market and a subsequent growth in supply. Several predicted:

*'We're assuming at some point that it will create a shared accommodation, HMO-type market. Landlords can potentially make a lot more money out of HMOs. You can cram a lot more people in'*

*'I can see more people falling foul of places like [name of HMO]'*

As a result, there was concern that should the changes create concentrations of HMOs, this would generate spill-over effects within local communities. Indeed, some areas of the city already have particularly high concentrations of HMOs due to the nature of the housing stock (typically large, Victorian-style properties) and some community tensions have developed due to the aesthetic quality of the HMOs and the anti-social behaviour of some residents. These effects have been documented in other geographical areas (see for example, Northern Ireland Housing Executive, 2009). Greater concentrations of HMOs could also have an impact of demand for services, including the police, local authority and health sector.

As such, it was important that key agencies in the city secured an evidence base about the lives of those living in HMOs. At this point, these concerns are not known to have materialised in Newcastle, but are occurring in other parts of the North East. Speaking in relation to Newcastle, one stakeholder reported:

*'I don't think we are seeing that kind of response. We've got a very good housing market and a good level of supply for those that need it. So, we're not seeing a squeeze and a push of people into that lower end of the market. We've not discharged a duty into the private rented sector because the people that we have got coming through as in need, we're managing to house within supported accommodation or YHN. And, landlords themselves aren't choosing to go into that market because of the supply of other residents'*

Whilst issues around HMOs have not been flagged to the local authority and other partner agencies as growing problems, the findings documented in this report highlight a number of points of concern and a subsequent series of recommendations for consideration.

## Research Findings

### **Entry Routes into HMOs**

There are a range of reasons as why people require accommodation in HMOs. Those identified through this research include:

- homelessness following prison release, hospital discharge and relationship breakdown
- being new to the area and requiring temporary accommodation until employment and settled accommodation is secured and
- eviction from supported accommodation and or a social/private tenancy.

In all cases, residents felt they had little choice over their housing options at the point of entry, with several having experienced rough sleeping or facing the prospect of rough sleeping immediately prior. Indeed, the difficulties associated with securing settled accommodation for offenders, as well as those who have been evicted from supported accommodation have been widely documented, both regionally and nationally; although measures are in place to support this (see Spencer and Corkhill, 2011, Harding et al, 2012). Stakeholders were largely correct in describing the HMOs as housing of last resort for those unable to access other forms of accommodation, due to lack of income, complex needs, not meeting the criteria for 'priority need', not having a local area connection<sup>5</sup> and housing exclusions. To this end, the HMO sector can be considered to play an important role in the housing market. Stakeholders commented:

*'It definitely plays a role because there are those who are exempt from statutory provision or some of the other providers' accommodation, so it fills a gap. The reality is there are still people who have exclusions from our supported accommodation and have very limited options'*

*'I think once people have been excluded from these provisions because of their behaviours and they haven't been able to sustain their tenancies, it becomes very much the last option for them'*

*'To me, it was always just somewhere you dumped somebody. If there was nowhere else to go, that's where you went'*

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<sup>5</sup> Such that local authorities do not have a duty to provide them with settled accommodation.

*'They just sort of mop up everything that would otherwise be on the street'*

Those with experience of rough sleeping appeared to be particularly grateful, however, for the accommodation, with several residents and stakeholders reporting short-term improvements in their health and wellbeing as a result of moving into the properties. One resident said: *'Yeah, yeah. Brilliant, yeah. It's better than being on the streets, you know what I mean?'*

The most common entry route into HMOs in Newcastle was identified by both residents and stakeholders to be self-referral or 'word-of-mouth'. Those interviewed who are local to the area reported to be aware of key HMOs in the area and/or were told about them by friends. When asked about their entry route, replies included, *'Well, I knew about the place so I just phoned them up and asked'* and *'Well I was looking for somewhere to stay. I was talking to a friend of mine and they said [name of HMO] had a room. And the next thing I know, I got a phone call saying, 'Right, you can come along, there's a room there for you'.*

Neither the local authority, nor any of the support services interviewed, refer people into HMOs in the city or actively promote them to individuals presenting with a housing need. This flexibility is afforded by the political leadership's on-going commitment to the funding of supported accommodation in Newcastle (Harding et al, 2013). Here, one stakeholder commented:

*'We don't place people directly in any of that accommodation, because we've got supported housing...our councillors have chosen to fund those things. We have a greater degree of a regulatory system there and quality standards around that, so we know where we are placing vulnerable people. Thank god we don't have to take those risks in placing people in other accommodation'.*

Referrals – albeit somewhat reluctantly – do appear to be made, however, by housing and homelessness teams from other areas, as well as mental health, prison and probation teams operating both within and outside of Newcastle. They reported that referrals into HMOs are made where there are no other options available to meet the person's need, either because there is no other affordable accommodation in the area or because no other provider will accommodate them because of their behaviours. One stakeholder explained:

*'I try to steer people away from places like [name of hostel]. I don't think they're a very nice place for anybody to be, so if I can get somebody into somewhere different, that's what I aim for. People tend not to last over there more than two or three nights and its desperation if they do go there'*

Spencer and Corkhill (2013) similarly found that higher concentrations of HMOs in some parts of the region, including Newcastle, result in the 'inward migration' of homeless and vulnerable people from neighbouring areas. Discussing various entry routes, residents reported:

*'I went to like [name of mental health trust]. Like where you go to see your CPN, your social workers or the psychiatrist. And I like told them I had nowhere to live and they gave us [name of HMO]'*

*'I was in a hospital, in [name of psychiatric hospital]. I was too much of a risk, the hospital, so they had to discharge us'*

*'I lived with my mam and she had some problems with her housing benefits and stuff and rent arrears and she didn't realise how much she actually accumulated in rent arrears. We got the eviction notice and then we tried to get that sorted but it was impossible to stop it. [The local authority]...first of all, they were going to send us to Sunderland but that was mostly men, ex-offenders. So we really weren't comfortable staying there. So, yeah, we got sent to another one'*

*'I go to...you can go for your breakfast and that at some of the places. [Name of organisation]... they got us in. Desperation. Would you like to live on the streets in the winter, and how cold it gets in the winter? Imagine 3.00am, 4.00am, when it's really, really cold. You think when you come out of the house on a morning it's cold. Just think of 4.00am, how really cold then'*

### **The Demographics and Service Needs of Residents**

Those living in HMOs in Newcastle are typically male, single adults (most of the city's large HMOs are male-only establishments). They range from the ages of 18 to 65+. Almost all are reported to be White British and from the local or surrounding areas. Nine of the twelve residents interviewed are from Newcastle. Two are from other local authorities in the North East. One is from outside of the region (they came to the North East for a detox programme in 2000). However, several residents also mentioned the presence of a number of Turkish and Polish residents and one stakeholder had heard reports of Lithuanian families renting rooms in one HMO. This was being investigated by the local authority's children's services department.

The previous section indicates that people tend to arrive at HMOs in challenging circumstances. It is unsurprising, therefore, that many have multiple and complex needs. Those interviewed had

limited educational attainment. Of ten residents who discussed education, four had no qualifications, two had gained some GCSEs at school and four had gained NVQs or other qualifications since leaving school. They typically had limited employment histories. Two had never worked, just one resident had temporarily been in employment while living in a HMO and several said they were not fit to work. One resident reported that just two of approx. 45 residents in their HMO were in employment. All residents interviewed were in receipt of benefits, although several reported financial difficulties as a result of benefit sanctions. Two landlords/managers, in particular, were said to be understanding about this:

*'There's quite a few of them have been sanctioned because they haven't done what they should be doing. [Name of manager] was brought up in the area...he's not the sort of bloke, that, you know...If you cause bother, you get hoyed out, but if lose your benefit, you'll not necessarily get thrown out'*

All but one of the residents interviewed reported unstable housing histories and experiences of homelessness (including sofa-surfing, living in supported accommodation and rough sleeping). Commenting on the housing histories of residents in their HMO, one resident said:

*'There's a few of them that's went through the hostel system and got a flat, and started living properly, and for whatever reason, it hasn't worked out and they've lost the flat and they're back on the streets and back in [name of HMO]....one lads been through the system in five year, four times'*

Most of the residents interviewed have a criminal record and several had been to prison. Offences were typically drugs, violence and homelessness related. Just one of three residents reported receiving help with their housing needs upon leaving prison.

However, alcohol dependency – and a 'culture of drinking' – was reported to be prevalent within the HMOs. The observations of stakeholders who had visited the properties included:

*'There was a couple of guys, both worse for wear, obviously had been drinking and very unkempt...looked as though they'd spent all their money on drink. I suppose it's what we call a wet house'*

*'The reception area was just full of drunks. Everybody was drunk'*



*'I got literally two steps into the room, I glanced around and I remember seeing about 7 or 8 people, all with bottles of cider in their hand, 9am in the morning, mortal drunk, trying to play pool'*

Similarly, residents stated:

*'[Name of HMO] was a lot of alcohol and drugs. Out of maybe ten people, nine of them would be all-time, chronic alcoholics'*

*'Alcohol. They just seem to get in and they start drinking and they've got problems and half of them don't even realise they've got problems. Threes one lad, takes anti-depressants, but he's just minged, all the time. And he'll just drink on top of that and he'll fall over and they'll just leave him 'oh just leave him on the floor. He'll just sleep for two hours. They'll just stay up all night. I've seen them, its starts on a Thursday night, basically finishes on the Sunday night, Monday morning...and just drink and drink'*

*'People were just drinking all the time. Plus the anger management. It was fighting in there and stuff and it was just no good, man. There was a living room, aye, which was messy. People used to get drunk and lie – sorry for using the expression – pee all over the settee and stuff like that'*

More unsettling, however, were discussions about the mental health of residents. One GP interviewed as part of the study reported a serious act of self-harm which took place in one of the HMOs a few years ago, whereby a resident set themselves on fire. Another stakeholder discussed supporting a resident who is an ex-serviceman with post-traumatic stress disorder. A former resident was described by their support worker as having a 'schizophrenic-type' illness, with private hostel accommodation being a 'last chance saloon' for them due to their behaviours. One resident talked about having mental health problems since they were a child and spending years going in and out of a psychiatric hospital. They explained:

*'My family took us to up to [name of psychiatric hospital]. I asked them to take me somewhere because I just didn't know how to cope with the way I was feeling and what was happening. The end of my youth, it was the end of the time when I felt good. I'm here, but I'm somewhere else at the same time and I'm all over as well. It's like I can't be helped, inside my head being ripped apart and all over'*

When asked about their mental health, the response of another resident was: *'Manic depression, borderline personality disorder'*.

There were also reports of residents having physical health limitations and learning disabilities. One stakeholder reported on the case of a current resident who has a severe sight impairment and physical limitations following a stroke (in addition to mental health problems). The resident has concerns about falling in the corridors, stairwells and bathrooms because they are poorly lit. The stakeholder described this individual as having *'fallen through the loop'*, but following four years spent living in the accommodation, they have become very withdrawn, are disengaging with services and are unwilling to move on. One resident discussed the case of another resident with autism. Physical health complaints reported amongst those interviewed were migraines, blackouts and alcohol-related health complaints. Commenting on the health of residents in one HMO, more generally, one resident had observed:

*'A lot of them are bad but its maybe through living on the streets, drinking, drugs, over the years. Emphysema, heart attacks. There's a lad there, had about six heart attacks in the last year...there's a place up there, he stays off the drink and he cuts his cigarettes down and then when he comes back to [name of hostel], it starts all over again. It's the influence of the others'*

There were lower levels of drug use in HMOs identified through the study than expected. There were several reports – by both stakeholders and residents – of 'snobbery' around drug use in the HMOs, with drug users typically made to feel unwelcome. Where drug abuse was reported, this was said to be most common among younger residents. Most of the residents interviewed had used drugs in the past but just one current and one former resident (at the point of interview) reported having a drug problem while living in the HMOs. One linked drug use to severe mental health problems which started in childhood. They explained:

*'I use them all the time. Without them, I don't function. But I don't use needles or anything like that. It takes the pain away from what you're feeling. And the pain that you are feeling is mental, it's not physical. So you can't deal with it any other way. You need the release of them chemicals in the brain to make you feel good all of the time. I feel horrible all of the time. I know there's something wrong with us, but nobody can help us. I try to help myself but I can't do it. I know if I could sleep properly and dream every night, I'll be able to free myself, but I don't get the chance'*

Interestingly, this resident did not consider themselves to have a drug problem as they felt they could stop taking drugs if they wanted to. Another resident started taking drugs at the age of 17 and linked this to living in hostels:

*'My problem was with heroin and crack, crack cocaine, and that was to do with all these, you know the hostels and that. I would go and do anything to make money, so when I go back on a night time, I could have some drugs...it was just a vicious circle altogether. At least I can, like, knowing now I can wake up in the morning, have my breakfast, go to the shop or go into town or something, come back, do what I need to do. I've got no like worries or anything like that. I don't have to think, "What am I going to do in the morning for like drugs"'*

Just one resident explicitly complained about the level of drug use within their HMO:

*'The drugs problem is, like, that's the main thing. We keep going to the management about it but nothing gets done. There's all these needles in the garden area and the council's been out but they just get told the management is like, "There's people with diabetes". They wouldn't put them out the window if they were. There's a lot of the top floor, mostly with the drugs and things. I know there's drug dealing going on in there'*

Overall, the above findings suggest that these HMO residents share similar characteristics to those accessing supported accommodation. Indeed, a study tracing the life histories of 82 homeless people in Newcastle identified that approx. 50% had experienced 'lifelong exclusion', as described above, as had most of those interviewed during the research process that were living in supported accommodation. Equally, however, the study identified that the remaining half had led unproblematic lives until the occurrence of a significant life event, which when coupled with addiction, had resulted in an episode of homelessness (see Harding et al, 2012). It is likely that HMO residents will fall into this group also. One of the residents interviewed had moved into a HMO because they were new to the area and needed somewhere to stay, while they looked for employment and more permanent accommodation. Another resident (and her mother) found themselves homeless, following eviction from social housing due to rent arrears. Both interviewees reported to have led relatively unproblematic histories until this point.

### **Length of Stay in HMOs**

Length of stay appears to vary significantly. The data suggests that the HMOs have on the one hand, a high turnover of short-term residents ranging from several days to months, and on the

other, cohorts of long-term residents, lasting over twenty years in some cases. This, to some stakeholders, reinforced the opinion that some large HMOs simply 'warehouse' people and offer little, if any, encouragement to residents to progress to settled accommodation. It must be acknowledged, however, that HMOs – although considered to provide temporary accommodation – essentially offer residential accommodation; the principle of moving people on goes against their business model. In other parts of the North East, however, some HMO landlords have accepted the idea of services providing 'in-reach' to residents, although this may result in some residents being supported to move on.

Broadly speaking, most of the short-term residents are understood to be engaging with services – including probation, advice services, crisis support, addictions and housing support – recognising that they have a range of needs which should be addressed. The residents engaged with through interview typically fell into this category and reported a desire to 'move on'. Just one had begun to regard the HMOs as 'home' and had engaged in a process of 'home-making' (Blunt, 2005). Conversely, the long-term residents were reported to have little, if any, engagement with services (except GPs) and limited aspirations to move on. Some stakeholders discussed this in terms of residents 'choosing' to make the HMOs their long-term 'home', although the extent to which the residents can be considered to be exercising choice is arguable. Nonetheless, the data suggests that engagement with services is a key variable affecting duration of stay. Just as supported accommodation operates on the basis of move on within two years, there appears to be a 'tipping point' beyond which the residents' environments and needs become normalised and accepted. Stakeholders agreed:

*'It's the ones where they have started to engage and come out of their dependency that they look to find alternative accommodation because they then recognise that they're not in a good place to be able to move on'*

*'It's only maybe when they've committed crime and they start to work along their probation and they start to work under Plummer Court, or something like that, that their life changes again and they want to get out of that chaotic and destructive behaviour and to move back into a provision that will support them'*

Talking about one individual with severe physical and mental health problems, a stakeholder explained:

*'He's been there four years and he just hasn't got any intention of moving by the looks of it. There's no reason why he can't have his own tenancy. I think he's got himself into a state now where he's happy where he is because he's being left alone, which is not a good thing. He's got a couple of lads, in the same boat at himself. I think it's the fact that whatever brought him in there in the first place, It's just ended up as a security net for him. He knows the place, he doesn't want to leave it'*

It is important to consider length of stay in relation to the impact of living in HMOs on residents' wellbeing. This will be discussed later in the report.

The extent to which residents are 'accepted' by others in the HMOs may also influence length of stay. In two HMOs, it was reported that drug users and people who have committed certain types of offences tend to be encouraged to move on. One stakeholder commented: *'One of my clients who I moved from there a few years ago, he got beat up quite badly when he was in [name of hostel]. He was on the sex offenders register with children and stuff, and I don't know if somebody knew about that or not, but he did have a very hard time in [name of HMO], while residents said:*

*'There have been rumours about paedophiles just getting out of prison, moved into [name of hostel]. When the lads find things like that out, they've got a tendency to move them out or they move out voluntarily, if you know what I mean. If you don't something's gonna happen to you'*

*'Most of the other residents were all right but if you got one person who moved in and they didn't like them then there would be conflict'*

## **Physical Property Conditions**

Twelve of the stakeholders interviewed had visited the hostels on a number of occasions; some in an enforcement capacity, others as support workers for specific residents. Stakeholders from probation, (mental) health and homelessness services appear to have had most engagement with the properties. These stakeholders have also engaged in frequent discussions with residents about their experiences of living in HMOs as part of their support plans. These stakeholders, in particular, described the physical quality of the buildings in negative terms, commenting on the poor quality of the décor, the state of disrepair of the properties and the lack of cleanliness. Reflections included:

*'Run down, the fabric of the building was very poor, threadbare carpet, your feet stuck to the carpet'*

*'It was quite dirty. The first time I went in, the carpet was disgusting and I was sticking to it, and then they were having a bit of a refurb, and the carpet was still minging when it got changed'*

*'There was a smell about the place...damp. You know when you go into like, a building that's been abandoned, you normally get this smell of like decay. The last time I was there, that's what it smelled like'*

*'Paint was peeling off the walls, you could see visible damp in the room I went in. And it looked as though people were trying to paint over it'*

*'The floors, I seem to remember, being pretty sticky. And then going upstairs into a very narrow, slightly rabbit warren kind of corridor, with bedrooms off it on both sides; again, very dark, no natural light, very dingy kind of feel to the thing, with pretty small pokey rooms, bedsit rooms, off this corridor'*

The residents interviewed talked at length about the physical conditions. Most reported that the properties typically have the facilities needed to fulfil their most basic needs. Feedback about the most positive aspects of their accommodation included:

*'You can get the hoover whenever you want. you can use the washing machine, there's two ovens where you can make...and there's a new one. It's alright'*

*'You have to wash your own bedding and stuff like that. It's good how they provide washing powder, and you don't have to pay for gas or electric or anything. You just use whatever you want'*

*'It's hard to choose the best thing about it. There's a lot of good things about it. The meals, the fact you can use the oven whenever you want; keep things in the fridge'*

*'There's a telly and Freeview box, so you can watch the telly'*

Discussions about the quality of the buildings and, more specifically, the quality of the bedrooms, kitchens and bathrooms, was less positive. The overall quality of the buildings was said to be poor, such that one former resident said:

*'I can guarantee you, 96% of the people probably want it knocked down or burnt down. I can guarantee that. It's a shambles. Really bad. I wouldn't put my worst enemy in there, to be honest'*

Several residents talked about the HMOs providing insufficient heating due to poor heating systems, broken heating systems taking a long time to repair and old windows. Here, comments included:

*'It was quite cold, the radiator didn't work and you weren't allowed heaters because of the electricity, you know? Seemingly, they used to check the rooms every week to see if anybody had heaters, but I was allowed one because my radiator didn't even work - single glazing, so it was really pretty cold'*

*'The room I'm in, it's clean, but it's drafty; a big gap in the window at the top. I've had to put my jacket back on because it was that cold'*

*'The heating was broke and they wouldn't pay the money for somebody to go and fix it. And then I fetched my own heater in and he said, "You're not allowed a heater, it eats too much electricity." I said, "Well you need to sort something out!" It was freezing, you know'*

The bedrooms were described as containing basic furniture (bed, wardrobe, dressing table and chair). Bedding appears to be provided, but there were several reports of mattresses and linen being old and stained, such that some provide their own. Recalling a conversation with a former service user, one stakeholder said:

*'He said the bed was filthy, he said he slept on top of the quilt because he was scared to sleep on the mattress because he didn't know what was on it and he just said he couldn't take any more. And he came back the next day and said I'd rather be homeless'*

Some of the rooms are said to be in a poor state of repair and unclean, although this is likely to be due, in part, to the lifestyle of some residents. One resident said: *'There are rooms in there, with older residents and younger lads, where you think, I wouldn't bring me dog in here. But for some, likes of [names of residents]. Their room is more or less theirs, so they've got big tellys and stereos and stuff, they're lovely'*, while another resident said, *'The bedroom was a state but I did my bedroom. I put my own carpet down. And I even got my own bed. I even painted it. I*

*just done it where I would spend all the time in my bedroom, you know. I wasn't going downstairs on a stinking settee or...'*

In one particular HMO, residents talked about a lingering infestation of bed bugs. They reported:

*'I don't know how many times I've sprayed the room with how many different insecticides, but it doesn't stop them coming back'*

*'The worst thing about it is the bed bugs...but the gaffer spends hundreds of pounds every week on sprays and hands them out to people and I think it's got these problems because some people choose not to deal with it and they get bed bugs and they don't care. Whereas if everyone would spray their own...it would kill them and they wouldn't come back'*

Stakeholders were also aware of the situation and mentioned this during interview:

*'From what I understand from [name of resident], he's bitten every night of the week by bed bugs. And even though he keeps himself as clean, keeps his laundry and that clean as he possibly can, the place is just riddle'*

*'And the client that we removed from the building had had some of his belongings stolen and he also was covered in bites from, which looked like bed bites or ant bites, he was covered in them. And he had said that he had, that had come from that particular place'*

Several residents also mentioned the presence of rats in the past:

*'There was mice running about and everything, man it was...It was shocking. It was shocking. It was bad like'*

*'There has been rats in the past in the backyard. But the lads, there was a couple of them got air rifles and you don't see many rats around there now'*

Some of the bedrooms have en-suites but residents are most likely to share bathroom facilities. Bathrooms, on the whole, were said to function as required, but to be often cold and unsanitary, to the extent that some refuse to use them and wash at friends/family's houses or at various support services:



*'The other bathrooms are oh, disgusting. Basically, you've got a toilet, a sink, a bath. There's no heating. There's nowhere for you to put a towel on a radiator. There'll be no curtains at any of the windows. They're just freezing cold. You would have to scrub the bath with bleach before you even get in'*

*'Well, put it this way, I wouldn't use them. I'd go to the toilet for a number one and that's it, you know. I go somewhere else for a bath or a shower. I think they're terrible. Damp and that, you know'*

*'They're a f\*\*\*ing s\*\*\* hole. Sometimes the toilets get blocked and that's a problem...Sometimes the water's been turned off because of plumbing problems. I couldn't even have a shower this morning'*

The kitchens in the properties were always said to be accessible, although the kitchens in one HMO are locked at 8pm each night in an effort to reduce thefts of food and to prevent cooking-related accidents by residents under the influence of drugs and alcohol. They typically contain cookers, microwaves, kettles, toasters and food storage facilities, although one HMO was said not to have cookers in the smaller kitchens. There was general reluctance amongst most interviewed to use the kitchens for cooking and storage purposes due to lack of cleanliness and frequent thefts:

*'It's there for you to put stuff in but you're a mug if you do, because by the time you walk upstairs and come back down again, somebody's taken it, so they basically keep what they've got and just eat day-to-day...they use the People's Kitchen for eating'*

*'Oh you could access the kitchens and all that, but you wouldn't cook in it because of the state of it. I was basically just buying outside all the time'*

*'The kitchens, well I'd only go in there for my cup of tea'*

*'Diabolical. The kitchen was diabolical. It was bad'*

All of the residents interviewed reported that breakfast is provided, although the quality appears to vary and some residents refuse to eat the breakfast due to the state of the kitchens. This is despite having to pay a 'top-up' fee for this, in addition to Housing Benefit. While some reported that a full English breakfast is provided, in one HMO, a resident stated:

*'Until recently, they never actually bothered providing breakfast. There's been a lot of management changes. Even so, breakfast is just some bread being put out and it's just toast basically. They get a standard budget of £5 a day for everyone. I've actually done the shopping for the breakfast before so I know exactly how much you get. You get £5 and you've got to take receipts back to the manager'*

As the above indicates, cooking breakfast, along with other jobs such as cleaning and security, are delegated to residents, who receive small cash-in-hand payments for this. In one HMO, arrangements were described as:

*'You get a full breakfast on a morning. There's about three of them, take turns. They'll say, Mick, it's your turn to make breakfast in the morning. If Mick has a skin full, there'll be someone to stand in. He'll get up and clean the cooker and clean the pans before he does it. Manager buys the food in. Whoever is on the door, it's their responsibility to guard the food'*

*'Whoever's on the door goes round at least twice in the night just with a black bag and they get pretty full with cans and bottles and all that, and he'll go round and tidy up and get the hoover out in the morning, so it's not that bad'*

Residents were in agreement that landlords and managers are slow to arrange repairs. They cited a range of examples where they have had to wait long periods of time in order for these to be carried out. As such, on occasions, they have refused to pay their rent or have tried to carry out the repairs themselves. Extracts from these discussions are presented below:

*'The heating was broke and they wouldn't pay the money for somebody to go and fix it. And then I fetched my own heater in and he said, "You're not allowed a heater it eats too much electricity." I said, "Well you need to sort something out!" It was freezing, you know'*

*'There was one time I had my window open and it was really windy and the window smashed, because it came off the latch. And I had to put, it was double sticky clear plastic on it for two month, because if you complained too much they wouldn't be happy, and it took them two month to actually eventually fix it. Do you know, so you had to be*

*careful, you didn't want to complain too much, because they would just basically come and kick you out'*

*'Well, a few weeks ago, the washing machine was broke and it took the guy about three weeks to actually agree to get a new one because people were saying they were going to reduce their rents and stuff because it should be provided. It's the same when the heating goes off, people are like they're not paying their rent until it comes in. Basically the guy who owns it, if he can get away with not doing something, he will. He doesn't want to spend money on the place'*

*'The owner is never there. We've got a manager but he only comes a couple of times a week so they've got someone who just basically collects the rent. Ask him anything and he's only reply is, 'No, I'm not authorised to do anything so it's no. Just put it in the log book'. You put it in the log book, show it to the manager and the manager says he'll get the guy who comes to collect the rent to make sure it's done and it never gets done'*

*'Basically people started doing their own repairs. They're getting someone in to do them. It's kind of like there's no-one supposed to be in the building but if you come in in the right time, will you just do this for us and then sneak them back out'*

Some stakeholders have tried to complain to landlords on residents' behalfs, but to little avail. The local authority stressed that all complaints made to regulatory services are investigated and where necessary, they have a range of powers at their disposal to manage improvements. The local authority's relationships with private landlords are likely to be difficult due to their regulatory nature. But, where landlords are required to make improvements, they are generally said to be responsive: *'We've not had to prosecute anybody and whilst they may carry out work that isn't marvellous, it's always enough just to scrape by'*. However, it was reported that few formal complaints are received. As such, one stakeholder conceded: *'I think we've got the powers to be able to do it. It's not that we can't or that we won't. I think it is just about complaints. If people don't complain, then there's not an awful lot we can do'*.

Indeed, none of the residents interviewed had complained about the quality of their accommodation to the local authority. Stakeholders similarly reported a reluctance among residents to make a formal statement about their experiences of living in the HMOs. The key reasons for this seem to be: fear of being forced to leave and becoming homeless, hoping that living in the properties is a short-term housing situation and not knowing how/who to

complaint to and what, if any, action can be taken. A lack of knowledge around enforcement was also identified amongst stakeholders. Here, comments included:

*'I'm struggling to see how [name of HMO] meets the minimum requirements. It begs what is the minimum standard?'*

*'To be quite honest, because we knew it was renowned, you knew it was probably pointless phoning them up and making yet another complaint'*

It was also suggested that some residents do not complain because their residential expectations are low, as a result of their life course, or staying in a HMO is preferable to other options, such as rough sleeping. Stakeholders postulated:

*'It becomes second nature and home to them and it's an existence through subsistence basically I think. The ones that generally make their way to [name of hostel] are, for want of a better word, on their bones and it's almost like, well this is my life and this is what I can expect, so what's the point in complaining'*

*'Some of them see it as a sanctuary, because they've gone under the radar. They're not being hassled by Jobcentre Plus for applying for jobs...they have an income coming in, their bed and breakfast is paid for and they've got freedom of movement'*

It could also be that residents do not complain because they do not have the capacity to make a judgement about the acceptability of their housing situation. For example, one resident who talked at length about bed bugs, also spoke very positively about living in the HMO and the kindness of the manager in offering residents bug sprays free of charge. This resident, however, also talked about being in and out of psychiatric hospitals throughout their life and being in 'constant mental pain'.

The property standards which these premises must adhere to cover issues such as fire safety, the provision and maintenance of facilities and the provision of furnishings, for example. They do not go into detail about environmental attributes such as the quality of décor and cleanliness. As one stakeholder explained:

*'It doesn't address anything like the decorative standards...you've got your standard fire safety for your furniture but it doesn't say that the furniture has to be good quality or new and there needs to be floor covering down, but it doesn't say as to what condition'*

Those with specialist knowledge of the regulations reported that the standards which HMOs must comply with are sufficiently comprehensive. They did not feel that it would be appropriate for the standards to be extended to cover décor and levels of cleanliness, for example. This is in part because furnishings in temporary accommodation are inevitably subject to a high degree of wear and tear (linked to the lifestyles of residents) and landlords cannot be held accountable for the behaviours of all residents. Some stakeholders also suggested that landlords are unlikely to make sufficient income from the HMO to be able to afford to decorate the properties to a higher standard (although this point was debated):

*'Unless they're over 35, they're only getting the shared room rate. So that's not a great deal of money, and they'll have help with contributions towards other things, like the heating and water. But I think we did work out for [name of hostel] that he really didn't have an awful lot left over once he paid the manager and obviously all the bills to keep a big old building going. We wondered why he did it'*

It was also pointed out that current legislation and regulations apply to either the whole of the private rental market or at least, significant parts of the HMO sector. As such, stakeholders suggested that instead of changing current legislation and regulations, it may be more appropriate to consider additional licensing practices and regulations for large HMOs providing accommodation to vulnerable people.

### **Psycho-Social Conditions within the Properties**

Discussions of the 'psycho-social' refer to the affective response which individuals have to their environments and the social interactions that take within them (Kearns et al, 2012). Residents typically talked about feelings of insecurity while living in the properties, due to the poor quality aesthetics of the buildings and poor quality or broken or missing locks:

*'All the front windows are, like, you know they're all falling to bits, but if you go round the back, some of the windows have got like holes, and they've been smashed. They haven't ripped the glass out and put new glass back in, or even plastic sheeting. They've just left it'*

*'My door is a bit dodgy...it doesn't lock properly...I got locked out and instead of going to the manager, I just pushed it open...They're slowly starting to replace them but it's a slow process'*

The buildings are generally reported to be noisy, due to residents and visitors coming and going, knocking on each other's doors and socialising in the communal areas. Stakeholders that have visited the properties drew attention to this too: *'Sound proofing, pretty poor, so lots and lots of noise you could hear, from neighbouring rooms and so on'*. For some residents, this added to their feelings of insecurity. They also spoke about a lack of physical comfort and ontological stability while resident in the HMOs, making comments such as *'I wouldn't say I feel comfortable; there's no comfort. It's somewhere where I put my head down'*. One female resident reported feeling uncomfortable about living in a mixed-sex environment. They, her mother and another female resident said to use the bathroom in groups, so that they were not left alone with male residents. Interviewees also spoke about a lack of privacy in the HMOs and the frustrations which resulted from having a lack of control over the living environment. For example, residents talked about not being able to control the heating and the problems this created in terms of drying clothes.

Feelings of insecurity were also linked to the behaviours of other residents, with incidents of theft and violence widely reported by both residents and stakeholders:

*'When I went back, my room had been ransacked, like the lock had been smashed in. They'd been in and my baccy had gone missing, and this and that. Most of my food had gone missing as well'*

*'People were getting their door kicked in, it was really horrendous, like. All I had was my clothes, and I had a cheap telly, and the (inaudible) box because I knew that there was no security there. But there was people maybe had left their girlfriend, and they would bring all their stuff so they would have a lot of, like, computers or flat screen TVs and they were getting broken in to'*

*'There was one guy came in and complained that he'd actually laid in bed scared stiff because he heard somebody come into his room and go and take money out of his'*

*drawer and there was nothing he could do about it...this guy was significantly bigger than him and he was scared of him'*

*'There was already a hole in his door he said, a big fist hole or foot hole through, and he says every time he glanced up from the bed he could see somebody looking through, must be eyeing up the room to see what they could pinch or whatever'*

*'I've been in there twice. Both cases with a member of my team to take a resident out of there to move into our accommodation. We actually moved the resident in without any belongings at all because his belongings had been stolen whilst he was in there. He was unable to report it to any members of staff'*

*'One guy went into this woman's room when she was asleep during the night and was rummaging around. So that unnerved her a little bit. He was gone the next day. He was evicted because he stole from somewhere else as well and the police got involved and they just arrested him'*

In some cases, residents had resorted to measures such as trying to barricade their rooms during the night and sleeping with their belongings under their pillows. One former resident said: *'I would have all sorts against my door, especially because there was a lot of drugs and violence - but especially with this guy, you know this "security man" because he would have a drink and he would be at people's door, wanting to fight'*. Others left the properties. One stakeholder reported: *'The lad spent one night in [name of hostel] and he came to us the next morning. He says he had his door put through twice that night'*.

There were frequent reports of the police being called to the properties, primarily for violence-related incidents (sometimes looking for residents, in addition to responding to residents). But some managers and residents were often said to be un-cooperative – some for fear of being perceived to be a 'grass':

*'There was somebody got beat up with a hammer, and then there was somebody got stabbed four times. And the police were called, and people who knew he'd done it, even the management knew, and there was nothing done'*

Commenting on the lack of management action in respect of anti-social behaviour, one stakeholder said:

*'The amount of clients that we've heard that have been physically assaulted and nothings been done by management in whatever way, shape or form'.*

Often, these behaviours were drug and alcohol fuelled. Coping with the level of drug and alcohol use within the properties is challenging, particularly for those who have suffered from alcohol-related problems themselves. Stakeholders sympathised with this, saying: *'It is appalling that even the hardened drinkers that we pick up off the streets and try and get them accommodation and give them a chance, are forced to live in such a small environment with 20 people who all do the same thing'*. Faced with this situation, several of the residents reported that they vacate the premises during the day and only return late at night. One former resident explained:

*'That's one of the reasons why I went out on a morning and come back late at night, so I could try and avoid these people, and when I come back, I would have to push through all these drunken people just to get to my room on a night time, and they're like, "Give us a pound, give us this, have you got this, have you got that?" and it was all, like when they were sitting there, it was like, the manager just let them sit and get drunk, basically. I would be freezing cold outside and stuff like that but I thought it was better staying outside in the cold, than staying in that place'*

Speaking about several residents that they had supported in the past, stakeholders commented *'I don't think the people that I've worked with have spent much time in the building, they just kind of sleep there and then go out during the day'* and *'He used to get up at the crack of sparrows to leave that building because he didn't want to bump into anybody else. He would get up and he would pack his bag and he'd take his belongings with him'*.

In several HMOs, residents were reported to have security roles. In one HMO, there was talk of a 'power clique' that operated in a quasi-management position. In another, one former resident talked openly about the abusive practices of a resident acting in this capacity:

*'There was a gentleman that lived there...the people that owned the place paid him to come and check people's rooms, but he was a drug addict and he was a bully, sort of thing, you know, he was using people's vulnerability to pick on them and beat them up'*



*and manipulate them. The turnover was horrendous because of this one guy. [The owner] used to come up the stairs and be abusing people verbally, because he was always drunk. It was crazy'*

Here, some residents reported feeling particularly vulnerable and powerless to make complaints. Not all residents have observed violence in the properties, however. One resident, for example, said: *'There's never any violence. Some people drinking, they do get loud when they're drunk, but there's not normally any violence'*. Furthermore, not all residents feel insecure living in the properties. When asked about their relationships with other residents, more positive responses included:

*'They're canny lads, and most of them have known me from...The one that runs it, I've known him for years. And other lads I've known for a while'*

*'Well they're all friendly, they're all friendly enough'*

*'They're alright, they're just like mainly old people...If you learn to get on, you're all right, you know what I mean'*

There were reports of residents looking out for one another. In one HMO, for those who fit in with a group of long-term residents – referred to as the 'knit' – it was reported that if anything was stolen from their room or someone tried to cause an argument with them, the group would protect them. The residents are said to bring food parcels back from services such as the People's Kitchen and will share the food out amongst the residents. They will also share alcohol and loan each other money. As such, the residents will help one another, albeit in a possibly dysfunctional manner: When residents have visits scheduled with their children, it was reported that the 'knit' will discourage them from drinking that day. One stakeholder commented that if they turn up for an appointment with a particular resident who has mobility issues and is not waiting for them in the reception area, another resident will go to let them know that the stakeholder has arrived and will help them downstairs to the reception. Residents will also go to the post office for this resident and collect his benefits for them. The stakeholder is not comfortable with this, but no problems around this have been reported by the resident. In another HMO, one resident reported to have become good friends with several of the other residents who all have low level needs and has started dating a resident:

*'There was a case where you'll either laugh or cry. I think if I cried I'd probably end up chucking myself out the window basically. Luckily on my floor, there's all nice people who I chat to and they're just all in the same, just trying to find somewhere to live as quickly as possible'*

They went on to say:

*'I'm starting to think of it now as home. I think it's because I know a lot of the other residents. There was this guy, he had some money problems and they were going to throw him out and all the other residents rang the manager and said, 'Look, we don't want him thrown out, can you not try and get him to...', you know, so they agreed that he'd pay a bit extra on his rent when he gets paid. So I think it's because I feel a bit settled because if it's about rent and things, I think the residents would kind of like club together and try and persuade the manager...'*

In one HMO, residents that have known the manager for a long time spoke positively about them:

*'Spot on. Obviously, he's a brilliant bloke, you cannot go wrong. If you're falling behind on the rent, he says pay me what you can't pay me this time, next time. So he is lenient. Obviously, if you do what he says and the sort of thing, he'll respect you more'*

*'The manager was good though. He was all right with me. I cannot say anything about him towards me. He was spot on'*

In another HMO, residents discussed a high turnover of managers in a short space of time, with highly varied attitudes towards residents and the management of the property:

*'She was a resident and then they employed her and she was very sympathetic to people's situation, but I think she had to leave because the owner realised all the rents weren't getting paid. [They] brought some guy in and basically he was a bully. If he didn't like you, "Out you go" and he would literally use force as well to get people out. But then he went...he's manager somewhere else now. The manager now is a nice guy because he'll sit down and try and help you but he only comes once or twice a week, usually if there's someone new coming. And then you've just got the rent guy who approaches everything as, "No, I haven't been authorised to do it so no". The owner...all he's concerned about is people paying on time'*

Several residents, from one HMO, in particular, reported problems with residents from the local community. One resident said: *'They get bother from people who live on the estate. They go out and have a drink, go round and pick on the lads from [name of HMO], like the vulnerable ones...they tar them all with the same brush, you know what I mean?'*. Another said: *'They would like shout things at you, like, "You tramp, you smack head" and stuff like that, "You alcoholic" and stuff like that, and I thought to myself, well, I'm no different to you, really. You could be in here one day'*. But, this experience was not widely reported.

### **The Impacts of Living in HMOs on Wellbeing**

It has long been recognised that residential environments are a key determinant of wellbeing, with literature from a broad range of disciplines evidencing a link between housing and other attributes of life, such as physical and mental health, social relationships, life satisfaction, self-esteem and identity (see, for example, Pearlim et al, 1981, Ineichen, 1993, Dunn, 2000, Francescato et al, 2002, Krieger and Higgins, 2002, Evans et al, 2003).

The relationship between housing and physical health has been most extensively investigated. Research from the field of public health has shown substandard conditions (such as damp and moulds), poor food storage and cooking facilities, indoor temperature, pests and ventilation to be associated with increased morbidities (Ineichen, 1993). Indeed, both residents and stakeholders made similar links.

It is difficult for the residents to maintain a healthy diet, due to the nature of the food storage and cooking facilities. The residents reported problems sleeping due to noise levels within the properties. Here, one said: *'Well, it's okay, but it's a bit noisy. Because my room...where my room is situated, it's got like stairs, next to it. And I can hear them going up and down the stairs. Well, they don't walk up, either stamp up or run up, you know, and you end up with creaking in the floorboards, you know, I hardly get any sleep. I get round about five hours kip of a night'*. Residents drew attention to chest problems as a result of indoor temperature, ventilation and damp. Others discussed skin irritations as a result of insect bites. One stakeholder was particularly concerned about the physical (and mental) health of a resident they were engaging with due to a lack of support within the HMO: *'I wouldn't be surprised to see [name of resident] back in hospital, because in my opinion he is starving himself. He's not eating properly. He doesn't have anybody there saying 'Come on, have a dinner or whatever'. Personal choice, you could argue that one. Whether he's got capacity to understand fully what he's doing, you could argue that one'*.

Physical health complaints were more likely to be reported, however, as a result of addictions, which were almost universally reported to increase while living in HMOs, as a coping mechanism for the poor physical and psychological conditions within the properties, the influence of other residents and the lack of support available. Feedback included:

*'The individual that we have, still have as a resident actually, has commented on a number of occasions how it was bad for him and he felt he was going to be starting to relapse into drug use again because of the amount of druggies within that particular provision'*

*'[Drugs]...it does make it worse because when you're actually, like, living there and you can't keep yourself to yourself - you just cannot keep yourself to yourself'*

*'Bad. More the young'uns where they've got into drugs. The prisons have more or less washed their hands, so they've went deeper into drugs and ended up in here. It's a lot of depression and basically the residents. You get in with your clique, and you think 'ah this is great'. you just, any sense of morality goes out the window'*

*'I started hitting the drink and...it was just, like, I would come home from work and the first thing I'd do is go to the shop and get a couple of cans of beer...before that, I'd been pretty good, I'd done really well. I'd been abstinent from alcohol and drugs for eight years until I moved in there and then I started really hammering the drink, and through hammering the drink I did eventually lose my job, because I turned up hungover one day and they could smell alcohol'*

Interestingly, however, one resident managed to reduce their alcohol intake while living in the property, having witnessed the effects of alcohol on others and not wanting to get into arguments with other residents. They explained:

*'To be honest I never touched a drink in there. If I was having a drink, I'd go out but I'd not drink in there. And people couldn't understand, 'I go "if I drink in here and sit in here, if you say the wrong word it'll kick off". I'd rather go out and come in and just get in my bed. And I did have a little bit of a drink problem. But it seems funny how I moved in there with a drink problem and I stopped drinking. I know would happen when I've had a drink, there would be conflict or I'd kick off and it's not worth it. I'd just stay off. If you had*

*a drink or drug problem and you moved in there, you can drink as long as you want – any time you want. So that wouldn't help you. It wouldn't'*

Another point is that some participants reported increases in drug and alcohol intake while living in the HMO, but didn't acknowledge this to reflect a decrease in their wellbeing.

Much more concerning, however, were the reported impacts of living in the properties on mental health (for a comprehensive review of literature on the relationship between housing and mental health, see Evans et al, 2003). Widespread reports of depression were linked to coping with the physical property conditions, the difficulties of maintaining personal hygiene, coping with the dependency-related behaviours of other residents, fears over personal safety, noise and lack of control over the environment and the future, more broadly. This last point is particularly important. Pearlim et al (1981, cited in Phillips et al, 2005: 278) poignantly wrote that one reason why poor environmental factors adversely affect people's wellbeing is that these stressors constantly provide *'inescapable proof of their inability to alter the unwanted circumstances of their lives'*. Feedback from residents included:

*'It's made us ... you feel low. You get that low feeling about yourself. Can't really explain how you feel because it's ... it is, it's hard to explain like, it's just disgusting and you're disgusted in yourself for letting you get there'*

*'I was just really depressed where I was living. I was really down...I couldn't see any future, do you know, it was a really depressing place and intimidating and like I say at night time and stuff it's not, you couldn't really sleep properly because you're always worrying about your door going in and the people that were there'*

*'It just felt that there was nothing really, like, living for and stuff like that, but like now that I don't ... It was just 'cause the lifestyle staying there, and like, people around you (inaudible)'*

*'Just felt depressed. How would you put? Depressed. No motivation to do anything really, apart from...to try to get out of there. But actually being in there, I just went to bed all the time, just lay in my bed and watched the telly and all that day in/day out'*

*'I feel every day was just the same thing. From morning til noon til night, I knew everywhere I was going on that day, I knew exactly what I was doing, so...You haven't*

*got no life, you cannot plan something, the rest of your life, staying in there. I had a monkey on my back, like'*

*'I would try and sleep as much as possible because it was a really depressing place. If you went out, just the thought to be going home...there was quite a lot of drugs, alcohol and violence, basically. It was really horrible and it did affect us. I sort of lost self-esteem and motivation'*

*'Depression. It was just life's situation basically. When I first went there though it was actually pretty bad because there was a lot of drunks living there and they would cause a fight. A guy got beat up outside my mam's door a couple of weeks after we moved in and that really unnerved her. I had some guy with learning difficulties next door to me and he'd always be knocking on my door'*

Stakeholders also commented on the mental wellbeing of the residents that they were engaging with over time:

*'The noise in the evening of people drinking outside the door, they felt very threatened. Anybody suffering with mental health, with potential PTSD, that affects them pretty badly and they don't feel as though they're in a safe environment and that's very key to us. '*

*'He used to come and see me, he would describe the conditions as he saw them, he would very clearly express how unsafe he felt there and it very profoundly had an effect on his mood and his sense of wellbeing, he was significantly depressed as a result of it. He did find it increasingly challenging, to do the Tuesday look at the adverts for properties, and all that kind of things. He became less and less able, to negotiate the allocation system, within Your Homes, because his mood had got worse and worse. I think he started to drink heavier, either because drink is so freely available or because his worsening mood led him to rely on alcohol more, to blank things out. So he was definitely in danger of falling into a downward spiral, through being housed there or housing himself there'*

One resident reported that their mental health improved when those with more complex needs high risk behaviours moved out of the HMO, while several residents and stakeholders reported similar effects when the residents that they were supporting move on to another form of accommodation. One resident reported, *'Once I got out of that environment, it was, it was a big relief and I stayed at a friend's house for about a year, and I was back to, I stopped drinking*

*again and I ended up in a Salvation Army, and I relapsed' , while a GP commented, 'He eventually found a property and moved out. He has managed to reduce his alcohol consumption and I think, as a result, his mood has recovered to a considerable degree. I think he's doing fine now'*

Several said it was difficult to maintain relationships with family and friends whilst living in the properties. Typically, residents are allowed family and friends to visit during the daytime, but they must stay in the communal areas, which are noisy and lack privacy. Others said they were embarrassed about where they lived so would not have visitors to the properties:

*'My friends, I would be embarrassed to tell them that I was living in [name of HMO]. I would be really embarrassed. One of my best friends who came up to visit me, he had a confrontation with the guy, the 'security man', so he never came back. So, yeah, nobody would come round. I would try and stay out of the property as much as possible, but you can only impose so much, do you know'*

*'I've got to go to Ashington to see them, because I don't really like to have them down here. Just made me distant...now I'm over here it's like very distant, you know what I mean'*

*'I was embarrassed to let anybody go there and see where I was living in and that. I didn't even tell them where I was living, man. I would tell my, my brother's going, "Where are you living?" "I'm not telling you". It affected it a lot, even getting girlfriends. I felt I couldn't get a girlfriend because if she asked, "Where do you live?"'*

Perhaps counter-intuitively, some found that living in the properties had a positive effect on their relationships with others, as they would see their family and friends more. Indeed, spending more time with family and friends – for those residents who were still in contact with them – played a key role in mitigating the impacts of living in the HMOs on their wellbeing. One resident rekindled their relationship with their family following the family hearing about his living conditions.

Just three residents discussed their experiences of employment while living in HMOs; all of whom had different experiences. One resident lost their job as a night porter while living in the

HMO, following relapse into addiction. Another reported that living in the hostel made it difficult for them to find and secure work, due in part, to the difficulties of staying clean and well presented:

*'I was working when I was with my lass and stuff like that and when I went to [name of hostel], that's when I wasn't. Because everything wasn't clean. I like to be clean and tidy going to work and all that. It was just a nightmare. There was no iron there; no nothing. It was just...The washer there was an old twin-tub thing. At that point I didn't care because like I'd split up with my lass, I was with her for five year and I just couldn't be bothered about myself, really'*

Finally, one resident reported that as a result of becoming homeless following eviction from social housing and moving into a HMO, they had begun engaging with a range of services, including mental health, financial advice and employment support and were motivated at the point of interview to establish a career for themselves. They stated: *'For a while, I just felt really lost and didn't really know where I belonged. But now, I'm actually starting to look at it as being a positive thing, because I'm changing my life. I've met a lot of people from different backgrounds and that's something that I think is good, especially for what I want to do. Even if I just do voluntary work or Citizens' Advice or somewhere like that, I want to help people'*.

Particularly important to note is that the majority of residents reported that the psychological and social property conditions were more detrimental to their wellbeing than the physical state of the properties.

*'It was really the social. I don't mind living where someone else is living, but I can't live where someone else is taking drugs and drinking and that, 'cause that's not helping me. So that was the worst thing'*

*'I think the one about feeling secure and things. It's always there that it's a hostel and I know you can stay there over a year but the initial contract is a year and it does say that the contract can be cancelled at any time by the owner and that's always in the back of your mind. You're scared of complaining sometimes because if it gets back to the owner, he might put you out. So I think it's just being feeling unsettled. I think that's the worst thing about it because you know that it's not your home'*



Stakeholders agreed that the psychological and social conditions within properties are of equal importance to the physical properties and the effective management of these conditions is something which they strive for in the supported accommodation sector. Yet, the importance of this is still largely neglected in discussions about academic and applied discussions of housing quality – particularly in respect of the private rented sector.

### **Engagement with Services**

Only a small proportion of the residents interviewed were engaging with services; primarily probation, adult services and mental health. Equally, stakeholders from these and one homelessness organisation said they were working with clients living in HMOs. It is thought that most of the residents of HMOs are registered with a GP, although the extent to which they actively engage is unknown. Eight of ten residents interviewed are registered with a GP and in one HMO, a resident stated: *'Yeah, a few people that live in the hostel, they're registered with this doctor's surgery. I actually think one of the guys I live with, I think he's on commission for the doctor's surgery because the minute anyone walks in it's like, "There's a good doctor's surgery down the road and there's a nice park down that way"*. It is likely that few residents, however, are registered with a dentist. Just three residents interviewed are registered with a dentist. One resident jokingly said *'I don't see the point, I've only got a few teeth'*, while another said *'I'd say 40% of them don't know what a toothbrush is'*. Some residents are known to attend crisis support services such as the People's Kitchen and food banks. None of the residents interviewed reported to be engaging with addictions services and just one was said to be actively looking for work with the support of an employment provider.

The research was unable to identify any support services that provide formal in-reach within the hostels. None of the support services engaged with through interview have partnership arrangements in place with HMO landlords. No posters or information leaflets signposting individuals to relevant services were said to be on display in the properties.

Stakeholders reported that it can be difficult to maintain contact with clients living in HMOs as it is difficult to know whether letters reach clients, there are no support workers present in the HMOs to encourage residents to attend appointments and residents often do not have mobile phones or frequently change their numbers. Stakeholders reported mixed receptions when

attending the properties and several said they do not feel safe visiting the properties. This is in part linked to the difficulty of distinguishing between staff and residents. They said:

*'There wasn't a general feeling of security in the building, I didn't personally feel safe and I've worked in prisons, in hostels for eight or nine years now. We carry an alarm and mine was on amber alert all the time I was in that building. It was just the feeling of chaos'*

*'I couldn't actually make any distinction as to who was staff and who were clients; nobody was wearing name badges, they weren't smartly dressed, they're quite dishevelled looking. The person that identified as a member of staff wouldn't speak to us...it was a very much, non-aggressive stand-off'*

*'The communal areas downstairs will often have people in it and it can be very difficult to work out who everybody is; are they residents? Are they staff? Are they people who've dropped in from outside? So there's something about not knowing who's there. What are they doing here? Are they meant to be here? Do they know why I'm here? All that kind of thing; that produces a slightly unsettling atmosphere'*

Some stakeholders have been asked to leave the properties after asking questions about the wellbeing of residents. One housing stakeholder reported a particularly negative encounter with a manager, where they were warned to stay away from the residents. Several residents also withdrew from working with the stakeholder for fear of eviction. It was clear that the manager felt threatened by the work of the stakeholder:

*'The managers always refuse to give references for housing applications, so I have to liaise with the housing office about the fact I can't get a landlord reference. One day, the manager rang me and threatened me about going on the premises and taking his tenants and stuff away'*

Recalling another bad encounter several years ago, one stakeholder said: *"This fella was ill, he had a brain injury and he was limiting his intake of alcohol at that point; rather than having a fit in the morning, he had a can of lager to straighten himself out. I took him down in my car, helped him in, he was very unsteady on his feet. I don't know if it was the Manager, but he says, 'Get that fucking cunt out of here now. And I says, 'I beg your pardon?'. The man's got physical health problems. He went, 'F\*\*k off'.* This agency has not referred residents to the property since.

As such, these stakeholders expressed concern that the primary motivation of landlords for running HMOs is financial gain; a strikingly different motive from those working in the homelessness sector. One stakeholder was particularly impassioned about this and said, *'I think we, as managers in [name of organisation], we work for [name of organisation] because we believe in what we're doing. I think if I was put in that place, I wouldn't be working there'*.

None of the services engaged with actively promote their services to HMO residents specifically, but said they would be happy to consider this in the future, agreeing: *'It is important that residents do not fall 'through the gap' or become invisible to relevant services'*. The difficulty, however, is working out how to engage with long-term residents who are thought not to be engaging with services. As stakeholders commented:

*'These people don't exist, they're completely out of the system'*

*'The problem is that the people that you're going to miss are the people who don't access services, and they're probably going to be the more entrenched people who have been there a long time...they tend to be older and maybe they're just drinking. I think the ones that are more transient are still accessing services and the services are trained to help them in different ways'*

Some services have tried building relationships with landlords, but without success. One stakeholder described the hostel world as an *'almost impenetrable force'*. Some GPs in the area operate Locally Enhanced Service (LES) schemes for homeless people, whereby practices make adjustments around requirements for documentation when people register etc. The GP stakeholder interviewed suggested that LES schemes could be extended to include HMO residents if relationships with landlords could be developed.

Pockets of good practice are emerging across the North East, however. For example, one homelessness charity has managed to develop relationships with two HMO landlords in Sunderland (work may be extending to Stockton and Middlesbrough also) and is providing in-reach to residents. They are also offering training to the landlords around safeguarding, for example, and are supporting them to improve their property conditions and management practices. In thinking about how this model could be applied elsewhere, the stakeholder suggested that the success of the model was due to helping landlords to understand that the focus of in-reach support is the wellbeing of residents – not simply 'move on' or enforcement action. No judgements or emphasis was placed on the quality of the building. This support could

include helping residents to use Personal Independent Payments, for example, to pay off some of their rent arrears to private landlords. The stakeholder confirmed that the landlords were concerned about the financial implications of residents moving to other forms of accommodation, but were not fundamentally opposed to residents addressing their health needs, for example. This suggests that financial gain is not the sole objective of HMO landlords. The peer methodology used to develop relationships with landlords was also felt to play a role in the success of the initiative, putting landlords at greater ease about partnership working. The organisation has offered the landlords some resources from the Homelessness Transition Fund (Single Homeless Fund from April 2015) to improve the security of the premises, through CCTV, for example. In two local authority areas, posts have been funded in the past year or so, with the post holders tasked with working with HMO and B&B landlords to improve physical property standards and support the wellbeing of residents.

A key issue of debate is the level of 'duty of care' towards residents that can be reasonably expected from landlords. There were mixed opinions amongst stakeholders about this. Some were clear that HMOs are residential properties. They do not operate as supported accommodation, nor do they receive comparable levels of funding. As such, it is not reasonable to expect landlords to provide the same quality of accommodation or range of services to residents as other forms of accommodation. Staff within the local authority calculated the level of income achieved by one HMO, based on occupancy figures. They reported to be shocked at how little surplus was generated. They commented: *'[name of hostel], just how little money it generated, really, compared to say, you know, [name of organisation], which would probably have got an extra £200,000 a year to deal with that same client group, so it was next to nothing. It really was just rent and housing management and no support'*. They went on to suggest: *'They do know their clients very well and they know what to do, it's just how much you can expect them to do when they don't get the additional payments, and it might be that if they were to have more funding they might actually be inclined to do more'*

Nonetheless, HMOs provide accommodation to a potentially high volume of people, with complex needs. As one stakeholder pointed out: *'It's always been ironic that probably the most high needs [and quite high risk] clients end up somewhere like that. Yet, the role of the hostels is simply to provide residents with accommodation to meet their most basic needs, as opposed to care and support'*.

## **Conclusions and Recommendations**

This project has generated important insights into the lives and experiences of people living in private hostel-type accommodation in Newcastle. Broadly speaking, the research indicates that a significant proportion of those living in large HMOs are likely to have multiple and complex needs, with the physical and mental health and substance misuse needs of the residents being particular concern. It is also likely that a significant proportion are not engaging with relevant support services. This is worrying in the context of living in a residential environment, whereby poor physical property conditions, feelings of insecurity, lack of privacy, comfort and control, the dysfunctional behaviour of other residents, unorthodox management practices and an absence of any professional support, are likely to be of significant detriment to their health and wellbeing. In this respect, it could be argued that the residents of large HMOs are more vulnerable than those living in other forms of housing, including supported accommodation. The needs and experiences of residents remain largely unknown and unrecorded, they fall largely outside the purview of official government statistics and public services and they are protected by a complex and fragmented national regulatory system which was recently described as narrow, weak and under-resourced (Rose and Davies, 2014). The research also highlights the stark degree of contrast between privately-run large HMOs and well-run, properly regulated voluntary sector hostels where residents are supported to gain the skills needed to move on. More broadly, problems surrounding HMOs exist because the definition of homelessness remains too narrow and due to the absence of the robust monitoring of single homelessness. Furthermore, if health and wellbeing is the over-riding goal of public policy, definitions of housing quality should not stop at whether a property is inhabitable, but whether housing plays an enabling role in people's lives (King, 2009; Clapham, 2010).

The aim of this research was not to suggest the closure of large HMOs. As the research indicates, they play an important role in the local housing market. Their closure would be likely to have an impact on levels of homelessness and place additional pressures on the local authority and supported accommodation providers, as well as a range of other services. It is also true that some of the long-term residents now consider these properties to be their homes. The research did seek, however, to identify a number of possible policy and practice changes to help improve the management and regulation of the sector and the wellbeing of residents. It is important to note that several of the recommendations outlined lie beyond the control of the local authority. The following recommendations are suggested:

- Homeless Link and other relevant organisations campaign to encourage central government to reconsider the minimum standards which private HMO landlords must adhere to, in order to ensure proper protection for those living in large HMOs.
- Central government review the scope (and application) of the ‘fit and proper’ person test in respect of large HMO landlords and managers.
- The local authority ensures the pro-active enforcement of licensed premises legislation, as far as resources allow.
- The local authority considers extending the application of Additional HMO licensing, to improve the poorest conditions and behaviours of landlords/managers.
- The local authority and relevant support services seek to improve awareness amongst all agencies that may be making referrals into large HMOs of the nature of these properties.
- The local authority and relevant support services consider what incentives could be used to encourage landlords to improve their properties and management practices.
- Commissioners actively encourage and support the voluntary sector to develop relationships with landlords/managers and deliver ‘in-reach’ services to HMO residents.
- The local authority seeks to improve awareness amongst key services about how to inform regulatory services about any concerns which they have about HMO property conditions, management practices and the wellbeing of residents. Equally, key services and support workers (particularly, police, probation and mental health) should be more proactive about advocating on behalf of residents.
- Information resources for HMO residents are developed about minimum standards, how to complain if these are not met and how to access help to move on other forms of accommodation and address their needs.
- The local authority and relevant support services offer landlords/managers support and training on topics such as safeguarding, benefit, housing legislation and the management of risk.

- The North East Regional Homeless Group, Homeless Link and the Department for Communities and Local Government seek to develop a more pro-active system for monitoring (and limiting) out of area placements into HMOs by other local authorities.
- Public health places a greater emphasis on tackling the health problems of vulnerable people living in the private rented sector, through the dedication of resources and appointment of staff, tasked with developing relationships with private landlords and providing in-reach services to residents.

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