Housing, Homelessness and Health

The Standing Conference on Public Health

Working Group Report

The Nuffield Provincial Hospitals Trust

SCOPH Members

Association of Community Health Councils for England & Wales

Association of Directors of Social Services

Association for Public Health

British Dental Association

British Psychological Society

Chartered Institute of Environmental Health

Faculty of Occupational Medicine of the Royal Colleges of Physicians*

Faculty of Public Health Medicine of the Royal Colleges of Physicians

Health Visitors' Association

Institute of Health Services Management

National Council for Voluntary Organisations

National Institute for Social Work

Royal College of General Practitioners*

Royal College of Nursing

Royal Institute of Public Health & Hygiene

Royal Society of Health

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Society of Public Health

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Acknowledgements

We should like to thank the Trustees of The Nuffield Provincial Hospitals Trust whose financial support of our vision of multiprofessional collaboration enabled the establishment of the Standing Conference on Public Health (SCOPH), a forum of national organisations of health and social care professionals. SCOPH was set up in 1992 in order to: identify issues of common concern and publicise consensus views; promote multidisciplinary education and training; identify research needs; and disseminate knowledge and good practice in public heatlh.

This is the first major report to be produced by SCOPH, whose working group on housing, homelessness and health is a concrete expression of this vision of multiprofessional collaboration, and we should again like to thank the Trustees of The Nuffield Provincial Hospitals Trust for graciously undertaking its publication.

Warm thanks are also due to Medical Imprint, a subsidiary of Haymarket Medical Communications, who, in an unusual collaboration between commercial and professional interests, have generously provided support for SCOPH's activities during the current year.

The uniqueness of this paper stems from the broad range of professional perspectives provided by the members of the working group. Thanks are due to the SCOPH bodies for selecting and supporting the participation of such excellent representatives, and to Professor Susan Smith, Mike Ashley and Kenny Macdonald who gave their time to this effort without being affiliated to a SCOPH member. We are also grateful for the advice and comments received from various individuals in the housing, academic and financial sectors. Finally, a special vote of thanks goes to Phillida Cormack, secretary to SCOPH, for her meticulous and untiring efforts in the production of this paper.

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> *"Public health is the science and art of preventing disease, prolonging life and promoting physical health and efficiency through organised community efforts for the sanitation of the environment, the education of the individual in principles of personal hygiene, the organisation of medical and nursing service for the early diagnosis and preventive treatment of disease, and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health."*
>
> Charles-Edward A. Winslow. The Untilled Fields of Public Health, *Science 1920*; 51:23.

The Standing Conference on Public Health is an organisation of professionals that deals with the entire spectrum of concerns defined above so eloquently by Winslow as public health.

SCOPH's concern with the impact of inadequate housing and homelessness on health led it to set up a multidisciplinary working group to take a fresh look at the complex issues involved. Its aim was not to create another research paper cataloguing the problem areas needing funding, but rather, using the body of existing research, to highlight the causal links between inadequate housing and ill-health and to make practical suggestions for improving the housing and care of vulnerable people.

Case studies highlight some of the gaps that were found between stated policy and practice and some of the inconsistencies and internal contradictions among the policies of different departments.

Three fundamental conclusions have emerged:

1. *The link between inadequate housing and poor health*
   There is a demonstrable link between bad housing and poor physical and mental health.

   Recommendations
   The costs associated with these health effects should be weighed against the costs of providing decent housing. Health services for homeless people should be accessible and their distinctive needs should be routinely assessed and provided for.

2. *Inadequate supply of decent, affordable housing*
   The gap between the supply of, and the need for, affordable rented accommodation seems stubbornly fixed at around 100,000 units[1] and current policies are doing little to reduce this. In addition, many homes in occupation are unfit or will soon be so because of lack of maintenance.

   Recommendations
   Government priorities must be changed to increase the supply of decent low-cost rental accommodation by:
   a) an intensive programme of renewal of existing stock;
   b) transfer of empty government properties to the social housing stock, and incentives to bring empty private sector homes back onto the market;
   c) giving local authorities the right to invest receipts from council house sales in new build schemes;
   d) grant aid for the provision of houses in multiple occupation (HMOs) of a decent, monitored standard;
   e) reinstating housing association grant rates to pre-1993/4 levels.

3. *The need for preventive social care as well as health care*
   Health, social services and social security providers need to work from a shared information base, in order to identify the most vulnerable groups and stem the downward spiral into illness, personal or family disintegration and homelessness.

   Recommendations
   Policies should be changed as necessary to permit and encourage collaborative responsibility. Providers should be permitted enough flexibility in the use of existing remedies and resources to unlock the benefit-dependence poverty trap.

1. The Context

The working party was created to consider appropriate strategies for identifying and tackling the health and welfare problems associated with adverse housing conditions and homelessness.

1.1 The problem

The lack of good quality affordable housing for people on low incomes has created two interlinked problems:

1. *Substandard, unhealthy dwellings which take a heavy toll on the health of the occupants, particularly children, with attendant costs for the National Health Service (NHS) and social services, as well as the long-term health of the nation.*

2. *An increase in undesirable situations associated with insufficient accommodation ranging from rooflessness, temporary accommodation and double households with overcrowding, to unsuitable sharing arrangements, eg children in parents' bedroom.*

Homeless and incipiently homeless people are not only marginalised by the housing service, but tend also to slip through many other parts of the welfare net. One key source of concern in recent years has been the distinctive health profile of the homeless population, which is associated with low incomes, inadequate living environments and limited access to primary medical care. Not only is the health of homeless people put at risk by their living space and their position in the welfare hierarchy, but people with special health and mobility needs are disproportionately vulnerable to becoming homeless in the first place.

A focus on housing is important in any discussion of homelessness and health for three reasons:

1. *Most commentators trace the recent rise of homelessness to far-reaching changes in the organisation of housing provision (Murie 1988).*

2. *Housing and homelessness are not two discrete states but rather two ends of a continuum. People who are disadvantaged by the housing system are sometimes housed and sometimes roofless: in between are a variety of arrangements from over-crowded low-income owner occupation to a cardboard box under Waterloo Bridge.*

3. *Social housing in Britain has a track record of 150 years of effectiveness as a health intervention, and could easily be geared up to meet current health and welfare needs if the health, social and economic benefits of such a strategy were recognised politically.*

1.2 The historical context

The Industrial Revolution led to a vast migration of workers to cities, a doubling of the population of Britain and the emergence of squalid slums. It was with the introduction of civil recording of births and deaths that the devastating effect of these living conditions became apparent, spurring Victorian reformers such as Sir Edwin Chadwick to take action.

In 1838 Chadwick chaired the Poor Law Commission which recognised the association between poverty, sickness and death in its 1842 'Report on the Sanitary Conditions of the Labouring Population of Great Britain'. In 1849 John Simon in his first annual report as Medical Officer of Health (MOH) of the City of London analysed the sanitary state of the City, implicating in particular water supply and housing and social conditions in the high mortality rate.

These reports, among others, paved the way for the Common Lodging Act 1851 and the Labouring Classes Act 1851, which allowed for inspection, supervision, and operation of lodging houses for working class families. The Torrens Act 1868 put the onus for repair on the owners of property and gave the MOH the power to enforce repairs at their expense.

In 1857 the MOH of Whitechapel referred to overcrowding as "the monster evil", and in 1874 the Royal College of Physicians passed a resolution to write to the Prime Minister about the causal link between overcrowding and disease.

The fear generated among the Victorians by the disease and social degeneration spawned by the urban slums acted as a spur to dealing with poverty and housing alongside health issues and, by the end of the century, considerable progress had been achieved in sanitation. However there was still much to be done with respect to housing and air pollution.

In 1862 the Peabody Trust was set up to build homes for workers at reasonable rents. This approach was echoed in model towns in Merseyside and Yorkshire, although, together with municipal housing, they accounted for less than 1% of the housing stock[1].

It was not until after the First World War that the need to provide homes for the returning soldiers spurred local authorities to embark on a massive building programme of 'homes fit for heroes'. These sturdy houses accounted for one-third of all new homes built between the wars.[1]

With the inception of the NHS in 1948 and the shift of responsibility for housing to the political arena, the previously inseparable links between housing and health were split. The post-war building programmes of the 1950s and '60s concentrated on quantity rather than quality, and laid the foundation for many of the health and social problems that afflict some of these council estates today.

The World Health Organisation's Healthy Cities programme, together with mention of the need for healthy homes in the Government's white paper, The Health of the Nation, and the research programme announced recently by the Chief Medical Officer for England, Dr Calman, on the links between ill health and poor housing indicate that we are starting to

come full circle in acknowledging the causal links between poor housing and poor health.

The experts acknowledge that there is simply not enough decent, low-cost rental housing available in this country, a deficit that has become more acute over the last decade as the rationale for housing interventions appears to have slipped down the political agenda.

The gatekeeping policies indicated recently by the Department of the Environment in its consultation paper, Access to Local Authority and Housing Association Tenancies (1994), will do very little to alleviate the underlying deficiency. Their reliance on the private sector to take up the slack in providing low-cost rental housing for people on low incomes runs the risk of ignoring the lessons of history.

1.3 A HEALTHY HOUSING POLICY

An acknowledgement of the importance of the social role of housing is particularly appropriate in the context of recent changes in the National Health Service including those surrounding community care. The Health of the Nation White Paper (1993) has illustrated a shift of emphasis in public health policy towards health promotion, disease prevention and strategies for enhancing care. These new directions are marked by policies that assign a greater role to individuals, communities and the private sector.

The Health of the Nation defines England's strategy for health in terms of creating a health dimension to all public policies, and calls for healthy alliances to secure healthy surroundings and to promote healthy lifestyles. Housing and health would seem particularly well-suited to such healthy alliances, since the British social housing system was designed to be explicitly 'health-selective' and to ensure that people with health problems are accommodated in locations with suitable access to care and support.

An adequate stock of affordable good quality housing would make a significant contribution towards, for example:

- *facilitating community care;*
- *improving employment prospects by facilitating geographical mobility;*
- *relieving some of the burden on the health service of physical and mental illnesses associated with cold, damp and inappropriate housing and overcrowding;*
- *reducing accidents that are a consequence of poor design, lack of facilities and inappropriate location;*
- *improving child development.*

The paradox of housing and health policies in the 1990s

Between 1979 and 1987 public expenditure on housing fell by more than 50%. The large-scale sell-off of council houses has further reduced the social housing pool, seriously undermining the efficacy of the social and health care role for housing provision. Commercial rather than social contracts now dominate the housing system and the scope for meeting health needs through housing provision is limited. Indeed, a residual public housing sector has become the welfare arm of the housing system at a time when its character, quality and condition make it least suited to that role.

These changes in the structure of housing provision help explain not only why homelessness is on the increase, but also why sick people are becoming and remaining homeless and, indeed, why marginal housing environments are increasingly unhealthy. It is ironic that these changes should be taking place just at a time when health policy is creating an opportunity for housing interventions to contribute more actively to the public health agenda.

The situation at present is that those people in most need are accommodated in the worst housing or do not have any housing at all. The use of housing finance to enhance the attraction of home ownership rather than to enhance the supply of affordable accommodation in all tenure sections has led to great inefficiency which has had repercussions for all sectors of society.

While interventions clearly need to be assessed carefully for cost-effectiveness, it is essential to take into account not only the costs that appear as budget items, but also the more long term but less visible health and social costs that are expressed in terms of quality of life and the effects on the next generation.

2.1 Housing Stock

The figures here relate primarily to England's and Scotland's housing stock, including the impact of unfit houses and obsolete houses:

Stock of Housing (December 1992, United Kingdom):		**23,878,000**	
By tenure:	owner occupation	15,792,000	66·1%
	private rented accommodation	2,280,000	9·5%
	housing association	816,000	3·4%
	new towns, local authority	4,990,000	20·9%

Source: Housing and Construction Statistics

Condition of stock

England

The most recent English and Scottish house conditions surveys[1, 2] were carried out in 1991 and the findings were released in 1993. The English House Conditions Survey's report presented a profile of England's housing stock by use, age, available amenities, state of repair and the socio-economic status of residents*. The fitness standard used in the 1991 survey was designed to link unsatisfactory housing to the health and safety of occupiers.

A dwelling is 'unfit for human habitation' if it fails to meet any of the criteria in the fitness standard below[3], ie it must:

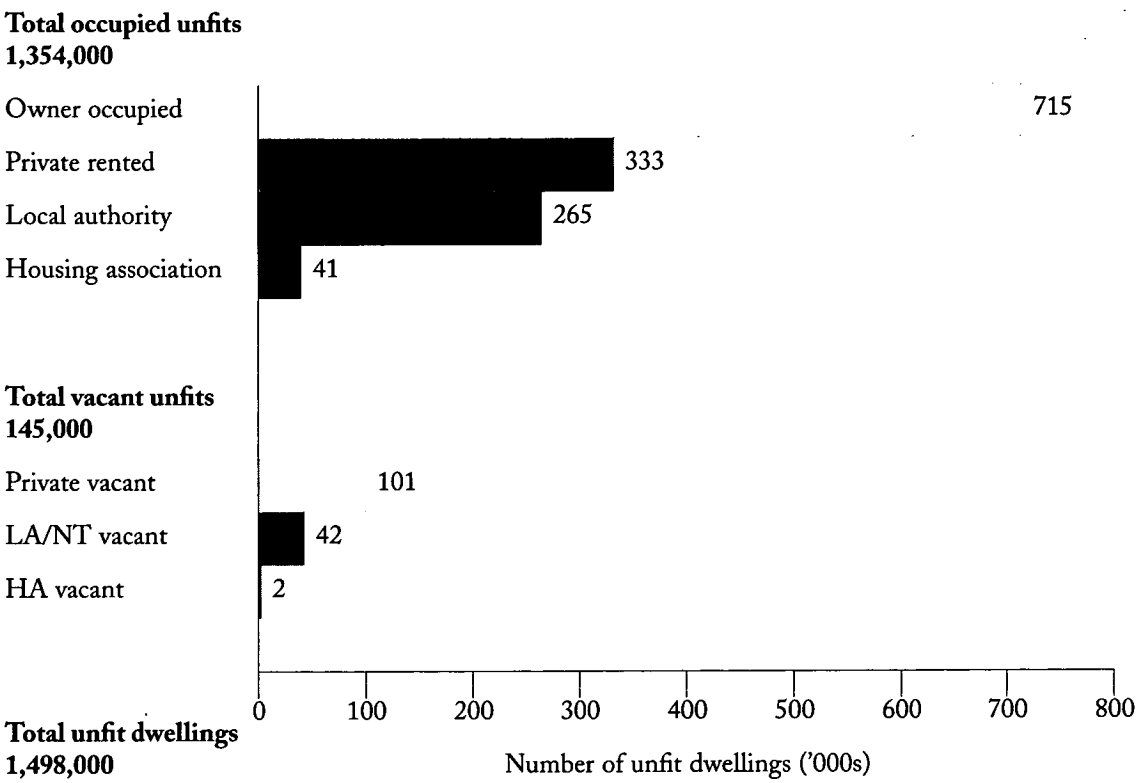
- *be structurally stable;*
- *be free from serious disrepair;*
- *be free from dampness prejudicial to the health of the occupants (if any);*
- *have adequate provision for lighting, heating and ventilation;*
- *have an adequate piped wholesome water supply;*
- *have satisfactory facilities in the dwelling-house for the preparation and cooking of food, including a sink with a satisfactory supply of hot and cold water;*
- *have a suitably located water-closet for the exclusive use of the occupants (if any);*
- *have, for the exclusive use of the occupants (if any), a suitably located fixed bath or shower and wash-hand basin each of which is provided with a satisfactory supply of hot and cold water; and*
- *have an effective system for the draining of foul, waste and surface water.*

Total Number of Unfit Houses in England: 1,498,000

The English House Conditions Survey indicated that the highest proportion of unfit properties was found among the oldest houses (those built before 1919) and those in the private rented sector.

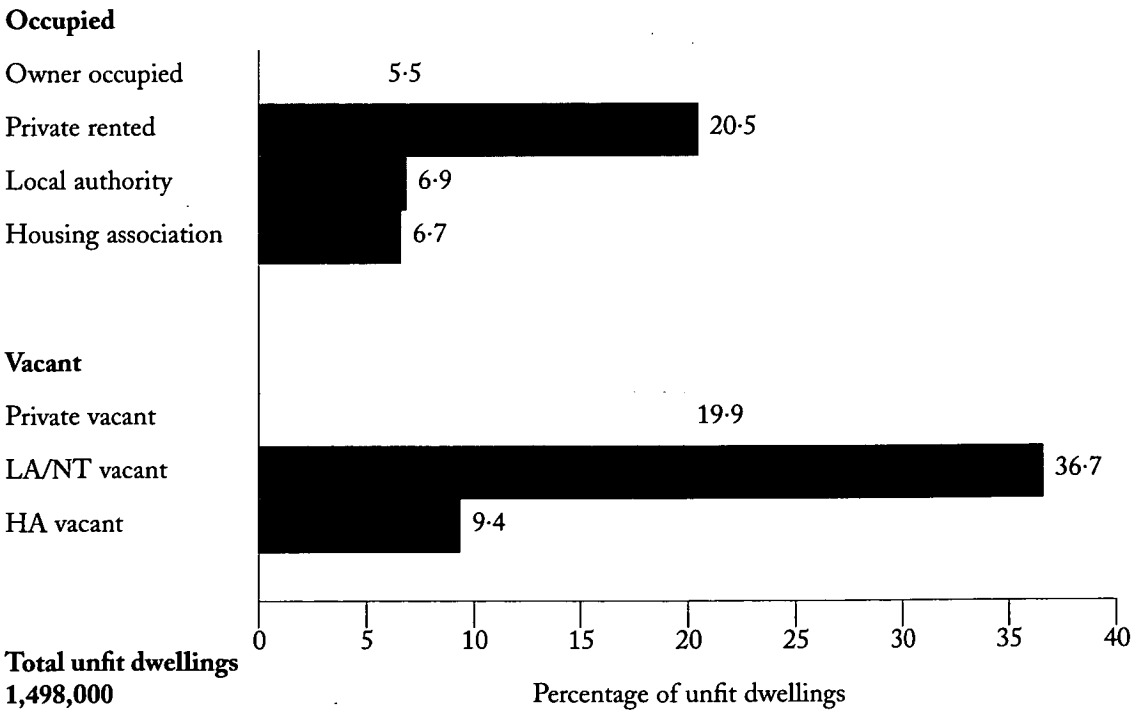
* The survey used as its primary bench mark of housing conditions the fitness standard set out in the 1989 Local Government and Housing Act and contained within section 604 of the Housing Act 1985. Guidance as to interpretation is contained within the Department of the Environment's circular 6/90.

Number of unfit dwellings by tenure and vacancy



Source: English House Conditions Survey 1991 (Crown copyright, reproduced with the permission of the Controller of HMSO).

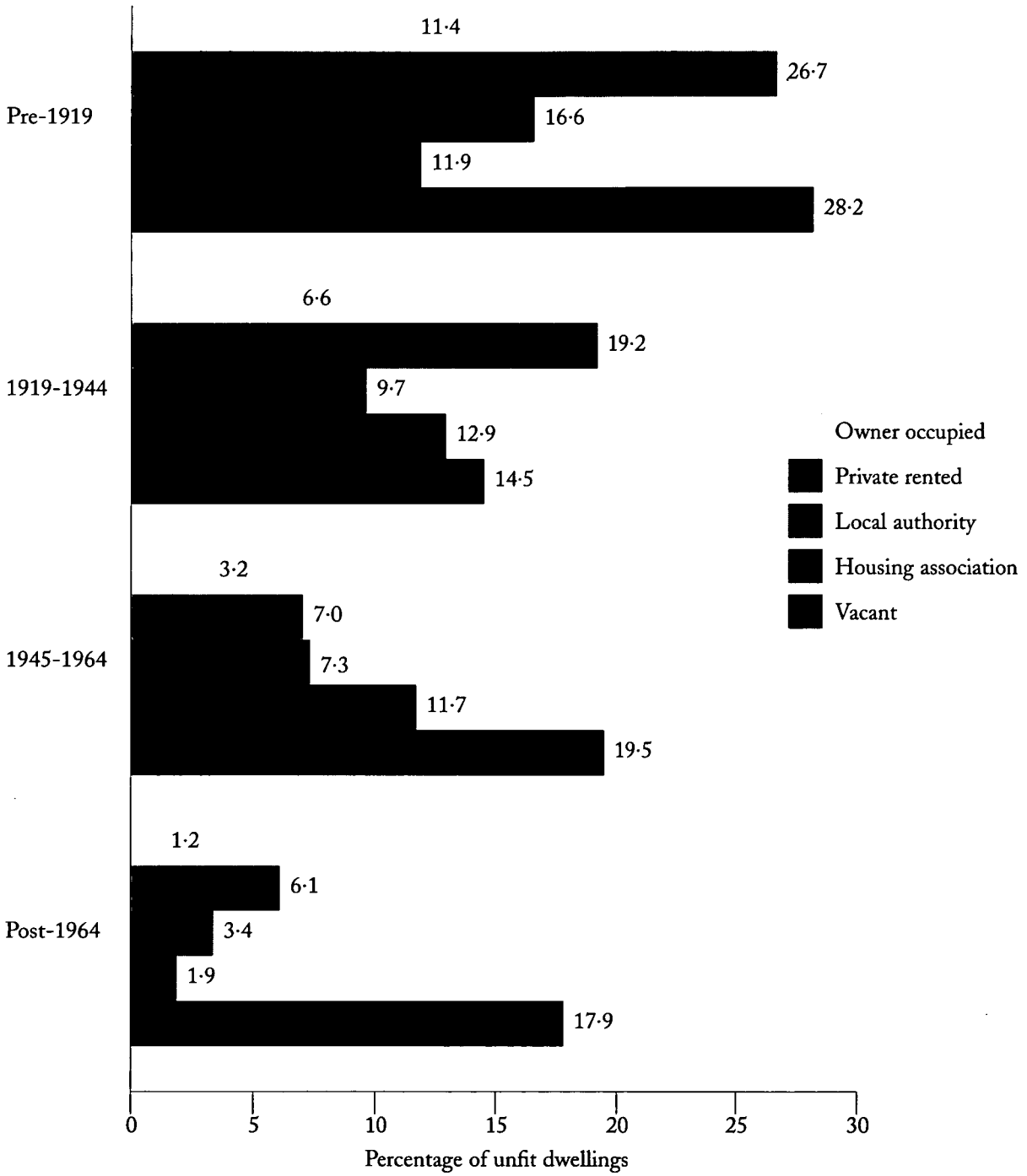
Unfit dwellings by tenure and vacancy as a percentage of total housing stock



Source: English House Conditions Survey 1991.

(All these figures exclude MOD property for which no data are available.)

Unfitness by tenure and date of construction



Source: English House Conditions Survey 1991.

Repair costs

The survey also provided a 'repair profile' of dwellings by estimating the financial cost of putting dwellings into good repair. The majority of dwellings needed a modest investment of around £130, but the worst 5% of dwellings in disrepair needed up to £8,620. The average repair cost was calculated at £1,130. It should be noted that all costings were based on cost indices and bear little relationship to true market costs of repairing a house. The survey does not comment on any health impacts caused by occupying unfit houses or those in disrepair.

Scotland

The first Scottish House Conditions Survey took place in 1991 and the results were announced in 1993. Dwellings were judged against the Tolerable Standard (Section 86(1) of the Housing (Scotland) Act 1987) which was used as the basis for the development of the Fitness Standard in England. A dwelling meets the Standard if it:

- *is structurally stable;*
- *is substantially free from rising or penetrating damp;*
- *has satisfactory provision for natural and artificial lighting, for ventilation and for heating;*
- *has an adequate supply of wholesome water available within the house;*
- *has a sink provided with a satisfactory supply of both hot and cold water within the house;*
- *has a water-closet available for the exclusive use of the occupants of the house and suitably located within the house;*
- *has an effective system for the drainage and disposal of foul and surface water;*
- *has satisfactory facilities for the cooking of food within the house;*
- *has satisfactory access to all external doors and outbuildings.*

Dwellings Below the Tolerable Standard (BTS)

Dwellings were found to be below the tolerable standard (as follows):

	% Incidence	No. of dwellings
BTS in occupied stock	4·7	95,000
BTS by age:		
pre -1919	11·8	51,000
1919-1944	4·5	17,000
1945-1964	3·7	18,000
post -1964	1·2	9,000
BTS by tenure:		
owner occupied	3·6	37,000
private rented	16·5	22,000
public – LA	4·4	33,000
housing associations	3·3	2,000
Scottish homes	1·8	1,000
BTS by dwelling type:		
houses	3·4	49,000
tenement flats	6·2	30,000
4-in-block	9·5	7,000
conversions	13·6	7,000
tower block/deck	4·8	3,000
BTS by location:		
urban	4·3	72,000
rural	6·6	23,000

Source: Scottish House Conditions Survey, 1991; published by Scottish Homes, July 1993 (Crown copyright, reproduced with the permission of the Controller of HMSO).

	% Incidence	% of households in BTS dwellings	No. of dwellings
BTS by economic status:			
employed	3·6	41·5	39,000
unemployed	7·2	10·0	9,000
retired	5·3	30·9	29,000
long-term sick	5·1	6·3	6,000
looking after home	6·5	8·4	8,000
other	6·9	3·2	4,000

Source: Scottish House Conditions Survey, 1991.

Observations on the survey findings

1. *The English House Conditions Survey (EHCS) is a national assessment of housing and is subject to the normal statistical sampling errors. Many housing practitioners charged with the job of producing housing strategies for local authorities contest the headline figure of 1·49 million unfit dwellings, believing it to be an underestimation. In the older industrial urban areas of northern England, unfit houses represent up to 29% of dwellings in some areas. Unfit properties are not spread evenly across all housing tenures and property ages. Houses built before 1919 and in the private rented sector are far more likely to be unfit, carrying a disproportionate risk of ill-health for the occupants.*

2. *Housing standards and housing economics*
   The cost of repairing England's unfit houses alone is estimated by the Government at £2,100 per unfit dwelling, making a total of £3·06 billion. Other estimates consider the EHCS's figure to be very low, and estimate the cost to be closer to £12·6 billion.

   The cost of ill-health associated with poor housing conditions is not mentioned in the EHCS, nor is it mentioned in the Organisation for Economic Co-operation and Development (OECD)'s 1990 economic analysis of housing policy. The OECD's main concern was that of 'questions concerning housing prices, affordability, social segregation, maintenance and modernisation and neighbourhood quality'.

3. *The Department of the Environment projects that from the mid 1990s, assuming continuing growth, there will be 1·5 million additional households by the year 2001, and 2·8 million by the year 2011. A large proportion of these will comprise single people and the elderly.*

2.2 HOMELESSNESS – DEFINING THE PROBLEM

The cause of Britain's growing homelessness crisis is the lack of affordable permanent housing for people who are unemployed or on low incomes. Public sector housing starts fell from an average of 111,000 a year during the 1970s to under 40,000 a year during the 1980s, incuding housing association starts.

The official figures, collected by the Department of the Environment (DoE), show that in 1992, out of 380,000 applications, 142,890 households (representing over 400,000 individuals) were accepted as homeless by councils in England under the homelessness legislation. This compares with a figure of 74,800 acceptances for 1982 and 112,400 acceptances for 1987.[7] Of households accepted as homeless, over 62,740 were living in temporary accommodation waiting to be rehoused.

2.2.a STATUTORY HOMELESSNESS

Households in extreme housing need can apply to a local authority for rehousing under Part III of the 1985 Housing Act. Applicant households need to demonstrate that they are homeless as defined by the Act; in priority need; are not intentionally homeless; and have a local connection with the council to which they are applying.

Local authorities currently have a duty under the Act to provide permanent accommodation to qualifying households. They also have a duty to provide temporary accommodation if no permanent accommodation is available or if a person is found to be homeless while other investigations are carried out prior to acceptance. These duties are, however, under review.

Temporary accommodation includes private sector leasing (PSL), hostel, short-life and bed and breakfast. Life in temporary accommodation typically means:

- *frequent moves from one location to another and therefore disruption of the household's social and caring networks and access to services;*
- *living in significantly more overcrowded conditions than all other tenure types;*[6]
- *lack of basic amenities;*[7]
- *being in poor condition housing;*
- *being located in expensive areas;*
- *longer stays for larger families;*
- *a loss of control over many aspects of the environment inside and outside the 'home'.*

The quantification of statutory homelessness usually involves looking at:

1. *The number of households who have made an application to a local authority (homeless persons unit) at any given time and the proportion/number of these accepted for eventual rehousing.*

2. *The number of households in temporary accommodation. (This is well researched in London by the London Research Centre, BABIE – the Bed and Breakfast Information Exchange – see below, page 21.)*

Acceptances

Many people applying as homeless are rejected by the council. Others despite being homeless under the Act may not fulfil other criteria such as having a local connection with the council or being ordinarily resident within a local authority. This is particularly true of single homeless applicants. Others leave the system before an investigation has been completed or prior to rehousing.[6]

Over the years one thing has remained stable. At a national level about half of those who make enquiries to local authority homeless persons units are accepted as homeless. The slight decrease in the number of acceptances during 1992/3 is most likely to indicate a stricter interpretation of the housing law rather than fewer households becoming homeless.[11,12,13] April 1991 also saw the DoE revising its system of recording the number of acceptances leading to a slight decrease. The number of households accepted for permanent rehousing under the homeless legislation in England was 55,530 in 1979, 144,780 in 1991 and 134,190 in 1993.[7] The number of households applying as homeless is no longer published.

The number of households accepted as homeless in England rose from 57,000 in 1979 to 151,720 in 1991 and 148,250 in 1992.[7] Although homelessness is at its most acute in London, accounting for one third of all homelessness acceptances, the metropolitan districts have experienced a greater rate of increase in official homelessness, as have areas in the South-East.[8] Rural homelessness tripled between 1988-92.[9] Scotland overall has seen a 75% increase in homelessness between 1982-93, rural Scotland a 95% increase between 1983-90 and remote Scotland a 150% increase in the same period. Homelessness has increased disproportionately among minority groups, and physically disabled people[10] experience almost double the rate of homelessness of other groups.

These quantifications ignore:

1. *Those who are placed in temporary accommodation who are waiting the outcome of the investigation into their homelessness status. If rejected these households are given a 'reasonable' amount of time in temporary accommodation (mostly bed and breakfast) to make alternative arrangements. Many stay on in bed and breakfast (B&B) by claiming housing benefit and becoming trapped into unemployment. They are frequently unable to move to private rented accommodation because housing benefit is paid in arrears, and they lack the money required for a deposit.*

2. *Those who have placed themselves in temporary accommodation, mostly B&B. For example, this group includes applicants whose immigration status requires that they have no recourse to public funds, and asylum seekers, whom the local authority has no duty to rehouse. There is an increasing number of such people who cannot be helped by the homelessness legislation.*

3. *Those placed in short-term private tenancies by local authorities which have thereby discharged their permanent rehousing duties. These households, however, continue to live in unsettled housing.*

4. *Those excluded because of the more stringent interpretation of the Act in recent years.*

This *official* statistic is thus a poor indicator of the number of households without a secure home.

Households in temporary accommodation
Key measures used to profile the use of temporary accommodation in London include:

- *the extent of its use by London boroughs;*
- *the type of temporary accommodation used;*
- *the extent to which London boroughs place households outside their own borough;*
- *the length of time spent homeless;*
- *the number of addresses lived at while homeless;*
- *the number and type of individuals involved.*

This information provides indicators of the conditions in which people are living, the level of access to health services and barriers to continuity of health and other care. Similar information systems do not exist outside London.

Numbers of households

There were 62,470 households in England in temporary accommodation in 1992,[7] of which 43,166 were in London alone. By September 1993 the number of households in temporary accommodation had dropped to 37,767. This decrease is likely to be due to more stringent application of homelessness legislation reducing the number of those accepted and increased numbers rehoused in shorthold assured tenancies.

Type of temporary accommodation used

Up until 1990, bed and breakfast hotels were used as temporary accommodation for households deemed homeless and awaiting full assessment under the Act, and for households awaiting rehousing. Numbers of households in B&B in London rocketed to 8,000 prior to

1990. Following the introduction of a subsidy by the DoE for the use of private leased accommodation, those councils needing to continue to use large amounts of temporary accommodation began to use privately leased properties. This stemmed the growth in usage of B&B. The use of PSL increased dramatically (see below). In 1992 the Government changed the financial framework again, and announced the shift from subsidy of accommodation to subsidising the occupier through housing benefit, thereby transferring the expenditure from one ministry to another. This had two results:

- *those councils with a large number of temporary accommodation units reduced substantially their use of B&B in order to cut costs;*
- *councils began to place homeless households in privately rented accommodation. The high rents in this sector were then subsidised by housing benefit, but the families were forced to remain unemployed to receive full benefits, thus becoming trapped in poverty.*

The change in use from B&B to private sector temporary accommodation for London

	1983	1987	1992	1993	1994
B&B	2,000	7,970	4,406	3,215	2,178
Private sector	–	666	23,848	25,564	19,971
Total in temporary accomodation	5,030	18,906	43,938	41,573	34,043

Sources: Bayswater Hotel Homelessness Project Newsletter May 1991
London Research Centre, B&B Information Exchange (BABIE), Homelessness in London Bulletin, Summer 1993
London Homelessness Forum Newsflash July 1994

NB Private sector: combines categories of private sector leasing and 'other private sector.'
Total: includes other categories of temporary accommodation eg refuges, hostels, short-life/short-stay, own accommodation.

Other types of temporary accommodation used include shortlife accommodation, hostels, refuges and own accommodation ('homeless at home').

Out-of-borough placements

Local authorities have a statutory duty to provide temporary accommodation to homeless applicants, but the type of accommodation at their disposal varies greatly. B&B hotels are characteristic of only a few areas, such as Bayswater in London, Blackpool and Hove. Councils may resort to privately rented accommodation or, as some areas have cheaper accommodation than others, to out of 'home' borough placement.

This makes life very difficult for households who inevitably need a high degree of contact with caring services and support networks. The use of the private rented sector has enabled those authorities with a sizeable private rented sector to avoid the movement of households across key geographical borders.

Increase in out-of-borough placements in temporary accommodation – London

	1987	1992	1993	1994
Homeless households placed outside own borough	5,800	14,067	10,963	3,479

Sources: London Resource Centre Homelessness in London Bulletins 2 and 3.
Family Homelessness in London Key Trends/Statistics up to March 1993, compiled by Bayswater Hotel Homelessness Project.

March 1993 saw London boroughs placing from 92% (Tower Hamlets) to 32% (Hillingdon) of their private temporary accommodation placements outside their own areas.

Length of stay in temporary accommodation

The average length of stay in temporary accommodation in 1987 was 33 weeks (8 months) and in 1991, 47 weeks. Larger families spend longer periods of time in temporary accommodation. London's social sector housing has a severe lack of larger properties. Private rented accommodation has often been broken up into small units for profit. The stock profile therefore does not match the needs of the population, eg families of at least six individuals living in Tower Hamlets have spent between 5 and 10 years in 'temporary' accommodation.

Tritter and Edwards[13] researching the experience of homeless families in PSL found the average applicant homeless household was composed of 4-5 people who stayed an average of two years in temporary accommodation. Families with more than six members waited an average of 3·4 years. The families had no idea when they would be rehoused permanently.

Number of addresses while homeless

The 'homelessness pathway' is a term used to describe the way in which homeless households are moved between various forms of temporary accommodation before being rehoused permanently. The pathway consists of various temporary accommodation stages. Most typically this involves a short stay in B&B during the council investigation. Then, once accepted, the applicant stays in two different private sector leased properties, followed by a move to permanent accommodation (secure tenancy) or an assured tenancy (six months to three years) in the private rented sector. Tritter and Edwards[13] found that the average number of moves for families (sample size 56 families with a total of 257 individuals) was three, but 20% of families had undergone four moves. 50% of families had been given less than six days notice of a move. In very few cases did the local authority provide practical or financial assistance to those families moving.[13]

Numbers of individuals involved in homelessness and temporary accommodation

There is now considerable research demonstrating that homelessness and the experience of temporary accommodation impair health and well-being significantly. This research is listed in London Homelessness Forum's information pack 'Key Data' produced in 1993.

Women, children and ethnic minorities are vastly over-represented in the statutory

homeless population. Figures show that 70% of officially homeless adults are women,[14] 85% of applicant households contain a woman and child(ren),[8] children are most likely to outnumber adults by, on average, 2 to 1.[15] A clear majority of these children, certainly in London and probably in other urban areas, are from ethnic minority groups. Ethnic minority households themselves make up 40-50% of the official homeless population.[8] All these people have specific health needs in addition to the health risks posed by homelessness and temporary accommodation. All are disproportionately impoverished. They have greater caring responsibilities and are more isolated socially prior to homelessness.

Homeless households contain a larger than average number of children. As a guide, the number of households in temporary accommodation needs to be multiplied by 2·4 to arrive at a rough estimate of the number of individuals experiencing homelessness at any one time. This provides some idea of the scale of the problem in health terms.[16] Research in Tower Hamlets[15] found that statutory homeless households contain an average of 3·83 individuals while Tritter and Edwards found the average homeless household to comprise four to five people.[13]

Government proposals on homelessness

The Government's proposals for 'Access to Local Authority and Housing Association Tenancies'[17] plan to increase the use of the private rented sector to the maximum degree possible. Indeed, under the proposals, the rehousing function of the local authorities will be curtailed severely. Applicants will not qualify unless they can demonstrate that they have no suitable accommodation in which they can reside and that there is no accommodation available in the area. Successful applicants will be given a limited period of time in temporary accommodation in which to find their own accommodation in the privately rented sector. The number of acceptances will decline.

Cost of temporary accommodation

The cost of providing one unit of B&B for one year is estimated at £13,150, and a unit of private sector accommodation at £11,000.[70] A conservative estimate of money spent on temporary accommodation for 1991/2 was £193 million for England and Wales, of which £121·8 million was spent by London boroughs.[11] Projections produced by the Bayswater project in June 1993, using London Housing Unit data, foresaw a rise to £350 million in 1994/5, or almost £1 million per day.[71]

Homeless families and others in temporary accommodation impose excess cost on the health service in increased consultation rates with general practitioners, health visitors and other members of the primary health care team.[19] Homeless families have an increased rate of unplanned admission to hospital 1·55 times that of the general population.[6,18] Pregnant homeless women have three times the rate of antenatal complications and twice the admission rate of all pregnant women.[20]

Unofficial homeless

Many households in housing need are concealed, because they are living as part of another household but would prefer to live in their own accommodation. In 1991 councils estimated there to be over 70,000[21] concealed households in London, and 1,200,000 throughout England.[22] Shelter has estimated there to be 1,712,000 hidden homeless in England alone. This figure comprises 8,000 people sleeping rough, 50,000 unauthorised tenants/squatters (31,000 in London), 60,000 single people in hostels,[1] 77,000 single people in lodgings (1989 DSS) and 317,000 households in insecure private tenancies.[22]

2.2.b Single Homelessness

Causes

On an individual level, single people become homeless for a variety of reasons, such as escaping violence or abuse, relationship breakdown and unemployment. The DoE's figures do not differentiate between families and single people but, in greater London, single homeless people account for 18 to 21% of the total. Many authorities have identified cuts in an already inadequate benefits system as making it difficult to secure or retain increasingly costly rented accommodation. Single homeless people are likely to make up only a small percentage of the official total figure, because under the homelessness legislation they have very limited rights to housing from local authorities.

Figures on single homelessness

There are no comprehensive figures for single homelessness nationally. Unofficial estimates put the numbers of single homeless people in London at 130,000, including 15,000 in short-life housing and 80,000 living unwillingly in overcrowded conditions in other people's households.

People sleeping rough – only part of the picture

The 1991 Census found there were 2,703 people sleeping rough in England and Wales, of whom 1,275 were in London and 1,428 in the rest of England and Wales. Though a national enumeration of rough sleepers is needed it appears that the Census failed to give an accurate picture. A recent independent study of homelessness in Birmingham found 61 people sleeping rough, despite a Census figure of zero. Similar discrepancies have been found elsewhere. Although the figures that exist are limited, they do, however, serve to demonstrate that 'street homelessness' is not just a problem seen in London.

Shelter, in its report 'Left Out', estimated there were 2,000-3,000 people sleeping rough in London and 5,000 in the rest of the country. Although assessments of people sleeping rough are important, they reflect only a small percentage of single homeless people. Many homeless people are forced to live in hostels and other forms of temporary accommodation. Many stay with friends and relatives, or live in poor, overcrowded and insecure housing.

Hostels

The number of single homeless people living in hostel accommodation is hard to assess

because there is no common definition of a hostel. However, figures produced by the DoE in 1991 showed there were 22,383 hostel bedspaces for single people in London and 37,759 in the rest of England, giving a total for England of 60,142 bedspaces.

Board and lodging

Unpublished data provided by the Department of Social Security indicate that, in 1989, there were 11,694 single claimants in board and lodging in London and 64,855 in the rest of Great Britain. Although not all would be threatened with homelessness, these figures point to the numbers in insecure and temporary private sector housing who need accommodation.

Squatters

It is difficult to assess the number of people who are forced to squat and not all squatters are single homeless people. The Advisory Service for Squatters estimates there are between 25,000 – 30,000 people squatting in London and 20,000 in the rest of England and Wales. In many localities being a squatter disqualifies people from homelessness or housing services, including financial help with deposits and housing benefit, and exposes them to the risk of sudden eviction and prosecution under the criminal justice system.

The need for 'move-on' housing

'Move-on' housing is self-contained housing for people to move on to from hostels. If it is not provided, hostels quickly become filled, and street homelessness will increase. The Government programme Single Homelessness in London (SHiL) estimated that in 1991/2 there was still a need for 10,458 units of 'move-on' housing and 11,698 units in 1992/3. A recent CHAR/Crisis report, 'Counted Out', estimated that in England and Wales (excluding London), there were 18,400 hostel residents in need of rehousing, with only 1,500 units of 'move-on' accommodation available.[23]

Vulnerable groups

There are 156,000 young homeless people in Britain, according to a Shelter estimate. Centrepoint Soho has estimated that there are over 50,000 young homeless people in central London alone. 'Counted Out' found that 44% of hostel residents living in England and Wales (excluding London) were young people under 26. Official statistics indicate that there has been a 48% increase in the numbers of young people accepted for housing by local authorities. Studies in London have shown that 40% of young homeless people were previously in care. These young people are particularly at risk of exploitation, prostitution, crime, drugs and human immunodeficiency virus (HIV) infection.

The London Research Centre has shown that 39% of households accepted as homeless in London are from black and minority ethnic groups. Single homelessness among black and minority ethnic groups is often hidden because many live in the most overcrowded and run-down housing conditions. 'Counted Out' found that 8% of hostel residents were identified as being from a minority ethnic group, compared with 3% of the general population in England and Wales (excluding London).

Women's homelessness is often hidden due to a lack of provision, with many women forced to stay in unwanted or violent relationships. A CHAR report, '4 in 10', found that 40% of young homeless women were homeless as a result of sexual abuse. 'Counted Out' found that, in England and Wales (excluding London), women comprised 55% of hostel residents aged under 18, 33% of residents aged 18-25, and 23% of all residents. There is an urgent need for more refuges and hostels for women fleeing relationships in which they are physically and sexually abused.

Mentally Ill

It appears that the Government has been successful in decanting patients from the psychiatric hospitals and moving them into the community. The work of the Homeless Mentally Ill Initiative (HMII)[24] and the Team for Assessment of Psychological Services (TAPS)[26] indicates that this system seems to be working because of the Government's clear approach and adequate resourcing (housing and staff support) of these people in the community.[25,26,27] The findings of the HMII indicate that those on the street with mental health problems tend to have had minimal contact with psychiatric services in the past. "Clients who had been hospitalised in the past reported multiple brief admissions with no evidence to support the common belief that the homeless mentally ill population includes large numbers of people who have spent many years in psychiatric institutions or who have been directly affected by the closure of long-stay hospital admission."[24]

Although the needs of long-stay psychiatric patients appear to have been met, there is a large group of acutely distressed homeless people with mental health problems. Many of these people are already chronically disturbed and others will become the 'new chronically mentally ill'. The HMII has begun to address this need; however, the initiative is not comprehensive and is only partially integrated with statutory mental health and housing services. Furthermore, it only addresses the needs of homeless people in a small number of boroughs in inner London.

Government Homelessness Initiatives

Rough Sleepers' Initiative (DoE)

In 1990 the Government announced the first phase of the Rough Sleepers Initiative, a £96m package designed to tackle the problems of homeless people sleeping rough in central London. Over a three-year period, the initiative has provided up to 840 places in direct access accommodation, 700 temporary places in privately leased accommodation, and will provide 2,200 units of permanent housing for people leaving hostels. The DoE has announced an extension of the initiative costing £86 million, which will run until 1996.

Despite the large number of bedspaces generated, the initiative has had a limited impact on street homelessness. In those areas of central London identified by the DoE, the numbers sleeping rough were reduced only by 322, from 741 in April 1991 to 419 in November 1992.[27] This is surely because the initiative has failed to recognise the true extent of homelessness, both within and outside London, and does not address the root cause of homelessness - the lack of affordable permanent housing.

Mental Health Initiative (Department of Health)
This Government initiative has been well resourced in terms of recruiting professionals to identify and work with people on the street and in direct access hostels in inner London, and has provided some well-constructed and resourced rehabilitation units. The downside of the initiative, however, has been in terms of permanent housing and supported accommodation.

Originally the Department of Health (DoH) had a commitment to provide funding for up to 150 bed spaces in hostel accommodation, with housing associations to provide 750 units of permanent accommodation. However, after three and a half years, few of the 750 units have materialised and the DoH has now revised this target to only 162 units. The DoH rationale is that "the slower than expected throughput of the hostels means that the original planning figure of 750 spaces is not yet needed." (DoH position paper 1994).[28] This contradicts the second report of the HMII[24] which highlights the failure to house clients once they have been registered, and this has frustrated professionals and clients alike. The existing hostels (rehabilitation units) have been filled/silted-up and there is nowhere for people to go.

The HMII report states that "failure to improve accommodation is strongly associated with failure of treatment." The report notes that "only one third of clients have improved accommodation" of whom only 9% have managed to move to independent accommodation.. It also points out that "there is a sizeable pool of people with disabilities equivalent to those catered for by supported housing but for whom there is no suitable provision available."

The initial investment in the initiative has not been backed up by adequate downstream housing. The DoH position that "there is slower than expected throughput" is because it has failed to negotiate support for this housing.

To reduce the number of long-term care places to 20% of the original commitment of 750 spaces is not going to improve the situation, and puts an added burden on the health and social services.

2.2.c Healthcare delivery to homeless people

While there is no automatic entitlement to housing or social services, everyone has an equal right to health care. This universal right, reaffirmed in the Patients Charter, is easily stated but often difficult to deliver to homeless people because of the requirements for getting on a GP's list.

> ***Mr M and his family made the five-mile journey from where he had been placed in temporary accommodation to get an emergency appointment with his doctor. He arrived at 5.30pm to find two other people waiting. When he gave his address he was told by the receptionist that he could not use this doctor and he had to go back to his 'local area' to see a doctor there. Mr M's daughter explained that they had not been told where to register with a new GP, and that this was an emergency. She eventually persuaded the receptionist to allow him to see the doctor. Mr M was asked by the doctor to make another appointment at the desk for one week's time, but the receptionist refused to make the appointment.***

Special problems

The problems associated with homelessness pose a considerable challenge to the conventional GP surgery system:

- *people in temporary accommodation and on the streets may have no money for transport and may have difficulty walking to the clinic, hospital or health centre;*
- *homeless people who have no contact with other welfare services are often turned away because they have no formal referral;*
- *homeless people may have difficulty in keeping appointments. It is hard to keep track of time and days when living on the street. Organising benefit payments, finding somewhere to sleep, or getting food for the day may take priority over an appointment at a clinic;*
- *there is a disproportionate number of homeless people who speak little or no English and often experience difficulty communicating with health service staff;*
- *homeless families are usually moved several times while they are living in temporary accommodation. People living on the street may find a habitual haunt is cleared by a local authority. Travellers are by definition very mobile. In each case, continuity of care is somewhere between difficult and impossible;*
- *homeless people have no clear information about what services are available to them and how they can be used. It is not surprising if they do not use a service when it is not advertised in places they frequent;*
- *homeless people may find unsympathetic attitudes among staff in conventional care settings not trained or accustomed to dealing with them.*

It is easy for even caring professionals to see these problems as intrinsic to the homeless person (who then becomes a problem patient). An alternative view suggests that it is the inflexibility of our primary care services that poses a range of special problems for homeless people when they try to exercise their right to health care.

Multiple needs

Homeless people frequently have complex and multiple needs that cross the boundaries of the various care providers.

> ***L, 37, is a widow with two children aged 7 and 5. Her husband died of cancer so she had to work to support the family. Unfortunately she developed multiple sclerosis and was no longer able to hold down her job as a publisher's assistant. Her house was repossessed and she became homeless. She was placed in a cramped, damp bedsit where the poor circumstances led to recurrent chest infections in the girls. The poor housing and worries led to a rapid downward decline in her multiple sclerosis and she became wheelchair bound.***

Housing, social services and social security policies at present have no preventive function, either collectively or individually. Prior to homelessness, social service and social security policies might have kept this woman housed and at work longer, and more in control of her health and that of her family.

Unless staff are well-informed about the availability of the resources in the community that can provide primary or community care, assist with housing and offer various kinds of continuing support, homeless people have very little chance of gaining access to these services.

2.3 The health effects of inadequate housing

Homelessness and adverse housing conditions are both largely a consequence of the same problem, ie the lack of good quality affordable housing for people on low incomes. An increasingly large number of people do not have a home at all, and several million people may have a dwelling place that does not fulfil the conditions for being regarded as a home.

Research into the health effects of inadequate housing is associated with a number of difficulties:

- *the close links between housing and other social variables, notably income and social class which are known to be related strongly to many aspects of health; and,*
- *the technical, not to mention ethical, difficulties in carrying out randomised controlled trials of different housing interventions.*

There is now a wealth of literature to show that cold and damp housing has a direct effect on certain health problems. The costs of inadequate housing in terms of the stunting of child development, mental ill health, the disruption of social relationships and the threat to the social fabric of society, while less readily quantifiable, are also significant problems.

Health risks of poor housing

There are several aspects of a dwelling that can be injurious to both physical and mental health. In particular, dampness/mould, cold and overcrowding are important risk factors for a number of health disorders. It should be noted that temporary accommodation often encompasses all of these.[29]

The P family were thankful when they were moved into their council home soon after they were married. They did not worry that the house felt very cold even though it was summer, and had a strange smell. They had their first child one year later. This child suffered from respiratory problems soon after birth with wheezing, coughing and severe distress. Water would run down the walls in winter and black mould appeared on the ceilings and walls of all rooms. The council advised the family to open the windows and turn up the heating. Their fuel bills reached £500 a quarter. Mr P lost his job with the closing of the shipyard and the family

got into debt. The child was twice admitted to hospital with severe respiratory distress. A second child was born and was diagnosed as asthmatic at the age of two. The council said there was nothing that they could do and that they were just one of many. Mrs P became depressed and isolated with two sick children. She received medication for her mental state and felt like a 'zombie'. In the interim Mr P left and did not return.

After six years the house was included in an energy efficiency scheme and was given superior insulation and an affordable heating and ventilation system. The house became warm and dry and the children's health improved. Mrs P came off medication and is now a member of the tenants' association.

Cold, damp dwellings and risks to health

Levels of heat in a home should be such as to provide for the comfort of the occupants and the maintenance and protection of their health. Insufficient heat is not only harmful in itself but also, by encouraging condensation, promotes the growth of pathogens in the internal environment.

Cold and damp in domestic housing are almost always found in conjunction with each other. Each is known to constitute a risk to health status and, where the two are in combination, it is likely that these risks are compounded.

Temperatures

Temperatures required for comfort tend to differ slightly between individuals and between age groups. They also differ in relation to the amount of activity being performed; for example, higher temperatures are needed to maintain comfort when sitting than when engaged in tasks about the house. It follows from this that those individuals who spend more time at home and who are less active will require somewhat higher average temperatures. Although everyone is potentially susceptible to low temperatures, the chronically ill, the elderly and infants are particularly at risk.

There is a wealth of evidence to support the suggestion that the mean temperature required to provide comfort for people at home and awake on an average day is 21°C.[30]

There is general agreement that the risk of respiratory impairment increases if the temperature drops below 16°C, that cardiovascular strain occurs below 12°C and that the risk of hypothermia increases as temperatures fall below 6°C.[31] The World Health Organisation recommends a minimum air temperature for the sick, the handicapped, the very old and the very young of 20°C.[32]

Trying to maintain an acceptable temperature level in inadequate housing is increasingly giving rise to fuel poverty. It is unfortunate that the people with the least to spend on heating are frequentlly housed in homes that are the hardest and most expensive to heat. The poor spend twice as much on heating (as a percentage of total income) as the rest of the population.[30]

Health implications of cold housing

An excess number of winter deaths in Britain has been observed for some years. Mortality tends to increase after a cold spell, particularly from myocardial infarction, strokes and respiratory conditions.[33,34]

There is both epidemiological and experimental evidence to indicate a relationship between exposure to cold and the physiological changes that may be implicated in both respiratory disorders and in heart disease.

Cold and respiratory function

Cold air can act as a direct trigger of bronchospasm and is linked, independently of smoking, with impaired lung function in men as measured by forced expiratory volume.[35]

A rapid change in air temperature produces greater respiratory effects than a gradual one. Thus, moving between warm and cold rooms, for example, at bedtime, when rising in the morning, or when getting up in the night to visit the bathroom, is particularly stressful.

A Report of the World Health Organisation indicated that chilling of the body was associated with increased risk of upper respiratory tract infections and that the breathing of cold air increases the risk of respiratory problems in babies and the elderly.[32] People in cold homes have been found to be twice as likely to suffer from poor chest health as people in homes with adequate temperature.[38]

Damp and mould

A damp home harbours several pathogens that can be damaging to health. Viruses and bacteria that give rise to infection are more common in damp houses.[37,38] Damp in the form of condensation facilitates the growth of mould.

Mould has long been known to be a source of respiratory allergens and there are case studies describing reactions so severe as to require hospitalisation.[39,40]

Several larger scale investigations have indicated that mould may be responsible for respiratory conditions resulting from allergic reactions, such as asthma, rhinitis, and alveolitis.[41,42,43]

A large, double-blind study carried out in Glasgow, Edinburgh and London demonstrated a dose-response relationship between the presence of dampness, visible mould and the air spore count in domestic dwellings and symptoms of allergy and infection such as sore throat, coughing, aching joints, headaches, fever and respiratory complaints. These results were independent of income, smoking in the household, unemployment, cooking and washing facilities and the presence of pets. Investigator, respondent and selection bias were also ruled out as explanatory variables.[47]

Similarly a study that used both objective and subjective measures of health status and housing conditions found strong associations between dampness/mould and respiratory symptoms, diarrhoea, vomiting and general health.[36]

These results were confirmed by a study of almost 15,000 adults and 13,000 children in Canada.[48,49]

The observed relationships between mould and ill health meet the criteria for the acceptance of a causal link as laid out by Bradford Hill.[50] That is, the data indicate a very strong relationship, the findings are consistent, the association is quite specific and the adverse conditions can be observed prior to the development of the health problem. Dose-response relationships have been observed between dampness/mould and the relevant symptoms, and the findings are biologically plausible.

Fungi of the genera Alternaria, Cladosporium, Penicillium and Aspergillus appear to be the most significant in causing allergic reactions. These are found in damp domestic dwellings.[44,45]

Fungal spores can give rise to three types of reactions: allergies, infections and toxic effects. Responses to the inhalation of fungal spores can range from mild through acute and severe, with flu-like symptoms, to irreversible changes in lung function after chronic exposure.

Certain fungi produce toxic metabolites, ie mycotoxins. These are contained in the spores of toxigenic fungi and have been established as causes of illness in humans and animals.[46]

Mycotoxins are readily absorbed through the membranes in the respiratory tract and enter the bloodstream causing damage to other parts of the body. Their presence in the lungs may interfere with immunity and contribute to diffuse alveolitis. Since mycotoxins can affect the immune system they may also exacerbate allergies and infections.

Overcrowded housing

The risk of transmission of infectious diseases, such as tuberculosis or dysentery, as well as figures for both total mortality and death rates for particular non-infectious diseases, are highly correlated with levels of crowding. The following are significantly associated with overcrowding: accidental and violent deaths (including suicide), especially in males; peptic ulceration, especially in females; heart attack and stroke, particularly in males; and cervical and lung cancer. Chronic bronchitis, asthma and emphysema also show significantly high correlations with overcrowding which are not explained by social deprivation factors or smoking.[51]

Poor housing conditions, particularly overcrowding, for infants and young children have been implicated as a risk-factor in heart attacks, chronic bronchitis and emphysema in later adult years.[52] Evidence from a UK cohort study, which followed up all babies born in a specified week in 1946, demonstrated that adult chronic cough and diminished lung function are positively associated with infant exposure to overcrowding. A possible mechanism is that the increased risk of recurrent chest infections in infants causes structural damage to the airways which leads to these effects in the adult.[53]

Inadequacy of temporary accommodation

A national survey of temporary accommodation showed that a substantial proportion of bed and breakfast hotels provided unsuitable accommodation, with an average of 16 people sharing a bath or shower and 20 people sharing one WC. 26% of the hotels were found by Environmental Health Officers to be lacking or inadequate in the provision of drinking water, food storage and cooking facilities.[54] A survey in London found 61% of bed and breakfast accommodation to be overcrowded, with two or more people to a room. Almost half posed a risk of fire with inadequate escape routes.[55] Both children and adults are at greater risk of accidents, particularly burns and falls, in such accommodation.[19]

P, 45, was a car salesman and an insulin-dependent diabetic. He separated from his wife and two children, and became homeless. His diabetic control deteriorated and he developed a diabetic retinopathy which, despite treatment, left him registered blind and he lost his job. After becoming unemployed he applied as homeless and was placed temporarily by the local authority Homeless Persons' Unit in a grubby bedsit until permanent accommodation could be found. Because of the inadequate and dirty accommodation he was placed in, he developed an infected foot which ultimately became gangrenous, necessitating a below-the-knee amputation.

Health, social services and social security provision did not protect P from losing his housing, his sight, his job, and his leg. As a result of his ill health he qualified under homelessness legislation for rehousing. However, his condition could not influence the type of accommodation he received, which has undoubtedly contributed to his present advanced state of poor health and considerably advanced disability.

P would normally be eligible under the Community Care Act for a comprehensive package of care. Referral would have been easier and quicker prior to homelessness, as his eligibility would have been indisputable on the basis of residence criteria. Once homeless, and thus not a resident, applications under the Community Care Act become easily delayed. Although P was in need of a high level of support care as well as housing, the homeless person's unit failed to make a referral for care and housed him in temporary accommodation detrimental to his health. Without a referral from local authority housing to local authority social services, P's chances of being appropriately rehoused are slim.

This case also illustrates the importance of communication between health providers and providers of housing services. Often the housing role of health providers begins and ends with referral for rehousing, and the best they can do is to get a household accepted as homeless. If their role could proceed to advocacy to prevent loss of housing or promote access to appropriate housing, it might help prevent the homeless trajectory which is so catastrophic to people with special needs.

Homeless people's health

There is considerable evidence for the relatively poor health of the homeless,[6] in particular susceptibility to infectious diseases such as pulmonary tuberculosis, musculoskeletal conditions, dermatological, neurological, and respiratory complaints.[56,57] Homeless women are vulnerable to problems during pregnancy[58] and their children are prone to behavioural disturbance.[59,60] Smoking among homeless women with families was found to be 41%, compared with a regional average of 29%.[27]

Access to health care for the homeless is recognised to be poor and it seems reasonable to conclude that whatever health problems may have existed prior to homelessness, the additional health hazards posed by having no home are likely to exacerbate existing conditions, to delay recovery from illness and give rise to new medical problems. In particular, the long-term effects on children's health give cause for concern.

Social effects of cold and damp housing

There is often a stark choice between spending money on fuel and spending it on food, clothing and amenities. This fuel poverty has a number of knock-on effects on physical and mental well-being. The inability to use all rooms in a dwelling because of inadequate temperatures and unpleasant mould growth leads to situations where families may spend most of their time in one warm room. Thus a shrinkage in available space occurs which leads to overcrowding. Children may find themselves having to do homework in a living room which is also occupied by adults watching television and other siblings engaged in a variety of activities. Where there is nowhere for children to entertain their friends, they may spend excessive amounts of time outside the home.

Where a bedroom or rooms cannot be used, children may have to share with adults or with siblings of the opposite sex – a situation that becomes increasingly problematic as children mature.

Mental health

The effect of homelessness and adverse housing on mental health has been much neglected.

Several studies have found significant relationships between cold/damp housing and symptoms of mental ill health. The constant strain of trying to keep the accommodation and clothing clean and fresh, time and energy spent in attempting to achieve remedies for dampness and cold and the experience of social difficulties in inviting people home can, in addition to continual discomfort, give rise to symptoms of depression and anxiety.[36,61]

In addition to its effect on self-esteem, the social stigma associated with living in certain housing areas can have a negative effect on employment prospects and credit ratings.[68]

Overcrowding is known to have deleterious effects. Enforced social contact can lead to irritability and tension and creates emotional disturbance in children, such that interaction with other children is limited. Social development may be affected, and a survey of parents and professionals reported delays in development of speech and motor skills.[69] Being in the

continual presence of others has been shown to impose mental strain on both children and adults and can impair the potential for satisfactory social relations. There is some evidence that children from more densely populated accommodation display more aggression and have poorer educational attainment and mental adjustment.[62]

These findings have implications not solely for the child's development but also for the emotional health of the whole family. At least one well-controlled study has found more measured hostility in families who find it difficult to get out, for example, because they live in high-rise flats or perceive their surroundings to be physically dangerous.[63]

If children can play outside, the parent(s) can gain respite and privacy and the children can indulge in a greater range of activities than they could indoors. However, the availability of a garden, yard or play area does not guarantee that it can or will be used, since this will depend, to some extent, on weather conditions and on actual and perceived dangers, such as being located near a busy road, or in an area of high crime. There may well be a reluctance to allow children to go outside without supervision and parents like to be able to look out on play areas. Bed and breakfast accommodation is unlikely to provide any play space for children other than that of the living and sleeping accommodation itself, which is often one room.

Behavioural and emotional problems in children resulting from an adverse living environment are likely to have long-term consequences which may persist well after the housing problem has been solved if, indeed, that happens.

Women

Temporary housing is particularly stressful for women with young children. The typical accommodation is overcrowded, noisy, has inadequate cooking and washing facilities and nowhere safe for the children to play.[64] The rates of admission to casualty departments reflect the dangers of scalds, falls, fires and traffic accidents that plague people living in HMOs and PSLs, and the burden of worry falls primarily on women.

The effects of having to live in unpleasant, uncomfortable, overcrowded and, possibly, dangerous accommodation, with no control over one's environment and without hope of respite is likely to give rise to mental ill health in the most stable of individuals.

Many women become homeless because they have fled from situations involving sexual abuse and violence. Whether single or with children, the conditions of inadequate housing may exacerbate any problems that already exist. In addition, a lack of contact with medical services by people who are on the street or moving frequently may allow psychotic conditions requiring control by regular medication to develop into florid episodes, with dangers to the persons themselves and, possibly, to others.

> ***N, 25, was evicted by her ex-husband and became homeless. She drifted into a squat, and her appalling living circumstances precipitated a depressive episode severe enough to warrant sectioning under the Mental Health Act. Each time discharge is mentioned she relapses because she has nowhere to go.***

People living in a squat run a high risk of sudden eviction and prosecution under the criminal justice system, and tend, therefore, to avoid contact with a range of support services. In many localities being a squatter also disqualifies an individual for homelessness or housing services, including financial help with deposits and housing benefit.

N was not helped until her state was severe enough to require hospitalisation, a personally costly and socially expensive option. Sheltered accommodation might have prevented her decline, and could provide a solution when she is discharged. As there is a severe shortage of such accommodation, N will probably be on the street until her next hospitalisation.

Obviously, people who live on the street will suffer all these hazards to a greater extent. In addition, low self-esteem and self-blame may engender hopelessness.

2.4 The true costs

The physical, emotional and social costs of inadequate housing are enormous. The costs to the National Health Service of cold housing alone have been estimated at £8,000,000 per year.[30] If the cost of accidents, infections, allergies and mental distress are added to this, the figure soars into tens of millions. In addition, if costs incurred by social services, the police, voluntary agencies and ordinary citizens are added, the financial burden of homelessness and bad housing rises to billions of pounds per annum.

In a study attempting to quantify the health costs of poor housing, Carr-Hill and Coyle[67] found that consumption of health services in their sample was about 50% higher than would be expected according to the National Housing Survey data, and would justify, in cost terms, an investment of about £3,000 per household.

Poor use of primary care leads to a correspondingly high level of secondary care. Research[65,66] has shown that homeless people are far more likely to go into hospital as unplanned acute admissions than other people in an inner city area. Homeless families were found to be 2·4 times as likely to experience an unplanned acute admission, while research in West Lambeth showed that the rate for people living on the streets was as high as 4·7.

This research, which emphasises the high use of unplanned acute admissions by homeless people, offers a potential way of calculating the additional cost of providing services. Since the current need for services is largely unmet, most measures of service use will underestimate the real cost of providing services appropriate to needs. A measure of how much more likely homeless people are to use a hospital bed than the rest of the population offers a useful proxy for the way resources should be allocated.

Weighted capitation

Funding in the health service flows down to Regions and, in turn, to Districts on the basis of the size of their resident population and the number of homeless people currently living within

the District. The Access to Health document 'How to count your homeless population' offers guidance on how to ascertain the size of the homeless population in a given district.

The Thames Regions (set to become two Regional Offices in 1996 if Parliament agrees) are all examining different ways of identifying the social factors that affect the cost of health care. None of these systems for weighted funding, however, reflects accurately the cost of extreme deprivation.

Within the Access to Health document is a weighting system for homelessness, based on the high level of unplanned acute admissions, that addresses this omission. The increased likelihood of each group of homeless people requiring a hospital admission is expressed as a weighting. This weighting can then be applied to the number in each group in a given District to increase funding in recognition of the extra costs of providing health care for homeless people.

The effect of this weighting is that homeless people, who comprise 1% of the total population, would account for 2·4% of the overall funding available. In 1993-94 North Thames (East) introduced this system in its entirety, and North Thames (West) used a modified version of it. All Thames Regions plan to use the system as outlined here in 1994-95.

Shift of resources to primary care

Any resources redistributed on the basis of the needs of homeless people will not be ring-fenced so it is essential that District purchasers who have gained funding on this basis should be made to account for how they use the money. There should be an expectation that services for homeless people will be identified as a priority. This does not mean that specialist services should be extended, although this may be appropriate in some areas, but rather that mainstream primary care services for homeless people should be improved, reducing the current reliance on acute care.

3. Conclusions

Internal contradictions in Government policy

1. *As section 2.1 (above) demonstrated, the Government's definitions of housing fit for human habitation are generally reasonable, although some health professionals believe that the tolerable standards for damp and cold are much too low. The problem, however, is that they are not enforced consistently and some 4·6% of occupied dwellings fall below these standards. In some areas, such as Glasgow, the figure is closer to 20%.*

2. *This report has marshalled evidence for the relationship between inadequate housing and ill health, and particularly the view that marginally housed people's health suffers as a result of such housing. Unfortunately the Government's commitment to a national strategy to improve health does not include adequate resources for improving these conditions. In particular, the availability of housing renovation grant-aid is woefully inadequate.*

3. *The Government has a strong commitment to improving the availability and quality of primary and community care, but homeless people find it difficult to access primary health care services. While the move to community care was intended to reduce the need for in-patient admission, there has been increased incidence of emergency admission and use of secondary care among those homeless households living in Bed & Breakfast accommodation and hostels. If the health of the community at large is to be improved, then these contradictions must be addressed.*

On 4 May 1994 the Government finally undertook an investigation of the link between ill health and poor housing. A research programme under the direction of the Chief Medical Officer, Dr Kenneth Calman, was announced which will look at the relationship between poverty and ill health, with particular reference to socio-economic conditions. It is hoped that the programme's conclusions fare better than those of the Black Report.[1]

Inadequate supply

In 1993/4 there were 131,790 households accepted as homeless, comprising around 400,000 people. Of these, 99,310 were homeless families in priority need. In addition, there were 4,430 acceptances of non-priority homeless. This category comprises mainly young people without children, many of whom are sleeping rough, but it is impossible to estimate accurately the size of this group. Over half of those accepted were placed in temporary accommodation.

The 1991 English House Condition Survey revealed 640,000 empty homes in England alone which equates to 3·3% of the housing stock. In 1992 and 1993 the number of empty properties increased considerably through a record number of repossessions by the building societies and lending institutions. In 1994, although the number of repossessions has reduced, local authorities are still having to rehouse a large number of former owner occupiers following repossession of their homes.

Early in 1994 it was estimated that the number of empty properties in the United Kingdom had risen to more than 800,000, of which over 80% were privately owned. Some 16,000 of these properties belong to the Government and cost between £100 and £200

million a year to maintain. There is now a consensus that, in addition to bringing back into use the empty properties, it will be necessary to build 100,000 homes per annum for at least the next 10 years to let at affordable rents. This figure has been endorsed by independent research carried out for the Housing Corporation in England. Yet there is no sign that the Housing Corporation will be allowed to finance this kind of building.

Condition and energy efficiency

In the United Kingdom there are 1·75 million homes that are either unfit for habitation or below the tolerable standard. These homes are occupied by 4·25 million people. Of the unfit homes, 200,000 have inadequate heating and at least 400,000 are affected by dampness which is so serious as to affect the health of the occupants.

It will cost £16.5 billion to remedy cold UK housing; ie £1,250 million must be spent each year over 12 years to bring 500,000 houses per year up to the 1990 Building Regulations Thermal Insulation standard. There are currently 6·6 million low-income homes that require this work, which means that about 16 million people are experiencing fuel poverty.[2] In contrast to what is required, only £550 million was spent on energy efficiency improvements between 1978 and 1991.[3] Moreover, the VAT charge on energy can only exacerbate this situation.

Precise figures for the number of homes in severe disrepair are not known, but are likely to be in the region of 1·5 million, affecting 3·66 million people. Thus in the United Kingdom as a whole more than 3·25 million homes are unfit for habitation or in severe disrepair, affecting more than 8 million people. Of particular concern is that more than one in five of all houses for rent in the private sector is unfit for habitation.

Most investment in improving housing conditions is carried out by private owners. Unfortunately, however, the distribution of that investment is uneven with very little money being spent on properties in the worst condition. The upgrading of the worst property is largely brought about by local authority intervention through improvement grants or local authority enforcement action.

Government investment in improvement grants in 1994 is about one-tenth that of 10 years ago. During this 10-year period, the Government has also introduced VAT on improvement works and removed tax relief on improvement loans. Both of these measures have been a major disincentive for owners considering improving their homes.

Home improvement agencies

There are now about 200 home improvement agencies (HIAs) based on the Care and Repair or Staying Put models. Since April 1991, home improvement agencies have completed over 41,000 jobs at a total cost of more than £100 million. The work has been targeted on the houses in the poorest condition occupied by the most vulnerable people. More than 90% of clients of HIAs are over 60 years old with 46% being older than 75 years. HIAs can deal specifically with renovation works and adaptations required to meet personal care plans as well as work of insulation, draught proofing and home security.

These home improvement agencies are normally established by voluntary organisations and are registered with the Registrar of Friendly Societies. Because of the nature of the work, home improvement agencies are rarely financially viable and they require additional support from local authorities, housing associations or the Department of the Environment. Increasingly, HIAs are receiving the support of social services through joint finance or special transitional grants through the community care programme.

Shared houses (houses in multiple occupation)

According to the Department of the Environment there are more than 340,000 houses in multiple occupation (HMOs) in England and Wales, providing homes for about 2·4 million people. The only national survey into conditions in houses in multiple occupation was undertaken by the Department of the Environment in 1985,[4] and this revealed that four out of five HMOs required statutory action to deal with inadequate means of escape from fire or inadequate facilities. 150 people die each year from fires in HMOs and a further significant number die as a result of defective gas or electrical appliances. The Department of the Environment research concluded by saying that "conditions in the nation's HMOs were an indictment of national and local government".

The first legislation to control unsatisfactory conditions in multi-occupied properties was introduced more than 30 years ago. Despite some important amendments to the legislation in 1988 and 1989, there is still no legal requirement for an owner to obtain prior approval before letting a multi-occupied property. Nor is there any statutory requirement for a local authority to inspect HMOs.

4. Recommendations

4.1 Solutions for healthy housing

The three fundamental issues are supply, condition and affordability.

> ***World Health Organisation Target 24 – "By the year 2000 all people of the European region should have an opportunity of living in houses that provide a healthy and safe environment."***

It should be appreciated that the scale of the task of resolving the nation's housing problems is so enormous that it requires a clear commitment from the Government, local authorities, the independent sector and private industry – and the taxpaying public must be persuaded of the importance of this renewal for all of us.

In the past there has been a failure, particularly by central Government departments, to develop coherent and consistent policies. The need for a national housing strategy has been reinforced by the effect of community care that demands joint working between health authorities, social services and housing authorities. A strategy is required from central Government that will restore and maintain expenditure on meeting the housing needs of the poorest and most vulnerable people in society.

The following recommendations indicate the types of initiatives needed to meet the identified housing requirements:

1. *Supply of affordable housing*

   ☞ *There is a general acceptance that at least 100,000 homes at affordable rent need to be created each year until well into the 21st century. At present there is a shortfall of at least 40,000 homes per annum against this target.*

   ☞ *Equally important to the supply of housing is the cost of renting. In many instances homes are created for which the occupants have to be unemployed to be able to afford the rent. Currently, rents for housing association property exceeding £400 per month are not uncommon. This situation is untenable and we suggest that the Government reinstate housing association grant rates to pre-1993/4 levels.*

   ☞ *Four per cent of the nation's housing currently stands empty, the vast majority being owned privately. Further incentives are needed to encourage owners to bring properties back into use. Every local authority should have an empty homes strategy. Government incentives to encourage owners to let their property could be provided through improvement grants and subsidised low interest rate housing loans.*

2. *New local authority housing*

   There is no logic in denying local authorities the opportunity to reinvest the capital receipts received under Right to Buy in new building. In 1980 when Michael Heseltine was Secretary of State for Environment he encouraged local authorities to commit themselves fully to the Right to Buy programme on the basis that they could reinvest the receipts in new construction. They should be given the right to do so. Local authorities

should also be able to use the capital receipts currently held in reserves for renovations.

3. *Improving bedsit and hostel accommodation (HMOs)*
   It is recommended that the Government should introduce an HMO licensing system immediately which would require compliance with standards prior to the owner opening the property for business. The licensing system should require local authorities to inspect properties regularly, at least annually, to ensure continuing good management and the maintenance of means of escape systems and the regular inspection of gas and electrical appliances.

4. *Rental deposit schemes*
   Many local authorities have recently established these in co-operation with charities and other voluntary organisations. In the past, many single homeless people have been denied access to housing because they have been unable to afford the deposit and as a result have slept rough or squatted in empty properties. Rental deposit guarantee schemes overcome this problem and ensure that properties are returned to landlords in good condition or, failing this, that they are reimbursed for any loss.

5. *Condition*
   - ☞ *Every local authority should be required to have a private sector renewal strategy that identifies the condition of the stock in the area and sets out a realistic programme for repairing and improving unfit or dilapidated houses.*
   - ☞ *The Government now plans to invest only about £280 million per year in improvement grants and other private sector renewal expenditure. Given this low level of Government support, it is no longer realistic to anticipate that there will be sufficient funds to maintain the mandatory renovation or disabled facilities grant programmes.*

   It is suggested that as an alternative to improvement grants, the Government should consider providing low interest loans paid through building societies but subsidised by central government and secured by the local authority. Moving from grant to loan could permit a five-fold increase in housing investment.

   - ☞ *To protect the community care programme it is recommended that small 100% mandatory means-tested grants should be retained where they are to pay for work to meet the requirements of individual care plans. These grants could replace the existing disabled facilities grant and minor works assistance.*
   - ☞ *To support area improvement programmes through renewal area action, it is recommended that the current grant arrangements for group repair should continue. Frequently carrying out grant repair is the only way of establishing confidence in deprived or dilapidated areas.*

6. *Energy efficiency*
   As described previously, damp and cold housing is a major contributor to poor health. However, the tasks of providing affordable warmth to more than 6 million families is too large for the Government to handle alone. What is needed is a Government-led strategy targeted to poor owner occupiers and to tenants of private accommodation.

   The Energy Saving Trust (EST) has put forward an ambitious 10-year plan[5] but this has been constrained by national legislation. The successful implementation of this 10-year plan would be a major achievement and would dramatically reduce premature death, particularly in winter, and admissions to hospitals of patients with respiratory complaints. The EST programme would also bring about a reduction in the extensive damage caused by condensation to the housing stock and would also reduce the carbon dioxide emissions resulting from the burning of fossil fuels.

7. *Home improvement agencies*
   The Government should seek to ensure that all communities have access to home improvement agencies and that they receive adequate levels of financial support. Receipts from council house sales might be a source of funding.

8. *Private sector leasing with housing associations as managing agent*
   Growing use is being made of these schemes. It is emphasised, however, that without adequate financial support from central Government, rents will be too high, thus denying access to those in greatest need.

9. *Establish new housing companies*
   The Institute of Housing's proposal for local authorities to create Local Housing Companies[6] which could lease housing stock with no consequential transfer of capital is an example of the kind of innovative thinking needed. This approach would enable the new housing companies to raise capital outside the public sector borrowing requirement in order to provide proper levels of investment for maintenance and improvement. The Government has undertaken a number of pilot schemes to explore the feasibility of this approach (eg Sheffield, Middlesborough), and the outcome of these is awaited with interest as they seem to provide a real possibility of levering in additional resources.

In assessing these recommendations, it is essential to take a holistic view of their costs in the context of savings to the NHS and social services and benefits to the community. It is crucial for the Treasury to take a cross-departmental view of these issues.

4.2 Improving healthcare for homeless people

Although homeless people may have greater levels of ill-health than average, the range and nature of this ill health is not much different from that experienced by the rest of the community. There is no reason to suppose that the health needs of homeless people cannot best be met by the same range of health care services advocated in recent NHS guidance.[7] This means access to high quality primary health care (including preventive medicine) backed by appropriate secondary care services and well-coordinated aftercare (community care).

There are undoubtedly a number of reasons why homeless people may not have good access to such care. Perhaps the two most important are:

- *the (often enforced) mobility of homeless people; and*
- *unsympathetic, and occasionally hostile, reactions from the providers of health care.*

Basic Principles

A number of basic principles of health care for homeless people can be identified:

1. *Access*
   The NHS needs to review its services to ensure that they are accessible to homeless people and that preventive health care and treatment appropriate to their needs is available. Providers must ensure that homeless people have unrestricted access to a health service of the same quality as that enjoyed by the general population.

   Details of services for homeless people should be publicised in places where homeless people are likely to see them.

2. *Assessment and monitoring*
   Health needs assessment for the local population should specifically identify the needs of homeless people. This requires the adoption of a clear definition of homelessness and efforts to establish the number of homeless people living in the district.

   Providers should monitor the utilisation of their services by homeless people, to measure both level of use and quality of service. This information should be used to inform service development.

3. *Development of services*
   Services should be developed in partnership with FHSAs so that homeless people have good access to primary care. These services should be coordinated with local authority housing and social service departments, voluntary organisations, housing associations and any other bodies with relevance to homeless people. Homeless people themselves should have the opportunity to influence the way health services are organised.

   In general, homeless people should expect to get their health care in the same way as the

general population. If special services dedicated to homeless people are required, they should aim to assist access to mainstream services.

4. *Flexibility*
   To maximise access, services should be provided flexibly; different types of service delivery will be required for different groups of homeless people.

   ☞ *Many of the services that have made themselves accessible to homeless people accept self-referral.*

   ☞ *If homeless people are going to use services, it is important that there are times when no appointment is needed.*

   ☞ *Hand-held records may offer an effective way of providing for continuity of care.*

5. *Special Needs*
   ☞ *Homeless people should not be discharged from hospital unless housing and support have been organised.*

   ☞ *Homeless people may be doubly disadvantaged by reason of their culture, ethnicity, disability or sexuality. Special efforts should be made to ensure that these groups have full access to high-quality health services.*

   ☞ *Health advocates may be needed to enable non-English speakers and homeless people who lack confidence to receive the care they need.*

   ☞ *Homeless people should have access to an ambulance to take them to the service if lack of transport is a problem.*

6. *Outreach services*
   Many homeless people still avoid using health centres, hospitals or clinics. They may have had a hostile reaction from a receptionist or from medical staff when their housing status became known. Meeting health needs may not be a priority when their housing or income support is uncertain. Health care offered at day centres, in hostels or even on the street may feel less intimidating, and may help individuals to feel more positive about going to health care units in the future.

   Health visitors can play an especially useful role by taking a proactive approach to delivery of health care to homeless people in different settings and offering much needed support to families in temporary accommodation.

7. *Training*

Health Service staff should be given training on how to work sensitively and effectively with homeless people. Training can challenge stereotypes of homeless people as well as provide information about resources available to meet their complex needs.

Training covering the following three areas should be developed:

- ☞ *causes of homelessness and information on the experience of being homeless. If staff are to treat patients effectively they need an awareness and understanding of why so many people are homeless and the conditions in which these people are obliged to live.*
- ☞ *housing, social and health care resources available to homeless people in the community.*
- ☞ *responding to the needs of homeless people effectively. Training should address the problems of helping patients with complex needs and difficulties. Many homeless people fall into this category.*

8. *Monitoring and evaluation of services*

For effective planning and evaluation of services, it is essential that the housing status of patients is known. Monitoring of housing status should take place in all health-care settings.

A clear operational plan for services for homeless people should be developed with quantifiable aims for measuring performance.

9. *Inter-agency liaison*

Homeless people have multiple needs; if a service is to address a health problem it will also need to address related social care and housing needs. This requires good relationships at all levels with other local providers of services.

To overcome the problem of the homeless falling between two stools, close links should be established among the health services and social care and housing agencies such as the social services, homeless persons unit (housing department), hostels for homeless people, advice agencies, housing associations, and day and drop-in centres.

These basic principles may read like a homeless patients' charter which could give homeless people access to a good standard of health care, were they to be endorsed and adopted by District Health Authorities and NHS Trusts. It may seem a modest proposal to suggest that a homeless person has a basic right to healthcare. How much more of a challenge would it be to suggest that the same homeless person has a basic right to affordable housing of acceptable quality?

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Glossary

B&B	Bed and breakfast
BABIE	Bed and Breakfast Information Exchange
BTS	Below tolerable standard
CHAR	Housing Campaign for Single People
DoE	Department of the Environment
DoH	Department of Health
EHCS	English House Condition Survey
EST	Energy Saving Trust
HIA	Home improvement agency
HIV	Human immunodeficiency virus
HMII	Homeless Mentally Ill Initiative
HMO	House in multiple occupation
MOH	Medical Officer of Health
OECD	Organisation for Economic Cooperation and Development
PSL	Private sector leasing
SHiL	Single Homelessness in London
TAPS	Team for Assessment of Psychological Services