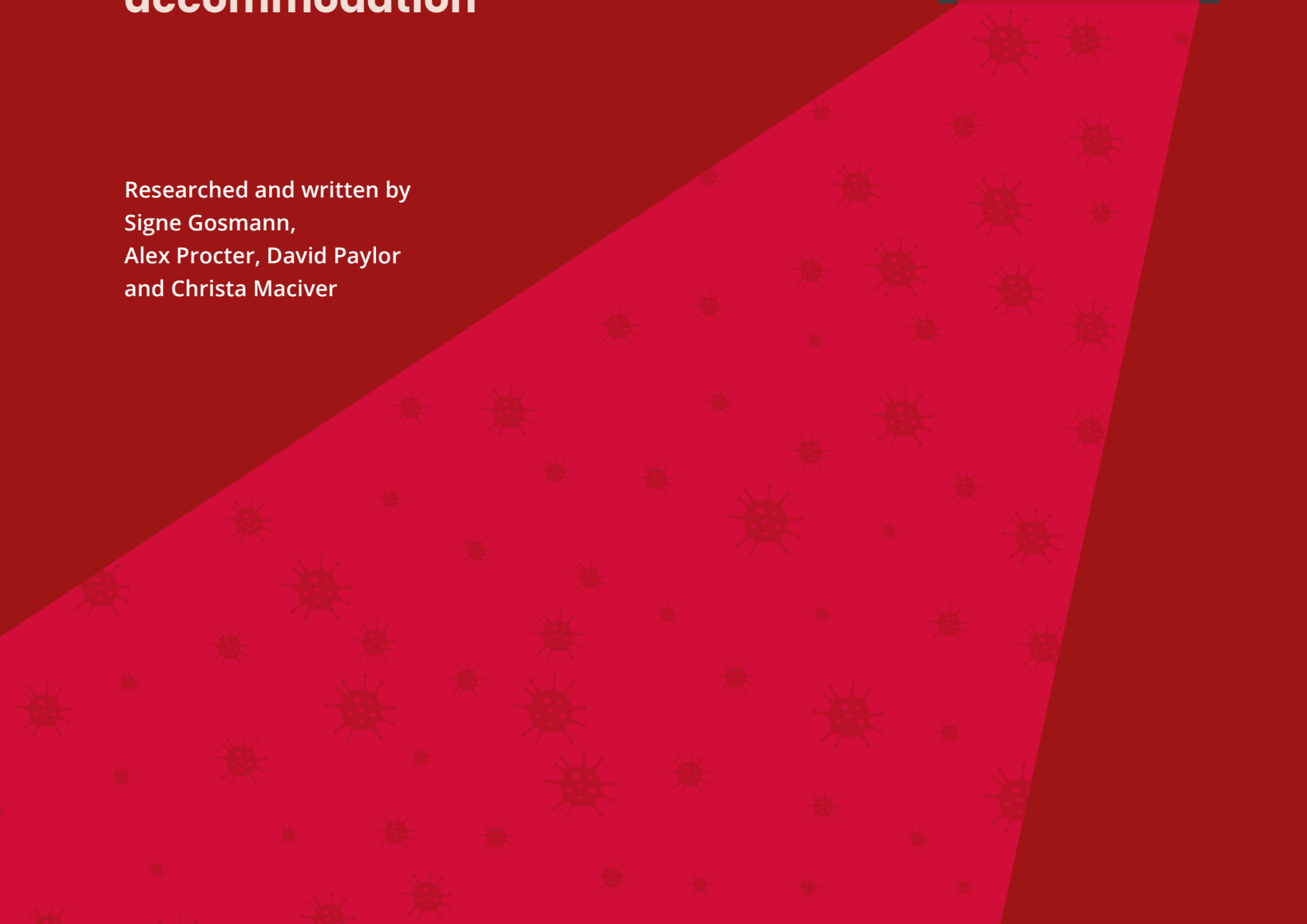
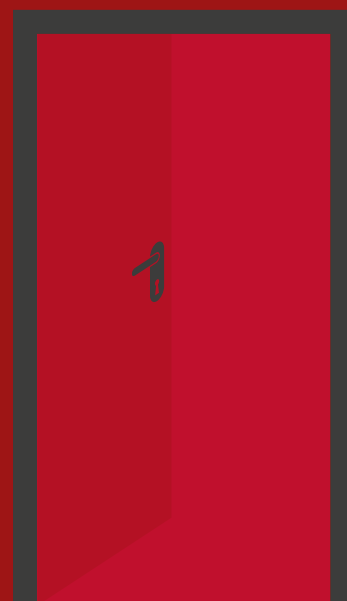


HIDDEN HOMELESSNESS EXPOSED:

**The impact of COVID-19
on single homeless
households in temporary
accommodation**

Researched and written by
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About Justlife

Justlife was established in 2008 to work with people who are 'close to the streets' living in unsupported temporary accommodation in Brighton and Manchester. We are in existence because we know that every time we do not act, another person suffers with deteriorating mental and physical health, become victims of crime, lose control of their life, drop off the bottom rung of the housing ladder or die prematurely.

We have frontline services in Brighton and Manchester as well as a Research and Policy team whose role is to influence local and national systemic change. Our aim across all activities is to ensure that all stays in unsupported temporary accommodation are as short, safe and healthy as possible.

Acknowledgements

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Most importantly, our thanks go to the 19 individuals experiencing homelessness who gave us their time and detailed insights into their lives. We hope this report will give justice to the trust they placed in us.

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List of acronyms

B&B	Bed and Breakfast
COVID-19	Coronavirus Disease 2019
EA	Emergency Accommodation
HMO	House of Multiple Occupancy
ONS	Office for National Statistics
PIP	Personal Independence Payment
PPE	Personal Protective Equipment
PTSD	Post Traumatic Stress Disorder
SMD	Severe and Multiple Disadvantage
SWEMWBS	Short Warwick and Edinburgh Mental Wellbeing Scale
TA	Temporary Accommodation
TAAG	Temporary Accommodation Action Group
UTA	Unsupported Temporary Accommodation

Executive summary

The impact of COVID-19 has been felt across the world. As the virus continued to spread through 2020, grave inequalities were highlighted in England by how its impact varied across populations. With the realisation that those without a home were particularly vulnerable to the virus, the government declared 'Everyone In' for 14,610 rough sleepers. And yet we have heard little about the support for, or impact on, the over 98,000 homeless in temporary accommodation.

This report, based on qualitative interviews with 19 individuals (17 men and 2 women) in Brighton and Manchester, sheds light on the impact of the pandemic and first national lockdown on single homeless households. Our research took place between 5th May and 24th June 2020, focusing specifically on those living in emergency and unsupported temporary accommodation. The demographic of those interviewed is comparable to the rough sleeping population in that they are White, British, middle-aged and face severe and multiple disadvantage (SMD).

At the outset, this project began with the assumption that the lives of those in emergency and unsupported temporary accommodation would be severely impacted, much like the general population at the time. However we found this not to be the case for many of our research participants, with eight of the 19 specifically saying their lives had not changed at all. The things that did change due to COVID-19 were interruptions to daily life such as support services being stopped, health appointments cancelled and not being able to see family and friends.

The issue that had not changed due to COVID-19 was the reality of life these homeless households faced in their temporary accommodation. Many live in negative environments, full of chaos, a lack of choice or agency over their lives, and faced with unclean living conditions. These individuals have existing physical and mental health issues, which are often exacerbated by the environment. In addition, five specifically referenced trauma while eight described living in stress-filled and dangerous circumstances that could lead to a trauma-response, such as finding their neighbour dead in the next room. Most surprising, seven of the 19 spoke of a disability, something we did not ask about. This unexpected learning suggests there is more we don't know about single homelessness and disability, especially when the proportion of those with a disability (37%) in our research is higher than the national average across England (21%).

These issues were not new because of COVID. Many research participants told us they were already effectively self-isolating before the pandemic hit. Within the homelessness system, temporary accommodation is used as a last resort for those who become homeless. Yet the lack of secure and settled housing for individuals to move on to, leads to long-term stays in negative environments, exacerbating existing challenges and entrenching many in unending homelessness cycles.

Even after the government effectively ended rough sleeping in a matter of weeks at the time by declaring 'Everyone In', there has been no conversation about how to address temporary accommodation as we aim to end homelessness. This is concerning in normal times but the onset of COVID-19 makes this even more worrying. Homelessness will increase as a result of the economic impact of the pandemic, pushing even more people into an already over-saturated temporary accommodation market. This will effectively push people into even worse accommodation for an unknown and unspecified period of time, where, as our research suggests, individuals face chaos, uncleanliness, trauma and the likelihood of worsening mental and physical health.

In addition to this, much of the accommodation is overcrowded and/or shared, which is a proven risk factor in the spread of COVID-19. This risk is exacerbated by the fact that many single homeless households live with comorbidities, making them more susceptible to the virus.

The combination of existing challenges of living in temporary accommodation, with the added risks relating to COVID-19, require action. We believe the sector can begin to address these challenges now through collaboration, more research and increased focus. We specifically call for:

- 1. Collaboration through Temporary Accommodation Action Groups (TAAGs)**
- 2. Research into disability and homelessness, and action to standardise disability in mainstream services**
- 3. Increased focus on temporary accommodation, in addition to rough sleeping, in plans for ending homelessness**

1. Introduction

We are living in unprecedented times. COVID-19 has affected everyone irrespective of background, and yet the virus has highlighted grave inequalities in our society, shining a light on injustices most of us, in normal times, are able to ignore. In the midst of this, realising that people without a home would be particularly vulnerable to getting, and spreading, the virus, the government declared 'Everyone In' and provided funding to bring rough sleepers off the streets¹. In doing so, they showed that when there is particular pressure, and certain inequalities can no longer be ignored, it is possible to solve something like rough sleeping in a matter of weeks.

According to the government, 14,610 rough sleepers, or those deemed to be at immediate risk of rough sleeping, were placed inside during this time (MHCLG 2020a). This is an achievement to be celebrated. However, these rough sleepers are only the visible peak of homelessness, latest government statistics report 98,300 households in temporary accommodation (MHCLG 2020b).

In 2017, Justlife published a population estimate of how many households were living in B&Bs in England at the time (Maciver 2017). This population is included in official temporary accommodation (TA) numbers published quarterly by the government. 'Lifting the Lid on Hidden Homelessness' showed that while official statistics recorded 5,870 households living in B&Bs, our figures suggested an estimated 51,600, almost 10 times what was officially recorded (ibid). With such gaps between official recording and the reality on the ground, the figure of 98,300 is likely to be a conservative estimate of households living in TA across England. These gaps conceal an unknown number of additional hidden homeless households; easily forgotten as most remain publicly unaccounted for and because they are no longer visible once indoors.

Hidden Homelessness is a homogeneous term for something that is varied in reality, used to describe individuals who are not visibly homeless, such as rough sleepers. Those who are considered hidden homeless can be sofa surfing, living in squats, or living in various types of temporary accommodation while hoping for a more secure long-term home. Consisting of both single homeless households and families, the hidden homeless make up the vast majority of those experiencing homelessness (Maciver 2017; Reeve and Batty 2011). Justlife focuses primarily on single homeless households living in temporary accommodation, specifically emergency accommodation (EA) and unsupported temporary accommodation (UTA). The findings in this report are particularly relevant to this cohort of individuals although it also sheds light on what the wider experience of people living in this kind of accommodation may be.

¹ On Friday the 27th March, the government asked local authorities in England to house all rough sleepers virus by the weekend, in order to contain the spread of the virus. This became known as the 'Everyone In' initiative. (<https://www.independent.co.uk/news/uk/home-news/coronavirus-homeless-rough-sleepers-hostel-shelter-government-england-a9429471.html>)

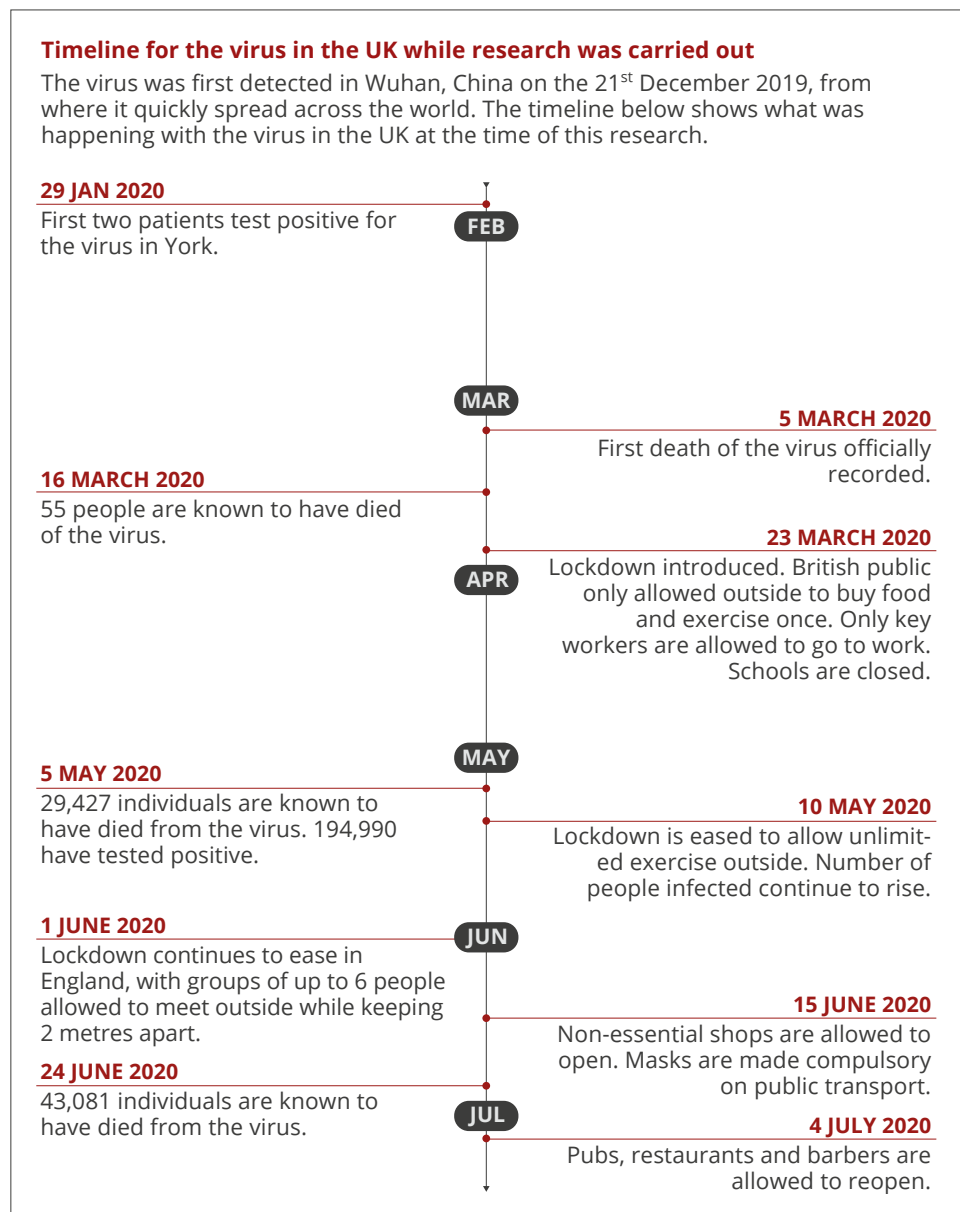
The aim of this research project was to gain insight into the impact COVID-19 has had on this population through qualitative interviews. The research was gathered through in-depth, semi-structured interviews with 19 hidden homeless individuals (including repeat interviews with four individuals) living in Brighton and Manchester, as well as surveys of Justlife frontline workers.

We embarked on this research with the assumption that COVID-19 would have severely interrupted the lives of our research participants. However, the majority of those we interviewed did not seem to connect their current life conditions to the pandemic, even when describing the isolation they were experiencing. In reality, many circumstances described by those we interviewed were impacted or exacerbated by the pandemic; they simply did not see the connection because the change they experienced had little significance for them.

This report presents our findings of how single homeless households in emergency and unsupported temporary accommodation were affected by COVID-19, but also what was impacting them beyond the pandemic. The first three sections, Context (2), Methodology (3) and Who we interviewed (4), provide a foundation for the report by outlining at what point in the timeline of the pandemic this research took place, the methodology chosen and the demographic of who was interviewed. The following two sections, Impact of COVID (5) and Beyond COVID (6), focus on the themes that arose from the interviews. The final two sections before the conclusion, Analysis (7) and Recommendations (8), bring together the learning from the research and highlights what we think should happen as a result.

2. Context

The research was conducted over an 8-week period between the 5th of May and the 24th of June 2020. During most of this time, the country was in lockdown (see graph below). All but essential workers, including hospital and supermarket staff, were working from home or furloughed². Many of those in more precarious employment lost their jobs. The streets in town centres across the country were largely empty.



² On the 20th March 2020, Chancellor Rishi Sunak introduced a furlough scheme in which the government paid up to 80% of wages for workers at risk of being laid off (BFPG 2020).

On the 5th May, 194,990 people had tested positive for COVID-19 in the UK, and 29,427 were known to have died of the virus. (Gov.uk 2020a). By the 24th June, when we concluded our interviews with residents in temporary accommodation, the number had increased to 43,081 deaths clearly attributable to the virus, an increase of 13,654 over eight weeks (COBR 2020)³. There was some national debate as to how to count deaths outside of hospitals, including in care homes (The Guardian 14th April), and a study from Imperial College London released in August showed that the true scale of infection was likely to have been 10 times higher than official figure (BFPG 2020; BMJ 2020).

³ On the 12th August 2020, Public Health England changed the way they counted deaths attributable to the coronavirus. Under the new definition, only deaths that happen within 28 days of a positive test are counted, leading to a reduction of 5,377 individuals from the total death count. At the time of research, there was no cut-off date (Gov.uk 2020b).

3. Methodology

The research is based on 19 in-depth semi-structured interviews with single residents of temporary accommodation, as well as surveys with Justlife frontline workers. The intention was to capture the impact of the pandemic as it was unfolding during the first wave. Along with a decision to use qualitative research methods, this led to a small sample size. In-depth semi-structured interviews were chosen as the best way to establish trust with respondents, and with that, gain a detailed insight into their daily lived experience during a pandemic.⁴ Although our findings are not representative of everyone's experience in TA at this time, they are indicative of the wider experience of the hidden homeless population.

All interviewees were selected with the help of Justlife's frontline team. Our team of frontline support workers have established relationships with individuals in emergency accommodation and unsupported temporary accommodation, and so they were in a good position to initiate the recruitment process through informal conversation. Where this conversation was positive, their mobile number was passed on to the research team, with their consent (see Section Four for more detail on the interviewees). The findings in this report therefore reflect the views of individuals who are in receipt of some degree of support. The majority of individuals in temporary accommodation however receive little or no support at all.

In addition to the interviews, we also used the Short Warwick and Edinburgh Mental Wellbeing Scale (SWEMWBS) to record a snapshot of their wellbeing at this time. Like the interviews, these surveys are only used as an indicative marker of mental wellbeing against the wider population in England. This is due to the limitations of the data gathered, as most scales were completed over the phone and only at one point in time. As a mere snapshot, the scales on their own cannot be attributed to these individual's general living situation.

⁴ For further information on sample size and qualitative research, see for example: Boddy, C.R. (2016), "Sample size for qualitative research", *Qualitative Market Research*, Vol. 19 No. 4, pp. 426-432. <https://doi.org/10.1108/QMR-06-2016-0053>
Sandelowski, M (1995) "Sample size in qualitative research", *Research in Nursing and Health*, Vol. 18 No. 2, pp. 179-183. <https://doi.org/10.1002/nur.4770180211>

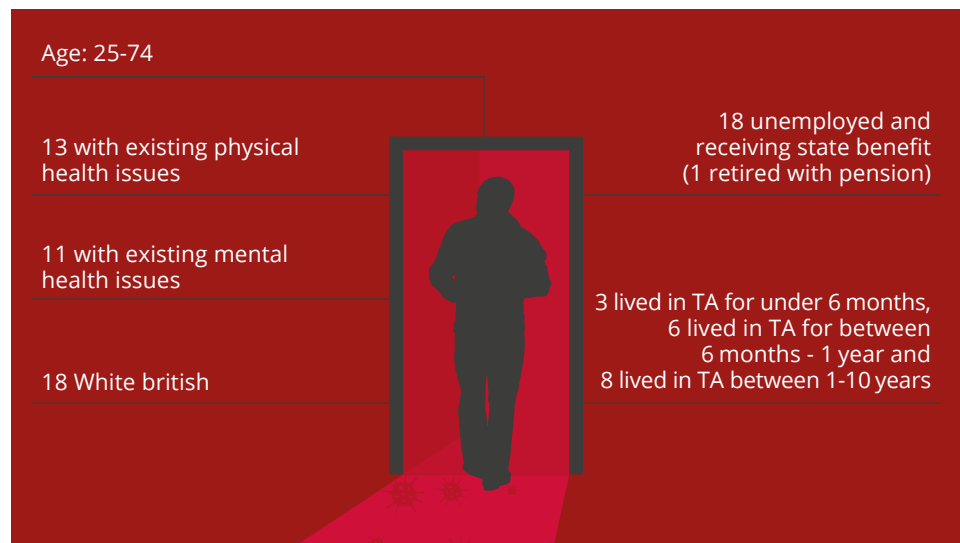
4. Who we interviewed

Those who participated in interviews were typically single homeless households with a mix of mental and physical health needs living in two forms of temporary accommodation: unsupported temporary accommodation (UTA) and emergency accommodation (EA).

Demographic data from those who participated in our research is comparable to existing data on rough sleeping populations, specifically in that they were primarily White, middle-aged, British men facing severe and multiple disadvantage (Fitzpatrick et al 2010). It is important to note that this demographic is not representative of the entire hidden homeless population in England⁵. However, the similarity between the rough sleeping population and the single-household hidden homeless population represented here, points to a cyclical relationship between temporary accommodation and street homelessness (Maciver et al 2016, Sanders and Reid 2018).

4.1 The resident

We interviewed 19 different individuals over eight weeks: 17 men and two women, 14 in Manchester and five in Brighton. The overwhelming majority of those interviewed followed the typical demographic of those living in these forms of temporary accommodation previously highlighted in our research: White, middle-aged, British, single and unemployed men facing complexities of both physical and mental ill health (Rose and Davies 2014, Rose et al 2016, Maciver et al 2016). Only two individuals claimed to be from other ethnic groups, one mixed heritage and one White European.



⁵ A notable exemption are those homeless individuals who have no recourse to public funds (NRPF) because they are not British nationals.

As pictured above, none of the interviewees were employed and all were receiving some form of state benefit. The majority of those interviewed, 15 out of 19, suffered from ongoing physical and mental health problems, including PTSD, chronic anxiety and depression, personality disorder, heart problems and diabetes among others. Four research participants specifically mentioned having a disability, with an additional three identifying health reasons for not being able to work.

4.2 The resident journey

The pathways into accommodation followed either 'official' or 'unofficial' routes. For the purpose of this research, we consider 'official' routes to be those where the individual is placed by some form of statutory services such as the local authority homelessness team, probation services or adult social care. It is important to note that not all who were placed through an official route were owed a main housing duty under homelessness law. Of the seven research participants placed via an official route, only four were placed by their local homelessness teams and in receipt of this duty.

Homelessness in England is defined by the Housing Act 1996 as:

- (1) A person is homeless if he has no accommodation available for his occupation, in the United Kingdom or elsewhere, which he—
 - (a) is entitled to occupy by virtue of an interest in it or by virtue of an order of a court,
 - (b) has an express or implied licence to occupy, or
 - (c) occupies as a residence by virtue of any enactment or rule of law giving him the right to remain in occupation or restricting the right of another person to recover possession.
- (2) A person is also homeless if he has accommodation but—
 - (a) he cannot secure entry to it, or
 - (b) it consists of a moveable structure, vehicle or vessel designed or adapted for human habitation and there is no place where he is entitled or permitted both to place it and to reside in it.
- (3) A person shall not be treated as having accommodation unless it is accommodation which it would be reasonable for him to continue to occupy.
- (4) A person is threatened with homelessness if it is likely that he will become homeless within 28 days.

(ShelterLegal 2020)

An individual does not immediately qualify for help if they are understood as homeless according to this definition. Individuals and families need to show that they are in priority need, and that they are not intentionally homeless, in order to be in receipt of a main housing duty, or what is otherwise known as a statutory duty (ShelterLegal 2020).

Once it is determined that someone is owed the main housing duty, local authorities are required to house these individuals in TA until the duty ends (ibid). Not everyone who is homeless receives the main housing duty from the local authority, whether in TA or not.

Others were placed by statutory services into the same TA, but via a different type of official path. The more unofficial routes were either through word of mouth, placement by a non-statutory support service or signposting without support. Along these definitions, nine research participants found their way into accommodation through unofficial routes and seven were placed through official routes. Three did not provide an answer to this question.

The research participants reported a varied range of time spent living in the accommodation. Nine residents had been in their accommodation between six weeks and one year, while the remaining 10 had lived there anywhere between two and 20 years.

Although all of our research participants are homeless due to the type and insecurity of accommodation in which they are staying, only seven of those interviewed described themselves as homeless, while 10 felt they were not (two did not answer). This appeared to be down to the perception of their current living situation, with some individuals saying "I have an address" or one female participant saying,

Urm well I'm in a hostel at the moment, so it's not homeless homeless, it's just basically a room.

A majority of the research participants however said they had previously been homeless (14 of 19), which is likely to have affected their view on their current situation. Those who said they felt they were not homeless had all, immediately prior to entering temporary accommodation, been either street homeless, sofa surfing or in emergency council accommodation. There was no correlation between how long an individual stayed in temporary accommodation and whether they considered themselves to be homeless. Two interviewees had lived in similar properties for seven years; one felt he was still homeless whereas the other did not.

4.3 Severe and Multiple Disadvantage (SMD)

Severe and Multiple Disadvantage (SMD) describes vulnerable individuals who are experiencing one or more of the following disadvantages: homelessness, substance misuse and offending (Bramley & Fitzpatrick 2015). They are typically men aged between 25 and 44 and, in addition to the disadvantage they live with, they experience marginalisation and stigma because of the disadvantages they are facing (ibid). All of the participants in this research are facing severe and multiple disadvantage, although to varying degrees (see section 6.1 for further detail). This suggests that most single homeless households living in TA are already facing complex challenges without the additional complication of a pandemic.

5. The impact of COVID-19

The primary impact of COVID-19 for those interviewed was one of life interruptions, specifically the interruptions in access to support services, the cancellation or postponement of healthcare appointments and the change in contact with friends and family. These generally mirrored the impact of the wider COVID-19 shutdown on the general public (Usher et al 2020). This section explores this impact from the perspective of the research participants as well as frontline workers.

5.1 Access to services

Nine research participants spoke about having lost access to one or more specialised support services. Three mentioned lost re-housing support (via housing services and probation support), five spoke of lost access to advice services (such as day centres, drop in centres, advice services) and five had lost access to wellbeing services (such as libraries for internet, befriending and activity groups).

The loss of re-housing support was a particular worry. Participants were either concerned because plans to move had been put on hold, or worried over the potential long-term impact the pandemic might have on re-housing options. One woman told us she had just been moved into unsuitable accommodation following a stay in a bail hostel post-prison. Her desire was to find work and housing in a part of the city she was familiar with, but the pandemic had made this difficult:

I'm looking for properties, and I can't get a job unless I get a house, if you know what I mean. And with COVID-19, properties are available but you've got to be 55-65, so I can't apply for it. So it looks like I'm not applying for any housing (...) it's not my type of property if that makes sense.

Two other participants said the support they had been receiving with rehousing applications had been put on hold due to service provision disruption during the pandemic. One said, *'Probation was trying to secure me permanent accommodation but the housing offices are shut at the moment... so...it's not looking likely at the moment.'*

Another talked about how the wait to be moved into more suitable accommodation had gone on for quite some time, and that he would just continue being "patient". This issue was of such importance to our research participants that five individuals specifically mentioned 'housing' when answering the question, 'Is there anything you need?'

Beyond interrupted re-housing support, another challenge was the way in which our research participants were able to access services. Three mentioned the fact that all contact was now over the phone and that change in processes, such as accessing prescriptions, was confusing.

Nine other participants felt there had not been much change because they were already shut in their room anyway, or because they weren't accessing services before the pandemic.

5.2 Health appointments changed, treatments postponed

Access to health services during lockdown was also impacted as a result of COVID-19. Four research participants reported non-urgent appointments or procedures cancelled for ongoing health issues including underlying stomach problems, heart conditions and arthritis. There were also four participants who had had more serious check-ups and follow-up procedures either changed to telephone only check-ins (cancer follow-up treatment) or entirely postponed (knee replacement, brace installation post back operation).

I'm waiting to have a knee replaced but that's been put back because of all the things at the moment. About three weeks ago I got a letter saying they would send me an appointment, and then (they) write to me to say it would be put back for six months because of the present situation. So I'm just waiting at the moment. It's ok, when I sit down and rest it's ok, but if I do a little bit of walking, I have to come back and rest again because it starts hurting.

Some research participants however had a different perspective. They told us that changes such as phone consultations or regular check ups with GPs and health care assistants and phone prescription ordering, fitted better with their needs and life in a positive way. Reasons for this included the fact that physical disabilities had made travelling to and from appointments difficult, and others felt they could build a better structure around their day and didn't have to worry about missing appointments.

I've been on the phone regularly with (the doctors), the only thing missing has been the actual face to face. But the support if anything has been even more, it's enabled me to pick the phone up more. While I was taking drugs and drinking I wasn't managing my medication well and I wasn't taking care of my diabetes. I speak regularly with my doctor now, I take my mental health and other medication religiously, as I'm supposed to when I'm supposed to.

The interruption to medical appointments and access to services therefore was dependent on the level of support received or type of medical appointments made prior to lockdown. This impacted the perspective of the research participants as to whether the pandemic affected their access to services and medical appointments. Section 5.4 below sets out the view from frontline workers, which gives a different perspective on the impact of these interruptions and changes.

5.3 Impact on social life and activities

Much like services were moved from in person to telephone consultations, so was contact with friends and family. 15 of our research participants were still in contact with family and friends, while the remaining four told us they were not. 10 of those still in contact with family relied either on a phone or the internet to keep in touch. Six specifically mentioned using the internet and social media, however no one mentioned having WiFi in their accommodation. All research participants relied on using either mobile data or a data enabled tablet that had been given to them by Justlife at the beginning of the pandemic.

One particular respondent said that being able to use a tablet (provided by Justlife) had made a “massive difference” and enabled them to connect with others in a recovery programme via Facetime and Whatsapp. Across the board people identified that access to technology had enabled them to stay in touch with people and get information about what was going on.

Eight respondents said they were unable to participate in their hobbies or recreational activities, including some people who were about to start service-based activity groups as part of their recovery/integration, such as creative groups or befriending services.

I was more or less already in lockdown. In the hostel I was just detoxing and I was keeping me head down, not seeing anyone, going to the chemist and coming back. I was just coming out of it, looking forward to playing guitar, doing a bit of reading outside. And now this is happening.

Two people mentioned not being able to go to the pub; one mentioned not being able to meet up with his partner, and one person’s usual routine of catching the bus and taking a day out had stopped.

5.4 Impact as described by frontline workers

We surveyed nine Justlife frontline workers across Brighton and Manchester. The observations gathered give a wider insight into the impact COVID-19 had on single homeless households in TA.

In contrast to the lack of impact that many research participants claimed COVID-19 had on their lives, all frontline workers were concerned about the impact they had seen on their clients. Food was an initial concern. For our research participants, this was addressed either through local authorities delivering hot food to those they had housed, or through Justlife's weekly food parcels for those now stuck inside and missed by other initiatives. One frontline worker said that the health of their clients was improving due to the better quality food supplied during lockdown.

The additional concerns of frontline workers for the most part mirror the themes that emerged regarding life being interrupted in the resident interviews, such as the interruption of medical services and support services. Everyone from the Justlife team felt the physical or mental health of their clients was affected. Workers were particularly concerned about the drop in support from other services, and the lack of face-to-face support for the most vulnerable. Isolation was observed as leading to deteriorating mental health in many client cases, and there was a concern for a general worsening of clients' health as appointments had been cancelled and services shut.

I called the mental health rapid response service (for a client) who said they cannot send anyone out unless they are certain they are going to commit suicide (mainly due to Covid). But as the client believed he was going to be killed, there was nothing they could do. MHRS repeatedly told us to go to the GP but we could not due to Covid. The doctor later phoned me and spoke with the client, he arranged meds and I went with the client to pick them up (on a bus where I could not sit with him) I took him back to his room (in a building I ideally should not be going in) and stayed with him until I believed he was safe to leave.

The access to services was only available on the phone and Justlife are the only people who were willing and able to support him. He's now doing ok but it's taken lots of visits and I have spent a lot of time with him and then report back to mental health services who are not doing face to face.

Seven frontline workers felt that the daily needs of their clients had changed as a result of the pandemic. This was mostly because they needed essentials such as food and prescriptions delivered to them, which took up most of the worker's time. Five said they felt busier than usual:

Most days are lots of frantic running around between pharmacies, supermarkets, EA buildings, often carrying lots of stuff. It's delivering hot and cold meals in big black boxes to people around the city, sweating under PPE. It's been PIP assessments and hospital appointments on speaker phone. It's been long reassuring phone calls with clients. It's been zoom and skype professional meetings. It's been unethical evictions with no or a couple of hours notice to vulnerable shielding patients who need to be rehoused. It's been lonely and isolating.

While the impact of COVID-19 and the subsequent lockdown did not necessarily create an increased sense of worry for clients, around half of frontline workers felt more worried about their clients' mental health and the challenge of providing support over the phone. However, three answered that they felt the same level of worry as they felt prior to lockdown. Two reasons given for this were that some clients were now eating better, and that the clients who were already more stable were generally coping ok. The predominant causes for concern were regarding what might happen next, whether immediate or long-term. The main worries recorded were to do with delays in housing due to potential increase in homelessness after COVID-19, leading to even longer stays in TA; delayed health appointments and procedures affecting health longer term; support projects closing due to lack of funding; and increased drug use after lockdown.

6. Beyond COVID-19

The themes that emerge from our interview analysis relating to life beyond COVID-19 can be split into two categories: themes that describe the client group and themes that describe their living context. While these existed regardless of the virus, they were affected in different ways by the pandemic.

With regards to the client group, seven individuals can be linked with disability or some form of restrictive physical health condition, eight to trauma and 11 to mental health problems. This description of a population with a higher than average degree of trauma, physical and mental health problems is not surprising when many residents in this accommodation face severe and multiple disadvantage. A substantial body of research already exists that connects trauma, physical and mental health problems with all forms of homelessness (see for example Goodman et al 1991, Fitzpatrick et al 1999, Homeless Link 2014, FEANTSA 2017, Evolve Housing 2018).

The second category looks at the living context in which many single homeless households find themselves. This context was consistently described as chaotic, with an emphasis on the lack of control, also confirming previous research in the area (see for example Rose 2016, Sanders and Reid 2018). These categories are explored separately below.

6.1 Themes that describe the client group

The themes that describe this client group can be broken down into three broad categories: trauma, disability and mental ill health. While the three are interlinked and often feed into one another, there are some distinct observations that can be made on each theme.

6.1.1 Trauma

Trauma was one of the first themes to emerge from our interviews with people living in TA. Depending on the way individuals respond, trauma can make living through a pandemic particularly challenging. Common reactions include anxiety and fear, grief and depression, avoidance, anger, guilt and shame (Back et al 2014). If multiple individuals living in shared TA have experienced trauma, the situation becomes volatile. It is impossible to predict the impact their trauma will have in a small shared space with lockdown restrictions.

Five of 19 research participants, more than 25%, can be linked to trauma with reasonable confidence; three because they themselves told us they had been diagnosed with PTSD, and two describe very shocking recent experiences finding people they cared about dead in the hostel where they live, leading one of them to attempt suicide over the course of our eight-week research. These last two scored very low on the SWEMWBS questionnaire (8 and 9 respectively out of a possible 35).

Many others described shocking experiences which certainly might be considered traumatic. As we did not ask about trauma, we cannot say with certainty that these people are traumatised, but it would be fair to assert that eight of the people interviewed have been in stress-filled and dangerous circumstances that could lead to a trauma-response:

You don't wanna know, it's a shithole, mind my language. You get beaten up, you get robbed, they take your money off you, they take your food off you, they do loads of things. It's like any hostel, you always get robbed.

This is perhaps not surprising when reading literature on homelessness and trauma. Furthermore, on the interplay between homelessness and trauma, researchers have documented that traumatic stress is so commonplace that it may be normative among those experiencing homelessness. (Goodman et al 1991; Hopper et al 2010; FEANTSA 2017; NAEH; Evolve Housing 2018)

Many people who find themselves homeless have been exposed to traumatic events that led to them losing their home. Examples from our research include a woman who left a relationship due to domestic violence only to find herself homeless; and a man who came out of a 10-month hospital stay to find his home trashed to such an extent that the police said it was unsafe for him to return. The Local Authority deemed him intentionally homeless, as he was not returning to his flat, and so he was left to fend for himself.

Others were less specific, albeit still describing the effect of trauma very clearly:

Between you and me (...) I have attempted suicide in the past. Due to the PTSD and all that, I lost all you know. It's not there at the moment but I used to, I used to have a noose next to my bed (...), like a comfort blanket, if things got really bad and I couldn't cope.

The people who populate various forms of temporary housing are often exposed to traumatic experiences during their stays there. Most of the single homeless households who find themselves in emergency accommodation or unsupported temporary accommodation are there because they have multiple complex needs, including poor mental health and a struggle with substance misuse. Some have come out of prison with nowhere else to go. One individual talks of feeling intimidated:

It's a mixture of illnesses in here. Terrible, terrible. It's boiling over you know, intimidation.

The threat of violence, robbery and death is never far away. Four respondents speak of feeling unsafe, scared and paranoid, although they are at pains to say that it is not their fellow residents' fault, they're just in need of help.

One accommodation in particular has seen a lot of deaths recently:

One of my neighbours on the right side, three months ago I found him dead. A month ago my neighbour on my left side I found him dead (...) Four people have died there now in the last six months. It's got bad juju there and I've seen three of them dead and found two of them. That got me a bit paranoid, my head doing overtime. I do a lot of thinking, I barely sleep as my head does overtime. That's why I need to speak to someone.

Another theme that came out strongly was control/chaos, which can be linked directly to trauma. Homelessness itself is disempowering and about loss of control (this connection is developed further in section 6.2).

It is noticeable from our research that those who receive some kind of support, or have a role/relationship with the landlord, are doing much better. One individual is a particular case in point. She has been moved to a one-bed flat and has received a lot of support. Although she has been diagnosed with PTSD, she gave the highest SWEMWBS score of all the interviewees.

6.1.2 Disability

Another theme that emerged from our interviews was disability. Disability covers a broad range of conditions, referring to both physical and mental impairments that have a substantial and negative effect on a person's ability to do normal daily activities over a period of at least 12 months (Equality Act 2010). The focus is on the effect rather than the diagnosis.

This study did not set out to look for disability, and yet it became apparent that a substantial proportion of our research participants were affected by some form of disability. In this section we look at the participants that spoke of physical impairment, and the effect it had on them, at a time when the country was in lockdown due to the virus.

Seven of the 19 research participants spoke of a specific disability or some form of restrictive health condition. At 37%, this is well above the national average in the UK of around 21% (Scope 2020a). The disabilities discussed by four participants in particular were limiting even prior to the restrictions imposed during lockdown.

One individual said:

My legs went bad about 6 years ago. I've not been out of the house for 6 years... I've not been able to go out anyway. I've been inside all the time.

These limitations however were often exacerbated by the lack of accessibility in the accommodation. The individual from the above quote, although primarily wheelchair bound, lived in a room up a flight of stairs.

Over the past couple of decades, disability campaigners have challenged the medical view of disability, that treats disability as an individual's bad luck, and argued instead for a social model of disability that emphasises barriers in society (Oliver and Sapey 1983, Scope 2020b). A simple example is glasses; without them, a large part of the adult population would be effectively disabled. Hearing aids, ramps and handrails are other well-known adjustments that may make a significant difference to daily living for people who experience physical impairments. A lift would have been transformative for the individual who had been stuck in his room for six years.

While the social model is widely acknowledged, there are still substantial barriers in society for people living with a disability. These seem to be particularly high for people living in emergency and unsupported temporary accommodation, where people are further disabled through the lack of assistive technology.

For another individual we spoke to, the lack of accessibility in his TA affected his ability to look after his personal hygiene:

What I do need is a shower, a decent shower

– So I guess that's difficult to follow hygiene rules, you don't have access to a shower do you?

No

– What have you got, tell me about your shower.

I've got a wardrobe, which is a shower. Single wardrobe at that

– So you can't get in it

No

– So when was the last time you had a shower?

I haven't had one for about half a year. I moved in in February, and about four months before I was there I couldn't have one, so over half a year

– So you haven't had a shower since, did you have a shower in prison?

I had one shower, that was it. And then they couldn't get me in there again because it was too dangerous

– Why was it dangerous?

There was nowhere to sit or nowhere to lean against. Last time I had a shower was when I was at xxxxxx, apart from that one shower in prison

– So the last shower you had was when you were in the care home?

Hm

– No good is it

No. Instead I'm having to get little strip washes

This is particularly unsettling during a pandemic when personal hygiene is of utmost importance, and highlights how inappropriate much of TA is for individuals living with disabilities due to the lack of accessible amenities. Unfortunately, these experiences are not unique to our research participants, but rather indicative of wider trends relating to how those living with disabilities are housed. A report for the Equality and Human Rights Commission found similar instances of unsuitable housing used for individuals living with disabilities:

“Some of those people interviewed had previously been housed by their local authority in upper-floor accommodation with either no lift or unreliable ones, even when authority staff knew that they were unable to manage stairs. Interviewees who had been housed in upper-floor accommodation reported an increased risk of accidents, increased stress and ill health, and additional costs imposed on the health service.”

(Satsangi et al 2018)

Not all disabilities are visible, including physical disabilities. It is likely that the number of single homeless households in temporary housing living with a disability is higher than what was found in this research, since we did not specifically set out to look for it. Further research is needed to understand the extent to which this population is affected by disability.

6.1.3 Mental ill health

Mental ill health has been identified as the most important type of disability associated with homelessness (Fitzpatrick et al 2010). While this statement may be influenced by limited research into the prevalence of physical disability among the homeless population, there is little doubt that mental ill health is ubiquitous in this group and associated with an increased risk of homelessness (ibid). That the conditions found in TA can be detrimental to people's mental health is also well documented (see for example Sanders and Reid 2018, Fitzpatrick et al 2010, Rose 2016). It was clear that Justlife's frontline workers were concerned for their clients' mental health, and particularly so during lockdown.

In preparing our research questions, we therefore designed several questions around mental health and well-being, including the SWEMWBS questionnaire, to test our assumption that mental health would be affected by the pandemic. Our assumptions proved to be well founded, although not exactly in the way we had imagined.

As described above, trauma came out strongly even though we didn't look for it. Although trauma and mental health overlap, the wider impact on mental health that living in temporary housing had on residents went beyond trauma. While eight research participants were connected with trauma, 11 told us they suffered from poor mental health.

The main mental health problems experienced by our research group were isolation, loneliness, paranoia and anxiety.

I'm feeling scared, trapped, very trapped, very scared, you know. I don't go out much you know (...). I do, I feel trapped and scared and forgotten about. That's what I feel.

When lockdown was imposed to curb the spread of the virus, house sizes and access to gardens became incredibly important to all of us. It quickly became clear that, while the virus itself could potentially affect anyone, lockdown did not affect everyone equally. People with access to adequate indoor and outdoor space were far better equipped to preserve and maintain good mental health throughout lockdown.

Individuals in shared TA have small rooms that are basically furnished with a bed and table. Some compared them to prison cells:

It's like a jail more than anything this hostel, the rooms are the same size as a cell. That's what it is, like a jail.

One individual had previously attempted to get arrested, as he thought prison was preferable:

I got arrested so I could go to prison and then try and start again to get a flat. But it didn't work out, I ended up here. So now we're going again.

A recent report on the mental health impact of lockdown suggests that social isolation in the form of quarantine is likely to aggravate existing mental health problems and can be experienced as a traumatic event (Usher et al, 2020). Our research confirmed this. For several research participants, the isolation and loneliness of lockdown increased their experience of paranoia and anxiety:

It's had a detrimental effect on me [lockdown], yeah. All my PTSD, spending a lot of time on my own, it's exaggerated it and made it worse, so it's not really healthy sitting in a room on my own.

However other research participants told us that lockdown made no difference to them, as they were already living in social isolation.

With my anxiety I can't get on public transport or anything. So I sit in my room all the time on my own anyway. (...) I do a lot of thinking, I barely sleep as my head does overtime. That's why I need to speak to someone, that's why I need a worker.

Five respondents reported that they are not in contact with friends or family and three spent most of their time confined to their rooms. While exacerbated by COVID-19 and the government guidelines on social distancing, it was clear that this social isolation existed for many before the onset of the pandemic. Several people commented that they had been 'self-isolating' prior to COVID-19 anyway.

There's not a lot of guidelines for me to follow. I don't go out of my house. I wash every day, I bathe every day like a normal person. I self-isolate without this Covid thing going on anyway. Don't make no difference to me.

The impact of ongoing isolation for those living in temporary housing was highlighted further in the responses given to the SWEMWBS, where, when asked to score how 'connected to other people' they felt, five respondents gave low scores (i.e. not at all, or rarely). These were not the same individuals who reported 'no contact' with friends or family.

6.2 Themes that describe context

Our analysis uncovered a high degree of chaos in the lives of people stuck in TA, and with that, a desire to gain control even over seemingly small things. Five individuals described their accommodation in a way that invokes images of chaos, nine individuals spoke of issues that highlighted a lack of control in their lives, while 11 spoke of things they tried to have control over. The sense of chaos came both from the physical and social environments found in this type of accommodation, and often came from other residents.

6.2.1 Social environments

Typically, temporary accommodation is populated by individuals with a history of substance misuse and mental health problems, many of whom suffer from past or ongoing trauma. It is a difficult social environment in which to find yourself if you are trying to recover from a history of abuse, crime, substance misuse or trauma. Many recognised that other residents were vulnerable and made a point of saying that they were not to blame, yet found it a very stressful environment to be in. While some found friendships in these accommodations, there was a significant degree of distrust between residents. Many mentioned the noise, 'anarchy,' and arguing as well as a concern over 'flimsy doors' to their rooms that make them feel unsafe.

You've got people in the hostel but I don't trust them enough, I don't let them in. I'll speak to them at the door sort of thing you know.

Some people did not have a lock on their door, making living in this environment even more stressful. Several respondents mentioned the ready availability of drugs making it difficult for those trying to come clean.

I'm an ex drug user, you've got a lot of drugs which brings a lot of temptation you see. (...) there's a lot of temptation to think I'll just have a one-off, and that one-off turns into a few occasions and before you know it, you've taken it every day again.

A concern that is particularly pertinent in a pandemic was over lack of cleanliness in the shared facilities such as kitchens, toilets, shower rooms and common stairways. One mentioned defecation outside of the toilet, while another spoke of vomit on the floor.

6.2.2 Physical conditions

In addition to having to live alongside unpredictable people, the physical conditions our research participants found themselves in were often very poor and could be difficult to keep clean regardless of who was staying there. Some spoke of an infestation of bedbugs, mice running freely around and sleeping next to walls covered in black mould.

We've got mice running around, like, you can see when they cross the floor at night. It should be condemned. Honestly, it's not a nice place to live this (...), it's full of bedbugs, it's full of mice, it's horrible.

Everyone's rooms got these bedbugs. They call them vampire bugs, not like that little mini woodlice (...) they're bright red, when you pop them it's just pure blood, they've been sucking on you.

This went beyond unpleasant for some. One individual felt the black mould had contributed to a relative's death in the accommodation where they were both staying. Another respondent had found a chair on the street and chose to go there to sleep to avoid being bitten by bedbugs in his bed at night. One individual thought that COVID-19 could be passed through the bedbugs:

The bedbugs are outrageous, they're passing on transmitted diseases when they bite other people. If the COVID-19 virus comes, we will all get it, we will all be transmitted, it will be transmitted to us easily. (...) One can devastate you, you know. And that's why, mostly, I can't sleep at night. I stay up till the morning and open the curtains and they go away.

This lack of control over their environment went beyond insecurity and conditions, it was also around the lack of choice with regards to housing. One woman was living in accommodation with nine men even though the reason for her homelessness was domestic violence. For another, the B&B was the only option presented to him after living in a bail hostel. Some were unable to leave their accommodation because they had mobility issues and were given rooms up flights of stairs.

6.2.3 Agency and control

It was in this chaotic environment that most research participants made it clear they had very little control over most aspects of their lives, and that they were keen to take back control where possible. For those who expressed they felt a lack of control, only one mentioned COVID-19; the pandemic had caused problems with his benefit claim, leading to loss of income. Others spoke of insecurity of tenure (unrelated to COVID-19) and the conditions of their accommodation, things they wished they had more control over. One woman, who had just moved into more long-term housing, described the insecurity of her previous accommodation:

You know emergency accommodation is on a 24-hour basis, and you can get kicked out at 9 o'clock in the morning with nowhere to go. Now I'm in long term temp, I know I could potentially be there for ten years if I wanted to.

Although many expressed resilience in the face of COVID-19, or resignation about this being the reality of their daily lives, eight individuals felt life was no different for them in spite of the pandemic. Some felt more positive and a sense of control because they had an active plan for how to negotiate moving on in life. This sense of purpose or direction could also be achieved through holding an 'official' role, such as cleaning or cooking breakfast for fellow residents in their accommodation. Having a relationship with the landlord gave a degree of agency in that they were able to negotiate rent reduction or other benefits, just as it gave a sense of being 'known'. It was evident from our research that having a trusted role in the accommodation was beneficial.

Because I do a little bit of cooking and cleaning, [the landlord] helps me out with the rent, so I don't pay a service charge. That's how that works. That's how I've been able to save a little bit of money for my deposit.

The majority however expressed a keen sense of lack of control in their lives. Some mentioned ways in which they were trying to gain control or have agency where they could. This manifested itself both positively and negatively. Those who reacted positively channelled their attempt at having control into going for walks outdoors or making plans for next steps. Others tried to take control in ways that had a negative effect on their lives, for example, attempted suicide or purposefully getting arrested.

We know from literature on trauma and homelessness that there is a strong connection between the ability to take control over one's own life and the interplay between trauma and poor mental health (Hopper et al 2010, Evolve Housing 2018, FEANTSA 2017). Homelessness itself is disempowering and about loss of control. Just as a chaotic environment will be detrimental to people's mental health and ability to recover from trauma, a sense of control and agency will foster resilience and a higher degree of wellbeing.

7. Analysis

The added uncertainty of a pandemic to existing life conditions in temporary accommodation highlights how fragile life can be for individuals stuck there. It has implications for individuals on a personal level as well as on a systemic level. It is important to note that the full impact of COVID-19 and the national lockdown was mitigated for the individuals interviewed here due to their engagement with Justlife. The majority of people living in this type of housing receive little or no support and, as a result, are likely to find themselves in much more difficult situations.

7.1 Personal level

Our findings add to, and confirm, existing literature that describe single homeless households in temporary accommodation as living in chaotic, insecure, poor conditions with very few alternative housing options (Rose and Davies 2016, Maciver 2017, Sanders and Reid 2018). Armed with this knowledge, our assumption prior to conducting interviews was that the lives of these hidden homeless individuals would be very disrupted by COVID-19 and the national lockdown that followed. We assumed that everyone would be locked inside insecure housing, that their already poor mental health would deteriorate further, and the virus would spread rapidly. However, our analysis shows the impact was more limited than expected. Our research participants were more preoccupied with other issues in their lives, because they didn't feel the pandemic could make their existing life situations worse.

The impact expressed by participants mirrored that of the wider society in that social life was interrupted and services were stopped or moved to telephone-only consultations. This affected regular access to support such as primary healthcare or re-housing support, which was especially challenging for three of our research participants but was also a key concern for our frontline workers. Those working closest with these individuals were concerned about deteriorating mental and physical health on a more rapid scale than during normal times. It was clear that research participants felt better supported, and frontline workers felt client's needs were better addressed, where face-to-face support was happening.

Another major change for these individuals was the contact with their friends and family. All our research participants were in touch with friends or family members, however this was often reliant on mobile phone data or a data enabled tablet provided by Justlife. This suggests that WiFi availability is key for this population to stay connected to their wider support networks.

12 of 19 research participants felt they were still being supported appropriately and eight of 19 felt COVID-19 did not impact their lives at all. Some even told us they were already effectively self-isolating before the pandemic. Those who had already been struggling with anxiety however, struggled with self-isolation as there were few distractions from 'bad thoughts' during long periods of being alone.

Beyond the immediate impact of COVID-19 on our research participants, our interviews painted a concerning picture of fragility and uncertainty that existed regardless of this global health pandemic. It is not necessarily comforting that so many involved in this research did not feel their lives had changed as a result of lockdown. Their reality, regardless of COVID-19, was one of life in poor quality accommodation where individuals faced past or ongoing trauma, disability, physical and mental ill health alongside problems with addiction and substance misuse. Many spoke about the chaos in their accommodation and the lack of control they have over the cleanliness of their housing, who their neighbours are and whether or not they will be able to move on.

No one reported themselves, or others known to them in similar living situations, to have had the virus. One participant, however, said he would quite like to contract it as he thought this might help him get access to housing:

I don't wish it on anyone, never will [the coronavirus]. But if I get it on the off chance, and it helps me with the council, yes. It would help me with accommodation wouldn't it.

It remains to be seen how the virus will affect this group, the pandemic is far from over. However, we know that there is a high prevalence of comorbidities amongst this group, and that many live in chaotic, overcrowded and/or shared accommodation, two known risk factors in the spread and impact of the virus. We also know that, while residents say not much has changed for them, their support workers are worried about their mental and physical health worsening on an exponential scale.

7.2 Systemic level

The problems described by our research participants point to systemic issues within homelessness services and the policies guiding them. Therefore, in order for them to be sustainably addressed, it is necessary to look at the wider context. Below we set out some specific concerns that arose from this research.

7.2.1 Direct systemic insights

A surprising number of individuals spoke about disability during the interviews, even though it was not a specific topic which we were exploring. Only four of the 19 had been housed because they were owed a main housing duty from their local authority, and 35% of the remaining 15 had a debilitating disability and/or health condition that varied from bad knees to lung cancer.

According to the Homelessness Reduction Act 2017 and the Homelessness Code of Guidance 2018, local authorities have a duty to help homeless households into accommodation, provided they are eligible (all British nationals are eligible), unintentionally homeless and in 'priority need'. Priority is given to those with dependent children as well as vulnerable adults (Gov.uk 2018).

It would stand to reason that most of the individuals interviewed here could be considered vulnerable, as they have a higher than average degree of physical and mental health needs. In addition to disability, there is a high prevalence of historical and ongoing trauma in the lives of those living in emergency or unsupported temporary accommodation. Many have experienced trauma throughout their lives but have never received support to overcome it. Instead, these individuals are faced with a chaotic environment, fear of immediate eviction, no choice on their neighbours, and sometimes shared facilities which are not clean. Many live surrounded by death and have been re-traumatised by it.

However, the majority of our respondents have not been considered to meet the criteria for priority need under the Code of Guidance (Gov.uk 2018). We recognise that qualitative research cannot be used to draw quantitative conclusions, however our findings highlight questions regarding disability and TA, and more generally the criteria for eligibility in the Code of Guidance that is used to judge whether an individual is considered vulnerable enough to receive support. As things stand, the bar is sufficiently high to leave most homeless individuals unsupported.

7.2.2 Wider systemic insights

Temporary accommodation is primarily used as a last resort, at which point, both single homeless individuals and families have no choice but this accommodation or the street. Some of the properties used for temporary accommodation occupy the darkest corners of the private rental market in England, where basic maintenance is not always prioritised. Mix this reality of trauma, other mental and physical health issues and, sometimes, disability, with a profound lack of choice in their lives, and it is clear that this is not a place from which individuals can easily move on, deal with their mental health or addiction problems or reconnect with the job market. The negative impact cannot be ignored; for the individuals stuck in these conditions, which should be bad enough in and of itself, but also for the wider society and public purse as this is no solution to homelessness. If anything, temporary accommodation exacerbates and entrenches the problems.

Despite this, homeless individuals are still placed in, or find their own way into emergency and unsupported temporary accommodation. Sometimes placements are made with little thought to their options for moving on from this accommodation, due to the intense pressure to find housing for individuals. Temporary accommodation is also a last resort for local authorities.

Figures released by the Office for National Statistics on the 10th July 2020 show 16 recorded coronavirus deaths of homeless people in England up to the 23rd June (Simpson 2020). A homeless person is defined by the ONS as someone with “no fixed abode” or who was staying in a known homelessness shelter at the point of death (ibid). This definition is likely to miss the majority of those living in most forms of temporary accommodation. It is therefore unlikely to be an accurate picture of how the homeless population as a whole has been affected by the virus.

A recent modelling study into how the COVID-19 has affected the homeless population in England included those living in some form of temporary housing such as, hostels and night shelters (Lewer et al 2020). The study suggests that the package of interventions instigated by the Government to curb the spread of the virus, such as avoiding shared accommodation where possible and including initiatives aimed at the general population such as social distancing and lockdown, potentially prevented more than 20,000 infections and 266 deaths among the homeless population up to the end of May 2020. In other words, without strong measures aimed to control the spread of the virus in these environments, the impact on this group would have looked very different.

Another study from greater Paris adds further evidence to this picture. Capturing the impact on homeless individuals in shared temporary accommodation by looking at the infection rate among individuals in 10 emergency shelters, two food distribution points and two workers’ hostels, this study found 40% infected with the virus (MSF 2020). Emergency accommodation in Paris has people sleeping in shared spaces, which, crucially, is not the case in the kind of temporary accommodation looked at in this report. However, the study also shows more than three times as many cases among those who share a bathroom with more than five people, than is the case among individuals who have access to their own bathroom. This will be true for most of our research participants.

It follows that temporary accommodation, specifically emergency and unsupported temporary accommodation, should be seen as high-risk environments for the spread of COVID-19, especially when the reality of comorbidities that include respiratory conditions and lack of cleanliness is commonplace. Until now, there have been surprisingly few cases of virus outbreaks in TA in England (Simpson 2020), but this could quickly change. If the virus enters these types of temporary accommodation, everything points to a scenario where the virus spreads quickly and with devastating effect.

As we write, homelessness in England does not look any closer to being solved. In spite of the ‘Everyone In’ initiative, which saw 14,610 rough sleepers housed temporarily in hotels (MHCLG 2020a), latest figures are not promising. On the contrary, with ongoing local and national lockdowns, and the economic turmoil that is already unfolding as a consequence of the pandemic, homelessness is on course to rise. Government interventions such as the furlough scheme and evictions ban provided a much-needed pause, but these initiatives were temporary.

After housing 14,610 individuals during the first part of the pandemic, the government promised 6,000 additional supported housing accommodation over two years to provide continued support for homeless individuals (MHCLG 2020a). This is a drop in the ocean compared to the now up to 29,000 housed under 'Everyone In' in total according to Prime Minister Boris Johnson (Thomson Reuters Foundation 2020), and the additional tens of thousands already living in temporary accommodation before the pandemic.

Temporary accommodation is already largely used as the central solution to ending homelessness. The use of TA is likely to increase if the government is to meet its promise to end rough sleeping by 2024, regardless of its negative impact and whether there is a pandemic or not (Gov.uk 2019). Demand will continue to grow on temporary accommodation resources, which on current trends can only lead to an acceleration in the use of the poorer quality short-term emergency and unsupported temporary accommodation. It will also make it more difficult for people to move on to secure housing.

Although the risk is clear, temporary accommodation does not feature in conversations around homelessness at the time of the pandemic. Public debate, along with political attention, is primarily focused on rough sleepers. While there is no doubt rough sleepers are vulnerable, they do not represent the full picture of homelessness vulnerability. Highly insecure short-term temporary accommodation is still not discussed in plans around ending homelessness and ensuring those who have been placed inside have somewhere safe to go.

The fact that this is not part of the conversation for ending homelessness means there is limited understanding of the full impact it has on those stuck in this type of housing. Not only is temporary accommodation not involved in conversations around ending homelessness, it is not included in the definition for homelessness that the Office of National Statistics includes for official COVID-19 deaths.

Our concern is that use of these types temporary accommodation will instead be increased, as a cheaper alternative with seemingly quick results. This would be a mistake in policy terms, and a tragedy for those ending up in these conditions. If the government is to meet its promise of ending rough sleeping by 2024, a combination of extensive policy changes, increased funding to key sectors and substantial investment in social and affordable housing will be needed.

An end to homelessness is obviously the long-term goal. In the meantime, while we wait for sufficient affordable housing to be made available, a series of actions at different levels can begin to improve the lives of people stuck in temporary accommodation. We set out our recommendations below.

8. Recommendations

The reality faced by single homeless households entering emergency and unsupported temporary accommodation is bleak at the best of times, but even worse during a pandemic. The lack of conversation around addressing these issues, when the full economic impact has yet to be felt, makes it even more concerning.

The panacea is more housing availability and choice, achieved through building more **truly** affordable,⁶ good-quality housing in the form of social housing and secure longer-term private rental options. **Increased investment in affordable and social housing** would therefore alleviate the accelerating growth of pressures as a result of COVID-19 within temporary accommodation across the country.

It is vital we take action both on existing challenges in temporary accommodation and those looming due to COVID-19. We should not, however, wait for more housing to be built before taking action. Hidden homeless households are currently suffering in poor quality, insecure, short-term housing where they are at a high risk of contracting and spreading COVID-19. We believe the following recommendations centred around collaboration, research and focus are key to impacting change now, while we are grappling with COVID-19, and as we move out of the pandemic.

1. COLLABORATION through the creation of Temporary Accommodation Action Groups

Temporary Accommodation Action Groups (TAAGs) are area-based networks that bring together stakeholders of TA in a local authority area, to improve the experiences of homeless households living there (Maciver et al 2016, Maciver and Yates 2018). Relevant stakeholders include, but are not limited to, local authority housing teams, support services, landlords, residents, mental health teams, drug and alcohol services and primary health care. The change-agenda is locally set, but it is within these collaborative forums that many of the challenges faced by residents highlighted in this report can start to be addressed.

Existing TAAGs in Brighton, Manchester, Hackney and East Sussex have worked together collaboratively to achieve positive impact. For example in Manchester, Environmental Health have now implemented changes based on the TAAG's recommendations, including reducing the length of licences they provide to new landlords to just one year, in order to increase landlord accountability, as well as including conditions within HMO licenses to encourage training, engagement with support services, and to report deaths on the premises within 10 days.

⁶ Affordable housing is typically set at 20% below market rate. There are ongoing conversations about what is affordable and who can access it. Particularly useful information can be found on the UK Collaborative Centre for Housing's website (for example: <https://housingevidence.ac.uk/is-it-time-for-a-right-to-affordable-housing/>) More detailed information about the government's definition of Affordable housing can be found at: <https://www.gov.uk/guidance/housing-statistics-and-england-housing-survey-glossary/a-to-z>

In less than a year, the work of the East Sussex TAAG reduced evictions from local TA and over the past year, residents in Brighton and East Sussex, through their involvement in the local TAAGs, have been involved in the creation of an Emergency Accommodation Charter. This key document focuses on improvements in standards and experiences of homeless households in temporary accommodation and was accepted by Brighton and Hove City Council to form part of the new contracts with local TA providers.

We believe TAAGs can also play a central role in bringing about other changes needed that are highlighted by this research:

- **Ownership and agency.** Participants in our research who were given a role in their accommodation were noticeably more resilient, highlighting the importance of ownership and agency in their lives. Where possible, residents should be involved in decision-making as equals and given trusted roles to increase their sense of control. Involvement in a local TAAG is one way to build ownership and for a sense of agency to develop.
- **Implementation of Trauma Informed Care across relevant sectors.** This report highlights the tendency for homeless households to struggle with poor mental health when living in temporary accommodation. In addition to greater access to mental health services, the creation of Psychologically Informed Environments (PIE) and Trauma Informed Care (TIC) are good practices which should be developed and adapted across organisations to improve support provision (Homeless Link 2017).
- **Provision of face-to-face support where possible.** Our research has shown that most participants preferred face-to-face support to that given over the phone. The frontline workers interviewed also felt this alleviated their concerns over the loneliness their clients may have been feeling.
- **WiFi provision in temporary accommodation.** The rollout of internet provision for people living in all forms of temporary accommodation helps combat loneliness by allowing connection and support to continue online.

2. RESEARCH into Disability and hidden homelessness

While there is a considerable body of research into mental health and homelessness (see for example Fitzpatrick et al 1999, EvolveHousing 2018), there is limited research into how physical disability affects this population. Indeed, disability as a charity sector seems quite separate from the homelessness sector.

A study from London however suggests that disability is widespread amongst the homeless population (Greeff), and a body of research has shown a convincing link between disability and poverty (see for example Laxton and Parckar 2009; Tinson et al 2016) which is known to increase the risk of homelessness. The findings from this research suggest that disability is also prevalent among those single homeless households living in emergency and unsupported temporary accommodation.

More research is needed to understand how disability affects this group of individuals, the extent, and why so many end up in this form of temporary housing.

Disability should also be mainstreamed across all levels of housing and homelessness services, specifically as part of the discussion around strategy, programming and funding of social housing and temporary accommodation. By being proactive in this way, rather than reactive once problems have arisen, the burden of argument is removed from the individual concerned. As advocated in the social model, this would address some of the barriers and stressors before they arise and reinstate some measure of dignity for individuals living with a disability in temporary accommodation.

3. FOCUS from national government and agencies to ensure Temporary Accommodation is included in plans for ending homelessness

This recommendation is key to unlocking systemic change. There is little conversation at the national level about temporary accommodation and its role in preventing the end of homelessness. The exclusive focus on rough sleeping suggests these short-term housing solutions will continue to be used in the long term to the detriment of the homeless households living in temporary accommodation. We, therefore, **recommend increased focus in national conversations around ending homelessness paid to hidden homelessness in temporary accommodation.**

Along with this increased focus, there needs to be an **all-encompassing, consistent definition of homelessness across all government bodies reporting on homelessness.** This would address the inconsistency in reporting on homelessness, brought about by the limited definition used by the ONS, and give a more truthful picture that includes the impact on all forms of homelessness.

There also needs to be **a recognition of the prevalence of isolation and loneliness in temporary accommodation through the Government's strategy for tackling loneliness**. It is recognised that loneliness can affect all parts of society, and has been described by policy makers as a health crisis that is as damaging as smoking (HM Government 2018). During this pandemic there is even more cause for including temporary accommodation within the Government's strategy on tackling loneliness and being part of the general discourse of the issue.

Ultimately, it is important, whether in collaboration, research or through increased focus, to **listen to people experiencing homelessness**. Almost all of our respondents had a very clear idea of what their needs were. A place to call their own was not surprisingly a unanimous desire, but, in addition, people also spoke more specifically of seeing a psychiatrist, having someone to talk to, having somewhere to dry their clothes, getting away from the temptation of readily available drugs, getting a hospital appointment for a long standing health issue and reconnecting with family members. Listening to those experiencing homelessness would lead to more effective targeted solutions to ending homelessness.

9. Conclusion

I haven't heard about virus checks yet. I think we'll be the last, coz I believe we're the undesirables of the world that live in hostels.

The biggest reminder this research gives is one of how inadequate the majority of emergency and unsupported temporary accommodation is for those experiencing hidden homelessness. This research paints a picture of individuals in accommodation that is unsuitable due to health needs (i.e. not being able to shower during a pandemic because the room is not accessible in a wheelchair) or find their way into temporary housing that is unsuitable for other reasons (bed bugs, black mould, lack of cleanliness). Once there, many are stuck in this kind of accommodation for long periods of time, only punctuated by spells back on the street, in prison or in hospital.

By any definition, these individuals are extremely vulnerable to the virus. The fact that our respondents were less worried about the virus than we expected does not mean that we should not be worried as a society.

It is clear that rising inequality has undermined our resilience to the pandemic as a country; the worst off are more vulnerable to the virus. People living in temporary accommodation fare badly on this scale, with ill health and poverty and no control over basic facilities. Sometimes not even the ability to lock their own door. The conditions are such that they are more likely to exacerbate existing problems than provide a route out of homelessness. The fact that they are hidden from view and do not always feature in official statistics is a further cause for concern.

Investigating how violence and crime affected the homeless in a mid-sized Southern metropolitan area in 1999, Fitzpatrick, LaGory and Ritchey described those who are homelessness as living in conditions where "crime may appear to be just another momentary hassle." (Fitzpatrick et al 1999, p.445)

This is no less true for the hidden homeless in 2020, who are housed in chaotic, insecure and often inappropriate temporary accommodation. When life is full of disruption, governed by chaos and lack of control, even something as big as a pandemic is just another 'momentary hassle' in a long series of hassles. It puts into perspective what the rest of their lives are like.

Literature

Back, S., E. Foa, T. Killeen, K. Mills, M. Teesson, B Cotton, K. Carroll, K. Brady, 2014: *Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure (COPE): Patient Workbook*. Oxford University Press

BFPG, 2020: *COVID-19 timeline*. British Foreign Policy Group: <https://bfpg.co.uk/2020/04/covid-19-timeline/>

BMJ, The, 2020: *Covid-19: Nearly 6% of people in England were infected by end of June, study suggests*. The British Medical Journal. <https://www.bmj.com/content/370/bmj.m3224>

Bramley, G., S. Fitzpatrick, 2015: *Hard Edges: Mapping severe and multiple disadvantage in England*. Lankelly Chase Foundation

COBR, 2020: *Testing and new cases (UK)*. Cabinet Office Briefing Rooms: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/895072/2020-06-24_COVID-19_coronavirus_slides.pdf

Equality Act, 2010: <https://www.legislation.gov.uk/ukpga/2010/15/contents>

Evolve Housing, 2018: *Breaking the Cycle of Trauma. The connection between trauma, mental health and homelessness*. Evolve Housing + Support

Fitzpatrick, K.M., M.E. LaGory and F.J. Ritchey, 1999: *Dangerous places: exposure to violence and its mental health consequences for the homeless*. American Journal of Orthopsychiatry 69(4), pp.438-447

Fitzpatrick, S., N. Pleave and A. Wallace, 2010: *Evidence Analysis for the Triennial Review: Homelessness*. Equality and Human Rights Commission

FEANTSA, 2017: *Recognising the Link Between Trauma and Homelessness*. European Federation of National Organisations Working with the Homeless, Position Paper

Goodman, L., L. Saxe and M. Harvey, 1991: *Homelessness as Psychological Trauma. Broadening perspectives*. American Psychologist, 46(11), pp. 1219-1225

Gov.uk, 2018: *Homelessness code of guidance for local authorities*. Ministry of Housing, Communities and Local Government

Gov.uk, 2019: *Prime Minister pledges new action to eliminate homelessness and rough sleeping*. Press release, Prime Minister's Office

Gov.uk, 2020a: *Foreign Secretary's statement on coronavirus (COVID-19): 5 May 2020*

Gov.uk, 2020b: *Behind the headlines: Counting COVID-19 deaths*. Public Health Matters blog, 12th August, 2020

Greiff, F.: *Governance and Disabled People who are Homeless*. Masters Dissertation, University of Kingston: https://drive.google.com/file/d/0B5_zwI0PEeSNjVhZTJIMjQtNmUzOC00MDEwLWEyNjctMjAyZjhhYzYk1Mzgw/view?hl=en

Guardian, The, 2020: *Care homes and coronavirus: Why we don't know the true UK death toll*. <https://www.theguardian.com/world/2020/apr/14/care-homes-coronavirus-why-we-dont-know-true-uk-death-toll>

HM Government, 2018: *A Connected Society – A Strategy for Tackling Loneliness*. Department for Culture, Media and Sport.

Homeless Link, 2014: *The Unhealthy State of Homelessness. Health audit results 2014*. <https://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf>

Homeless Link, 2017: *An Introduction to Psychologically Informed Environments and Trauma Informed Care* https://www.homeless.org.uk/sites/default/files/site-attachments/TIC%20PIE%20briefing%20March%202017_0.pdf

Hopper, E., E. Bassuk and J. Olivet, 2010: *Shelter from the Storm: Trauma-Informed Care in Homelessness Services Settings*. The Open Health Services and Policy Journal, v. 3, pp. 80-100

House of Commons, 2020: *Households in temporary accommodation (England)* Briefing Paper number 02110, 12th October 2020

Laxton, C. and G. Parckar, 2009: *Fuel Poverty and Disability*. Leonard Cheshire Disability

Lewer, D., I. Braithwaite, M. Bullock, M. Eyre, P. White, R. Aldridge, A. Story, A. Hayward, 2020: *COVID-19 among people experiencing homelessness in England: a modelling study*. The Lancet Respiratory Medicine. September 23rd 2020.

Maciver, C., C. Snelling, A. Fleming, B. Davies, 2016: *The Journey Home. Building a solution to Unsupported Temporary Accommodation*. IPPR North with Justlife.

Maciver, C., 2017: *Lifting the Lid on Hidden Homelessness*. Justlife

MHCLG, 2020a: *Dame Louise Casey calls on community partners to help with COVID-19 Crisis*.

MHCLG, 2020b: *Statistical Data Set. Live Tables on Homelessness*. Updated 29th October 2020

MSF, 2020: *Vulnerability and prevalence of COVID-19 in the Île-de-France region*. Medecins Sans Frontieres (MSF) International

NAEH, 2012: *Addressing Post-traumatic Stress Disorder Caused by Homelessness*. National Alliance to End Homelessness

- Oliver, M., B. Sapey, 1983: *Social work with disabled people*. Palgrave Macmillan
- Perrin, P., O. McCabe, G. Everly, J. Links (2012): *Preparing for an Influenza Pandemic: Mental Health Considerations*. Cambridge University Press
- Reeve, K. and E. Batty, 2011: *The hidden truth about homelessness. Experiences of single homelessness in England*. Crisis
- Rose, A., B. Davies, 2014: *Not Home. The Lives of Hidden Homeless Households in Unsupported Temporary Accommodation in England*. IPPR North
- Rose, A., C. Maciver, B. Davies, 2016: *Nowhere Fast: The journey in and out of unsupported temporary accommodation*. IPPR North with Justlife
- Sanders, B. and B. Reid, 2018: *'I won't last long in here'. Experiences of unsuitable temporary accommodation in Scotland*. Crisis
- Satsangi, M., D. Theakstone, P. Matthews, J. Lawrence, K. Rummery, S. Mackintosh, S. Baghirathan, G. Boniface, 2018: *The housing experiences of disabled people in Britain*. Equality and Human Rights Commission, Research report 114
- Scope, 2020a: Disability facts and figures: <https://www.scope.org.uk/media/disability-facts-figures/>
- Scope, 2020b: Social model of disability: <https://www.scope.org.uk/about-us/social-model-of-disability/>
- ShelterLegal, 2020: Overview of legal definition: https://england.shelter.org.uk/legal/homelessness_applications/defining_homelessness/overview#_edn1
- Simpson, J., 2020: *At least 16 homeless people have died of coronavirus, new data reveals*. Inside Housing, 10/07/20
- Thomson Reuters Foundation, 2020: *Revive COVID-19 homeless scheme during winter, UK government urged*. <https://uk.reuters.com/article/us-health-coronavirus-britain-homeless-t/revive-covid-19-homeless-scheme-during-winter-uk-government-urged-idUSKBN27M26G>
- Tinson, A., H. Aldridge, T.B. Born and C. Hughes, 2016: *Disability and Poverty: Why disability must be at the centre of poverty reduction*. New Policy Institute
- Usher, K., N. Bhullar, D. Jackson, 2020: *Life in the pandemic: Social isolation and mental health*. Journal of Clinical Nursing, 6th April 2020.



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