

Supporting tenants with multiple and complex needs in houses in multiple occupation: The need to balance planning restrictions and housing enforcement with support

Dr Steve Iafrati

University of Wolverhampton

Faculty of Social Sciences

Nursery Street

Wolverhampton

WV1 1AD

s.iafrati@wlv.ac.uk

Abstract

The number of houses in multiple occupation (HMOs) in the UK has increased significantly in recent years, with recognition that this sector often houses some of the UK's most vulnerable tenants. Government responses to the growth in HMOs has focused increasingly on landlord enforcement and planning controls, with more limited attention on the needs of vulnerable residents. Drawing on new research with HMO tenants with multiple and complex needs (MCN), attendance at HMO working groups and consultations with stakeholders, this paper argues that whilst there is a need to address some of the issues associated with HMOs through landlord enforcement and regulation, it is important to balance this approach with appropriate support for tenants with MCN. For many people, living in an HMO can exacerbate personal challenges they may be facing. However, researching experiences of living in HMOs from a tenant perspective shows that positive outcomes are possible when tenants with MCN are supported to address their needs. At a time when the number of HMOs is continuing to increase, it is important to explore the significant role of support provided to tenants with MCN.

Keywords: Houses in Multiple Occupation (HMOs); Multiple and Complex Needs (MCN); enforcement; support

Introduction

Concerns regarding under-supply and affordability of housing have been widely acknowledged (Lyons et al, 2017; DCLG, 2017a; Baxter and Murphy, 2017; Wilson and Barton, 2018). Alongside insufficient supply of housing (Wilson and Barton, 2018; Archer and Cole, 2016; Heath, 2014) and concerns regarding housing affordability (Hodkinson and Robbins, 2013; Poon and Garrett, 2012; DCLG, 2017a; Baxter and Murphy, 2017; ONS, 2018), there has been decreased government confidence in the social rented sector post-2010 alongside a faith in market solutions to address declining levels of home ownership (Archer and Cole, 2016; Wilson et al, 2017; Manzi and Morrison, 2018). Indeed, between 2010 and 2018, affordable housing options reduced as social rented housing completions declined from 62,817 per year to 39,562 and affordable rented housing completions similarly declined (DCLG, 2017b). Additionally, significant welfare reforms, including Local Housing Allowance¹ limits and benefit freezes, have created additional barriers for some people who are trying to access safe and affordable housing (Manzi, 2014; McKee et al, 2016; Simcock, 2017; Wilkinson and Ortega-Alcazar, 2017; Rugg and Rhodes, 2018a; 2018b).

Amid problems of affordability and perceived 'crises' within housing, there has been a gradual shift in the composition of housing tenure across the UK. Between 2001 and 2018, the proportion of households in owner occupation has consistently declined as the number of households privately renting has increased from 10.1% of dwellings to 19.9%, an increase in the numbers of

¹ Local Housing Allowance rates are used to calculate Housing Benefit for tenants renting from private landlords.

private rented dwellings from 2.1m to 4.8m (MHCLG, 2019). One characteristic of this growing private rented sector has been an increase in houses in multiple occupation (HMOs). Government estimates in 2010 suggested that there were between 236,000 and 379,000 HMOs (DCLG, 2010). However, this has subsequently increased, with estimates of 497,000 HMOs in England and Wales at the end of March 2018 (Wilson and Cromarty, 2019), although some suggest that the figures underestimate the true number of HMOs, with many existing 'below the radar' (Mullins et al, 2017).

Low cost privately rented HMOs, reflecting a national pattern, are mainly located in some of the most deprived neighbourhoods in the UK (Smith, 2012; Barratt et al, 2012; Ward 2015; Depledge et al, 2017). The growing geographical concentrations of HMOs (Smith, 2012; Barratt et al, 2012; Ward 2015; Depledge et al, 2017) has led to concerns regarding neighbourhood related stigma, issues regarding anti-social behaviour, drug dealing and burglary (House of Commons, 2007; Davies and Turley, 2014; Cole et al, 2016). The expansion of the HMO sector has also raised concerns that it encourages 'opportunistic rogue landlords who feel the business risks for poorly managing their accommodation are outweighed by the financial returns.' (DCLG, 2017c: 4).

At the same time, a growing body of research identifies how the changing housing landscape – including the growth in numbers of HMOs – has affected the lives of some of the most vulnerable renters in the UK; those who experience the fewest housing choices (Barrett et al, 2012; Rose and Davies, 2014; Green and McCarthy, 2015; Barratt et al, 2015; Cole et al, 2016; Barratt

and Green, 2017) and are often limited to housing characterised as the ‘bottom end’ of the private rented sector (Rugg and Rhodes 2008: 21) or housing of ‘last resort’ (Irving, 2015). Indeed, it is suggested that HMOs ‘often house vulnerable tenants’ (Wilson and Cromarty, 2019: 3), including those with multiple and complex needs (MCN). The term MCN includes those with experiences of institutional care, the criminal justice system, mental/physical health problems, homelessness and ‘street culture activities’ (Fitzpatrick et al, 2013; Shelter, 2017; Newbigging and Parsonage, 2017; Barrett et al, 2012), often encompassing those who fall between the ‘gaps’ in welfare provision (Bramley et al, 2015) who can be ‘openly targeted’ for exploitation by unscrupulous landlords (Rugg and Rhodes, 2008).

While concerns have been raised regarding the growth of HMOs by successive Governments since 2008 (Wilson, 2017), responses have focussed on increasing landlord enforcement and regulation (MHCLG, 2018a), providing local authorities with increased powers through Selective Licensing and planning restrictions (DCLG, 2015; DCLG, 2016; DCLG, 2017d; Wilson, 2017; MHCLG, 2018b), Article Four Guidance of The Town and Country Planning (General Permitted Development) Order 2015², as well as introducing the Rogue Landlords Enforcement Grant and an enhanced role for licensing of HMOs in section 125 of the Housing and Planning Act (2016) (Wilson and Cromarty, 2019). This represents a government approach to managing concerns regarding tenant wellbeing in HMOs through enforcement against perceived ‘rogue

² Article Four provides local authorities with greater powers to refuse planning permission for previously domestic houses to be changed to HMOs and to limit the number of HMOs in certain neighbourhoods.

landlords' (DCLG, 2017c; 2017d; House of Commons, 2018). However, this approach does not address how to support vulnerable tenants to achieve positive and sustained tenancies (Rugg and Rhodes, 2018a; 2018b).

With the size of the HMO sector unlikely to decrease in the near future, it will continue to house a concentration of tenants with MCN. This makes appropriate policy interventions increasingly important. Current literature and research examining the experiences of HMO tenants provides a valuable insight into the challenges faced by many tenants (Barratt et al, 2012; Smith, 2012; Barratt et al, 2015; Barratt and Green, 2017; Wilson, 2017). This paper aims to add to this debate drawing upon unique insights from new research focusing on the lived experiences of HMO tenants with MCN, as well as consultations with HMO working groups and stakeholders, which compare the experiences of two case study areas; one where support is provided to HMO tenants and one where support was absent. The article highlights that whilst enforcement and planning controls within the HMO sector remain important, positive outcomes for tenants can only be achieved through balancing this with appropriate support to vulnerable tenants. Whilst recognising the importance of mental health support for tenants with MCN (Barratt et al, 2012), support also needs to encompass physical health, social inclusion and economic support.

Methods

This paper draws upon ongoing research in two geographical areas focusing on the experiences of HMO tenants with MCN (Iafrati, 2019), with analysis based on in-depth interviews with 16 HMO tenants, eighteen months of attending two HMO working groups, and nine interviews with members of the working groups and other relevant stakeholders.

The research locations were chosen for two key reasons: firstly, both of them have significant HMO sectors that are large enough to warrant research; and secondly, stakeholders had identified the HMO sectors in both locations as sufficiently problematic to necessitate the launch of the working groups.

The interviews with tenants were important to understand the lived experiences of HMO tenants with MCN and ways in which housing provision can exacerbate personal challenges. Recognising the challenges of accessing HMO tenants (Aldridge, 2016), the researcher worked with various gatekeeper organisations to identify and make initial contact with tenants. Purposive sampling was used (May 2001; Morse, 2007) to identify a variety of interviewees, including those with needs related to health, debt, experiences of the criminal justice system, homelessness, and substance misuse. The tenants were approached by gatekeeper organisations to explain the research and if they agreed to be involved, they were introduced to the researcher who provided further details about the project. Semi-structured interviews were arranged at venues where interviewees felt at ease, with the interviews conducted in private and designed as relaxed, guided conversations. Of the 16 tenants interviewed, 13 came from separate HMOs and three came from a

voluntary sector managed HMO where tenant support is provided. Two of the interviewees were female and 14 were male, with their ages ranging from, approximately, late-twenties to early-sixties. All lived as single tenants, though some did speak of partners who lived elsewhere.

The interviews focused on how they had come to live in a HMO and their subsequent experiences within the accommodation, but also exploring people's wider experiences in terms of health, homelessness and institutional living. Thematic analysis was used to analyse responses from interviewees through a process of coding (May, 2001; Potter, 2004; Dey, 2007; Holton, 2007).

The HMO working groups were forums where a range of agencies come together to provide integrated and co-ordinated support (Bramley et al, 2015). They comprised those with a direct interest in HMOs, including the police, the fire service, GPs, local authority housing enforcement officers, voluntary sector advice providers, and local authority housing officers. Also attending on an ad hoc basis were organisations representing those over-represented in HMOs, such as former prisoners, people experience unemployment and refugees. Attending the HMO working groups provided a policy and evidence context for challenges created by increasing numbers of HMOs. Interviews with working group members and stakeholders included local authority housing officers, voluntary sector advice providers and organisations working directly with vulnerable people with experience of HMOs. The composition of the two HMO working groups were different, with one mainly comprising of housing enforcement and housing officers, whilst the other had a more diverse

membership comprising health professionals, the voluntary sector and housing providers. The working groups discussed the growing number of HMOs in the two areas in order to identify ways to address associated problems. The meetings discussed local evidence and challenges, how the different partners were working with HMO tenants and landlords, as well as the experiences of tenants that had been reported to the different agencies. Attendance at these working groups provided important contextual information, particularly in relation to the approaches being used with regards to enforcement and/or support with the two different areas.

Ethical approval for the research was granted by the University of Wolverhampton's Faculty of Social Sciences Ethics Committee. Principles of informed consent and anonymity underpinned the research. Before each interview, participants had the opportunity to ask questions and decline participation. Consent forms were used to reiterate their understanding of consent. To protect anonymity, pseudonyms have been used for the participants. The following sections present the key findings from the research, presenting the analysis from two case study areas; one where support to tenants was limited one where specific models of support were being provided.

“I don't feel safe”: Exploring the experiences of tenants with MCN in HMOs where support was limited

A total of 13 people were interviewed who were not currently receiving any specific support linked to their HMO tenancy. Many tenants identified mental health challenges at the centre of their MCN, which was compounded by former experiences of prison, poor physical health, homelessness and substance abuse. Similar to existing research that identifies the prevalence of negative housing experiences amongst vulnerable tenants (Barratt et al, 2015; Irving, 2015; Barratt and Green, 2017; Wilson and Cromarty, 2019), the interviews identify a number of key issues, including confusion over payments or debts to landlords; concerns around safety relating to criminal activity within HMOs; and the broader impact of their experiences on their overall health and well-being.

It was evident that many tenants are often confused about the payments they were making to their landlord. The majority of participants suggested that they were being charged rent in the region of around £80-90 per week. Many were making payments to their landlord from their social security benefits; however, because the Local Housing Allowance did not fully cover the rent, the tenants had to cover the shortfall. It was clear that some tenants had subsequently incurred debts which were not always fully understood. For example, one interviewee, Colin, had been homeless prior to moving into the HMO and had mental health problems. Similar to previous examples of tenants being exploited by landlords (Rugg and Rhodes, 2008), Colin had been living in the same HMO for approximately 18 months and indicated that he was in debt to

his landlord, which he was required to repay before he would be able to move anywhere else:

"I used to be homeless before living here. I used to sleep in [a local park]. I had problems after my Mum and Dad passed away... Now, I always pay my rent on time but my money [benefits] is not enough for the rent and I have to give the landlord more money... He [the landlord] says I am now in debt and cannot move out until I have paid the debt." (Colin)

Interestingly, in one case a tenant (Carl) indicated that he had taken on the role of enforcing repayment of debt for the landlord in return for a reduction on his own rent. Carl had been living in HMOs owned by the same landlord for approximately five years. He stated that he was employed by his landlord to help *"manage his properties"*. The landlord was suggested to have six properties and was *"keeping houses at four rooms to avoid paying the licence"*. Part of his role involved working with the landlord to target tenants in rent arrears:

"You get kids in the house, no one answers the door. We go in anyway and they are hiding in the wardrobe... If the tenant owes money, we take the TV or other stuff, even if it's only £20 [of arrears]."

Although at first glance Carl may appear complicit in the poor treatment of tenants within the HMO, the fact that his role had been linked to his own

tenancy in terms of a reduced rent arrangement suggests that his situation was equally precarious should he no longer wish to undertake that role.

A significant concern for many tenants was feeling a lack of safety within their HMOs. This appeared to primarily relate to criminal activity, in particular drug dealing, taking place within a number of the HMOs. Indeed, almost half of those interviewed spoke of drug dealing in the HMO where they lived, with one instance of a room rented solely for that purpose, whilst others spoke of being threatened by 'customers' if they were refused entry to the HMO. For the majority, there was a general sense of intimidation of "good tenants" in the HMOs, which in many cases appeared to be increasing. Recounting her experiences, for example, Irene explained:

"I don't feel safe. I share a house with young people, they sell drugs and I have been stopped [by the young people] from getting into the house... there's always fighting, drug dealing, loud music and parties in the house."

Irene had been living in various HMOs in different cities for "many years" and in common with many other HMO tenants with histories of mental ill health (Barratt et al, 2012; Barratt et al, 2015) had a background of anxiety and depression. Feeling unsafe in the house, Irene indicated that she would either spend long periods of time away from the property or be stuck in her room all day to avoid the behaviours of other tenants:

“[I] wait until they [the young people] have gone and then I leave the house. I leave early in the morning and come back late at night. I spend all day away. I just come back to sleep... if I don’t go out early, I can be stuck in my room all day”.

For Colin, there were similar feelings of insecurity and fear. He commented,

“There are some nice people in the house sometimes. But a lot of them take drugs and I have been threatened by a drug dealer. I didn’t want to let him in the house... it’s not really safe... I get broken into two or three times a week and my food is stolen from the kitchen. There’s no lock on the cupboards and the garden is messy... [Increasingly] there are more bad tenants. They bully. There is more drug dealing.”

In addition to the criminal and anti-social behaviour within the properties, there were also concerns about the conditions within the HMOs. For example, daily living appeared to be made harder by living in a house that was “dirty” and where there were periods without amenities such as heating and hot water. However, it was evident that very few tenants reported these issues. For some, these related to concerns that reporting issues to landlords may result in eviction, as Irene highlights:

“I am stuck. I cannot speak to the landlady. She has kicked out tenants for complaining... The bathroom has no safe lock. The

kitchen and washing machine is too dirty. No hot water or heating for days. It's got worse in the last few years.

Overall, these experiences contributed to the lack of a sense of 'home', typified by Irene who commented, "*It's where I live, but I wouldn't say it feels like home*". Additionally, it was evident that people's experiences within their HMOs were contributing to their declining mental health. This is illustrated by Derek, who is in his 60s and had been living in HMOs most of his adult life since leaving care and a psychiatric hospital at the age of 20. Spending most days alone in his first-floor room, Derek stated:

"I have anxiety and learning difficulties. I don't really go out... There's only two foot next to the bed. It's too small for a chair. Some days I just lie on the bed. There's no sitting room... I have a lot of tablets. Angina, inhalers, that sort of thing. I am on anti-depressants... I can't get up and down stairs very well, it's difficult for me. So I just stay in my room really."

Derek's experience can be compared with Irene (above) who spent as much time as possible away from the property. However, in many ways their situations were similar in that their experiences within the HMO were leading to social isolation, with both appearing to be trapped in patterns of behaviour that were impacting on their wellbeing.

In terms of support for this group of tenants, in all interviews, landlords appeared to demonstrate little duty of care in relation to tenants' welfare. It

was evident that some of those who were interviewed were reliant on family and friends, whilst others had used community centres to try to develop their support networks. Thus, where support was available, it primarily came from informal networks or, less frequently, voluntary sector organisations.

The stakeholder interviews included a representative of one of the community centres that was being accessed by some of the HMO residents. They described seeing many vulnerable people living in HMOs that were visiting their community café and who often talked about the impact of their housing on their wellbeing. This stakeholder even described being aware of an instance where a tenant with a history of substance abuse was being 'paid in alcohol' to carry out maintenance for the landlord, as well as a number of examples where tenants in rent arrears had been physically threatened. Another stakeholder who was interviewed represented a voluntary sector organisation supporting people who are homeless or in insecure accommodation. They recognised the negative impact of private sector HMOs, but felt that there was often no other housing options for many of the people that they were supporting. Although these organisations were available within this geographical area, and some participants were accessing these types of community or voluntary facility, overall people appeared to be receiving very little support directly related to their accommodation with variable access to such resources.

“We can talk about what we need”: Exploring experiences of tenants with MCN in supported HMOs

The experiences and issues outlined above are typical of experiences highlighted in previous research about HMOs (Barrett et al, 2015; Irving, 2015; Barrett and Green, 2017; Rugg and Rhodes, 2018a) but also in research about the private rented sector more broadly (Manzi, 2014; McKee et al, 2016; Simcock, 2017; Wilkinson and Ortega-Alcazar, 2017; Rugg and Rhodes, 2018a; 2018b). However, this can be contrasted to the experiences of HMO tenants who were provided support alongside their accommodation.

This section focuses on three interviews with HMO tenants and three key stakeholders in HMOs that provided specific support functions. This included both an HMO run by a voluntary sector organisation that specifically housed tenants with MCN where there was an emphasis placed on providing tenants with support for their needs, but also a chain of private HMOs that adopted a model of working closely with the local authority to support vulnerable tenants. The profile of the tenants in these cases was comparable with the HMOs discussed in the previous section in terms of accommodating people with substance abuse issues, mental health problems and experiences of the criminal justice system. Although there is obviously a need to recognise the limitations of the research in terms of the sample size, exploring these contrasting experiences does suggest that the support function was enabling more positive outcomes for tenants.

With regards to the voluntary sector HMO, in addition to accommodation the residents were provided support with issues such as social security benefit claims, shopping, cooking, education, employment and health advice. There

were also weekly house meetings, where people could discuss any issues they were having within the accommodation. Furthermore, it was evident that regular repairs and maintenance was undertaken within the house. Consultation with the HMO lead indicated that they had previously worked as a drugs outreach worker which had shaped their recognition of the importance of providing support to address tenant wellbeing.

This recognition of MCN by the HMO was reflected in the experiences of the tenants. In contrast with HMO tenants in the previous section, one of the first points raised by Terry, who had lived at the voluntary sector HMO for six months, was that the HMO felt like “home”. Terry found the HMO a place of support that allowed him to “change my life”, adding that:

“I’ve spent most of my [adult] life in prison. But not now, [The voluntary sector HMO landlord] helps keep me out of prison and I am now providing clean drug tests... I get support with filling in forms and benefit claims... We have house meetings every week and we can talk about what we need.”

Within this HMO, the narrative of the tenants appeared to be far more optimistic for the future. Like Terry, the two other interviewees described their satisfaction with their current accommodation but also expressed a feeling of ‘home’, albeit temporary in nature and those interviewed talked about their plans to move on to their own accommodation at some point in the future. However, at present, the HMO was providing a stable base, with appropriate support to enable them to address some of their needs. Keith, for example, had

been living in the HMO for six months. He wanted to move on once he had addressed his physical health problems, but had also been given the opportunity to undertake volunteering and training:

“I have done some volunteering and then started an eight week [training] course. Then I started mentoring others. It’s hard when you have a criminal record, but I want to get a job and get a flat of my own.”

Brian, who had been living in the HMO for nearly one year, was also currently volunteering and involved in training to learn a trade, with these opportunities being signposted and supported by the landlord. Both Brian and Keith stated that being a prison leaver was an obstacle to finding employment, but felt that the support being provided through the HMO was vital in enabling them to progress towards paid employment.

Although interviewees described the positive aspects of their current accommodation, similar to the experiences described in the previous section, there were still issues within the HMO. For example, interviewees described experiences of other tenants bringing drugs into the property and theft. However, in contrast to the feelings of intimidation and powerlessness described previously, the tenants had felt sufficiently empowered to report the problems to the landlord, but also be involved in addressing the issues. Specific examples were given where the landlord had evicted those behaving inappropriately to protect the wellbeing of the other tenants.

It obviously needs to be acknowledged that the HMO described above was a voluntary sector organisation and had a specific support remit in addition to the provision of accommodation, which is very different to the private sector HMOs within the previous section. However, the research also included consultation with the manager of a chain of private HMOs who attended one of the HMO working groups. They were currently accommodating over 100 people, including vulnerable tenants i.e. homeless people, those with substance abuse issues and people escaping domestic abuse. They worked closely with the local authority and other agencies in that area to identify tenants' needs and deliver support through partnership working. They stated that, from a commercial perspective, investment in maintaining the properties and supporting tenants had no financial reward for the company in a market where there is sufficient demand for HMOs and expenditure did not lead to higher rental income. However, they recognised the importance of the support role in terms of tenant well-being and were committed to support vulnerable tenants to address some of their needs.

Highlighting how tenancies at the HMOs could be managed in a way that sought to mitigate potential harm, the private HMO chain and the voluntary sector HMO used a model of floating support (Clarke, 2016; Quilgars and Pleace, 2017; 2018; Pleace and Bretherton, 2019) as a way to balance housing enforcement with awareness of tenant wellbeing. As such, as well as the accommodation function, they also provided advice, guidance and signposting services, as well as publicising volunteering and training opportunities, and

even developing tenant forums that would give tenants a voice and sense of control over aspects of their environment. This contrasts sharply with the interviewees who had very limited access to support and whose accounts described a deteriorating mental health, isolation and a sense of powerlessness over the negative aspects of their accommodation.

Conclusions

This article has sought to add to the growing debate on experiences of the HMO sector by drawing up new research with HMO residents but also a range of wider key stakeholders who are supporting HMO tenants. Like previous research, this research recognises that the HMO sector has common themes in terms of providing low cost accommodation, housing a large proportion of people with MCN, but also representing a growing source of concern for national and local policy makers. However, there is also a recognition that the sector is not homogeneous, with the exploratory research presented here drawing on the accounts of residents from two distinct types of HMO provision.

Government policy appears committed to addressing some of the issues associated with HMOs, providing local authorities with increasing powers to regulate this sector. However, there are concerns as to whether a focus on regulation is able to also address the needs of tenants, particularly those with MCN.

Concerns were raised across the HMO working groups in this research that whilst enforcement of unsafe and neglected properties was vital in order to improve tenant experiences, greater planning controls could risk further limiting housing availability for those with the fewest housing choices. Indeed, in the case of local authorities in this research, a decision was made not to control the growth in HMOs as it may risk displacement of issues to other areas and be detrimental to those with MCN. In this respect, the HMO working groups included in the research felt that, while HMOs were far from ideal, they resulted from growing housing pressures and increased demand within the private rented sector. Furthermore, while it was evident that housing was a critical factor that could exacerbate MCN, the interviews suggest that HMOs alone were not deterministic of poor outcomes. Indeed, the accounts of some residents suggested that it was possible to have positive experiences and rebuild their lives when appropriate support is provided.

Despite such findings, the general direction of travel for addressing problems associated with HMOs remains greater levels of enforcement and regulation, licensing and changes to planning regulations, which alone are unlikely to have a significant impact on tenants with MCN. With the private rented sector continuing to grow nationally, HMOs are likely to continue being a significant element of housing for those with MCN. As such, housing policy in relation to HMOs has reached a point where it would be beneficial to review of how approaches to landlord enforcement and planning regulations, can be balanced with tenant support to achieve better outcomes.

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