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EU Housing Exclusion report (in particular, pp.238-243):

http://www.york.ac.uk/inst/chp/publications/PDF/EUExclusion/HOUSING%20EXCLUSION%2026%20May%202010.pdf

Crisis 'Homelessness Monitor' report on impact of recession on all homeless groups, including young people. This current report is for England (though welfare reform issues are equally relevant in Scotland), but we have now been given funding by Crisis to do a similar Scottish Homelessness Monitor for next year - publishing in September 2012:

http://www.crisis.org.uk/data/files/publications/HomelessnessMonitor_ExecutiveSummary.pdf

The recent Centrepoint report on 'Ending Youth Homelessness' - the points that Yvette made about the 'culture' of throwing young people out at age 16 come out here, and there is discussion of respite care and the other prevention options, bespoke routes through the statutory system etc discussed today (including Birmingham St Basils work I mentioned):

http://www.york.ac.uk/inst/chp/publications/PDF/EndingYouthHomelessness.pdf

The major review of youth homelessness across the UK (= my point about major improvements in preceding decade across the UK):

http://www.jrf.org.uk/publications/youth-homelessness-uk

The recent Newcastle report on homelessness prevention - including their innovative Young People Service:

http://www.sbe.hw.ac.uk/documents/Fitzpatrick_et_al_2011_Homelessness_Newcastle_report.pdf

Suzanne Fitzpatrick
Heriot Watt University
29 November 2011

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Pathways into Multiple Exclusion Homelessness in the UK

A Summary of Key Research Findings

The overall aim of this project was to provide a statistically robust account of the nature and patterns of 'multiple exclusion homelessness' (MEH) in the UK. A multi-stage, quantitative survey was conducted in seven cities where existing data suggested people experiencing MEH were concentrated.

Key points:

- There is a very high degree of overlap between experience of the following domains of 'deep social exclusion': homelessness; substance misuse; institutional care; and 'street culture' activities (such as begging and street drinking)

- Homelessness is a particularly prevalent form of deep exclusion

- There are five distinct 'experiential clusters' within the MEH population, with the most complex forms of MEH being associated with childhood traumas of various kinds, and concentrated amongst men in the middle age range (especially those in their 30s)

- MEH service users in Westminster (London), and those who had migrated to the UK as adults, report lower levels of support needs than the rest of the MEH population, suggesting that their problems are more 'structural' and less 'individual' than those of other MEH service users

- The chronological ordering of MEH-relevant experiences is remarkably consistent within people's life histories, with substance misuse and mental health problems generally preceding experience of homelessness, including rough sleeping, and other adverse life events

- It is important to avoid conflating 'pathways in' with 'pathways out' of MEH: while housing-related problems may not generally be the starting point for MEH, the provision of stable housing is likely to be an essential element in ending it.

Introduction

The overall aim of this project was to provide a statistically robust account of the nature and patterns of multiple exclusion homelessness (MEH) across the UK. MEH was defined as follows:

> People have experienced MEH if they have been *'homeless'* (including experience of temporary/unsuitable accommodation as well as sleeping rough) *and* have also experienced one or more of the following other domains of 'deep social exclusion': *'institutional care'* (prison, local authority care, mental health hospitals or wards); *'substance misuse'* (drug, alcohol, solvent or gas misuse); or participation in *'street culture activities'* (begging, street drinking, 'survival' shoplifting or sex work).

In order to generate a statistically representative sample of people experiencing MEH, a multi-stage research design was adopted in the following urban locations where existing information suggested people experiencing MEH were concentrated: Belfast; Birmingham; Bristol; Cardiff; Glasgow; Leeds; and Westminster (London).

The study involved three main stages:

1. Selection of a random sample of six 'low-threshold'[1] services working with people experiencing deep social exclusion in each location[2], including not only homelessness services but also those targeting other aspects of deep exclusion, e.g. substance misuse, street-based sex work etc.

2. A *'Census Questionnaire Survey'* was then conducted with all of the users of these low-threshold services over a two-week 'time window'. 1,286 questionnaires were returned in total.

3. Finally, an *'Extended Interview Survey'* was conducted with a sample of users of low threshold services whose census responses indicated that they had experienced MEH. These interviews were conducted face-to-face and lasted 46 minutes on average. Particularly sensitive questions were asked in a self-completion section. In total, 452 extended interviews were achieved.

The analysis presented was weighted to take account of disproportionate sampling and non-response bias.

Key Findings from Census Questionnaire Survey

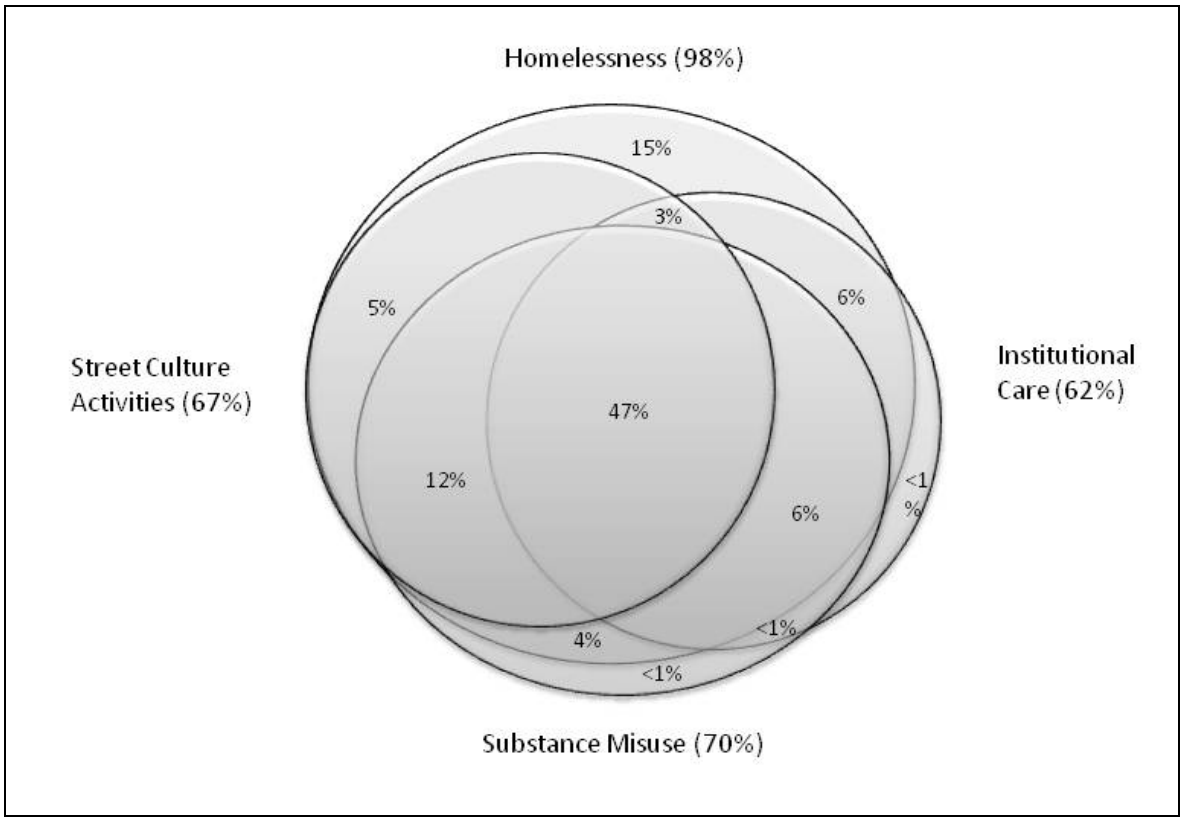
The census survey of low threshold service users demonstrated that experience of each of the four domains of deep social exclusion was extremely widespread amongst this population. Almost all (98%) had experienced homelessness, 70% had experienced substance misuse, 67% street culture activities, and 62% institutional care (Figure 1). Consequently, the degree of overlap between these domains was

[1] 'Low-threshold' services are those that make relatively few 'demands' of service users, such as day centres, soup runs, direct access accommodation, street outreach teams, drop-in services, etc.

[2] Leeds was a half-size pilot study prior to the main-stage fieldwork, so only three services were selected there. A total of 39 services participated in the study overall.

also very high, with almost half (47%) of service users having experienced all four domains.

Figure 1: Overlaps Between Domains of Deep Social Exclusion



Source: Census Questionnaire Survey, 2010. Base: 1,286.

The census survey also demonstrated that homelessness was a particularly prevalent form of exclusion, with its experience reported as widespread amongst those accessing services aimed at other dimensions of deep exclusion, such as drug misuse. In fact, while service users recruited from these 'other services' were somewhat less likely to have slept rough than those recruited from homelessness services, they were just as likely to have stayed in a hostel or other temporary accommodation, and were actually more likely to have stayed with friends or relatives because they had no home of their own or to have applied to the council as homeless (Table 1).

Table 1: Experience of Homelessness, by Type of Service

Indicator	Homelessness Service	Other Service	All
1. Stayed with friends, relatives or other people because had no home of own	78%	87%	80%
2. Stayed in a hostel, foyer, refuge, night shelter or B&B hotel because had no home of own	83%	82%	83%
3. Slept rough	80%	69%	78%
4. Applied to the council as homeless	70%	84%	73%
Base	**1,112**	**174**	**1,286**

Source: Census Questionnaire Survey, 2010

Key Findings from Extended Interview Survey

The main phase of the study used extended interviews to explore in detail the experiences of those low threshold service users who had experienced MEH, as defined above. These MEH service users were predominantly male (78%), and were concentrated in the middle age ranges (approximately half were 30-49 years old).

Overall extent of experiences

Table 2 presents the overall extent of MEH-relevant experiences within this population. The most prevalent – affecting over half of all MEH service users – included all of the forms of homelessness specified; mental health problems; alcohol problems; and street drinking. The least prevalent experiences – affecting less than one fifth of all MEH service users – were having been in local authority care; having been the victim of sexual assault as an adult; having had a partner who had died; engagement in survival sex work; repossession; and bankruptcy.

Table 2: MEH-relevant Experiences and Median Age of First Occurrence

Experience	Percent	Median Age*
1. Stayed at a hostel, foyer, refuge, night shelter or B&B hotel	84%	28
2. Had a period in life when very anxious or depressed	79%	22
3. Stayed with friends or relatives because had no home of own	77%	20
4. Slept rough	77%	26
5. Applied to the council as homeless	72%	27
6. Had a period in life when had six or more alcoholic drinks on a daily basis	63%	20
7. Involved in street drinking	53%	18
8. Went to prison or YOI	46%	21
9. Used hard drugs	44%	19
10. Divorced or separated	44%	32
11. Were a victim of violent crime (including domestic violence)	43%	20
12. Shoplifted because needed things like food, drugs, alcohol or money for somewhere to stay	38%	20
13. Attempted suicide	38%	-
14. Thrown out by parents/carers	36%	17

15.	Begged (that is, asked passers-by for money in the street or another public place)	32%	28
16.	Engaged in deliberate self-harm	30%	-
17.	Admitted to hospital because of a mental health issue	29%	26
18.	Injected drugs	27%	22
19.	Charged with a violent criminal offence	27%	-
20.	Evicted from a rented property	25%	28
21.	Made redundant	23%	26
22.	Abused solvents, gas or glue	23%	15
23.	Left local authority care	16%	17
24.	Victim of sexual assault as an adult	14%	-
25.	A long-term partner died	10%	43
26.	Had sex or engaged in sex act in exchange for money, food, drugs or somewhere to stay	10%	17
27.	Home was repossessed	6%	34
28.	Experienced bankruptcy	6%	29
Base		**452**	**-**

Source: Extended Interview Survey, 2010

*No data was available on age of first occurrence of four of these experiences as they were asked about in the self-completion section of the questionnaire where follow-up questions on age were not used, except with regards to survival sex work

The median age at which these experiences *first occurred,* presented in Table 2, provides some general sense of likely routes into and through MEH. However, to interrogate MEH pathways systematically the research team examined whether there were specific clusters of MEH-relevant experiences and explored the sequencing within these clusters.

Clusters of experiences

Statistical clustering techniques were employed to investigate whether there were particular subgroups within the MEH population with common sets of experiences. This resulted in the following set of five clusters.

Cluster 1: 'Mainly homelessness' This cluster accounted for nearly one quarter of MEH service users and was the least complex overall (5 experiences on average). Cluster 1 cases were less likely than the MEH population as a whole to report experiences within the non-homelessness MEH domains, particularly substance abuse and street culture activities. This group was overwhelmingly male (84%) and mainly aged over 35. Notably, a disproportionate number of Cluster 1 cases had migrated to the UK as adults (35%) and a majority (53%) were located in Westminster. Both migrants and service users in Westminster face particularly severe structural barriers to meeting their material needs – exceptionally tight local housing markets and restricted access to welfare benefits respectively – which may mean that they are at risk of MEH from a lower 'threshold' of personal support needs than is the case for other sections of the population.

Cluster 2: 'Homelessness and mental health' This cluster accounted for over one quarter of the MEH population, and its members displayed moderate complexity (9 experiences on average). A key feature of Cluster 2 cases was experiences associated with mental health problems: 86% reported experience of anxiety or depression and 51% had attempted suicide. Supporting previous evidence of a link between mental health issues and women's experience of homelessness, Cluster 2 was disproportionately female (39%).

Cluster 3: 'Homelessness, mental health and victimisation' This was a smaller group (9% of the MEH population), which may be viewed as a much more complex and severe version of Cluster 2 (15 experiences on average). Mental ill health was a defining characteristic: experience of anxiety or depression was reported by 100%, suicide attempts by 91%, being admitted to hospital with a mental health problem by 89%, and 75% had self-harmed. Cluster 3 members had also experienced exceptionally high levels of victimisation - 71% had been a victim of violent crime, and 40% had been a victim of sexual assault as an adult. Nearly half (48%) had been in local authority care as a child. This group was rather younger than the MEH population average.

Cluster 4: 'Homelessness and street drinking' This was also a smaller group (14% of the MEH population), and comprised a moderately complex set of cases (11 experiences on average). The defining experience of this group was street drinking (100%), with extremely high levels of problematic alcohol use (96%) and rough sleeping (98%) also reported. Other indicators of street culture activities were also common: 56% had begged and 47% had engaged in survival shoplifting. Divorce or separation was widespread in this group (65%). Cluster 4 members tended to be

older (84% were over 35 years old), almost all were male (98%). Membership of this cluster was most common in Glasgow.

Cluster 5: 'Homelessness, hard drugs and high complexity' This cluster accounted for one quarter of the sample, and was the most complex (16 experiences on average). The defining experience was use of hard drugs[3] (100%), with very high scores generally on the substance misuse and street culture domains. Although involvement in survival sex work was uncommon across the whole sample (at 10%), 21% of this group reported this experience (almost all of them women). Anxiety/ depression was almost universally experienced (95%), and rates of attempted suicide and self-harm were also high (56% and 47% respectively). Experience of prison was very prevalent (77%), with a strong theme of violence as both victim (56%) and perpetrator (51%). Cluster 5 members tended to be in the middle age range; most were in their 30s.

Explaining complexity

These 'experiential clusters' generally move from relatively simpler cases with fewer MEH-relevant experiences (Cluster 1 especially, but also Cluster 2) to more complex cases (Clusters 3 and 5 especially). Regression analysis was used to investigate which social and economic background factors had an *independent effect* in predicting the most complex experiences of MEH, when other factors were held constant. This analysis does not predict the likelihood of a member of the general public experiencing MEH, but rather asks: amongst members of the MEH population, what predicts whether they have had a more or less complex set of MEH experiences?

Factors associated with more complex MEH experiences, other things being equal, included:

- being male;
- being aged between 20 and 49 years old (especially in 30s);
- having experienced any of the following as a child: physical abuse or neglect, there sometimes not being enough to eat at home, or homelessness;
- having had parents who experienced drug, alcohol, domestic violence or mental health problems;
- having had poor experiences of school (i.e. truancy, exclusion, bullying);
- having lived on welfare benefits for most of your adult life;
- being recruited to the study from a drugs or other 'non-homelessness' service.

[3] The term 'hard drugs' was used to denote those commonly associated with deep social exclusion, such as heroin and crack cocaine. This short-hand term was necessary for filter questions given the wide variation in drug markets and street names across the UK. Follow-up questions confirmed that most respondents understood this term as intended and did not include 'recreational' drugs such as cannabis.

Factors associated with less complex MEH experiences, other things being equal, included:

- being female;
- being young (under 20) or older (over 50);
- being an adult migrant to the UK (but this was not so true of A10 migrants);
- being a Westminster (London) respondent;
- being in steady work for most of adult life;
- being recruited to the study from a homelessness service.

Sequencing of experiences

While some suggestion of sequencing is implicit in Table 2 in terms of the median age at which these experiences first occurred, this issue was examined more rigorously by focusing on the actual sequential ranking of experiences for individual MEH cases. The average sequential ranking used in this analysis controlled for variations in the number of MEH-relevant experiences reported by service users.

Across the MEH population as a whole, four broad phases within individual MEH pathways were identified:

- **Phase 1 - Substance misuse:** The experiences which tended to happen earliest, if they happened at all, were: abusing solvents, glue or gas; leaving home or care; using hard drugs; developing a problematic relationship with alcohol; and/or street drinking.

- **Phase 2 – Transition to street lifestyles:** There was then a group of experiences that, if they occurred, tended to do so in the early-middle part of individual MEH sequences. These included: becoming anxious or depressed; survival shoplifting; engagement in survival sex work; being the victim of a violent crime; sofa-surfing; and spending time in prison. These experiences seem indicative of deepening problems bringing people closer to extreme exclusion and street lifestyles. Also featuring in this early-middle ranked set of experiences was one adverse life event: being made redundant.

- **Phase 3 – Confirmed street lifestyle:** Next, there was a set of experiences which typically occurred in the middle-late phase of individual MEH sequences, and seemed to confirm a transition to street lifestyles. These included: sleeping rough; begging; and injecting drug use. Being admitted to hospital with a mental health issue also tended to first occur in this phase, as did two of the specified adverse life events: becoming bankrupt and getting divorced.

- **Phase 4 – 'Official' homelessness:** Finally, there was a set of experiences which tended to happen late in individual MEH sequences. These included the more 'official' forms of homelessness (applying to the council as homeless, and

staying in hostels or other temporary accommodation) and the remaining adverse life events (being evicted or repossessed, and the death of a partner).

Another important finding was that sequencing within each of the five experiential clusters tended to mirror this overall temporal pattern. In other words, *if* an event occurred to an individual MEH service user, it tended to occur at approximately the same point in their MEH sequence regardless of which cluster they were in, even though the chances of it having happened at all varied significantly between clusters.

Policy Implications

There are a number of policy and practice implications of this analysis:

- This evidence strongly supports the argument that there is a very high degree of intersection between deeply socially excluded groups. There is a pressing need to coordinate responses across all aspects of these people's lives, rather than 'view' them through a series of separate 'professional lenses'.

- Service providers working with people experiencing MEH should be alert to the probability that most of their service users will have experienced a range of forms of trauma in childhood, and a large proportion may have exhibited extreme forms of distress in adulthood (such as attempted suicide or self-harm) without the agencies necessarily being aware of this. The development of 'psychologically-informed' service environments should be a priority.

- Service providers may wish to take into account the 'clusters' of experiences described above in designing tailored services for different groups within the MEH population, though it must always be borne in mind that such broad categorisations are not a substitute for individual needs assessments.

- 'Visible' forms of homelessness – including applying to the council as homeless and staying in hostels or other forms of homeless accommodation – are typically rather 'late' signs of MEH, and preventative interventions should focus on earlier signs of distress wherever possible.

- Schools, drugs and alcohol services, and the criminal justice system are likely to come into contact with people vulnerable to MEH before housing and homelessness agencies do, and must be central to prevention efforts.

- However, it is important not to conflate 'pathways in' with 'pathways out' of MEH: while housing-related problems may not generally be the starting point for MEH, the provision of stable housing is likely to be an essential element in ending it.

- While the policy emphasis – and public sympathy – often focuses on younger and older homeless people, and on women who are homeless, it may be argued that there is a 'forgotten middle' of men in their 30s who often face the most extreme forms of MEH.

- The profile and experiences of migrants facing MEH in the UK are likely to differ in quite fundamental ways from those of the indigenous MEH population, and they require bespoke services tailored to their specific needs.

About the study

This study, entitled *'Multiple Exclusion Homelessness Across the UK: A Quantitative Survey'*, was funded by ESRC grant number RES-188-25-0021-A. It was one of four projects supported by the ESRC MEH Research Initiative. The study was conducted by Suzanne Fitzpatrick and Sarah Johnsen at the Institute for Housing, Urban and Real Estate Research (IHURER), Heriot-Watt University, with input also from Glen Bramley (Heriot-Watt University), Michael White (Nottingham Trent University), and Nicholas Pleace (University of York). The study fieldwork was conducted in 2010 in collaboration with TNS-BMRB and a wide range of voluntary sector partners.

Suzanne Fitzpatrick
Heriot Watt University
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