# Benefits for Health

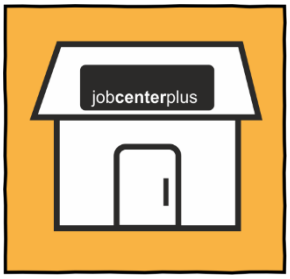
## Literature, policy and learning

## Contents



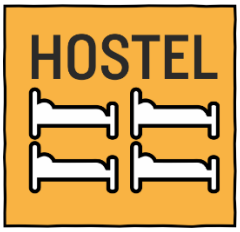
## Introduction

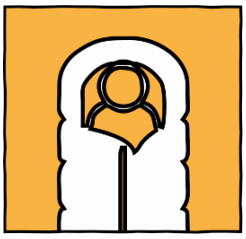
Benefits for Health is a research study exploring how health and welfare systems are experienced by people who are homeless and how these two systems intersect and impact on their lives. The study, conducted by Groundswell, was led by researchers with experience of homelessness. The research engaged 242 people who are currently experiencing homelessness in London, whose stories were collected using focus groups, case studies and one-to-one survey-based interviews. This research feeds into a wider campaign which is focused on improving access and maintenance of welfare benefits for people experiencing homelessness, to ensure they get the welfare and health support they are entitled to. The following document outlines the background literature, policy and learning related to welfare, homelessness and health that has guided the Benefits for Health research.




## Current picture of homelessness

Homelessness – including people sleeping rough, in hostels, shelters, sofa-surfing and temporary accommodation as well as those living in overcrowded and unsuitable accommodation – is increasing[i]. The high cost of private rental accommodation, a lack of social housing on the backdrop of rising austerity and stagnating wages have contributed to rising poverty and, consequently, the incidence of homelessness.



In a recent visit to the UK, Professor Philip Alston, United Nations Special Rapporteur on extreme poverty and human rights, tells, "in England, homelessness is up 60% since 2010, rough sleeping is up 134%"(ONCHR, 2018)[ii]. Reflecting this, it is estimated that 320,000 people are homeless in Britain (Bulter, 2018)[iii]. In 2018/2019, an estimated 8,855 people slept rough in London and 170,000 people in the capital have no home (Butler, 2019)[iv]. These are only estimated figures that do not take into account hidden homelessness, for example people who are sofa-surfing and living in sheds and cars etc, and therefore, actual figures are expected to be higher[v].

## Health a contributing factor in causing homelessness

There are many causes of homelessness and factors that perpetuate homelessness. Previously, reasons for homelessness were often perceived to be down to individual life choices, but it is increasingly understood that homelessness is a consequence of a complex mix of personal circumstances and systematic inequalities. As reported in the Crisis Homelessness Monitor (2019:2), "*homelessness is multidimensional, with no single "trigger" that is either "necessary" or "sufficient" for it to occur*" (Fitpatrick et al, 2019)[vi]. Intersecting factors vary according to time, geography and other demographic factors. These current systematic barriers and the backdrop of austerity create new, and exacerbate existing, personal vulnerabilities[vii]. For example, mental and physical health issues, disabilities, addiction, learning differences, family breakdowns, offending issues, immigration issues etc. Given homelessness often happens because of a multitude of structural and individual factors, it is difficult to collect information on the main determining factors causing homelessness. However, the current common causes of homelessness are reported to be increasingly structural, for example poverty as a result of low wages, long waiting periods for Universal Credit (UC), high rents, precarious tenancies, a lack of council housing and a depleting welfare state (Crisis, 2018)[viii].

Mental and physical health are factors causing and perpetuating homelessness that are often overlooked (Mental Health Foundation, 2016)[ix]. Groundswell research that founded HHPA (Homeless Health Peer Advocacy) in 2010 found that health was a contributing factor to people becoming homeless and also significantly

contributed to perpetuating homelessness[1]. Furthermore, a recent report by Groundswell (2020)[x] on the health of women experiencing homelessness found that physical health issues were the second biggest cause of homelessness. Despite this evidence, the connection between homelessness and health remains overlooked; as Dai and Zhou (2020: 1)[xi] state, "*the feedback effect from health to homelessness is either ignored or downplayed in the existing studies of the health of homeless people*".

## Homelessness creating and compounding health issues

It is apparent that not only is health a common factor in causing and contributing to homelessness, but it also plays a part in perpetuating homelessness. One reason for this is the health issues associated with homelessness. The health of people who are homeless is often poorer than that of the general public, characterised by a tri-morbidity of physical ill-health, mental ill-health and drug and alcohol addiction (Medcalf and Russell, 2014)[xii]. People experiencing homelessness frequently face devastating health challenges, resulting in an average age of death of 44 years for men and 42 for women (ONS, 2018)[xiii]. By comparison, the mean age of death for the general population was 76 years for men and 81 years for women (ONS, 2018)[xiv]. Due to the stresses and traumas of homelessness, people are more susceptible to developing new health conditions and/or existing health conditions are exacerbated. The Homeless Health Link Audit details that 78% of people experiencing homelessness reported having a physical health problem and 86% reported having a mental health problem (Homeless Link Health Needs Audit, 2015)xv. Some of the most common problems reported included pains in joints, dental issues and chest pain/breathing problems.

## Homelessness and challenges of accessing healthcare

Homelessness not only causes mental and physical health issues, but barriers and inequalities in terms of accessing healthcare services can perpetuate and exacerbate these health issues and homelessness itself (Stafford, and Wood, 2017)[xvi]. Research conducted on behalf of Groundswell by The Young Foundation (2016)[xvii] identified multiple personal, practical and systematic barriers homeless people experience in accessing and receiving healthcare. Personal barriers include issues with negative prior experiences, low confidence, fear of hospital settings and lack of knowledge about the services available[xviii]. Practical barriers include having no fixed address, making it difficult to register and attend planned appointments; difficulty getting to appointments because of mobility and/or lack of money, and having multiple competing priorities and stresses, such as the need to find somewhere to stay and something to eat[xix]. The systemic barriers include a lack of understanding among

[1] To find out more about HHPA visit https://groundswell.org.uk/what-we-do/healthandhomelessness/homeless-health-peer-advocacy/

NHS staff, as well as actual and perceived stigma towards homeless people. As a result of this, there can be barriers to effective communication between people experiencing homelessness and NHS staff (Lanklley Trust, 2015)[xx]. Further, the healthcare system can be complicated to navigate, and services can be disconnected (Faculty for Homeless and Inclusion Health, 2018)[xxi]. These issues are compounded by the chaotic lifestyle that homelessness can create and are especially difficult for those with mental health and/or substance misuse issues.

These barriers can affect the access and quality of care for people experiencing homelessness. As a result, people who experience homelessness access a disproportionately higher number of secondary and unplanned health services, for example, ambulances and A and E services (Lacobucci, 2019)[xxii] (Stafford, and Wood, 2017)[xxiii]. Further to this, there is a high rate of missed outpatient appointments, and people experiencing homelessness do not often access early and preventive healthcare (The Young Foundation, 2016)[xxiv]. This is a significant cost to the NHS (NHS North West London. 2013)[xxv], but more importantly, these health inequalities cost people their lives. Groundswell's Homeless Health Peer Advocacy (HHPA) service was created to address these inequalities and improve the health of people experiencing homelessness (The Young Foundation, 2016)[xxvi].

## Homelessness and welfare


In addition to health issues and challenges with accessing healthcare, welfare issues are also a common factor in causing and perpetuating homelessness. Benefit delays, administrative errors, sanctions, a lack of understanding amongst staff and challenges accessing benefits are key factors in causing and perpetuating deprivation, and, consequently, homelessness (The Trussel Trust. 2016)[xxvii]. The Trussel Trust highlights that the most frequently given reasons for which people are referred to food banks are benefit delays and benefit changes. In addition to this, the latest Crisis Homelessness Monitor (2019:xiv) [xxviii] found that "nearly two-thirds of local authorities anticipate a "significant" increase in homelessness as a result of the full roll-out of UC, with a further 25 per cent expecting some level of increase". A House of Commons Committee report on youth homelessness and UC highlighted that "92% of survey respondents…identified that delayed UC payments were having an impact on youth homelessness" (House of Commons, 2015)[xxix]. A report from Crisis (2015) [xxx] found that 21% of survey respondents had become homeless as a result of being sanctioned.

There are many structural and personal barriers people experiencing homelessness face in claiming benefits. As a Homeless Link report (2013:3) [xxxi] explains, "*for homeless people facing these challenges, it can be particularly difficult to meet the conditions of the benefits system, or to understand the consequences of noncompliance*". Vulnerabilities and stresses of homelessness make the formal and bureaucratic systems difficult to navigate and for people to engage with the system (Shelter, 2020)[xxxii]. People experiencing homelessness often lack the resources to be able to comply with their 'claimant commitment' and the conditions of the benefits system (Batty et al, 2015)[xxxiii]. For example, the financial means

to get to Jobcentre appointments, to job interviews and to pay for clothes for interviews. In other cases, the stresses of homelessness and other competing priorities, like finding somewhere to sleep and something to eat make it difficult to attend Jobcentre appointments (O'Carroll and Wainwright, 2019)[xxxiv] (Reeve, 2017)[xxxv]. Since the rollout of UC there have been numerous research studies exploring its impact on people experiencing homelessness (see for example O'Leary and Simcock. 2019[xxxvi]; Barker, 2020[xxxvii]; Shelter, 2019[xxxviii]). Research by Groundswell on Universal Credit explored how the challenges of accessing Universal Credit had on the impact on the health of people who are homeless[xxxix]. The report also highlights the challenges of demonstrating ill-health for people experiencing homelessness.

## Welfare benefits and relationship to health

People seek the support of benefits because they have a disability and/or health condition that prevents them from work and/or are facing other challenges like unemployment or homelessness. People who are disabled or who have health conditions that limit their ability to work need the support of welfare. Regardless of the condition, receiving benefits requires evidence from health professionals and assessments with DWP representatives. In recent years there have been changes to the welfare system stemming from the DWP's aim of having an extra one million disabled people in work (Department for Work and Pensions. 2017)[xl]. This, in part, was created based on the idea that work was the best route out of poverty. For people with health conditions and disabilities this has meant changes to assessments, conditionality criteria and in 'proving' ill health and disability (Etherington and Daguerre, 2015)[xli]

Both academics and activists have warned about the effect this is having on claimants with disabilities and health issues (Disability Benefits Consortium, 2019)[xlii]. In Cooper and Whyte (2017)[xliii] Pring describes the changes to welfare reform as an 'attack on disabled people' who are being penalised for health conditions. The reform is having effects on physical and mental health, including depression, anxiety and health impacts of poverty and the inability to meet basic needs. In some cases, this has caused self-harm and suicide. Barr et al (2015: 339)[xliv] states, "*the Work Capability Assessment was independently associated with an increase in suicides, self-reported mental health problems and antidepressant prescribing*". Given the significant health issues people experiencing homelessness face and the challenges they have in accessing healthcare, and therefore 'proving' their health conditions, welfare conditionality can have a significant impact on health and further exacerbate existing health issues (Reeve, 2017)[xlv]. Research from the Joseph Rowntree Foundation (2014)[xlvi] also highlights how conditionality can lead to a range of "unintended effects, including: distancing people from support; causing hardship and even destitution;

displacing rather than resolving issues such as street homelessness." Further to this, the report highlights how people experiencing homelessness are disproportionately affected by welfare conditionality.

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