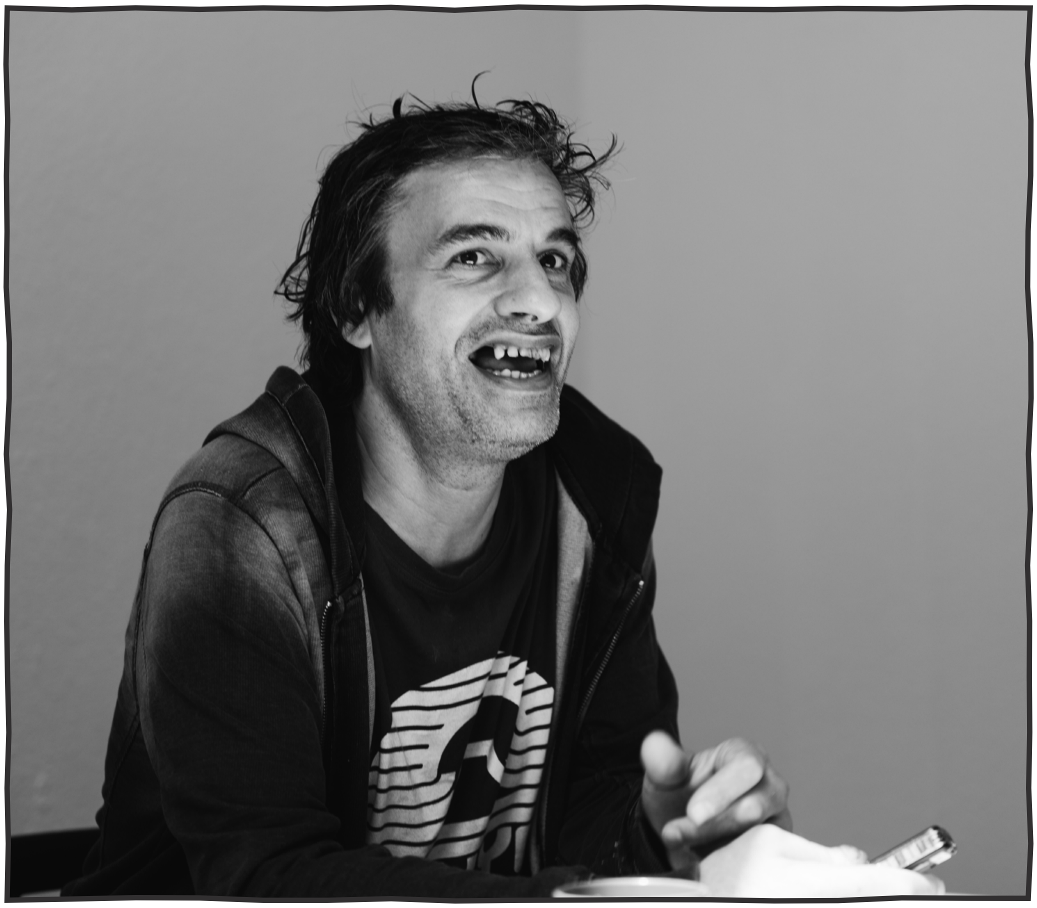
Benefits for Health

Exploring the connection between welfare, health and homelessness

Groundswell
Out of homelessness

Trust for London
Tackling poverty and inequality



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Acknowledgements

This research would not be possible without funding from Trust for London (TFL). Thank you for supporting this work and for your commitment to improving access to welfare and health for people who are homeless. Thank you to the advisory group who have supported and guided this research. We would also like to say a huge thank you to the following services who warmly welcomed us and enabled us to complete this research[1]. A massive round of applause to the six volunteer researchers for your enthusiasm, passion and commitment. We have thoroughly enjoyed conducting this research with you. Lastly, we would like to thank the people who took time to participate in this research; thank you for sharing your stories with us at a difficult time in your lives.

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[1] This includes 999 Club, Ace of Clubs, Bethany House, Branches, Bromley Homelessness Shelter, Connections, Conway House, Cyrenians, Edward Alsop Court, Harrow Road Assessment Centre, Holy Trinity Brompton, Passage Assessment Centre, Riverside House, Salvation Army Croydon Citadel, Spitafields Crypt Trust, St Cuthberts Drop-in Centre, The Vineyard and Union Chapel.

Contents

Executive summary

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' and 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.

The Benefits for Health study shows how the relationship between health and welfare benefits for people who are homeless is complicated. Due to a tightening of eligibility criteria and conditionality, the process of applying, receiving and maintaining benefits has a significant impact on the health and well-being of claimants. Additionally, the challenges of navigating the complex benefits system by people experiencing homelessness were common, and individual health factors often played a significant part in exacerbating these challenges. Despite the significant health challenges faced by participants and the health-related benefits and easements that exist to support them, those who are homeless are often excluded from these protections. Due to a lack of flexibility in administrative systems to support the needs of people who are homeless, expectations set do not adequately take into account multiple and complex health and social care needs that may affect the ability to engage with the welfare system. However, for those who were able to claim and maintain welfare benefits successfully, this had a positive impact on their health and wellbeing. This illustrates there is space for health and welfare systems to improve joined-up working to improve the lives of people facing homelessness.

The following section highlights the key findings of the Benefits for Health study:

Poor health and issues with benefits are causes of homelessness and are continued challenges for people experiencing homelessness

- Many participants (54%) reported that physical and mental health issues and/or addiction contributed to them becoming homeless and 20% cited issues with benefits as a cause of homelessness
- Where benefits issues were cited as a contributing factor in causing homeless, 60% of participants also cited mental and/or physical health issues as contributing to them becoming homeless.
- The health profiles of the participants showed a significant proportion (83%) were either experiencing poor physical health and/or mental health.

Challenges in navigating the benefits system were common, and often ill-health or disability was a cause or contributing factor that further embedded these issues.

- The process of claiming benefits was highlighted as a key challenge by participants; 65% of participants agreed with the statement; "being able to claim benefits when I was homeless was difficult". The application process, easements and adjustments were often not adequately explained or applied to claimants.
- Often participants felt they were not on the correct benefits for their high health and wellbeing needs.
- Unrealistic expectations were placed on participants in order to maintain benefits.
- Physical and mental health issues often exacerbated the ability to manage claims successfully. For example, participants missed or were late for appointments because of ill-health.
- Challenges maintaining claimant commitments caused sanctions. Of those who were receiving benefits, 28% had been sanctioned in the past 12 months, and over half of these were sanctioned for more than four weeks.

Welfare challenges had a significant impact on the health and wellbeing of people experiencing homelessness.

- For many participants, their income from benefits was reported not to be enough to live healthy lives. This was particularly important for those who were currently sanctioned or had deductions from their benefits. Over a third (35%) of participants reported that they received less than £300 a month.
- Often the requirements placed on claimants who are homeless do not account for individual circumstances including how being street homeless or unstably housed can impact the ability to stick to their claimant commitment
- Participants commonly shared how 'benefits stress' was a constant reality when homeless and are amplified due to sanctions, work capability assessments, providing proof of ill health and the stress of adhering to claimant commitments
- Sanctions and delays in payments caused participants significant stress resulting in participants not being able to eat and in some cases, engaged in activities that were not good for wellbeing. For example, some participants went hungry, stole or needed to beg.
- Participants shared examples of where the limited trust they had in the welfare system impacted on their engagement with broader health and social care system. For instance, a negative experience with the DWP influenced the perception of other support services and vice versa.

Despite high health needs, challenges in accessing healthcare were common among participants and were often exacerbated by challenges with benefits.

- Use of emergency care was common; a third (37%) having accessed accident and emergency care in the last 12 months, and 27% had been admitted to hospital in the past year.
- Misunderstandings around requirements for benefits in terms of accessing health care were common. For example, participants were not always aware of their entitlements when receiving benefits and challenges with proving receipt of benefits meant some participants were unable to access medication and other health services.
- Among all participants who had accessed or tried to access, 52% had challenges accessing dental care, 43% accessing an optician and 41% accessing prescribed medication from a pharmacy.
- Managing competing priorities in terms of health and social care support could often be a challenge. It can also mean that people experiencing homelessness may miss out on essential care and services.

The benefits and health systems could be working in a more integrated way for the benefit of the health of people who are homeless.

- Participants shared examples of where staff at the Jobcentre had been supportive. However, only 36% of participants felt the staff were knowledgeable about homelessness.
- Being in receipt of the "right" benefits was felt to have a positive impact on the health and wellbeing of participant.
- The importance of good relationships with staff at the Jobcentre is key to maintaining trust in the "benefits system" and also the broader social care system.

The Benefits for Health project, including this study, has been funded by Trust for London, an independent charitable foundation who aim to tackle poverty and inequality in London.

Introduction

Recent studies have shown that structural issues such as the high cost of private rental accommodation, a lack of social housing, stagnating wages and welfare reform have exacerbated the effects of austerity and contributed to rising poverty and, consequently, homelessness (see O'Leary & Simcock, 2019,[i] Barker, 2020,[ii] Shelter, 2019[iii]). These issues can create new and compound existing mental and physical health issues.

These are numerous personal and structural challenges people experiencing homelessness experience when navigating welfare entitlement and living with physical and/or mental ill-health. For instance, having no fixed address, no identification, the challenges of getting to appointments and complying with system administrative processes while experiencing the stresses that come with being homeless inflates exclusion from support.

However, despite these overlapping challenges, for people who are homeless, health and welfare needs are not always dealt with holistically. This is in sharp contrast to people in the "housed" population, where chronic ill-health is recognised as a qualifying factor for eligibility for financial support from the state. Despite changes to welfare benefits in response to these issues, claimants, and those who support them, are still experiencing system fragmentation.[2] While anecdotal evidence of the connection between health, homelessness and problems with benefits are abundant, research is still limited. More work needs to be done to gain a clearer understanding of the experiential realities of trying to access welfare while experiencing homelessness and poor physical and mental wellbeing. The following study fills a gap in current literature surrounding benefits, welfare and homelessness. Using a mixed-methods approach, led by researchers who have personal experience of homelessness themselves, this study explored how people who are homeless experience the health and welfare systems and how these two systems shape and impact on their lives.

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[2] It is important that this research is interpreted in the context of the continuous changes being made to UC.

About Groundswell

Groundswell works with people with experience of homelessness, offering opportunities to contribute to society and create solutions to homelessness. Participation is at our core because the experience of homelessness is crucial in making decisions that affect lives and ultimately help people to move out of homelessness.

Groundswell exists to tackle:
- **Homelessness** - everyone has the right to a safe home and to contribute to society
- **Health inequalities** - everyone has the right to good health and a right to access healthcare
- **A lack of participation** - people who have experienced and escaped homelessness should inform the solution
- **A society that doesn't work for everyone** - the system has been designed in a way that restricts opportunity; it needs to change to work for everyone

We achieve this through:
- **Good health** - we believe good health creates a foundation to move out of homelessness. Groundswell's people-focused health work and innovative services enable people who are homeless to access the health care they need; because everyone has a right to good health
- **Progression** - we are committed to developing and supporting a workforce of people with experience of homelessness to participate in designing and delivering solutions to homelessness while progressing in their own lives
- **Creating Change** - Groundswell brings together insight from people with experience of homelessness; we use this insight to tackle issues through changing practice and challenging policy. We believe that the experience of homelessness brings insight that can help tackle the issues of homelessness and create change.

Background information on changes to the benefits system

Before exploring the findings of this research, it is important to outline changes to the welfare system. Benefits and welfare provision are designed to give practical and financial support to anyone who is out of work, receiving a low income or those with a disability or medical condition. However, there was concern among some that the welfare system was too generous and was giving claimants a "hand out" rather than a "hand up"[iv]. This was creating an unnecessary overdependence on state support by claimants. In response to this, the 2012 Conservative and Liberal Democrat Coalition Government made extensive revisions to the provision of welfare via the Welfare Reform Act (2012). These changes included enhanced levels of conditionality in qualifying for, receiving and maintaining benefits (Reeve, 2017).[v] Claimants would also be obligated to meet certain behaviour-based conditions of their benefit (such as attending work-focused interviews).[vi] If claimants did not meet the conditions of their welfare benefit, they could face sanctions (Welfare Conditionality, 2017).[vii]

The introduction of Universal Credit (UC) was designed with the hope of simplifying the welfare system and creating more incentives for people to get into work. As stated by the Department for Work and Pensions (DWP), the main aims of UC were to:

1. **Make the benefits system fairer and more affordable**
2. **Reduce poverty, worklessness and welfare dependency**
3. **Reduce levels of fraud and error**

(GOV UK, 2015)[viii]

UC rolls six existing benefits into one single benefit but with different component parts based on the capability to work including "work based group", the "limited capability for work group" and "limited capability for work and work-related activity group".

In addition to the introduction of UC, the Government has initiated changes to the welfare system with the aim to get a further one million people with disabilities and long-term health conditions into work (Department for Work and Pensions, 2017).[ix] However, these changes to eligibility, alongside a rigorous screening process, have made the process of claiming difficult. Studies have shown changes in entitlement, and the process of applying for benefits has negatively triggered and impacted the mental and physical wellbeing of claimants (Barr et al., 2015).[x]

However, there have been easements made within the benefits system that can support the health and wellbeing of claimants. Many of the following easements have been introduced since the rollout of UC; however, some pre-date UC. The following list is not an exhaustive list of available benefits, but are the main adjustments explored in this research.[3]

All benefits

- Rent can be paid directly to the landlord
- Payments can be made weekly or twice monthly
- Alternative forms of ID are permitted if the claimant does not have the relevant ID available

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[3] Due to the continued changes with UC and the fact that regions are on different stages of rollout, we asked participants to think about adjustments made in the past 12 months or if they had been homeless less than 12 months to think of adjustments made while they were homelessness.

- Claimants can claim without an address or bank account
- Claimants can access benefits on the phone as well as online

Specifically for Universal Credit

- When claimants are homeless, the number of hours they are expected to look for work can be reduced on a month by month basis
- Advance payments to support claimants during the five-week wait for first UC payment
- Claimants can apply for a bursary to help them get to job interviews and with clothes for interviews[4]

Personal Independence Payments

- PIP assessments can be carried out where claimants are living

For a full discussion of the issue, please see **groundswell.org.uk/benefitsforhealth**.

Methodology in brief

The research was conducted using a peer methodology where a team of six volunteers with experience of homelessness were involved throughout the research process from designing the research questions, forming the research tools, conducting all of the fieldwork and analysing the data. Employing the principles of peer methodology was critical to the success of the research. One main advantage of using a peer methodology is a rapport based on shared experiences could be built between the researchers and participants, which could encourage participants to take part in the research and give more authentic responses. Furthermore, researchers felt the research experience helped them to use their previous experience of being homeless to raise awareness and push for solution-focused change with hard to reach groups.

Including the six researchers who led the study, a total of 248 people with experience of homelessness contributed to this study. Participants in this study had a range of accommodation situations, including living in homelessness hostels (40%), rough sleeping (14%) and night shelters (15%). Most participants (76%) identified as male and 23% identified as female. A range of methods were employed in this study to engage people with experience of homelessness, including 221 surveys, three focus groups with 16 participants and 10 qualitative case study interviews. In addition to this, two in-depth interviews with practitioners working in homelessness services were conducted to give additional context to the research.

Pseudonyms have been used throughout this report in order to protect the anonymity of the participants who took part in the study.

The research took place between November 2019 and March 2020 in homelessness services across London including homelessness hostels, day-centres, winter night shelters and women's services. The survey data was collected on electronic tablets using SurveyGizmo. The data was then analysed in Excel and Nvivo.

A full and detailed methodology and profile of participants are featured at **groundswell.org.uk/benefitsforhealth**.

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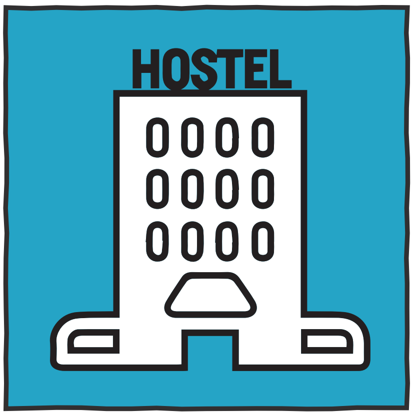
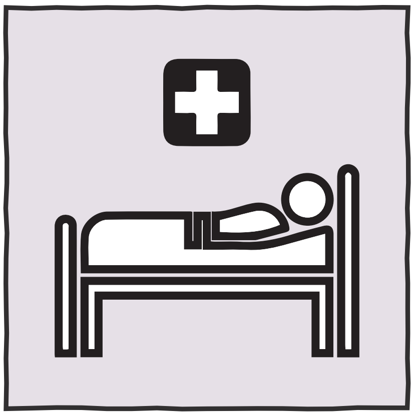
[4] Those on legacy Job Seekers Allowance (JSA) can also claim for this





Research findings

Benefits, health and journeys through homelessness

Living with physical and mental health issues and navigating the challenges of the welfare benefits system is a reality for most people experiencing homelessness. A significant proportion of participants in this study are facing physical and mental ill-health issues that, in many cases, have been contributing factors to why they have faced homelessness and why they find it difficult to escape homelessness. Welfare benefits should play a significant role in preventing and tackling homelessness when people face ill-health; however, for many participants, the safety net was not always accessible. The research findings will be structured into three key parts; first, the causes of homelessness in relation to health and healthcare usage by those experiencing homelessness. Second, we explore the causes of homelessness in relation to benefits issues and peoples' interaction with the welfare state. Finally, the findings will discuss how homelessness, benefits issues and ill-health intersect by breaking down the process of applying, receiving and maintaining benefits. Following this, a conclusion and recommendations for change will be outlined.

Causes of homelessness: health factors

This section of the report will look at the causes of homeless that are linked to health factors. There were multiple, complex and intersecting reasons for participants becoming homeless.[5] As mirrored in other literature, participants rarely cited one cause instead listing a range of structural and personal factors that were coexisting and having a compound impact on why participants became homeless (see Crisis (2019).[xi] However, mental ill-health was the most common factor, with 37% of participants reporting this as a major cause. By using a broad definition of mental health to include addiction issues, over half (54%) of participants reported that this contributed to them becoming homeless. The literature exploring the link between homelessness and addiction is vast, where substance misuse and addiction are used as coping strategies for mental crisis and to deal with the stresses of homelessness.[xii] A smaller proportion, (14%) spoke of how physical health issues were a contributing factor to becoming homeless.

Participants were also asked the extent to which they agreed with this statement; "my health (physical and mental) issues contributed to me becoming homeless", and 57% agreed or strongly agreed.

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[5] We presented a list of possible causes, and participants choose as many as they felt were relevant to them and also had the opportunity to add their own.

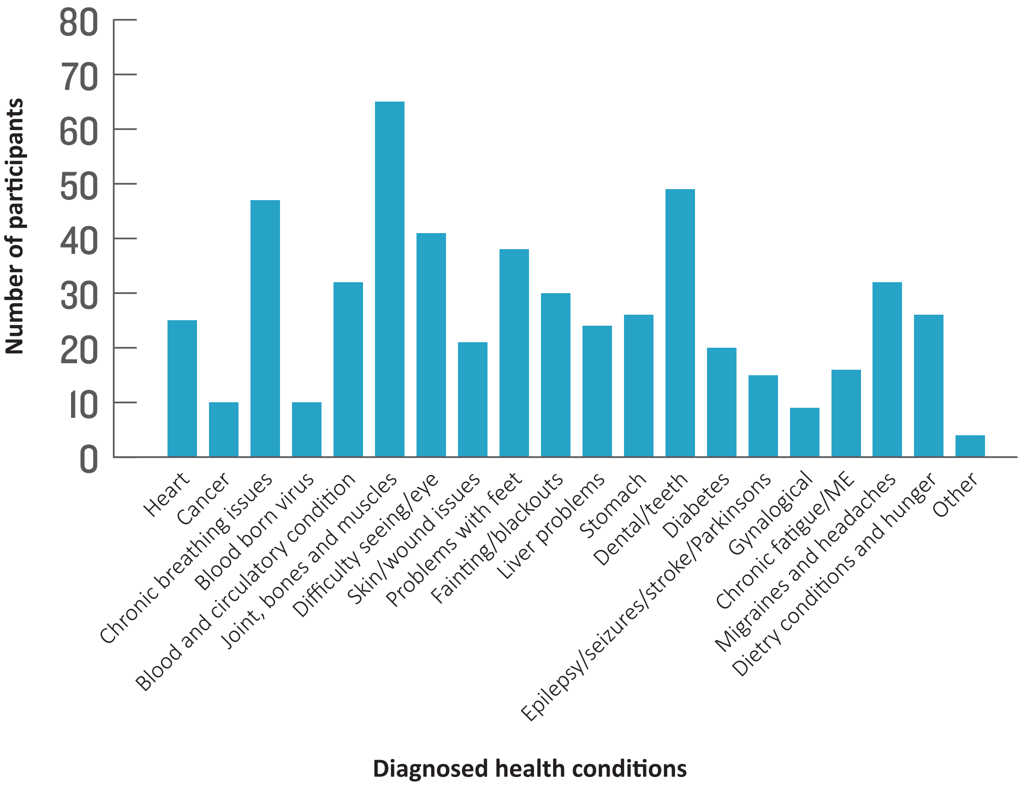
Mental and physical poor health is increasingly recognised as a significant contributing factor causing homelessness. However, Dai and Zhou (2020: 1)[xiii] state that despite the established and emerging research showing the concerning high levels of poor ill-health experienced by those experiencing homelessness, health as a cause of homelessness is often still “downplayed”.

Health while experiencing homelessness

Health factors can be a significant factor in causing homelessness, however it is also important to consider health when a person is experiencing homelessness- particularly as the stresses of homelessness can exacerbate existing health conditions and create new ones. The Homeless Link Health Needs Audit (2015)[xiv] reports that 77.5% of people experiencing homelessness live with ill-health. These figures are consistent with the data in this research that shows the high level of ill-health people experiencing homelessness are having to live with. Participants commonly faced significant physical and mental health issues and often lived with disability: 62% reported to currently have a physical health issue, 62% reported[6] to be facing mental health issues, and just under a quarter (23%) reported to live with a physical disability.

The physical health issues faced by participants were diverse. Participants were asked to choose from a range of areas of the body for which they had a diagnosed medical condition.[7] The most common issues were joints, bones and muscles (29% of total participants), dental issues (22%) and breathing and respiratory issues (21%) which are represented in figure 1. These findings support previous research by Groundswell who found correlations between those that experience homelessness and ongoing chronic pain (Groundswell, 2018),[xv] poor oral health (Groundswell, 2018)[xvi] and respiratory issues (Groundswell, 2017).[xvii] These issues are compounded by healthcare services not always being “user-friendly” to those with multiple and complex needs.[xviii]

Figure I: Graph showing diagnosed physical health conditions of participants



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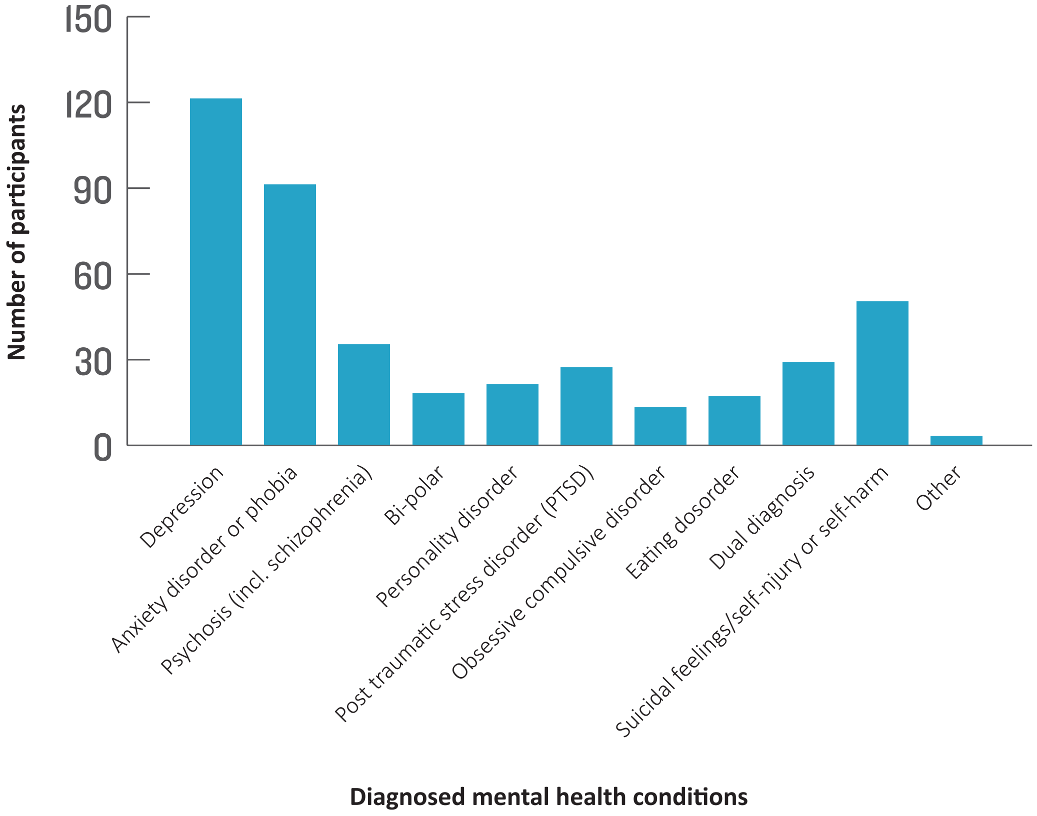
[6] This was self-reported data from 221 surveys.

[7] Participants could also add other conditions not present on the list.

Mental ill-health was also prevalent among participants, and many reported to have a diagnosis or were receiving support but not yet been diagnosed. As evident from the graph below, the most common mental health issues were depression (55% of total participants) and anxiety disorder or phobia (41% of total participants).[xix] Other common conditions included self-harm and/or attempted suicide (23%) and psychosis (16%). Notably, often participants reported having a diagnosis for more than one mental health condition. Akin to physical health conditions, we found that the challenges of accessing support often exacerbated mental health conditions.

Figure 2: Graph showing diagnosed mental health conditions of participants



Within the NHS system and other community-based support, there can be a tendency to see mental and physical health as separate concerns; however, physical and mental ill-health can be inextricably interlinked (Mental Health Foundation, 2020).[xx] The data shows that the participants in this study faced significant challenges with their health, often dealing with coexisting issues with physical health, mental health and disability. In fact, 43% of the participants reported to be facing coexisting physical and mental health issues, and 83% reported to be living with either physical health issues, mental health issues or both. An overarching concern is that challenges in accessing healthcare for people who are homeless can often mean that health issues may be undiagnosed and therefore untreated (Kings Find, 2020[xxi]; Paisi et al., 2019).[xxii] As such, there may be an under-representation of actual conditions.

Access and usage of healthcare while experiencing homelessness

Given the high health needs among the participants in this study and the wider homeless population, there is a significant need for access to quality care from healthcare services. It is well documented that people experiencing homelessness can face challenges in accessing healthcare due to structural, personal, administrative and practical barriers (Kings Fund, 2020)[xxiii] and (Paisi, 2019)[8]. Commonly these challenges can force people who are homeless to rely on emergency care which is seen as easier to access rather than with primary or other preventative care routes (NHS England, 2018).[xxiv]

This is reflected in this study with over a third of participants (37%) having accessed accident and emergency care in the last 12 months[9], and 27% had been admitted to hospital in the past year. Among participants in this study, a high proportion (84%) had attempted to access primary care services in the past 12 months, the most common being a GP (74%), a pharmacy (52%) or a dentist (43%). Given that this research is particularly concerned with the intersection between health and benefits, we will explore the challenges of accessing services that require proof of exemption in more detail in a subsequent section.

Causes of homelessness: benefits issues

This section of the report will consider how benefits issues can directly cause homelessness. Problems with benefits were common, with 20% of participants reporting that this was a contributing factor to homelessness. Delays in payments, lack of efficient and timely coordination between low-income employment and benefit payments, and benefits not covering the cost of rent were reported to trigger homelessness. One participant explained that their experience of becoming homeless was due to not understanding the benefits system and not realising the welfare state can "top up" low employment income. As a result, the participant was unable to pull together the funds to maintain a tenancy:

> *"What made me homeless in the first place? I have never had my own place before. Didn't understand about benefits. I just did what I always do. I started work, part-time, so I come off benefits. And you know, you don't talk about what you are going to get paid and all that, you don't go into detail like that. So I got my money, so I must have started that right just before they get paid. I got £200 to last me a month. And then, I owed one month's rent. And then when I do get decent money the next month, another lot of money, they want two lots of money, two month's rent. And I only work part-time. So straight away, I am behind, and I can never catch up. So because of the benefits, it made me lose my home because I owed money."*

Many participants also became homeless as a result of getting into rent arrears because they could not pay the difference between what they received from the Local Housing Allowance and their rent; 24% of participants cited rent arrears as a cause. As highlighted in research by Crisis[xxv], the benefits system can play an important role in preventing homelessness, but among participants in this study, some became homeless because of the complex configuration of benefits and housing entitlement, exacerbated by ill-health and/or addiction.

Among participants for whom benefits issues had contributed to them becoming homeless it was common for them to also be struggling with mental health, addiction and physical health challenges

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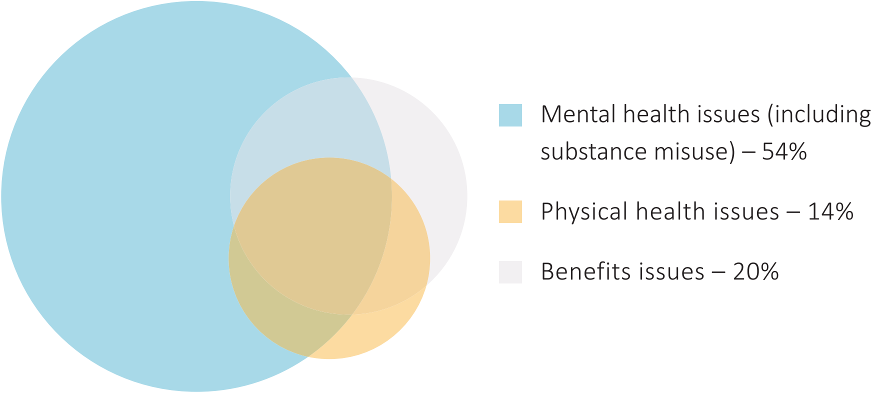
[8] Paisi, M. Kay, E. Plessas, A. Burns, L. Quinn, C. Brennan, N. and White, S. 2019. Barriers and enablers to accessing dental services for people experiencing homelessness: A systematic review. Community Dentistry and Oral Epidemiology. 47(2), pp.103-111

[9] For participants that had been homeless for less than a year (23%), we asked them to refer back to the period since they had become homeless.

at the same time. Where benefits issues were cited as a contributing factor to homelessness, only a quarter did not feel that mental or physical health issues had not also contributed to them becoming homeless.

Figure 3: Self reported factors that contributed to participants becoming homeless



One benefits advisor from a homelessness service who was interviewed explained their experience supporting a client:

> *"She was suffering from depression. She was seeing a GP. But she was renting a place and she - she didn't have any idea of what to do and when the landlord increased the rent, she just felt 'oh, I can't afford it'. And she walked away from the tenancy. And she started to stay with friends. And of course, that resulted in the friends saying 'oh, sorry you can't stay here tonight' or 'you have to find somewhere else'. And that worsened her depression. And when I met her, she was practically without bags. She has not been seen as having a priority in terms of council accommodation, although she was in the process. But she was – the depression was so acute that I was quite concerned for her, as she - she was in a really bad state."*

The following case study from Gary illustrates the interconnection between benefits and homelessness, and subsequently, how homelessness can impact health and the ability to access healthcare.

Case study – Gary

Gary has been street homeless for six months and has experienced homelessness multiple times in his life. He told us that he was made homeless this time due to benefit sanctions and subsequent rent arrears. He was renting a room in a shared house that cost £1200 a month explaining that it was the only place he was offered after he had been homeless before. He was subject to the benefit cap and needed to pay the difference between his rent and the money he got from his housing benefit with what he was earning. He was struggling to make enough from working and got into rent arrears and became homeless again.

Gary spoke about he was concerned as he was passing blood. His doctor told him he needed an investigative operation. However, he told us that he refused the operation as he was concerned about being not allowed back to his GP if they found out he was homeless. He also said he was worried about having the operation and not having anywhere to recuperate after it. On top of this Gary was also suffering from depression, PTSD and had self–harm/suicidal ideation. Gary was not receiving any benefits at this point and spoke about the challenges of meeting the requirements of the Jobcentre.

> *"You have to walk around looking for food and shelter, which interferes with the requirements of the Jobcentre and job searches. You need a computer and Internet access. Libraries only give 1 hour. If homeless your mind is not always clear, you are tired. My Jobcentre is very far from where I can get my support."*

In addition to the housing benefit cap, we also found that some participants were made homeless because of the confusion around UC. This is illustrated in volunteer field notes to the right;

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Volunteer Researcher Field Notes

"She was a job seeker on UC. She was then advised by the Jobcentre to take on a cleaning job. But her wages did not cover her rent. She also had to wait a few weeks for her wages to arrive in her account. Her UC stopped completely straight away, including her housing benefit. This meant her rent was unpaid. She also did not have the money to travel into her work and buy food. She resorted to asking her frail elderly mother for money. The mother lived in a nursing home. This was very stressful for this young lady as she felt guilty and embarrassed doing so. She felt bad about causing her mum to worry and about having to admit she was not doing well."

(Volunteer researcher notes, April 2020)

This finding is supported by research from Crisis (2019)[xxvi] which illustrates the sharp rise of homelessness as a result of the rollout of UC and consequent sanctioning (Crisis, 2015).[xxvii] Furthermore, research from Trussell Trust (2016)[xxviii] states that benefit delays, administrative errors, sanctions, a lack of understanding among staff, the confusing system and barriers to access are key factors in causing and perpetuating deprivation, distress and consequently homelessness. In fact, the challenges in communication between the Jobcentre and claimants were firmly represented in the research data, where people had not received important letters about appointments and assessments which had gone to previous or "care-of" addresses which had worsened claimant's circumstances. Similarly, letters could not always reach people in temporary accommodation, particularly when living in larger homelessness hostels. As this researcher wrote in their field notes:

> *"A man in his 40s got thrown out of a hostel due to disagreements and possibly not sticking to the hostel rules. He got an invitation to a health assessment, except he did not receive it, as he was on the street at this point. He did not attend his appointment, as he did not know about it. His benefits were cut off. When I spoke to him, he had no income, but he was placed in another hostel by this point".*

It is also important to note that the digital divide between people who are housed and those who are homeless or at risk of losing their homes is a key issue in healthcare systems (Micklethwaite, 2016),[xxix] welfare systems (Harris, 2020)[xxx] and access to services more broadly (Lemos and Frankenburg, 2014).[xxxi] For example, within the UC system, in particular, there is a need for regular access to log absences, update work searches, log changes of circumstances, provide details of health conditions, check claimants' commitment and to send messages to work coaches (Understanding UC. 2020)[xxxii]. Of those in receipt of UC, 55% reported having difficulty or had been unable to access the online system when facing precarious living situations, which puts claimants at risk of being sanctioned. This stakeholder explained the challenges homeless claimants have:

> *"They still have the problem of not being able to always contact the Jobcentre because they don't have a phone or computers they can't even log their absences. Like once it is gone through as missing*

> *something unless you have got loads of reasons and get a doctor's note or whatever, then it's usually just an absence".*

The challenges of the online system for people who are homeless have been highlighted in previous research (Harris, 2020).[xxxiii] Inadequate access to necessary technologies, limited ICT-skills, literacy and English language barriers, as well as learning difficulties, make it exceedingly difficult for many people who are homeless to apply for and manage their claims online (Lemos and Frankenburg, 2014).[xxxiv] This can push people experiencing homelessness into even more uncertain positions. A benefits advisor shared this example of the challenges their clients faced with accessing the online system:

> *"I have seen clients who can barely read text messages sent to them. So the likelihood that they will log in to a computer on their own sometimes… And especially if they are rough sleeping, or just from area to area, staying with friends, haven't got stable accommodation. […] So they have not been aware of what they have been asked to do. [With one client I supported…] it wasn't just missing appointments. And it was just purely because I couldn't get in touch with her; she didn't have a phone. She was so chaotic; it was just impossible to find her, and then she would be sanctioned."*

As highlighted in a recent study by Groundswell (2020)[xxxv] on UC, and academic research,[xxxvi] the move to further digital management of benefits can present a significant issue for people who are homeless or for whom face to face interactions are of vital importance in ensuring support is timely and appropriate.

Benefits received by participants

As already discussed, the welfare state is a mechanism to provide a safety net for those who face adverse experiences; however, for those experiencing homelessness, there appears to be a disconnect. The benefits system is composed of several different universal and selective benefits depending on a claimant's situation and need. The research explored participants' access to benefits, broader engagement with the benefits system and their perception of how easy it was to access support. In this study, 85% of participants were receiving benefits, 14% were not, and 1% were not sure what support they were receiving.[10] The participants who were not currently receiving benefits were either rough sleeping or squatting. Among participants receiving benefits in this study, the most common claims were Housing Benefit (59%), UC (53%), Employment and Support Allowance (ESA) (35%) and Personal Independence Payments (PIP) (19%).[11] Of those receiving UC (N=99), 9% were also receiving PIP and 1% receiving new style ESA.

Of the 33 participants who were not receiving benefits or who were not sure, 24 (73%) had tried to access benefits since they were homeless but were not able to. This was for a range of reasons, including participants not being aware or confused about their entitlements and Jobcentre staff not being aware of, or not implementing, necessary adjustments to help people claim. In fact, 65% of participants agreed with the statement; "being able to claim benefits when I was homeless was difficult".

Similarly to the aforementioned challenges in accessing healthcare, difficulties in accessing benefits while experiencing homelessness included long waiting times for applications to be processed, not having an address, having issues with identification and/or documentation and Jobcentres being too far away.

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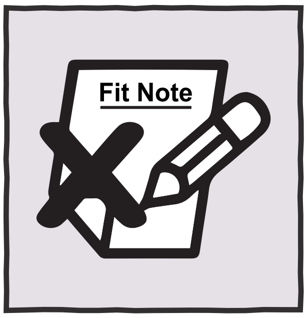
[10] It is likely given that much of the research was done in hostels that require housing benefit, that a higher proportion of people were receiving benefits compared to the broader homeless population.

[11] It should be noted that claimants can receive more than one benefit at one time. For example, someone living in a hostel could be receiving housing benefits, UC and ESA as an additional element to their UC claim.



Notably, challenges were particularly prevalent for those receiving UC. Some participants told us that applying for benefits involved a lot of bureaucracy and that it was not worth the stress involved:

> *"Benefits are hard to claim when you are no fixed abode and a lack of I.D. I used to claim but was hard work because of all the red tape and bureaucracy".*

While there are not always claimant requirements for people who have "recourse to public funds", 21% of all participants reported that they had been refused access to benefits in the last year because they did not have an address and 16% because they did not have identification. However, there were cases where the Jobcentre had adapted to allow people in this situation to claim, with 13% of those accessing benefits (N= 188) allowed to access with alternative forms of ID, 10% using the Jobcentre as their address and 9% were able to receive benefits without a bank account. Despite this, the experience and perception of many participants significantly differ, and there is a need for increased flexibility in the application process of applying for benefits when claimants are experiencing homelessness.

We asked participants whether they felt that they were receiving the correct benefits. It was clear that many participants thought they were not on the right benefits or were confused about which benefits they should be entitled to. Of the participants who were receiving UC, 44% felt they were not on the correct benefit. Some participants elaborated and described what benefit they think they should be on and why; of those who did, most felt they should also be on PIP or ESA because they had a serious medical condition or disability. Among the general working-age population receiving benefits, 33.8% are on PIP, and 30.8% were on ESA.[xxxvii] Given the physical health, mental health and addiction issues among those facing homelessness, it seems a higher proportion should be on these benefits.[12] The following field notes from a volunteer researcher explain the circumstances of one participant they spoke to who was not receiving any benefits despite her health conditions and housing situation:

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[12] As mentioned, 35% were receiving ESA and 19% were receiving PIP

Groundswell
Volunteer Researcher Field Notes

"I spoke to a disabled lady about 60 years old who walked with a Zimmer frame. She was very mentally agile and apart from a difficulty with movement due to a joint disability, she was full of life and determined to fight all obstacles in her life. She had her health assessment, and despite a new diagnosis confirming her disability, she was awarded smaller benefit as if her health improved. She appealed. Then all her benefits were stopped at once. She had no income for six months. She survived thanks to her hostel and having friends. She also had access to a key worker, health worker, social worker, who agreed that she needed support due to her health condition. The hostel was willing to wait for her rent until the benefits were sorted. However, she felt trapped as she did not have money to go anywhere out of the hostel unless a friend would pay for her travel. She managed to get by thanks to getting food at the hostel, food bank, donations of toiletries at the hostel. She won her appeal and was waiting to receive her money. She had been staying in homeless hostels for many years".

(Volunteer researcher notes, April 2020)

A lack of communication about the adjustments available was a core issue in the research where only 23% of participants claiming UC had been given DWP guidance on claiming UC when homeless. Only 16% of those claiming UC had the number of hours they are meant to look for work adjusted and 25% had been made to take a job/training opportunity that they felt was not appropriate. Notably, only 7% of those receiving UC had been given a bursary to support them with transport to get to interviews and clothing for interviews. While some claimants may not want or require this bursary, this support could be more widely communicated. Related to this, 44% of participants who had applied for UC in the last year had received advance payments while they were waiting for their first benefit payment.

Our evidence suggests that communication and timely implementation of easements, guidance and support that would help a claimant to be able to comply with their claimant commitment is limited and inconsistent. An explanation of this could be due to work coaches not always understanding the lived experiences of homelessness and health issues, in addition to them not having the knowledge of appropriate easements available. A support worker spoke of how work coaches are not aware of easements available:

> *"And I think a lot of … the work coaches don't actually know a lot of things. Like, for example, the easements which you were talking about… you would just expect them to suggest that to someone who is really struggling".*

The relationship between homelessness, health and welfare

The overlap between mental health (including addiction), physical health and benefits was a significant finding in the research. Where benefits issues were cited as a contributing factor in causing homeless, 60% of participants also cited mental and/or physical health issues as contributing to them becoming homeless. Out of the participants who have a physical and/or mental health condition, 27% of them simultaneously experienced issues with benefits. How this relationship between these three factors manifests in the day-to-day life of those experiencing homelessness will now be explored.

Claimant status and accessing healthcare

While many NHS services are free at the point of contact, some services require payment or proof of exemption, for example, medication from a pharmacy, dental care and optometry. Among all participants who had accessed or tried to access these services, 52% had challenges accessing dental care, 43% accessing an optician and 41% accessing prescribed medication from a pharmacy. When considering people not living in hostels or other supported housing, this figure is significantly higher. For example, among those who were currently street homeless, 69% who had attempted to access these primary care services reported to have had difficulties. For people who were ‘sofa surfing’, almost all (8 out of 10 participants) reported having challenges accessing services.

We asked participants to elaborate on the challenges they faced when accessing healthcare treatment and services. Participants highlighted issues with registration because they did not have an address, could not provide the necessary information, or they did not know how to register. Barriers associated with not having an address or changing address also made it difficult to pick up prescriptions, which could have severe health consequences. A volunteer researcher writes about a participant who was denied a prescription (see notes right):

Groundswell Volunteer Researcher Field Notes

“One man had been refused his prescription medication by a pharmacist despite having his prescription and his ID. As he was visibly a street homeless at the time, the pharmacist accused him of having stolen the documents and did not dispense it without a proof of where he lived which this man could not provide. He was haemophiliac”.

(Volunteer researcher notes, April 2020)

A participant who was sofa surfing, and had not been able to claim benefits, spoke of how she had mobility issues and asthma. And that she could not afford a new crutch after she lost hers and that getting asthma medication was difficult because she had no fixed address. Practical issues associated with homelessness also impeded the ability to access healthcare. One participant spoke of how accessing healthcare was a challenge because they were unable to wash and wear clean clothes:

> *“I was sleeping rough, and you need an address. When you sleep rough, you feel dirty, so you do not want to go to optician when you feel dirty”.*

We found a particularly strong correlation between the benefits status of participants and challenges in accessing primary care. For example, among those who were currently in receipt of benefits, 62% reported having had difficulties accessing primary care, including prescribed medication, dental care, hearing aids, glasses, crutches and dietary supplements. Among those who were not receiving benefits (or were unsure if they were receiving) and had tried to access primary services, 86% had challenges accessing prescribed medication, 54% had difficulties accessing dental care and 50% with accessing an optician. Being unable to afford these services or prove exemption was difficult for many participants.

Since the introduction of UC, entitlements around healthcare have changed, meaning not all claimants can receive payment exemptions (NHS, 2020),[xxxviii] only those earning under £435[13] can receive free dental care, prescriptions and glasses.[xxxix] Due to the challenges that people experiencing homelessness can face in accessing both healthcare and benefits, this can have a compound impact on the likelihood of receiving care. One participant spoke of how they were charged for a dental appointment despite being on benefits that would exempt the charge:

> *"It was a dental appointment, so I think it was about £90. But my dentist knew that I was on benefits, so I think somehow we cleared it in the end. But originally, they [receptionist] said that I had claimed that I wasn't entitled to".*

In another case, a participant was refused her medication because she could not demonstrate that she was on benefits:

> *"A lady at a Boots pharmacy refused to give me the medication for which I had a prescription. Be sure; I was homeless. I had with me my bags and possessions. I had my ID, but she did not believe it was me and was questioning me about if I was working or on benefits. She wanted a proof of benefit in addition to my ID. She refused to dispense my medicine".*

The following case study also illustrates a challenge a participant had with proving exemption when trying to receive dental care:

Case study - John

John lives in temporary accommodation and is in receipt of UC. He has had significant issues with his oral health since he has been homeless. A support worker informed John that he should be entitled to free NHS dentistry as he is in receipt of benefits. When John arrived at the dentist he was asked to fill out a form and provide "official" proof of his benefits. The form John was filling out it did not have a tick box to say that he is in receipt of UC. The receptionist also required him to provide a letter to say he is in receipt of UC but since it is online he was unable to get this. Because of this, he was unable to access dentistry and continues to suffer from oral health issues.

Among participants, there was clearly confusion about entitlements to care and the relationship to welfare benefits. Participants commonly gave examples of where they, the people who support them

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[13] It should be noted this is for single claimant and the amount varies depending on whether a claim includes a partner or child.

and in some cases professionals working in medical settings were uncertain of these entitlements. As this participant stresses:

> *"The DWP has to be more informed on the rights of the applicant when applying for and receiving benefits, i.e. half-price oyster cards, free dental, free prescriptions".*

However, some participants felt there was a role for the DWP and Jobcentre to help claimants to understand their rights in terms of access to healthcare and could also assist with insisting health services and primary healthcare must allow registration of those without a fixed address.

Navigating claiming, homelessness and health

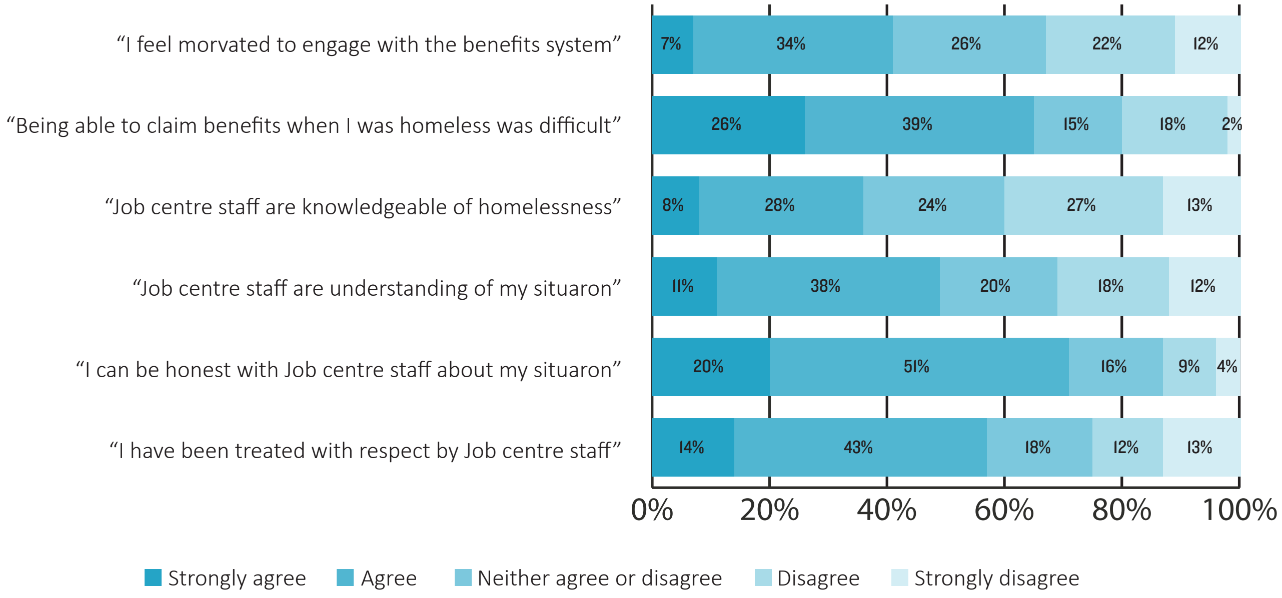
The report has already touched on the challenges of managing benefits and the effects of sanctioning on the already precarious positions people are in. However, we need to look more closely at how health conditions affect the process of applying, receiving and maintaining a welfare claim. This is because ill-health and conditionality can be a driving factor in alienating people experiencing homelessness from support and good health.

When participants were asked to what extent they agreed with this statement, "the process of applying for benefits has had a positive impact on my mental and physical health", 48% either disagreed or strongly disagreed. Similarly, when asked the extent to which they agreed with this statement, "receiving benefits has been good for my mental and physical health", 28% disagreed or strongly disagreed. This research found that the main influencing factors in the ability to claim and maintain benefits and manage health issues for people experiencing homelessness were as follows: relationships with the DWP; sanctioning and issues with payments; proving incapacity while homeless; and receiving and maintaining benefits.

Factor I: Relationships with the DWP

The following graph outlines participant attitudes towards Jobcentre staff. It is important to map the extent that participants felt respected, listened to and supported. This is because we found that the experience claimants had was very much dependent on their work coach and/or staff they dealt with at Jobcentre branches. Some Jobcentre staff were highly supportive of participants, understood their housing situation, how their housing situation affected them and applied the necessary flexibilities to support them. However, other work coaches appeared not to be aware of the flexibilities or chose not to implement them. It is these gaps and inconsistencies that need to be explored further in order to improve and sustain the positive services and support that are delivered to people experiencing homelessness.

Figure 4: Graph showing experiences with Jobcentre staff



This research has found that there is a lack of awareness and implementation of adjustments and easements. For participants who were in receipt of UC (N=99), 41% did not have any adjustments made, and 67% had not been told about the adjustments or were unsure if they had been told. For UC, the first interview with a work coach is normally an opportunity for discussing any issues and challenges a claimant might have, which would inhibit their engagement with the Jobcentre. Then a claimant commitment outlines the conditions for receiving welfare[xl] which should "be tailored according to the claimant's capability and personal circumstances, taking account of any vulnerability, complex needs or health issues" (UK Parliament, 2018).[xli] Setting these commitments and the adjustments or easements within them is at the discretion of the work coach.[xlii] However, not all work coaches fully appreciate the debilitating impact of certain health conditions. A focus group participant told us:

> *"When it's mental health, they don't seem to understand mental health. And then that annoys you because that meeting, you have got people who are judging you, sitting across this table, typing away. You can't see what they are typing".*

In fact, participants identified a need for more training for staff around homelessness, with only 36% of participants feeling staff were knowledgeable about homelessness. A benefits advisor shares their concerns about this issue:

> *"Sometimes you get really good work coaches, but sometimes they are just really unaware of the difficulties of our clients particularly".*

The fact that DWP staff are not always aware of the issues faced by claimants without a home is also reiterated by Beatty, Foden, McCarthy and Reeve (2015)[xliii] who note, "some studies note the failure of Jobcentre Plus advisors to pick up on these health barriers that are likely to affect participation (of homeless claimants) from the beginning". Furthermore, this research has identified that participants can often find it difficult to disclose sensitive personal information, particularly in relation to homelessness, learning difficulties, mental and physical health issues and/or addictions. Having to explain their situation to multiple staff in the Jobcentre or in spaces that did not offer privacy could often aggravate this. Of participants who were claiming UC, 87% said that their work coach was aware of their housing situation, but many Jobcentre staff may not be aware or ask about exactly how their housing situation affects claimants' health and their ability to engage with the system.

However, even when health conditions were disclosed, claimants felt a distinct lack of empathy regarding the overlap between health, homelessness and welfare support with reductive attitudes being demonstrated by work coaches and administration procedures. An example of this was where health challenges prevented attendance at appointments:

> *"There was times when I was going through a lot of head and body pain, a lot of like really, really severe painful burning sensations in my body. And in my head. And if that would happen and I had an appointment, and it meant that it delayed me getting to an appointment – I think there was one time this happened. And I was even sick on the day. And I missed my appointment by … 15 minutes late. And they said they couldn't see me. And even though I said I was willing to wait there all day, I am so sorry this has happened, I was just feeling so unwell. It was just "well you should have left home earlier". But then again, how I don't know… that the pain was going to start and this was going to happen. And of course … even when I offered and said I am willing to wait here all day so that I can be seen, I was just told that is not an option, and there was too many people to see, too many appointments. So it was written down on my account. And if it happened again I was told then I would receive a sanction. And then my benefits would be stopped. So that put me in a place where I was feeling completely worthless and that everything was my fault—and even more stressed out, more distressed. Which was contributing to the physical symptoms I was feeling as well".*

Another example demonstrates where participants felt like the issues they were going through were undermined and that they were to blame for their situation:

> *"You just get really, really down sometimes when you are spoken to in a really derogatory way by somebody who is meant to be helping you, like a work coach or whatever. And I … there's very much – I mean I don't want to say it's all of them because I have met some people working in UCs, who are clued up about what's going on. Even if they don't openly speak about it, so those people can be very helpful. But I also met some other people who very much make you and other people who are claiming benefits feel as if it's your fault that you are in this situation."*

Benefits and requirements should be adapted to best meet the needs of the individual- taking into account accommodation situations, physical and mental health challenges, disability and learning difficulties/differences. The consequence of information on health and social care needs not being shared openly and health conditions not being taken seriously, is that unreasonable expectations are placed on homeless claimants, which can result in pushing claimants into further social exclusion as illustrated by the case study below:

Case study - Ali

Ali had been living in a hostel for a few weeks after being made homeless when he left prison. He was receiving UC and felt he should be on PIP because of his mental health, physical health conditions and substance misuse issues. He has chronic breathing issues along with blood conditions and multiple mental health conditions including PTSD, depression and self-harm and suicidal ideation. Ali had experienced numerous challenges with the benefits system including not being able to access the online system, not receiving doctors' notes in time, not having sufficient funds to get to appointments and losing documentation needed to claim benefits. Despite the Jobcentre being aware of the multiple challenges he was facing, including his health issues, no adjustments or easements been made to his benefits. He was later sanctioned for not attending an appointment because he was sectioned in hospital at the time. In addition to this, Ali said he sometimes could not afford his prescribed medication; he was unaware that he was entitled to free prescriptions. More generally, he spoke of not having the right support to help him to claim the health benefits that he felt he was entitled to.

Factor 2: Sanctioning and issues with payments

The impact of sanctioning and/or being left without income is extremely damaging. It can place a significant burden on a person's health and wellbeing, particularly when the person experiencing homelessness does not have the resources to be able to cope. In fact, 86% of those who had been sanctioned said that the sanction had a negative impact on their mental and physical health. One participant shared their experience after being sanctioned:

> *"I sank into depression, and my mental health condition has deteriorated since. The experience has also caused me memory loss".*

In this case study, Melanie described how a sanction meant she was unable to get medication for her health conditions.

Case study - Melanie

Melanie has been sofa surfing and living in hostels for over 10 years. She had multiple physical and mental health conditions that made her feel suicidal. She is not receiving benefits because she was sanctioned for being late for a Jobcentre appointment. She spoke of how the sanction made her feel ashamed, and it had caused "stress, panic, isolation, lack of sleep and a poor diet". As a result of the sanction, she was unable to afford some of her medication for her asthma and the money for travel to get the pharmacy.

Of those who were receiving benefits, 28% had been sanctioned in the past 12 months, and over half of these were sanctioned for more than four weeks. Of the 53 participants who had been sanctioned, 26 appealed with a mandatory reconsideration, and 22 were successful in their appeal. This finding echoes research from Crisis (2015)[xliv] that highlights that people who are homeless are twice as likely to be sanctioned and have their allowances and housing benefits cut than the general population. No income meant that accessing food was a significant challenge. Many reported being totally reliant on food from day-centres and soup runs. As highlighted in previous studies (Batty et al., 2015),[xlv] participants commonly reported that they had resorted to "begging, borrowing and stealing" to survive. These issues were particularly difficult when participants were living with drug or alcohol addictions. Often the result was turning to crime to manage this. As one participant described:

> *"Benefits sanctions… money come down and comes down, and you can't get it… so I started stealing. Just to steal alcohol… I wasn't even just stealing food. I was just walking in. […] I felt that this puts me in jeopardy then because there is prison involved in that".*

Claimant commitments that do not take into consideration the health issues claimants face can set people up to fail as it forces them to adapt to a system that does not recognise their needs, even when there is significant contact with the healthcare system. More broadly, issues with sanctions show that this nudge tactic is not achieving the stated aim to promote compliance with the Jobcentre and incentivising work (House of Commons Work and Pensions Committee, 2018).[xlvi] Ironically, sanctions can push people further away from good health, recovery and work:

> *"Was sanctioned, which directly led me to full-blown relapse. Associated criminal behaviour led to a three-month prison sentence. This was a life-threatening situation. Because of this, other people suffered."*

The heightened level of stress due to claimant compliance and the effects of sanctioning needs to be taken more seriously as previous research exploring the health impacts of Work Capability Assessments shows that the Work Capability Assessments were independently associated with an increase in suicides and self-reported mental health problems (Veigh, 2015).[xlvii] These findings are reflected in Mo's story:

Case study - Mo

Mo had been homeless for over two years after the death of a family member and a subsequent eviction. He was living in someone else's council property but had spent time rough sleeping, squatting and living in temporary accommodation. Not long after he became homeless, he was sanctioned for 26 weeks after a serious operation and a stay in hospital. There had been a mix up between the Jobcentre and GP, and the Jobcentre was not informed about his situation. He was not well enough to go to the Jobcentre after the operation to sort out the problem. He later asked for a "mandatory reconsideration" but was not successful. He told us that this situation with his benefits made him suicidal.

There had been a mix up between the Jobcentre and GP, and the Jobcentre was not informed about his situation. He was not well enough to go to the Jobcentre after the operation to sort out the problem. He later asked for a "mandatory reconsideration" but was not successful. He told us that this situation with his benefits made him suicidal.

In addition to sanctioning, there were also delays and inconsistencies to payments. If an application was successful, then challenges could continue while initial payments were made. Long waiting periods made it difficult for claimants to get their basic needs met day-to-day. One participant explains:

> *"[I feel] Anger and resentment… Waiting [for benefits] is lethal. My simple lifestyle saved me along with a friend who stored my stuff".*

Another participant shared how the delays in first payment had driven them towards behaviours that were risky for their health:

> *"While waiting for benefits to be issued at the start, I had to turn to crime and prostitution to support myself".*

Many participants were also not forewarned about any delays or sanctions in payments and only found out when they realised they had no money in their account. This was especially prevalent among those claiming UC, as the system is online making it difficult for people to check their account. Participants shared other examples of poor communication where decisions such as sanctions and deductions were not communicated well face-to-face or when work coaches did not know the reason for the sanction in their journal. One participant explained:

> *"Because sometimes you would have your benefits deducted and you would not know about it until it's been actually deducted. Because you would say to yourself 'well hold on, surely if somebody has claimed you, you would have to be informed first that a) the person has made a claim. And b) if the claim is valid'".*

Furthermore, backdated payments paid as lump sums were highlighted by participants as unhelpful for people in active addiction or recovery. Similar challenges are echoed in other research on benefits and homelessness (Crisis, 2015).[xlviii]

Factor 3: Proving incapacity while homeless

As health and disability issues among participants (62%) are at higher rates than the general population (34%) (Homeless Link Health Needs Audit, 2015),[xlix] it could be presumed that rates of claiming health benefits would be higher. However, as mentioned previously, they are either equal or lower than the rates for the general working-age population where 30.8% and 33.8% receive these benefits, respectively[14] (DWP Benefits Statistical Summary, 2020).[l]

Participants spoke of the problematic and burdensome process of applying, and they commonly described how engaging with the benefits system impacted on their wellbeing, using phrases like "nervous", "panicky", "suicidal", "stressed" to describe their experiences. The process of completing forms and answering questions was difficult. Participants reported how the questions, especially in work capability assessments, did not relate to their own needs, did not capture their situation of being homeless and/ or did not recognise the extent of their ill-health. This was especially the case for those with mental health issues. In fact, trying to navigate the complex and lengthy application process successfully often required support. The following participant told us:

> *"Because if it wasn't for my mental health advisor doing the forms, I would never have ever been on it. I wouldn't have even started that process. That whole – it's just such a pain… I was unwell to the point where I don't really know what the lady was doing while she set me up for benefits and I just continued getting it. So I don't really know the process. I just signed paperwork, and that was it".*

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[14] 35% of participants were receiving ESA and 19% were receiving PIP.

Furthermore, some participants did not feel like they were believed, and would have to "perform" their disability/health condition or gather evidence to prove they were deserving of support:

> *"Having to get sick notes every month was always pressure and stress. The DWP don't like it when you go on the sick… and make it hard for you to claim by making you jump through loads of hoops, so you almost give up claiming".*

This was often a humiliating and stressful experience for claimants, who could still end up being refused welfare support. For example, 31% of those requiring to look for work had been told they were unfit to work by a doctor, but this was not recognised by the Jobcentre. Some participants explained that they felt that the DWP had more power than GPs and deemed people fit for work when they were not. One participant told us:

> *"It feels they are there just to deem people fit for work. They seem to have more power than a GP or mental health worker in deciding whether you are ill or not. Hence, they control how much money you get".*

In this context, participants felt that these assessments seemed unnecessary, punitive and undermined the claimant. One benefits advisor that we interviewed agreed:

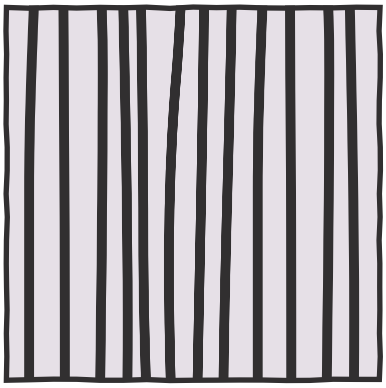
> *"For example, like if a doctor said this person medically can't work for year… why – like I understand they need to do their own assessment. But… It's still kind of like… If the doctor has said they can't work, why do they need to go through this really stressful assessment?"*

The net effect of homelessness, not being able to navigate the system, not having a key worker to support them, or being repeatedly sanctioned, meant that participants would often give up and/or walk away from the process as it was too long, stressful and complicated. As this participant explained:

> *"I should be on ESA, but I can't be bothered with the DWP because they make your life hell if you want actually to arrange something. It's not only that. I have been trying to [claim] because you know, I have a lot of health issues other than arthritis and bells palsy. I have a frozen shoulder. And it's been a struggle going actually to… even the ESA – it was so much. Going through the assessment and everything. And being treated the way they treat people. So I don't want to go through that".*

Some participants felt that the only way to be able to claim PIP was to go to a tribunal and that many were put off applying because of this. If claimants are successful at the point of the tribunal, but not at the first assessment, this raises questions of the effectiveness of the approach to assessing the eligibility of claimants. As this participant explained:

> *"Three and a half years I was fighting them for PIP. Because when I came out of the hospital, I should definitely have got PIP, I didn't get it. So I was thinking well, you know, I have got all the criteria, so how come I haven't got it? I had a double hip operation. So I went through it again. Didn't get it again. Not even on mobility when I am on crutches… But this time I kind of got upset, and I said no, this ain't right".*



In other cases, we found that a lack of interconnection between housing, health and welfare systems meant that participants were not able to get health assessments they should have been entitled to. This is demonstrated by Emma's story below:

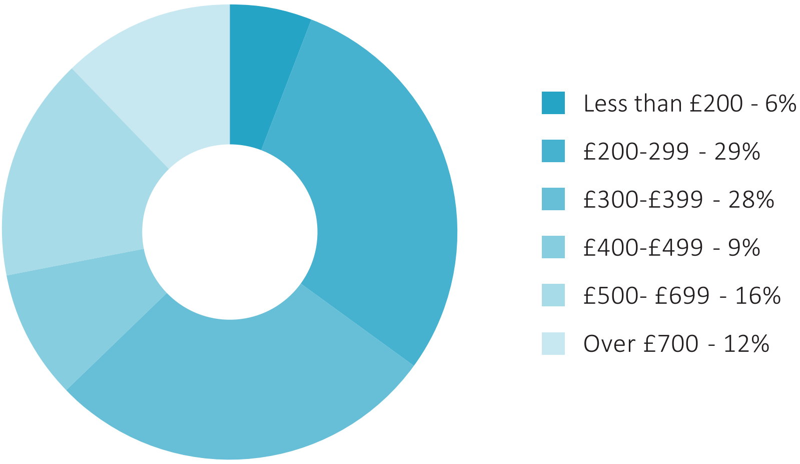
Case study - Emma

Emma was living in a winter night shelter. She wanted an assessment for her mental health so she could apply for ESA. She was told that she could not get an assessment because she did not have an address, and she should wait until her housing issues were resolved before she could get an assessment. This meant she was not able to receive the health benefits (ESA) that she felt she was entitled to. During this time, she still had to look for work despite not having the time or feeling well enough to do so. She felt that the mental health assessment would have also helped her housing situation, as she would have been deemed "priority need".

Factor 4: Receiving and maintaining benefits while managing health and homelessness

When participants received their claims, some expressed that the amount they received was not enough to cover the costs of living a healthy life; eating well, doing activities and engaging with people in the local community. Over a third (35%) of participants reported that they received less than £300 a month and a further 28% received between £300-£400, which can be demonstrated by the chart below:

Figure 5: Graph showing amounts participants were receiving



For those in receipt of less than £300 a month 68% received Universal Credit. There has been considerable discussion in the media and in from research studies exploring the challenge of living on benefits income, particularly with regards to Universal Credit (Hepworth et al., 2019).[li]
One participant spoke of how they felt it was not enough to survive:

> *"It's just not enough. No one can live on that. Especially if you have the health condition, which means you should be getting the money".*

Some (particularly those in receipt of UC) described how the amount they were paid was so low that they thought deductions from advanced payments, sanctions and budgeting loans had been made when they hadn't. Another spoke of how the very low amount of income they received had an effect on their health:

> *"It's (benefits) made me more anxious and more depressed through the lack of support and funds as I receive only £222 a month, and I cannot live off that. It's £222 a month due to advance payment reductions and a budgeting loan".*

The cost of weekly service charges for participants living in temporary accommodation meant that a significant proportion of UC payments would be deducted immediately. One participant who was living in a hostel and in receipt of UC spoke of how, despite being on benefits, some days she didn't have enough to eat:

> *"If I was able to have that money (referring to ESA) I wouldn't have been in – still going through situations like yesterday where almost the whole day I didn't eat. So I do think that they - and of course that causes stress. It can exacerbate psychical health problems as well".*

To be able to maintain benefits, there is an onus on the claimant to be able to manage their benefits and engage with the Jobcentre or DWP, which ties into government rhetoric of individual responsibility (Dwyer and Wright, 2014).[lii] This is very difficult for individuals who are experiencing homelessness (Public Health England, 2018)[liii] and Multiple Exclusion Homelessness[15] (MEH) (Fitzpatrick et al., 2012: 149).[liv] For example, 57% of participants either agreed or strongly agreed with the statement "when I am homeless, my health conditions (physical and mental) have made it difficult to manage benefits". In some cases, poor mental health and/or more control over their benefits has meant that participants had engaged in activities that had further compounded their negative situation, as one participant described:

> *"Mental health issues can make you spend in an impulsive way; this can cause you to not spend wisely and not make your money last for the two weeks, budgeting is poor when you have a tendency to gamble".*

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[15] "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)'". (Fitzpatrick et al., 2012

Being able to maintain benefits also reiterated practical barriers: 24% of all participants accessing benefits had lacked the funds to get to appointments, 27% had missed or been late for a Jobcentre appointment and 26% had felt they were unable to go to an appointment due to a lack of support. The daily need to survive is prioritised over claiming benefits, particularly when rough sleeping. As one participant explained:

> *"A lot of the times your mind is caught up in your day to day thing of how to get food, how to wash. And where you are going to spend that night. So sometimes to be thinking of - not necessarily work, but just to be thinking of benefits and what you have to do to get the benefits is kind of a secondary thing in a sense where literally you are just looking to be fed that day […]".*

In addition, some participants were too severely ill to be able to engage with the welfare system:

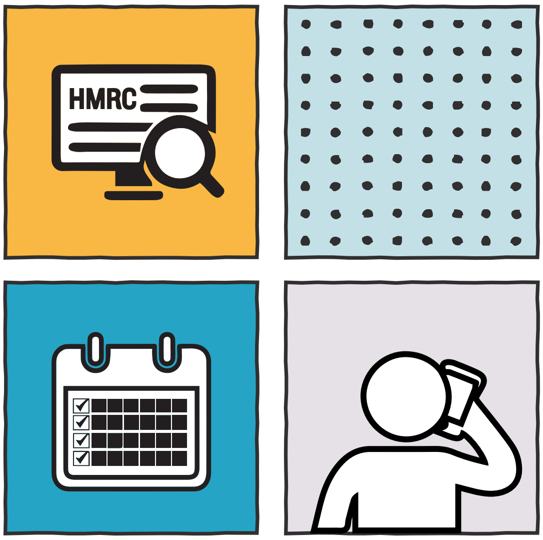
> *"Well the fact I was down, I was... didn't know what was going to happen. Do you know what I mean? I was down; I was anxious, depressed. I was having... What do you call them? Anger issues, which I am still having, which is part of the PTSD."*

Due to the high levels of health needs among people experiencing homelessness in this study, participants who could access healthcare also had to balance appointments across health and social care sectors. Attending appointments for various support services can take significant time, particularly when you lack the funds to travel and have conflicting medical appointments. Participants reported challenges re-arranging appointments with the Jobcentre and healthcare settings. When these issues are present, there can be a choice between jeopardising benefits income and leaving health issues untreated. We heard from a number of participants who had been sanctioned when they were receiving in-patient treatment at a hospital. One survey participant reported: "I got sanctioned because I missed two appointments when I was in hospital". Another participant described:

> *"[The sanction was caused by a…] F*ck up after serious operations, between the hospital, GP and Jobcentre. No money and not well enough to make appointments. Had to beg, borrow and steal. Not accepted. Not allowed to register. Made me suicidal".*

This shows a lack of communication between health and welfare institutions and demonstrates the need for healthcare services to be able to have more power in assisting with claimant commitment exemptions. It appears that the onus again is placed on the individual receiving care who may not be in a position to advocate on their own behalf and cope with the unnecessary mistakes and inefficiencies of the system. In another example, one participant talked about the ongoing logistical challenges he faced in trying to get excused from his Jobcentre appointments while taking part in a substance misuse rehabilitation programme:

> *"I went, and there was no money. So I phoned them [DWP] up again. And they said 'oh, we didn't get a letter'. And I told you that... I told you I am in detox. And the detox doctor won't give me a three-month letter... you know, I am in rehab. And then they said we need a letter from rehab. So the rehab finally gave me a letter".*



In fact, for claimants who are returning to work or where their work patterns fluctuate due to health conditions, repeatedly proving evidence for incapacity to work or letting the Jobcentre know about changing circumstances is particularly difficult. For claimants who have cyclical and/or fluctuating health conditions, this issue has been well documented (Child Poverty Action Group, 2018).[lv] More broadly, regardless of their health issues, for those on irregular hours that can change on a weekly basis, particularly with UC payments which may differ each month making budgeting and planning tricky (Ibid).[lvi]

Other challenges in maintaining benefits were as follows; not being able to look for work and difficulty using the online system. This focus group participant explained:

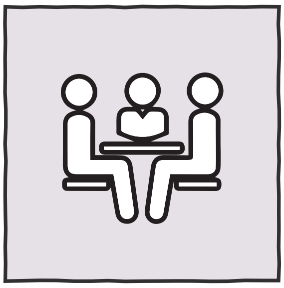
> *"Because even if you are homeless, you still have to provide evidence of job search. Which obviously is a lot more harder because you are not in a stable situation".*

Due to these negative experiences of applying, waiting for and receiving benefits, there was a systematic lack of trust in the benefits system. Negative experiences with the Jobcentre and the staff could have long-lasting effects and break down the trust that claimants have in the welfare system. This was compounded by experiences of unjust decisions, intolerance of running late to appointments, rude staff or administrative errors being common. Such experiences appear to be contrary to the role of benefits to support people in times of need. One participant shared their experience:

> *"[My] experience of benefits, especially the process of applying makes me not want to be on benefits or trust the system. Because they messed up my housing benefit, I had no faith to bother to go to their appointments".*

We found that negative relationships with the DWP had a knock-on effect on the self-worth and self-confidence. As one participant told us *"I lost faith in the system, felt discriminated against, (I felt) a loss of self-worth"*. Feeling let down by the benefits system may not only limit motivation to engage with support, but the impact on wellbeing may make it less likely for people to be able to engage well with other statutory and third sector services. As this participant explained:

> *"They don't understand me and my message. I miss appointments. I am stressed and suspicious of people. I make it worse - I get angry".*



Benefits and the positive impacts on health

This report has focused on where there is fragmentation between health, homelessness and welfare systems which can impact negatively on the health and wellbeing of participants. It is important to know what is not working in the system in order to make changes, but equally, it is important to recognise what is working well in order to sustain a positive health impact on the lives of participants. There is evidence from the data to suggest that being in receipt of the right benefits, with the appropriate level of engagement with the DWP and enough income it can have truly positive impacts. For example, benefits can offer a sense of security and reassurance at times when physical and mental health or disability can create uncertainty in people's lives. As one participant explained:

> *"But the thing I would say is it is helping me out at the moment. I don't have to think about financials; financially I don't have to think that I am... what I am going to do next. What am I going to do next week, what I am doing the week after that, what I am going to do at the end of the month? Because I know there is money coming in. I am not living a luxurious life. Not a lifestyle I really want to live. But I am living a life".*

Another participant spoke of how benefits "stopped him from starving and turning to crime". The ability to be able to afford basic needs like food, clothing and toiletries and the sense of security that receiving benefits can positively impact on the health of people experiencing homelessness. For example, 49% of participants either agreed or strongly agreed that being in receipt of benefits has had positive impacts on their health. Further to this, participants shared stories of where being in receipt of benefits had allowed them to focus on their recovery.

> *"I don't have to worry about my health... being able to buy food and drink etc. It gives me peace of mind".*

This would indicate that when the system works well for people, it has a positive impact on people's health and wellbeing.

Conclusion

This research project highlights the interconnection between the challenges of homelessness, health and welfare benefits. We found that issues with benefits were common reasons for homelessness, including benefits not covering the cost of rent, sanctions and payment issues. Mental and physical health are other factors that contributed to homelessness; half of the participants in this research cited physical and/or mental health as a cause. In addition to health and benefits being causes of homelessness, we also found that participants faced challenges accessing and maintaining benefits when they were homeless. Due to Jobcentre workers not always understanding homelessness and health, alongside the challenges in disclosure of personal information, health and social care issues that may inhibit the ability to adhere to the commitment may be overlooked. Consequently, targets and expectations that are set by Jobcentre staff may not be achievable or realistic.

These findings have demonstrated that the experience of homelessness is often at odds with how the benefits system and welfare conditionality are currently designed. While we found that some easements were being implemented to make the process of claiming and maintaining benefits easier, their implementation was limited and inconsistent. This relates to the broader findings that homeless claimants were forced to adapt to the system, rather than the system adapting to support the needs of the individual. While many participants felt staff were understanding, only a third felt staff were knowledgeable about the stresses of homelessness.

Half of the participants felt that the process of applying for benefits negatively impacted their health and wellbeing. Furthermore, being unable to comply with the system had an impact on health and wellbeing. This was especially the case for those who were sanctioned – sanctions exacerbated addictions, caused people to go hungry and in some cases, made people feel suicidal. As a result, there was a cyclical impact where managing benefits created and exacerbated mental health issues which then further impeded the ability to maintain benefits.

Despite the significant physical and mental health challenges of participants, many were not receiving health-related benefits that could support their conditions. The combined issues of ill-health and managing a complex welfare system meant that many who were likely to be entitled to health-related benefits were not able to claim. Consequently, meaning that those who could benefit the most from health-related benefits like ESA and PIP are those least unable to follow through with the claim. Furthermore, we found that health conditions impacted on claimants' capacity to maintain their engagement with the benefits system. For example, being able to make and attend appointments, and there were instances where claimants were subsequently sanctioned due to ill-health, being in hospital or rehab. In addition to the challenges of not being able to claim health-related benefits, participants also had difficulties accessing health services that required payment or proof of exemption; for example, prescribed medication, dentistry and optometry.

We found that when the system works well for people, receiving benefits can have a positive impact on health and wellbeing. This suggests the continued need to consider health in the context of homelessness and welfare systems and for healthcare providers and the DWP to work more closely together. It also stresses the need for greater recognition within the benefits system for the health challenges people experience when they are homeless and how benefits can be a gateway to good health.

What participants say needs to change

The participants who, in the research, suggested that changes needed to made to the benefits system to better support the health and wellbeing of people experiencing homelessness fell into the following themes:

Understanding homelessness and the overlap with health issues	• *"Please talk to these benefits people who are still harassing the homeless people. That is what we need. The main thing. I think they should get connected. The homeless and the Jobcentre. When they see this guy is homeless, they're supposed to make everything easy for you"* • *"See them (people who are homeless) as a human"* • *"Better understanding of homelessness"* • *"Greater understanding, empathy, sensitivity"* • *"More training for frontline workers in understanding the trauma of being homeless"* • *"Encourage them (people who are homeless) to ask for help if they need it"* • *"Listen to them (people who are homeless)"*
Building relationships, person-centred approaches and trust	• *"Treat people as an individual"* • *"Homeless people should be consulted in the matter"* • *"Take the medical evidence by itself without having to go to an assessment and repeat it over and over"* • *"In an ideal world, a team of multidisciplinary support for individual needs and continued follow up"*
Better understanding of easements and adjustments	• *"The DWP has to be more informed on the rights of the applicant when applying and receiving benefits , i.e. half-price oyster cards, free dental, free prescriptions"*

Reforming and streamlining the welfare application processes	- *"Less rules to get help... make it easier"* - *"I think they should reduce or delete sanction"* - *"The online system could be improved. A lot of people cannot access computers and things like that"* - *"Higher benefits, greater advertising of options to receive benefits every week"* - *"More support is needed, especially when you don't know what you're entitled to"* - *"Universal credit is a nightmare. Scrap it! (There are) so many delays and mistakes"* - *"Ensure it is easier to claim for people who have no access to identification and also for people with depression and anxiety issues as they can face difficulty attending appointments and therefore shouldn't be sanctioned for their health"* - *"Better to provide more access to benefits people on the phone or more face-to-face appointments to make it easier. Online access can be very difficult and complex"*
More specialist support available in Jobcentres	- *"Also for DWP to take into account that an individual who is trying to better themselves should not be penalised/sanctioned"* - *"Having a support worker to take them to the Jobcentre"* - *"There could be a specific homelessness advice person who really knows his (her) stuff"* - *"Should have a homeless keyworker in every Jobcentre"*

Recommendations

Based on the findings of the Benefits for Health research and what participants have told us needs to change we suggest the following recommendations for welfare and health systems to better support the health and wellbeing of people experiencing homelessness.

The Department of Work and Pensions (DWP) and Jobcentre Plus should ensure that claimants who are experiencing homelessness are on the right benefits and have appropriate easements in place. Steps should include:

- **Consider homelessness as a health need.** The realities of homelessness mean that there is a high likelihood that people experiencing it will face physical and mental health challenges. By acknowledging this in policy and day-to-day decision making it will help claimants to access the appropriate benefits and flexibilities.
- **Increase the adoption of health benefits.** Health related benefits and health components of Universal Credit (UC) should be made easier to access for people experiencing homelessness. Many people experiencing homelessness are highly likely to meet the criteria for these benefits, but face challenges in making claims or demonstrating incapacity due to their situation. DWP staff should work with support providers for people who are homeless to ensure claimants are on the right benefits.
- **Moderate the use of sanctions and deductions.** Sanctions and deductions can have a serious impact on an individual's health and wellbeing and should not be applied to claimants whilst they are homeless. In cases where they are applied, there should be a full review of the impacts they would have before decisions are made, including ensuring they do not put people at risk of homelessness.
- **Appropriate and proportionate evidence.** DWP needs to reassess requirements and evidence required for work capability assessments, Personal independence Payments (PIP) assessments and health components of UC so they are appropriate and proportionate.
- **Accessible information and communications.** Information provided whether written or person-to-person should be accessible to people who face literacy challenges, who live with learning difference and/or who have challenges communicating and accessing information due to their housing situation and/or support needs.

Measures should be taken to improve the quality of service provided by the DWP and Jobcentre Plus to better support people experiencing homelessness. Steps should include:

- **Homelessness training.** Training should be delivered for frontline DWP staff to understand the challenges people who are homeless may face accessing and engaging with benefits and healthcare, including raising awareness of local homelessness services. This training should be led and designed by people with experience of homelessness and delivered face-to-face or online.
- **Greater awareness of flexibilities and easements.** DWP should also ensure that all frontline staff are aware of the flexibilities and easements that can support those at risk of or experiencing homelessness. These include alternative payment arrangements, budgeting support and the use of flexible support funding.
- **Specific Point of Contact (SPOC).** Each Jobcentre Plus should have a SPOC who has undertaken enhanced training around homelessness and has a comprehensive understanding of the needs of people experiencing homelessness in relation to benefits. They will provide support to Jobcentre staff who are working with people experiencing homelessness. The SPOC should also be responsible for building partnerships with homelessness services.

- **Identifying health and housing need.** Job coaches and other claimant facing DWP staff should actively engage claimants around their housing situation and health and wellbeing needs; this information should be recorded on DWP systems. The DWP should consider developing a method to identify triggers in DWP systems that would mark people at risk of homelessness including, health and wellbeing factors.
- **Engaging appropriate support around health and housing needs.** If health or housing needs are identified the claimant should receive specific support and advice according to their needs. Jobcentre staff should work with the specific point of contact to:
    - **Refer and signpost to support.** Claimants should be linked to appropriate health and wellbeing support and if they are homeless or at risk of homelessness to support including local authorities (in line with the Homelessness Reduction Act).
    - **Provide information and resources to access healthcare.** Job Coaches should issue health and wellbeing packs with information on local health services and entitlements to care e.g. free prescriptions, dental care, eye tests and vouchers for glasses and financial support to get to health appointments. These resources should be explained to the claimant and questions answered.
    - **Providing evidence.** If the claimant has faced challenges around proving entitlement to healthcare or proof of address, a proforma letter that outlines the benefits (and therefore entitlements) or includes proof of address/ID for registration should be provided.
    - **Flexibility in support.** The DWP should ensure that Jobcentre staff have flexibility in the length of time they have to support claimants in delivering the above steps.
- **Health and wellbeing in claimant commitments.** The claimant commitment should be personalised to the needs of the claimant and coordinated with support provided by other specialist organisations. When it is reviewed at each appointment, the health and wellbeing and housing situation of the claimant and their impact on the ability to meet commitments should be discussed. If health and wellbeing needs are identified, the claimant could be set tasks around accessing primary care to meet these needs (e.g. registering with a GP). For claimants who are able and available for work activities, tasks relating to health and wellbeing should be included instead of those relating to finding employment like ‘job searches’.

National government should ensure that benefits are ample to be able to support the health and wellbeing of people experiencing homelessness and wider society. Benefits should cover the cost of living. Steps should include:

- **Increased income from benefits.** The basic rate for UC has been increased for a year in response to the COVID-19 pandemic and should remain indefinitely as a bare minimum required to live a healthy life. The increase should also be extended to people on legacy benefits such as Job Seekers Allowance.
- **Benefit cap lifted.** The benefit cap should be lifted to enable claimants to benefit from increased payments.
- **Local Housing Allowance (LHA) at the 30th percentile.** To ensure people do not need to pay the shortfall between their housing benefit and rent LHA should be maintained at the 30th percentile.

Health and social care workers need to be better informed of the rights and entitlements of people who are experiencing homelessness around benefit entitlements and access to healthcare. Steps should include:

- **Awareness of homelessness benefits rights and entitlements.** Support workers working with people experiencing homelessness should be provided with training and clear information that ensures that they are aware of access to benefits, easements and mandatory reconsideration.
- **Information for primary health care providers.** Healthcare workers in primary care (including those working in dentistry, pharmacy, optometry and General or Community Practices) should be provided with training and clear information on health entitlements for benefits claimants around entitlements to ‘pay-for’ health services (prescriptions, glasses, dentistry).

The Ministry of Housing, Community and Local Government and the Department of Work and Pensions should ensure that data is captured on benefits usage for people experiencing homelessness. Many of these recommendations presented would be more effectively implemented and monitored by gathering and sharing data to better support those experiencing or at risk of homelessness.

In addition to our own recommendations we fully support the reforms to the welfare system comprehensively put forward by Crisis[lvii,lviii], Turn to Us[lix], Shelter and those on welfare conditionality put forward by Welfare Conditionality[lx].

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