



Centre for
Homelessness Impact

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Homelessness and disability in the UK

By Beth Stone and Emily Wertans

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About the Centre for Homelessness Impact

The Centre for Homelessness Impact champions the creation and use of better evidence for a world without homelessness. Our mission is to improve the lives of those experiencing homelessness by ensuring that policy, practice and funding decisions are underpinned by reliable evidence. Person-first language

This report uses person-first language, putting a person before their circumstances. This is to avoid defining an individual by homelessness, which should be a temporary experience.

Accessible summary

People with disabilities are more likely to face challenges in their day-to-day lives than people without disabilities. These challenges, such as unemployment, financial hardship, and lack of support can increase the risk of a person with a disability becoming homeless.

This paper discusses information provided by the UK government and researchers which shows that people with disabilities are more likely to experience homelessness than people without disabilities. However, there are issues with the way disability is defined, and information is collected, which may mean that the number of people with disabilities experiencing homelessness is actually higher than what is reported.

It then identifies barriers that make it difficult for people with disabilities to leave homelessness. These barriers include; whether a person is considered to have a disability and can access a diagnosis, unsuitable housing and support, the fact that unmet needs relating to disability can extend length of homelessness, and the difficulty of identifying and supporting multiple different needs.

Next, this paper examines information on how to improve support for people with disabilities experiencing homelessness. Based on this information it argues that suitable, accessible housing must be provided alongside person-centred support. This paper also suggests that support services need to work together and that better support must be made available across the UK. The paper recommends changes to how the UK government and homelessness services provide support to people with disabilities experiencing homelessness. Finally, it considers gaps in our understanding of how people with disabilities experience homelessness and what research is needed in the future to fill these gaps.

Foreword

By Lígia Teixeira

To understand the challenge of ending homelessness we must understand that this is not a static problem. The scale of the problem may ebb or flow according to political priorities or the economic climate, as we know all too well as the cost-of-living crisis means that numbers of people experiencing homelessness are rising once more in the United Kingdom. Within these numbers, however, are larger flows of new people entering homelessness while others exit. For all the good work of people working within the homelessness system, a substantial number of people exit homelessness on their own initiative. Such individuals prove to be more resourceful than the system intended to help them.

This is important context for this policy paper about the intersection of homelessness and disability. It highlights consistent higher levels of physical disabilities and health conditions within homeless households and shows its prevalence is likely to be underestimated by official data. Distressingly, it finds that barriers faced by people with a disability make it harder to get support and to exit homelessness. These obstacles include difficulties in getting a diagnosis from a GP, in order to get support; unsuitable environments such as noisy homeless hostels that can overwhelm people with some neurodevelopmental conditions; and acute shortages of accessible housing with lifts, ramps, mobility aids and lowered surfaces that are essential to daily living for people with certain disabilities. That people impacted by both disability and homelessness face such barriers seems wrong on multiple levels.

Moreover, it means their chances of exiting homelessness on their own initiative are severely limited. They depend on the system working well in every instance.

As we know, some disabilities are not visible. One of the many important and deeply concerning insights of this paper is how rates of homelessness among people with learning disabilities and autistic people may be considerably underrepresented by official data. One survey of support for single people affected by homelessness found that on a single day 13% of individuals visiting day centres and 13% of people living in specialist accommodation had a learning disability. In the general population 2% of people are estimated to have a learning disability. Separate studies of caseloads of homelessness outreach staff and homelessness services have estimated that 12.3% and 18.5% respectively of people they supported had autism, compared with prevalence of autism of between 1 and 2% in the general population. We should not treat such figures as definite; we should, however, see them as prompts for urgent investigation and research into specific interventions tailored to the needs of these individuals.

This publication is the fourth of our series of policy papers looking at homelessness through the lens of inequality and how this interacts with specific population groups. The first looked at homelessness among young people who spend part of their childhood in the local authority care system. The focus of the second was on homelessness and people who are lesbian, gay, bisexual, transgender or whose sexuality or gender identity is not heterosexual or aligned to their sex registered at birth. The third considered the relationship between homelessness and ethnicity.

These groups are not, of course, mutually exclusive; some people will be in more than one or indeed all four. Our policy papers looked at care experience, sexuality and gender identity, ethnicity and disability separately because there are factors specific to each that interact with homelessness in discrete ways.

And yet, there are strong commonalities. Prevalence of homelessness is higher within each group. This is especially shocking for children leaving local authority care in England: a quarter of people experiencing homelessness have been in care at some point in their lives, data show. Data collection about people who are affected by homelessness within each of these populations is poor and inconsistent. All are under-researched. And there is a pressing need for new thinking to try out and test new approaches to relieve and prevent homelessness in each population.

This is our challenge if we are to bring an end to homelessness in the UK for good. We must build a stronger evidence base for what works and, just as important, what does not for different sub-populations. We must put these insights at the fingertips of people who deliver and commission homelessness services. And, perhaps most of all, we must create a capacity and culture change within the system so that this becomes the norm: so that evidence-based practice is embedded and, whenever a plausible solution is suggested, it becomes second nature for everyone in the room to ask: is there an evidence base for whether this will work for those most at risk?

Lígia Teixeira is Chief Executive of the
Centre for Homelessness Impact

Introduction

Evidence shows that people with disabilities in the UK face significant economic, political and social marginalisation, with this disparity steadily increasing in recent years. As such, the risk of homelessness and housing precarity for people with disabilities has also increased. Examining this risk is especially critical as the current cost of living crisis and hostile housing market forces thousands more people into homelessness.¹ However, the intersection between disability and homelessness is commonly overlooked by research, policy and interventions.



Responding to increasingly high levels of homelessness, in recent years there has been a surge in UK legislation aimed at managing or preventing homelessness. As will be explored in this paper, disability can, but does not always, qualify a household for housing duty under priority need in England, Wales and Northern Ireland. Further, the fact that street homelessness has been identified as a priority need in Wales should strengthen protections for qualifying applicants. Priority need was abolished in Scotland in 2012. Additional prevention duties were introduced in Wales in 2014, and England in 2017, which could mitigate risk of homelessness for people with disabilities.² Similar proposals are currently under legislative review in Scotland.³

There are an estimated 14.6 million people with disabilities in the UK, representing 22%, or roughly one in five of the general population.

Homelessness has also been the focus of departmental strategies, with Scotland, Wales, and Northern Ireland publishing action plans on ending homelessness.⁴ The plans emphasise the importance of person-centred approaches, increasing sector expertise, and improving transitional support. These factors may have particular relevance for people with disabilities and are explored throughout this paper.

It is too early to assess the success of these initiatives, but it is important to acknowledge that they are framed by a hostile climate. There is a clear policy implementation gap between protective homelessness legislation and the experiences of people who are homeless and vulnerably housed. Legislation, whilst well intended, is consistently undermined by a lack of affordable housing and the negative impact of austerity measures, such as the systematic defunding of social support, on people's standard of living. As this paper will show, these concerns are acute for people with disabilities who are at increased risk of social exclusion and marginalisation.

It would be an oversimplification to suggest that every person with a disability experiences homelessness in the same way. Factors including co-occurring disabilities, intersectional identities, geographical location and personal agency dictate that each person will interact with and interpret homelessness in a unique way. Despite this variation, with the latest Office for National Statistics data highlighting how frequently illness, health conditions and disability are present within deaths of people experiencing homelessness in England and Wales⁵, the dangers associated with a lack of access to effective support cannot be understated. As such, the need for a more thorough exploration into this topic is vital.



Excluding disability benefits from income, the poverty rate for people with disabilities is 32%, some 12% higher than poverty rates in the general population

Responding to the challenges mentioned above, this paper details:

- An outline of disability in the UK.
- A description of the prevalence of disability and homelessness in the UK.
- An analysis of the barriers to effectively supporting and relieving homelessness for people with disabilities.
- A presentation of current intervention and support initiatives throughout the UK.

In addressing the above areas, this paper considers challenges including the barriers to implementing current policy initiatives, discrepancies in the recording and presentation of statutory data throughout the devolved nations, and factors which reduce service accessibility and engagement for people with disabilities. This paper concludes in synthesising evidence on best practice and recommendations, highlighting research and knowledge gaps.

Disability in the UK

What is disability?

From a medical perspective, disability describes a range of clinical health conditions, which can include conditions present at birth, developmental conditions, progressive conditions, and impairments resulting from injury. In this sense, disability is a broad term, referring to a diverse group of people with a wide range of needs and abilities. However, it is also important to consider the transient nature of disability. The World Health Organisation (WHO) acknowledges how disability results from the interaction between health conditions and environmental and personal factors.⁶ From this perspective, inaccessible social environments are disabling, and the removal of barriers to social participation may reduce or negate the impact of disability in daily life.

Local authorities have a duty to provide emergency housing to people experiencing or at risk of homelessness who have a priority need.

In the UK, a person is generally considered to have a disability if they have a physical or mental impairment that has a ‘substantial’ and ‘long term’ negative impact on their ability to carry out normal daily activities.⁷ There are an estimated 14.6 million people with disabilities in the UK, representing 22%, or roughly one in five of the general population.⁸ Recording prevalence of disability is not without issue, as some people with impairments may not consider themselves disabled, or be comfortable with disclosure. Despite these considerations, the number of people reporting a disability in the UK has steadily increased over the past decade, with a marked upward trend in reported mental health impairments.⁹ The way disability is reported and recorded is important, as achieving ‘disability status’ can have both positive and negative consequences relating to how people are accepted in society and the support they are provided with.

The legal framework

National and international legislation aims to protect the rights of, and afford equal opportunity to, people with disabilities in the UK. In 2009, the UK ratified the United Nations Convention on the Rights of Persons with Disabilities (CRPD). This international treaty covered a wide range of areas including access to: health, education, employment, justice, personal security, independent living, and information.¹⁰ Through ratifying the CRPD, the UK demonstrated a commitment to promoting and protecting human rights for people with disabilities and establishing full equality under the law. The Equality Act (2010), applying to England, Wales, Scotland, and parts of Northern Ireland¹¹, sought to further protect people with disabilities from discrimination and unfair treatment. Under the Equality Act (2010), employers and organisations in the UK must make reasonable adjustments to ensure equal access to education, employment, and other services, for people with disabilities.

People with disabilities in England should also be afforded protection under the Care Act (2014).¹² This legal framework sets out how local authorities should provide social care for all adults with care and support needs, and includes new safeguarding duties for adults who are at risk of abuse or neglect, including those with disabilities. Similar protections are enshrined in the Community Care and Health (Scotland) Act (2002), which sets out expected health and social care standards, and the Social Services and Well-being (Wales) Act (2014), which aims to improve the well-being of people in need of care and support and transform social services.¹³



In 2021–22 physical ill-health/disability accounted for 17% of recorded support needs.

People with disabilities' experiences in the UK

Whilst the above may give the impression of a robust framework of disability legislation, further investigation reveals the UK is falling significantly short of its commitments. The United Nations Committee on the Rights of Persons with Disabilities' 2017 review of progress the UK has made on its obligations is highly critical, noting failures in multiple areas, including people with disabilities' access to, and standards of, housing.¹⁴ The report concludes the UK has not done enough to ensure the CRPD is reflected in UK law and policy.

Outcome measures, recording the experiences of people with disabilities in the UK, highlight a pattern of social and economic exclusion and deepening poverty rates. In 2022, working age adults with disabilities were more than twice as likely to live in poverty than those without a disability. Excluding disability benefits from income, the poverty rate for people with disabilities is 32%, some 12% higher than poverty rates in the general population.¹⁵ Poverty rates for people with disabilities have remained consistently high over the last 10 years. There are multiple factors which drive these rates, including the extra costs associated with disability. Research by Scope in 2019, found that people with disabilities faced extra costs of an average of £583 per month, in comparison to non-disabled households. One fifth of people with disabilities faced extra costs of more than £1,000 pounds a month. On average these costs were equivalent to almost half of income, excluding housing costs.¹⁶ The additional costs associated with disability are woefully undercompensated by disability benefits.

Despite an increase in the proportion of working-age adults with disabilities in employment, UK government data reveals that disability employment rates of 53% remain significantly lower than the employment rate of the general population (83%).¹⁷ An Office for National Statistics investigation in 2021 measured outcomes across multiple areas of life for people with disabilities in the UK.¹⁸ It found that people with disabilities are less likely to hold a degree as their highest qualification (25% in comparison with 43% of people without disabilities), 13% of people with disabilities have no qualifications at all, compared with 5% of people without disabilities. In terms of housing, people with disabilities are more likely to be in social housing (25% in comparison to 8%), and less likely to own their own home (40% in comparison to 53%) than people without disabilities. These outcomes reflect a wider culture of disability exclusion, as people with disabilities face substantial barriers to social participation and acceptable standards of living. These social and economic barriers are also causes of homelessness. This suggests people with disabilities may be at increased risk of experiencing homelessness.

In 2021–22, 46% more households were identified as having a physical disability than in 2015–16.

Disability and Homelessness: recording and prevalence

Homelessness and disability in the UK

Whether a local council has a duty of support to people with disabilities experiencing homelessness depends on national legislation, which differs across the UK. In England and Wales, local authorities have a duty to provide emergency housing to people experiencing or at risk of homelessness who have a priority need. In Northern Ireland, priority need is determined by the Housing Executive (NIHE). Priority need criteria include people who are vulnerable because of a disability or health condition. Applicants must evidence increased vulnerability due to a disability or health condition, and that this vulnerability would lead to elevated harm compared to most other people if made homeless.¹⁹ Vulnerability is determined on a case-by-case basis. People with disabilities making a homelessness application to a council in Scotland do not need to evidence why their disability makes them vulnerable but are assessed on other general criteria, pertaining to whether they are homeless, how they became homeless, and whether they have a local connection to the area. Most of these general criteria also apply to Northern Ireland, Wales, and England in various forms.

Differences in the way homelessness is assessed affect how the number of people with disabilities experiencing homelessness is recorded. It is a legal requirement that local authorities collect and report data on people owed a homelessness duty. This is collected via the Homelessness Case Level Collection (H-CLIC) in England and the Access Homelessness Monitoring System (HL1) in Scotland. Statistics on homelessness for Northern Ireland are sourced from the NIHE, and in Wales data are collected by local housing authorities via quarterly statistical returns and published on StatsWales. Additional annual homelessness data is published on the Welsh Government website²⁰.

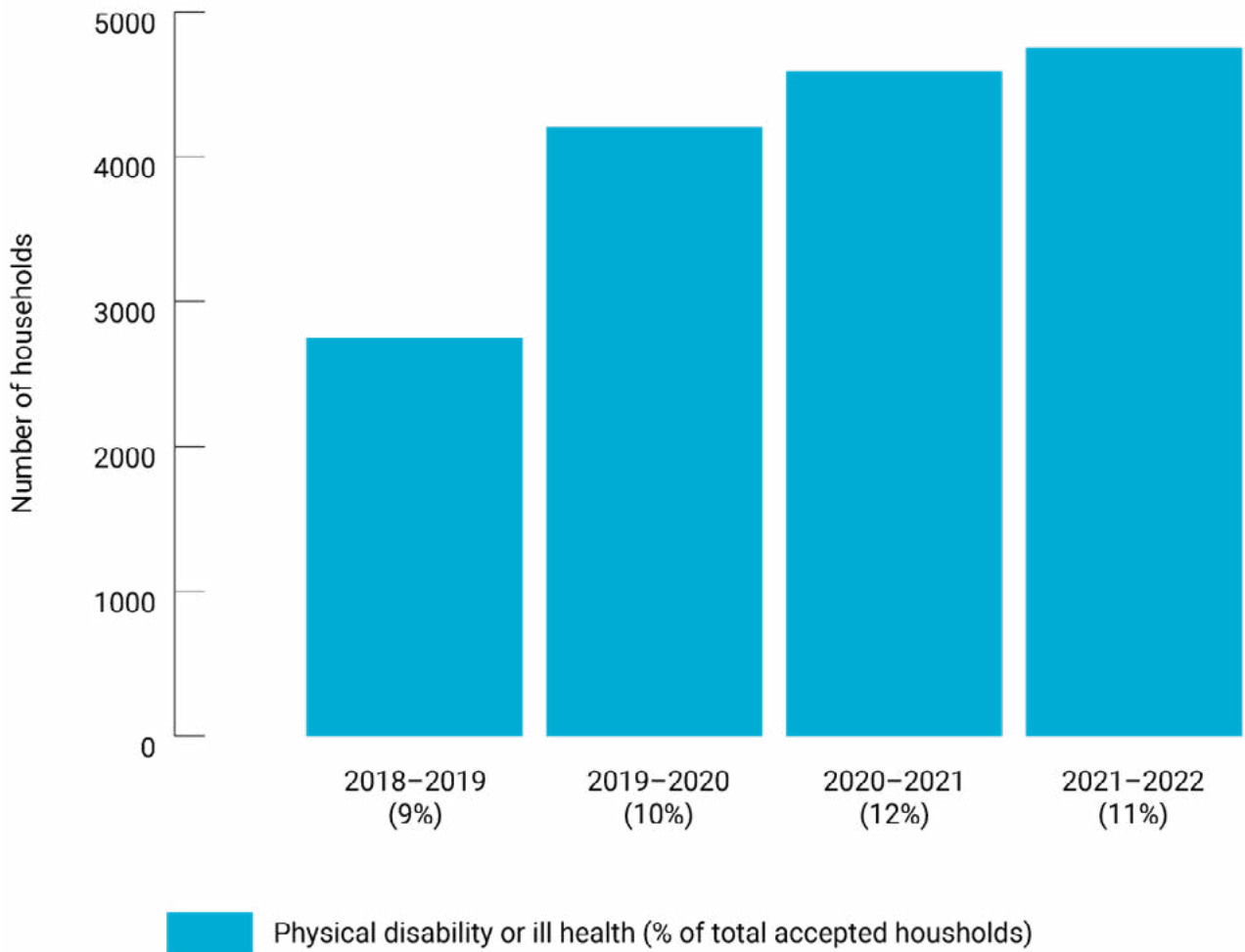


Excluding Northern Ireland, published statutory statistics only include disability data for households which were found to be owed a homelessness duty by their local council. People with disabilities applying for homelessness support may be referred to social services

and there are no national guidelines regarding how priority need and vulnerability are assessed. It is therefore likely that statutory homelessness statistics underestimate the number of people with disabilities experiencing homelessness across the UK. Despite these considerations, available data suggests that people with disabilities are increasingly at risk of experiencing homelessness in the UK. This data is explored descriptively below.

In England, H-CLIC records information on people in priority need due to physical disability or ill-health. Figure 1²¹ presents data from 2018 to 2022 on households owed a main duty by priority need due to physical disability or ill health. Comparing 2018–19 to 2021–22 the number of households owed a duty for this reason has increased by 73%. There has also been a slight upward trend in the proportion of total households owed a duty by reason of physical disability or ill-health since 2018 (9% of households in 2018–19 to 11% in 2021–22). This data does not capture those with neurodevelopmental conditions or disabilities related to mental ill-health.

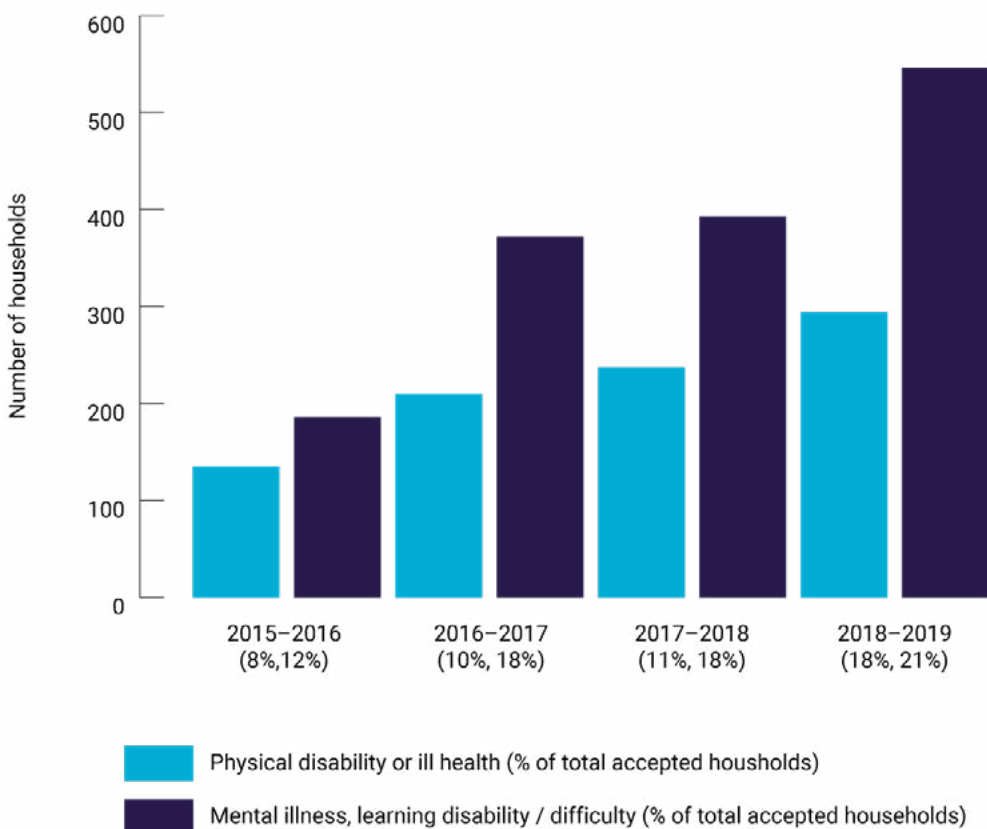
Figure 1



Households in England owed a main duty by reason of disability

Priority need data is collected in Wales but was paused during 2020 due to COVID-19. Figure 2²² presents data returned by local authorities on the disability categories by which households qualified for priority need from 2015–19²³. This shows a steady increase in the number of households owed a duty for either a physical disability or mental illness, learning disability or learning difficulties. In 2018–19 11% of households were found to be vulnerable due to a physical disability and 21% were vulnerable due to mental illness or learning disability/difficulty. The vast majority of households in both categories are single person households (87% of physical disability, 91% of mental illness or learning disability/difficulty in 2018–19).

Figure 2



Households in Wales owed a main duty by reason of disability

As with the English data, the steady increase in duty owed by reason of disability could indicate that more people with disabilities are being made homeless and/or an increase in priority need acceptances. The increasing number of disabilities reported in the general population over the past decade may also be a contributing factor. Conclusions are difficult to draw from the Welsh data due to the conflation of learning disabilities/difficulties with mental health. As well as meeting priority need criteria the data for both England and Wales only includes people who were found to be eligible for assistance and unintentionally homeless.

In England, H-CLIC collects information on prevention and relief duties owed to households due to support needs. Table 1²⁴ shows an increase in yearly trends in relation to physical ill-health / disability and learning disability in England. In 2021–22 physical ill-health/disability accounted for 17% of recorded support needs, second only to history of mental health problems (26%). Whilst the number of households claiming for relief due to learning disability has steadily increased over the last 5 years, this has remained fairly constant as a percentage of total households (4–5%).

Table 1

| England: Number of households owed a homelessness duty (prevention or relief) by disability support need categories | | | |
|---|-----------------------------------|---|----------------------------------|
| Year | Total households owed either duty | Physical ill-health and disability (% of total) | Learning disability (% of total) |
| 2018/19 | 269,510 | 35,860 (13%) | 11,030 (4%) |
| 2019/20 | 289,810 | 42,090 (15%) | 12,550 (4%) |
| 2020/21 | 270,580 | 40,390 (15%) | 12,500 (5%) |
| 2021/22 | 278,130 | 46,910 (17%) | 15,060 (5%) |

England: households owed duty due to physical and learning disabilities

Scotland also records support needs for households assessed as homeless or threatened with homelessness. Table 2²⁵ presents support needs by physical disability and learning disability. As with the English data, the number of households identified with physical and learning disabilities as a percentage of total households has remained fairly constant. However, the number of people presenting with these support needs has increased. In 2021–22, 46% more households were identified as having a physical disability than in 2015–16, 15% more were identified as having a learning disability. As households can present with multiple support needs, they may be represented in both the physical and learning disabilities categories for both England and Scotland.

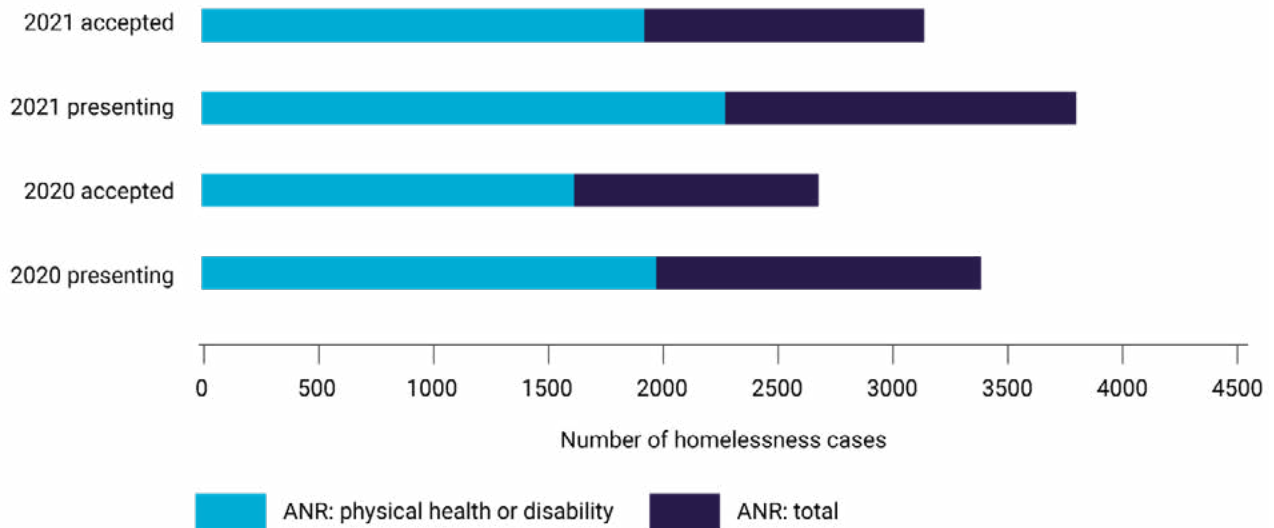
Table 2

| Scotland: Disability support needs identified for households assessed as homeless or threatened with homelessness | | | |
|---|---|----------------------------------|----------------------------------|
| Year | Total households assessed as homeless/ threatened with homelessness | Physical disability (% of total) | Learning disability (% of total) |
| 2015/16 | 28,609 | 1,179 (4.1%) | 738 (2.6%) |
| 2016/17 | 28,776 | 1,315 (4.6%) | 714 (2.5%) |
| 2017/18 | 29,386 | 1,535 (5.2%) | 822 (2.8%) |
| 2018/19 | 30,274 | 1,555 (5.1%) | 847 (2.8%) |
| 2019/20 | 31,612 | 1,847 (5.8%) | 935 (3.0%) |
| 2020/21 | 28,042 | 1,281 (4.6%) | 762 (2.7%) |
| 2021/22 | 28,882 | 1,716 (5.9%) | 849 (2.9%) |

Scotland: homeless/threatened with homelessness physical and learning disability support needs

In Northern Ireland, rehousing applications by people whose accommodation is not reasonable (ANR) are processed via statutory homelessness applications contributing to comparatively high recorded instances of statutory homelessness²⁶. The NIHE does not break down priority need category by reason of disability. However, ANR categories are delineated, revealing that ANR by reason of physical health or disability is the largest group of Full Duty Applicant ANR cases. Figure 3²⁷ presents data from 2020 (when data began to be collected by calendar, not financial, year) and 2021. It reveals that ANR by reason of physical health or disability accounted for 58% of presenting and 61% of accepted homelessness cases in 2020, and 59% of presenting and 61% of accepted cases in 2021. Whilst the way that statistical homelessness data is recorded by the NIHE affects comparability with the rest of the devolved nations, this data offers insight into the significant housing accessibility issues which affect people with disabilities and increase risk of homelessness. Unsuitable and inaccessible housing is explored in more detail below.

Figure 3



Accommodation not reasonable in Northern Ireland by reason of disability

Measuring disability types in homeless populations

Statutory homelessness data captures broad categories of disability (or ill-health) and excludes people with disabilities who were not owed a duty, for example, those in England and Wales who were not deemed vulnerable by reason of disability. It also excludes people with disabilities who are categorised as being owed a duty for reasons other than disability. A further way of recording disability is through homelessness service use and interaction. These data may be particularly useful for identifying ‘hidden disabilities’ which include physical, cognitive, and neurodevelopmental conditions which are not immediately apparent to others but can have significant impact on day-to-day functioning and support needs. UK based evidence is examined for two ‘hidden’ disabilities in Spotlights 1 and 2.

Spotlight 1: prevalence of learning disabilities in UK homeless populations

What is it?

A learning disability usually denotes a reduced intellectual ability and difficulty with everyday activities.

What does government data tell us?

In statutory data collection, learning disabilities are often grouped with mental health and/or learning difficulties which makes it difficult to tell the extent to which learning disabilities are overrepresented in homeless populations.

How else is it measured?

An annual review of support for single homeless people in England reported that on a single day in 2021, 13% of day centre clients and 13% of accommodation provider clients had a learning disability.²⁸

Why does it matter?

These figures are considerably higher than the estimated 2% in the general population. Contrasted with the 5% of homeless households identified as having a learning disability support need in England, this could suggest there are considerably more people with learning disabilities experiencing homelessness than those who are owed a housing duty of prevention or relief.

Spotlight 2: prevalence of Autism Spectrum Conditions in UK homeless populations

What is it?

Autism is a lifelong condition which affects how people interpret and interact with the world around them. Autism is associated with social difficulties and rigid and repetitive behaviour patterns.

What does government data tell us?

Autism is not a priority need criteria and is not currently recorded in government data collection on homelessness duty and support needs in any of the devolved nations.

How else is it measured?

In 2018, a novel research study estimated prevalence of autism in the caseload of a UK homeless outreach team at 12.3%.²⁹ Further research in 2019 estimated autism prevalence in a sample of people using homelessness services at 18.5%.³⁰

Why does it matter?

These estimates are significantly higher than the 1–2% general population estimate suggesting autistic people are at acute risk of experiencing homelessness. Given the sensory processing and social difficulties associated with autism, current provision is likely to be unsuitable. The research also suggests that autistic people experiencing homelessness may not have a clinical diagnosis.

These examples are important as prevalence of certain disability types in homeless populations could indicate specific risk factors associated with individual disabilities. However, identifying disability and support needs amongst homeless populations is a longstanding area of difficulty for multiple reasons. These can include:

- Many studies relying on GPs case notes which often contain selective recording.
- Health status typically being measured through the categories of mortality and morbidity, with the former giving little information about lived experience regarding wellbeing, and the latter being explored in only a small-scale way.
- Evidence on individual disability types usually being localised to specific areas and sampling frames, reducing comparability.
- Research focusing on specific conditions examining only a fraction of the types of disabilities which are present in homeless populations.

Despite these concerns, research consistently suggests that cognitive and neurodevelopmental conditions, including traumatic brain injury, autism, and ADHD are overrepresented in homeless populations.³¹ Constituting one of the most explored areas of disability amongst homeless people, research has also consistently found higher levels of physical disabilities and health conditions within households affected by homelessness. For example, research conducted in London and Birmingham found that chronic diseases, mostly notably respiratory disorders, epilepsy, heart problems, stroke and diabetes, were self-reported as present at a consistently higher rate by homeless, as opposed to housed, participants.³² Considering all disability categories, an analysis of single people experiencing homelessness reported a disability prevalence rate of 39%.³³ This representation is much higher than that which is presented in statutory homelessness data and estimated general population rates.

Despite research gaps, this prevalence data is helpful in highlighting the scale of people with disabilities experiencing homelessness. Having established this, additional questions are raised regarding the different ways people with disabilities might experience homelessness and barriers to effective support and relief.



Disability and Homelessness: barriers to effective support and relief

Despite needs and experiences varying considerably within and between disabilities, identifying overarching trends in presentation can enable better research, monitoring and responses in the future. The following sections outline some of the barriers to homelessness service access and engagement in relation to disabilities. Six key themes are identified and discussed: meeting a disability threshold; obtaining a diagnosis; inaccessible housing; unsuitable support provisions; perpetuating factors; and, diversity of need. These themes were identified through analysis of available research and reports focussing on people with disabilities' experiences of homelessness. UK based research is prioritised with reference to international research where relevant.

Meeting a disability threshold

What constitutes a disability will differ depending on place of diagnosis, how diagnostic instruments were employed and a person's personal identity preference. In lieu of disability, a person can instead be labelled as having a condition or health requirement. In some cases, this variation is due to a disability threshold not being met. In other cases, this is due to contention in what constitutes a disability, a rejection of the term 'disability', or a lack of understanding of technical language. In practical terms, this creates significant inconsistencies in recording practices surrounding disability and homelessness.

This issue is particularly pertinent when considering mental health. Rates of mental ill-health are exceptionally high in populations affected by homelessness, with a recent audit finding 82% of respondents experiencing homelessness in England had a mental health diagnosis, with common diagnoses including depression, anxiety and Post-Traumatic Stress Disorder.³⁴ A mental health condition can be recognised as a disability when it meets the criteria as set out under the Equality Act. Various mental health associated diagnoses, such as schizophrenia or bipolar disorder may also constitute a disability.

However, for reasons including limited access to diagnostic services, lack of professional expertise, non-disclosure and misuse of screening questionnaires, the context as to whether people with mental ill-health can be classified as disabled is often unclear.

This trend is not limited to mental health however, with similar discrepancies found in the recording and monitoring of conditions and disabilities which are self-reported or observed. For example, recent research on the link between homelessness and chronic pain highlights a disparity between the number of people experiencing chronic pain and those who consider themselves to be disabled.³⁵

Whilst self-identifying with the label or identity most comfortable for the person is important when navigating disability, in practical terms this means that inconsistent and unclear measures are used regarding disability and homelessness. This, in turn, poses challenges for funding, understanding and responding to support needs appropriately.

Factors associated with homelessness, such as exposure, vulnerability to abuse, prolonged substance misuse and deterioration of mental health conditions can lead to the onset of disability.

Obtaining a diagnosis

For both monitoring and support purposes, the need to have an up-to-date and medically certified diagnosis is instrumental to be formally considered, and responded to, as a person with a disability. The Covid-19 pandemic resulted in many GP practices moving screening and consultation appointments online. For those with limited access to resources, such as a stable internet connection, or a private personal space from which to conduct online appointments, the opportunity to access a doctor and diagnosis is significantly affected.

Securing a diagnosis is not a new challenge for people experiencing homelessness. However, research shows that the lack of a stable and secure local address prevents many from being able to register with a local GP practice at all, despite NHS and National Institute for Health and Care Excellence (NICE) guidelines stating that such a requirement is not necessary.³⁶ As such, without a formal diagnosis, many people with disabilities experiencing homelessness are left without recognition or support.

Issues of diagnosis are further complicated by factors associated with homelessness which may affect symptom presentation. In research studies, measures to record instances of specific cognitive disabilities tend not to be validated for use in homeless populations. Additionally, these studies rarely investigate co-occurring disorders and overlapping symptoms which may reduce the accuracy of measurement.³⁷ These concerns have also been raised by homelessness services, who describe the difficulty of obtaining an accurate diagnosis for clients presenting with complex and overlapping symptoms, particularly when a diagnosis is reliant upon behavioural observation and self-reports. These concerns are made more acute by current system pressures and dwindling resources. Some of the difficulties involved in meeting a disability threshold and securing a diagnosis are explored in testimonials 1 and 2.

Testimonial 1: securing a diagnosis for homeless clients with neurodevelopmental conditions

‘Supporting homeless individuals to access an assessment for ADHD or autism is practically impossible. Their address can change several times a year so they miss important letters, they often have addictions or chronic mental health problems that make engaging with others difficult, and they can struggle to concentrate on long term goals because they have to focus on daily survival instead. Symptoms are normally masked by drug abuse or other mental illness, so professionals don’t explore further... without a formal diagnosis, it can be difficult for a client to get their needs taken seriously, or even have the language to describe and understand these needs.’

Higher Needs Floating Support Team, Support Worker

Testimonial 2: securing a diagnosis for homeless clients with cognitive difficulties

‘Many of the people we work with have undiagnosed learning difficulties. Despite proving they cannot manage a tenancy or take care of themselves it can feel like care agencies will push back on accepting responsibility, even though they meet the Care Act threshold. I have had instances where agencies have asked the person to independently call their GP and request a learning difficulty assessment when it has been clear that the person is not capable of doing this or working a phone. It can be difficult as my clients often struggle in office/assessment type settings to articulate their day-to-day experience which can come across as underplaying their learning difficulty or that it doesn't exist.

The process of diagnosis without intense agency support therefore can take years or not happen at all... I feel that they get lost in the system and do not get the tailored support they need to secure a diagnosis.'

The Bridge – Homelessness to Hope, Caseworker

Inaccessible housing

As emphasised above, disability is a risk factor for homelessness primarily due to associated socio-economic disadvantages such as poverty and unemployment. For eligible people with disabilities, social care services should act as a safety net, preventing street homelessness. The passing of responsibility of housing from homelessness to social care services may account for the lower representation of people with disabilities in the statutory data in comparison to research studies. However, whilst local authority guidance states that an applicant's medical, physical and sensory needs must be met by their housing provision, a chronic shortage of accessible, safe homes and lack of appropriate support across the UK represents a significant barrier to housing people with disabilities.



Related to many physical disabilities are accessibility requirements to enable a person to fully navigate or engage with a space. This can take the form of lifts, ramps, mobility aids, lowered surfaces and more. These provisions, however, are typically absent from homes and shelter or hostel provisions. Inaccessible accommodation therefore represents a barrier to exiting homelessness, as well as a factor that causes onset. In England only 7% of homes incorporate minimal accessibility features, and in Scotland only 0.7% of local authority housing and 1.5% of properties managed by registered social landlords are wheelchair accessible.³⁸ The impact of lack of accessible housing is explained by a person with Multiple Sclerosis who previously experienced homelessness in testimonial 3.



There is a lack of consistency throughout the country in terms of what is offered, its quality and its budget, resulting in a postcode lottery of effective support

Testimonial 3: The impact of inaccessible housing on length of homelessness and wellbeing for a person with Multiple Sclerosis

When I ended up on the streets, I didn't feel worth anything. My disability didn't help. The council didn't know how to help me, nobody did. Everyone seemed to only see my disability and didn't want to do wrong so did nothing. It took 10 months, of the council saying they could do nothing before I got offered a hostel room & another year before I got permanent accommodation. When I did get a tenancy agreement it was not disabled modified, no accessible shower as of yet, I'm still waiting. My health has deteriorated because of the disruptions to my housing. I'm grateful for a place that's mine, just waiting for the moment I can truly call it home.

Charlston Aslet

In the current climate, the waiting times for reasonable adjustments for social housing are substantial. Worryingly, for those without a proven medical need for reasonable adjustments, exiting a property due to inaccessibility could result in being deemed as intentionally homeless and therefore not eligible for a main housing duty moving forward. The difficulty of finding suitable, accessible housing for people with disabilities at risk of, or experiencing, homelessness is described in testimonial 4.



Testimonial 4: difficulty of securing appropriate housing support for autistic people

When you have a disability, getting appropriate housing support feels nearly impossible. I don't feel like my needs were ever taken seriously. I was told the only option was shared accommodation. Being autistic, living with multiple different people is not an option for me. They didn't listen and I was told if I actually needed the support I would take whatever I could get. Even when I was in a psychiatric hospital, with a housing worker, I was discharged homeless, into very unsafe and chaotic circumstances. This made my mental health deteriorate further. I feel extremely lucky that I eventually found one good support worker who listened to my needs and goals, which means I now have safe and secure housing.

Megan

Unsuitable support provisions

As highlighted in testimonial 3, unsuitability of provision is not limited to physical disabilities. Those with cognitive disabilities or neurodevelopmental conditions, including traumatic brain injury, learning disabilities and autism, can also have associated accessibility needs. In all cases, reasonable adjustments are commonly required to enable service users to access support provisions. Meaningful access to these services is vital as they can act to prevent and relieve homelessness, in addition to providing invaluable support for a person whilst actively affected by homelessness. However, similar to inaccessibility within housing provisions, support services often do not meet the needs of disabled service users. Accessibility of provision and services will have a different meaning for different people. For some, accessibility might relate to physical needs. For others, this term might denote the overall suitability, appropriateness and generally how fit for purpose a service is. The concept of 'backdoor accessibility' proposes that environments are typically constructed for non-disabled, able-bodied people, having been later adapted to allow people with disabilities access to the provision. Whilst in some cases this approach does afford access, this is not always effective, and is commonly not to the same standard as non-disabled people's access.³⁹

The provision of subsidised housing alongside site-based social services has been shown to significantly improve residential stability among people with poor physical and mental health.

For service users with physical disabilities, similar barriers to those outlined in testimonial 3 exist, with support services sometimes being physically inaccessible, such as through having high work surfaces and no wheelchair entrances. For cognitive and neurodevelopmental conditions, a lack of awareness (particularly if someone is undiagnosed or has not disclosed) can lead to misinterpretation of behaviour by support workers. In homelessness hostels and shelters this can result in sanctions and evictions.⁴⁰ For those in their own private accommodation, without support services identifying or responding to the needs of those with cognitive or neurodevelopmental conditions, there is an increased risk of homelessness through exploitation from acts such as cuckooing and disability hate crime. Once a person is homeless, their availability to be further victimised on the basis of their disabled or homeless identity is further heightened. Limited awareness, knowledge and specialist skills also represents a significant barrier to service engagement for autism, other neurodevelopmental conditions and cognitive disabilities.⁴¹

These barriers to service engagement are explored in relation to neurodevelopmental conditions in testimonial 5 and cognitive disabilities in testimonial 6.

Testimonial 5: barriers to supporting clients with neurodevelopmental conditions

‘Symptoms can be labelled as the person being ‘hostile’ or ‘eccentric’. Even if a professional suspects there are needs that are being missed, it is difficult for them to know where to go for advice. This means clients miss out on tailored support and are less likely to succeed in support settings... If they are able to make a positive relationship with a support worker, the professional is unlikely to be able to work with them for the 3–4 years it will take for an ADHD/autism referral to be processed and an assessment carried out. Supporting a client for more than a year is frowned upon in homelessness services, normally due to a lack of resources.’

Higher Needs Floating Support Team, support worker

Testimonial 6: barriers to supporting clients with cognitive disabilities

‘I feel that GPs, social workers, and those that are frontline need additional training to support those who are experiencing homelessness and have disabilities, especially learning difficulties for example effective communication, understanding things like illiteracy and not assuming somebody opens their letter and can read it, also [considering] how learning difficulties can present in a homeless setting.’

The Bridge – Homelessness to Hope, Caseworker

Crowded and chaotic hostel environments may be particularly unsuitable for people with neurodevelopmental conditions, who can struggle with interpersonal interaction and processing sensory stimuli. This can result in disengagement with services and increased rough sleeping. Familiarity and adherence to routine whilst street homeless can also be a barrier to outreach engagement for autistic people. Whilst research on autism and homelessness is in its infancy, initial investigation suggests that rehabilitation is short lived due to unsuitable provision and continued socioeconomic exclusion, resulting in subsequent cycles of episodic homelessness.⁴² These concerns may also be applicable to other neurodevelopmental conditions, such as ADHD, but there is a dearth of research in this area.



Perpetuating factors

Many disabilities or health conditions mandate the need for particular living conditions to not exacerbate a person's symptoms, such as warmth, dryness or sometimes health equipment. Equally, as highlighted above, the psychosocial symptoms associated with some cognitive and neurodevelopmental conditions may be aggravated by unsuitable social and spatial settings. The aforementioned environments are significantly harder to control when homeless, particularly when rough sleeping or in emergency housing. Factors associated with homelessness, such as exposure, vulnerability to abuse, prolonged substance misuse and deterioration of mental health conditions can lead to the onset of disability.⁴³ For example, research suggests traumatic brain injury may be both a cause and a consequence of homelessness.⁴⁴ As such, situations of homelessness can cause onset or deterioration in both physical and hidden disabilities, in addition to physical and mental health.

The perpetuating relationship between homelessness and disability is not one directional, as the impact of inaccessible provision and support for people with disabilities can lead to episodic or recurring homelessness. Disability is therefore not only a risk factor to homelessness, but also constitutes a significant barrier to successful rehabilitation in the current climate of ineffective support. For those with cognitive and neurodevelopmental conditions, research suggests unsuitable provision can result in disengagement with homelessness services, which in turn increases risk of returning to hidden forms of homelessness such as rough sleeping and sofa surfing.⁴⁵ In these cases, unsuitable provision may include requirements for service users to apply for, or engage with, support services online. Digital literacy is a privilege that some people with disabilities, particularly those with learning disabilities, may not have. The way in which absent support pathways may both cause and perpetuate homelessness is explored in relation to cognitive disabilities in testimonial 7.

Testimonial 7: absent support pathways resulting in homeless onset and continuation

‘Many people experiencing homelessness have diagnosed or undiagnosed learning difficulties that make it difficult or impossible to manage a tenancy. Particularly in paying bills, managing money, self-care and keeping the property to a safe and clean standard. Many of these people build up huge debt with energy companies and landlords, eventually leading to homelessness. It also elongates homelessness at every step of their journey for example them communicating their circumstances, requiring ID for referrals, not attending appointments due to lack of understanding of the system they are in.’

The Bridge – Homelessness to Hope, Caseworker

Whilst the evidence on how disability perpetuates homelessness is limited, research suggests disability may be associated with longer duration of homelessness.⁴⁶ There is also evidence that disability may increase difficulty of exiting homelessness when combined with other factors.⁴⁷ The impact of the interaction between disability and other factors in relation to homelessness is discussed below.

Diversity of need

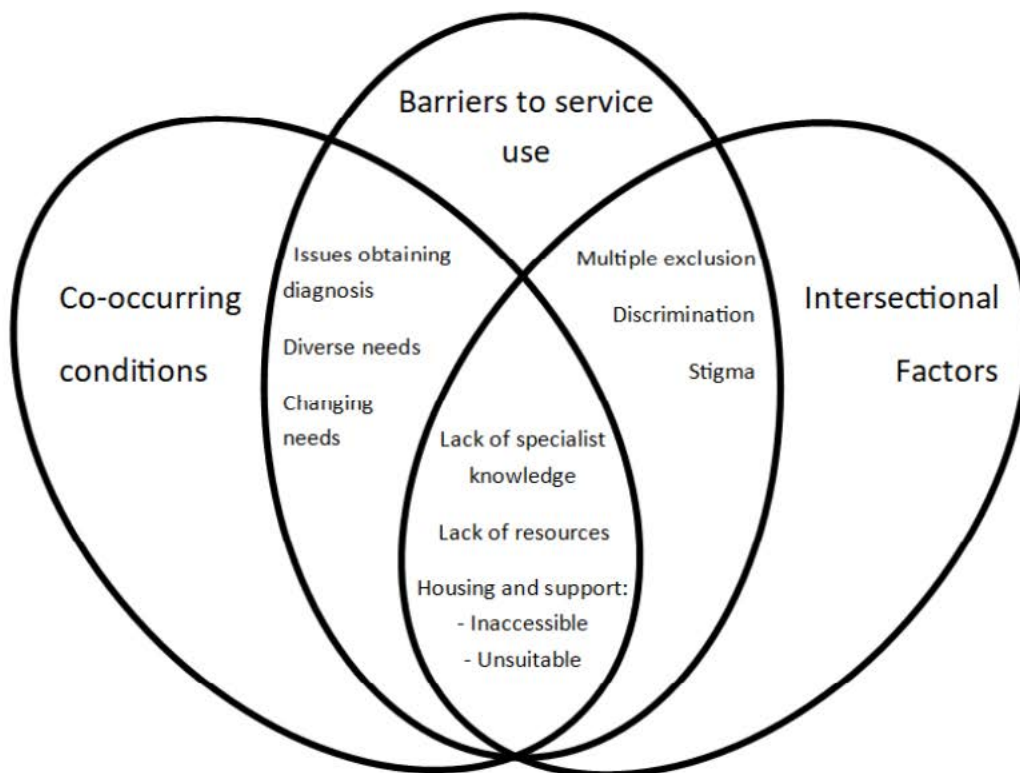
Many people with disabilities who experience homelessness have additional mental and/or physical health conditions and further intersectional factors, such as poverty and substance misuse, may complicate the identification and support of specific needs. Individual support needs are collected in England (HCLIC) and Scotland (HL1). In 2021–22, 28% of homeless households in England and 21% of households in Scotland were identified as having two or more additional support needs.⁴⁸ However, recorded support need categories differ between the two nations, and neither data collection method details the level of co-occurrence between disability and other factors. There is therefore a need for further research on the overlap between different disabilities and health conditions with consideration of the impact of intersectional factors.

The term 'Multiple Complex Needs' (commonly presented as MCN) describes a range of experiences, backgrounds, and personal factors, which present in a co-morbid fashion. Whilst the MCN label is used to better identify and support individuals with varying support needs, in practice this reductionist language can act to alienate those who are placed into this category. The risk of reducing a person to the label of 'multiple complex needs' can instil reluctance to engage, which can in turn impact practical factors to service delivery, such as a lack of information sharing and communication.⁴⁹

An alternative way of understanding complex needs is through a multiple exclusion approach. Multiple Exclusionary Homelessness (MEH) describes a state of exclusion which results from the interplay of different causes and consequences of homelessness.⁵⁰ MEH is of particular relevance here due to the socioeconomic disadvantages described in section ii, which can result in poverty and homelessness for people with disabilities. In a sample of individuals experiencing MEH, nearly half of 58,000 people who experienced three disadvantage domains (homelessness, offending and substance use) also reported a limiting long-term illness or disability.⁵¹ MEH is arguably a better way of understanding the intersection between homelessness, disability and other factors, as it acknowledges diversity of need whilst promoting co-ordinated responses, as opposed to situating the problem with the individual.

A significant number of people affected by homelessness are navigating various complex situations, both short-term and long-term, and as such there is a need to recognise that having a particular disability does not mean that there is a homogenous need or experience amongst all with the same diagnosis. However, as has been discussed, disability issues are often inextricably linked with factors which complicate presentation and support needs. Figure 4 illustrates how multiple overlapping and interlinked factors create barriers to service accessibility for people with disabilities experiencing homelessness.

Figure 4



Factors resulting in service inaccessibility for people with disabilities experiencing homelessness

Addressing practical and implementation challenges

In response to the challenges outlined, various interventions and support services are currently available in the UK which may be beneficial to people with disabilities at risk of, or experiencing homelessness. However, challenges and barriers remain in terms of navigating and accessing these provisions. This section outlines some of the most prominent challenges to people with disabilities experiencing homelessness fully benefiting from available resources and also considers where resources are lacking. These challenges are detailed alongside evidence and interventions that demonstrate how such barriers might be overcome, minimising the chance of episodic or recurring homelessness. Evidence on good practice was sourced through the Centre for Homelessness Impact's Evidence and Gaps maps⁵² and supplemented by additional database and grey literature searches. Whilst this section focuses on improving UK practice, international evidence is discussed where relevant.

Improving consistency of provision

Across the nations of the UK different approaches are adopted in terms of how need is prioritised and how people with disabilities experiencing homelessness are responded to. Particularly in relation to support and relief provision, services, projects and interventions are typically localised and often offered by standalone support services. Irregularities are also prevalent in statutory provision. For example, in a survey of local authorities, the Equality and Human Rights Commission found that around half had specially trained in-house assessors responsible for housing applications made by people with disabilities (43% England, 63% Scotland, 65% Wales).⁵³ As such, there is a lack of consistency throughout the country in terms of what is offered, its quality and its budget, resulting in a postcode lottery of effective support.

Such inconsistencies can not only be confusing for service users and applicants, but with expectations going unmanaged and unmet, resources can end up being needlessly spent and a lack of future engagement is more likely. It is important to have approaches that meet local need, and unique and adapted service delivery should not be discouraged. However, it is vital that services offered are thorough, accessible and address authentic need. Whilst areas hold unique challenges that will require a specialist approach for effective results, many complexities regarding homelessness and disability transcend geography. As such, through following an evidence-base of good practice (as detailed below) and avoiding problem solving in silo, organisations and policies can be created using less resources, and then adapted to address specific concerns.

Improving housing in conjunction with support

The Scotland Prevention Review Group recommended that accommodation should meet the needs of the households applying, including accessibility requirements for people with disabilities.⁵⁴ Creating more accessible, adapted, and safer homes is also a priority set out in the 2021 UK National Disability Strategy. As well as addressing the need for more accessible housing, certain models of housing support may be suitable for people with disabilities experiencing homelessness.

The Housing First model is an example in which wrap-around support is offered, and whereby the specifics of support can be built in, which may overcome some of these challenges presented in this paper. Through this approach, safe, stable and often private housing is provided to a person or family, with all other support needs, such as disability, mental health, and addiction, being addressed in conjunction to this. This model has been piloted widely throughout North America, Europe, and increasingly so throughout the UK, yielding good overall results including increased housing stability in the short, medium and long term.⁵⁵ Evidence suggests that Housing First may be an effective model for supporting people with multiple diverse needs including disability and mental health difficulties. For example, Housing First models have been shown to be effective in reducing homelessness in the long term for people with psychiatric disabilities⁵⁶ as well as reducing instances of hospitalisation.⁵⁷ An example of how Housing First has been used to support a client with a neurodevelopmental condition is presented in testimonial 8.

Testimonial 8: Using a Housing First model to support a client with a neurodevelopmental condition

‘Housing First was introduced to a client (H) who was sleeping rough despite having a room in a shared house because he struggled to cope with the others around him. He was described as being unique and unusual, and had problems with paying bills and hoarding. Due to Housing First being able to take a person-centred approach and work flexibly, I was able to explore H’s difficulties from his point of view. It became clear that although he hated the term ‘hoarding’ and felt insulted by its use, he readily agreed that the amount of clutter he had collected was problematic for him. He explained he found it hard to work out what items can be thrown away and welcomed help with this.

Within a few weeks I had helped him clear out several bin bags of out of date food, and together we made some simple rules to decide when an item could be binned or recycled. Housing First was able to offer him a self contained flat to live in, and since he moved in over 3 years ago he has never slept rough.'

Higher Needs Floating Support Team, Support worker

The person-centred approach adopted by Housing First based models usually involve simultaneous specialised support provision to increase chance of success. The importance of providing housing alongside other forms of support, such as income assistance, or peer support, is emphasised by evaluative research.⁵⁸ For instance, the provision of subsidised housing alongside site-based social services has been shown to significantly improve residential stability among people with poor physical and mental health.⁵⁹ Further, the provision of specialised employment support in coordination with supportive housing has demonstrated higher retention of housing and employment amongst people with disabilities and mental illness.⁶⁰

For people with intellectual and developmental disabilities, specialised cross-sector programmes, involving accommodation provision alongside support from social services and professionals with relevant expertise have been shown to improve long-term housing outcomes and better meet complex and diverse needs.⁶¹ Supported housing can also be effective in increasing long term stability and reducing isolation as exemplified in testimonial 9.

Testimonial 9: Providing long-term support through supported accommodation

‘Long term support is key and, although independence is always the goal, understanding somebody’s capacity and abilities. Supported accommodation is sometimes better and prevents isolation.’

The Bridge – Homelessness to Hope, Caseworker

Meeting needs through collaborative working

As demonstrated above, there are a number of support provisions which reduce risk of homelessness when provided in conjunction with housing. As such, there is increased incentive for streamlined and effective collaborative working, to not only reduce unnecessary duplication of provision, but also to increase the overall quality and efficiency of services.

Multi-agency approaches are heralded as best practice for meaningfully and effectively addressing a wide variety of support needs relating to homelessness. Integrated and well-coordinated services may actively work to both support and relieve homelessness for people with disabilities, particularly for those with multiple diverse needs. Research in Canada has highlighted how an interdisciplinary intervention, offering case management, peer support, access to psychiatric care and community services resulted in significant improvements in mental and physical health status for homeless adults with unmet health needs.⁶² In the UK, integration exists between services at varying levels. Recent NICE guidance, based on a review of international literature and published in 2022 with support from the Centre for Homelessness Impact, formally recommends multidisciplinary support in order to fully and adequately meet the various ongoing needs of people with health and social care needs that are being actively affected by homelessness.⁶³ The benefits of these approaches are outlined in testimonial 10. A more consistent approach through the integration of health and local council services is also recommended by the UK government's recent Health and Social Care Integration white paper, which may have particular relevance for people with disabilities for the reasons outlined above.⁶⁴

Testimonial 10: multi-agency working for supporting disability and homelessness

‘A multiple agency approach with the intention of preventing homelessness is the first step, ideally with a support worker that has a good rapport with the person and can understand their needs to advocate to agencies on their behalf. The Housing First approach is so vital, but not yet used commonly, but it is evident that hostels are not ideal for those with disabilities. Additionally acting quickly from first identifying somebody is rough sleeping is vital, otherwise people are at risk of becoming entrenched.’

The Bridge – Homelessness to Hope, Caseworker

Improving accessibility and suitability of support

Multidisciplinary and coordinated approaches to support and housing provision must also be accessible for people with disabilities experiencing homelessness. The concept of 'backdoor accessibility' highlights how expecting people with disabilities to navigate provisions and spaces that have not been explicitly designed for them can hinder service access and engagement. With the barriers identified by this paper in mind, responding to the various needs held by a client group, services must be designed with those requirements at the fore to enable provision to be fully accessed and engaged with. Examples of accessible practice might include:

- Physical accessibility
- Awareness of sensory environment
- Trauma informed

Research is lacking on how best to improve the physical and sensory environments of homelessness services. Within the fields of healthcare and the criminal justice system, there is evidence that environmental changes, which are relatively easy to implement, may benefit people with neurodevelopmental conditions.⁶⁵ Initial piloting of environmental checklists indicates improvements in accessibility of health services for autistic people and people with ADHD.⁶⁶ Equally, whilst there is a need for trauma informed care (TIC) for people with disabilities experiencing homelessness, particularly those experiencing multiple disadvantages, there is a lack of consistency in how TIC is delivered.⁶⁷ There is some evidence that increasing training on trauma improves service delivery, but that this needs to be framed by wider systemic changes in homelessness

services.⁶⁸ Given these challenges, it is imperative that people with disabilities are meaningfully involved in service design and development. The recent Fulfilling Lives research project into multiple disadvantages demonstrated the short and long-term merits of co-production within intervention design and delivery to ensure that final outputs best reflect the needs of people using services.⁶⁹

A further barrier to accessibility of services can occur when eligibility is dependent on obtaining a clinical diagnosis. Given the difficulties of obtaining a disability diagnosis whilst homeless, there is a need for increased awareness of how different disabilities may present amongst housing and homelessness service professionals. The use of screening tools may help professionals to identify and respond to disability without the requirement of a formal diagnosis⁷⁰. Training and evidence-based toolkits exist to help professionals identify and appropriately support clients with 'hidden' disabilities, such as learning disabilities and autism.⁷¹ Adoption of training and use of such resources needs to be much more consistent to improve support on a national level. Furthermore, services need to be willing to make adaptations to provision and ways of working for people who do not have, or are yet to receive, a disability diagnosis.

Meeting needs through improving communication and outreach

Despite the UK hosting many policies and practices designed to support people with disabilities experiencing homelessness, there exists a discrepancy between these provisions and those who need to access them. Low uptake of service provision does not necessarily equate to low need or interest. Instead, for people with disabilities experiencing homelessness, this often represents barriers to access and navigate the service. With recognition that this is an under-served community whose voice is seldom heard, methods of advertisement and engagement would be better presented in alternate formats that more accurately reach those in need. This dictates a need to move away from traditional approaches of communication. Instead, in order for people with disabilities who are homeless or insecurely housed to access their provisions, there is a need for adaptations such as easy read documents, specially trained advocates, and peer support groups. Guidance on making information about services accessible for people with disabilities is set out in the Accessible Information Standard (AIS)⁷², and has been a legal requirement for public sector organisations providing health or social care in England since 2016.⁷³

Often containing complex language, a need for digital literacy, a knowledge of how to identify and navigate systems or identify relevant services, and an ability to advocate for oneself, many who require available support are unable to benefit from it. For those with neurodevelopmental and cognitive conditions, there is an evidenced need for simplifying overly complex systems.⁷⁴ Guidance based on a mixed methods study recommends developing expert skills within outreach teams to improve communication and

engagement with people with learning disabilities and traumatic brain injuries.⁷⁵ More broadly, a growing body of evidence has called for less ‘crisis orientated’ services, in favour of increased outreach support such as out-patient care and work in non-clinical settings.⁷⁶ This approach involves simplifying support pathways and information so that it is accessible to enable greater uptake, continued engagement, and better housing and clinical outcomes.

The call for more rounded and holistic services is mirrored by wider homelessness, health and disability research, with further recommendations for increased access to support provisions that are trauma-informed and person-centred. Research also highlights how uptake might increase when the support offered is in-reach work undertaken by those with a honed insight or personal lived experience relating to the needs of their service users.⁷⁷ Small scale evaluative projects substantiate this claim, indicating improvements in engagement with people with disabilities experiencing street homelessness when outreach staff have lived experience or when interventions are peer delivered⁷⁸ Making these changes would arguably benefit many people experiencing homelessness as well as those with disabilities.

Conclusion and recommendations

Research consistently shows that people with disabilities are over-represented in homeless populations. Statutory data likely underestimates the scale of this issue. Whilst the intersection between disability and homelessness is acknowledged by government, the homelessness sector, and related fields, there is a lack of understanding of the specific issues people with disabilities experiencing homelessness face.

Despite UK guidance mandating a duty of care owed to people with disabilities facing and affected by homelessness, there remains confusion in terms of where responsibility for action and support lies. Furthermore, there is a lack of consistency across the UK in terms of support provision and quality. This paper has identified six key barriers to preventing and relieving homelessness for people with disabilities:

1. Meeting a disability threshold
2. Obtaining a diagnosis
3. Inaccessible housing
4. Unsuitable support provision
5. Perpetuating factors
6. Meeting diverse needs

These barriers represent a significant risk of the needs of people with disabilities going unmet, thus prolonging homelessness and reducing the possibility of exiting homelessness in the long-term. In response to these barriers, this paper has explored the existing knowledge base and considered current support provisions regarding disability and homelessness in the UK. The following recommendations have been developed to improve recording and monitoring, increase effectiveness of support provision, refocus policy initiatives, and direct future research in this area.

Improving recording and monitoring disability

- **Consistent, clear and transparent recording of people with disabilities applying for housing duty.** Findings from this paper suggest a review of the terminology used by the UK nations is needed to improve consistency and comparability of collected data. To avoid misrepresentation, categories, including ‘learning disabilities’ and ‘mental ill-health’, should not be conflated. It is also essential that each nation publishes information on how many people with disabilities apply for homelessness support, as opposed to only those who receive a duty. This would enable a more accurate estimation of the number of people with disabilities experiencing housing precarity and homelessness.
- **Consistent, clear and transparent monitoring of disability within the homelessness sector and statutory bodies.** This is needed to better understand which disabilities are present in homeless populations and to identify associated needs. This includes clearer distinctions between physical disability, cognitive disability, neurodevelopmental conditions and mental ill-health, with consideration of overlap and intersection between conditions. Recording of disability should be guided by the development of national standards which use consistent terminology and are informed by consultation with people with

disabilities. Given the difficulty of obtaining a diagnosis whilst homeless, recording should note where a disability is suspected but not obtained. To actualise this recommendation, there is a need for improving awareness of disability presentation across relevant sectors. This is explored below.

Increasing effectiveness of support provision

- **Increasing accessible housing provision.** Increasing safe and accessible housing provision is vital to enable people with disabilities to exit homelessness in the long term. Improvements are needed in multiple areas of housing provision including emergency and short-term accommodation and independent housing (including social housing). However, as this paper has explored, adapting existing provision can be problematic, due to the concept of ‘backdoor accessibility’. It is therefore also important to work with people with disabilities to ensure new provision is developed on the principles of accessibility and usability.
- **Removing barriers to support provision through co-production.** Co-production should be utilised in service design and delivery to ensure that provisions address authentic needs and are trauma informed, safe spaces. Access to such provision should not be diagnosis dependent but should be led by the identification of needs by both the person concerned and professionals with relevant expertise. It is also necessary to improve how information about available support is communicated to potential service users. Working with persons with lived experience, professionals must identify and address communicative barriers to increase uptake and encourage prolonged engagement with services, particularly within outreach work.

- **Promoting collaborative and person-centred working.** Wraparound, multi-agency and whole person approaches to interventions are needed to identify and meet diversity of need. Evidence suggests that interventions such as Housing First, or supported housing initiatives, may be particularly effective in rehousing people with disabilities and multiple needs and preventing episodic homelessness. However, housing and support options must be founded on a person-centred approach acknowledging individuality and preference.
- **Increasing awareness and training.** The recommendations above require increased awareness of disability across the homelessness and related sectors. Professionals need specialist training on identifying disabilities and adapting ways of working in accordance with need. This is especially important for people with 'hidden' disabilities, and those who present with multiple diverse needs. Notably, some of the necessary changes highlighted in this paper concern adapting how professionals work with people, such as the way information is communicated and behaviour is interpreted. In this sense, these changes should be relatively easy to implement within existing support structures provided professionals are enabled to develop the necessary knowledge and skill sets.

Refocusing policy initiatives

- **Increasing recognition of the intersection between homelessness and disability.** The impact of austerity policy on poverty and socioeconomic disparity for people with disabilities increases risk of homelessness. Inclusive policies and strategies, beyond the homelessness sector, are needed to better identify and respond to risk factors to homelessness for people with disabilities. This would enable a proactive preventative approach, as opposed to one which is reactionary.
- **Improving consistency.** In relation to support, prevention and relief, there is a significant gap between policy guidance and people with disabilities' experiences of accessing housing and homelessness services. Due to subjective interpretation of policy 'guidelines' and regional variance in provision there is a need for a more consistent approach in policy implementation. This should include a clear and standardised use of the 'priority need' categorisation in relevant countries.
- **Responding to diversity of presentation.** Current policy initiatives are broad in scope, with a lack of particular attention to specific disabilities. This paper has highlighted how existing measures may result in certain groups of people falling through the cracks of service provision, particularly when disabilities are undiagnosed or are 'hidden'. Responding to this issue, policy must be extended to recognise differences in a person's presentation and needs. In doing so, it is important to avoid an exclusionary approach, wherein certain disability labels dictate eligibility for support. As such, policy changes should be informed by consultation with the disability community.

- **Increasing funding and resources.** The realities of experiencing homelessness and disability provide a stark contrast to the values outlined in existing homelessness and disability guidance emphasising a significant policy implementation gap. In response to the highlighted issues, it is critical that sufficient funding is allocated to meet the newly released priorities relating to accessible, adapted and safe homes in the National Disability Strategy, and those relating to increasing sector expertise and developing person-centred approaches in the national strategies for ending homelessness.

Directing future research

- **Exploring the relationship between specific disabilities and homelessness.** As this paper has explored, people with disabilities' experiences of homelessness are not homogenous, and their needs can vary greatly. Whilst some disabilities feature more frequently in research and conversation, others are notably more absent. This demonstrates the need for disability specific research to better understand how certain disability types may impact homelessness experience. This would also allow for the identification of specific barriers to exiting homelessness and inform best practice.
- **Mapping pathways through homelessness.** The majority of research identified in this paper is cross-sectional, with limited consideration of the relationship between disabilities and homelessness over time. Given the unsuitability of current provision and increasing socioeconomic disparity experienced by people with disabilities, there is need for further exploration of how people with disabilities may experience episodic homelessness across the life course.

- **Measuring the effectiveness of interventions.** This paper has highlighted how the evidence base for what works best for people with disabilities experiencing homelessness is lacking. Evaluative research is often small in scale, specific to local provision and tends to conflate disability with other factors of interest, making it difficult to provide general recommendations. Whilst there is evidence of promising practice and initiatives which are beneficial to disabled people experiencing homelessness, future research should concentrate on measuring the effectiveness of interventions with a mind to making recommendations which are applicable at national level.

Annex

Note on terminology

This paper adopts person-first language in the use of ‘people with disabilities’ as opposed to identity-first ‘disabled people’. This approach emphasises the value and worth of a person as opposed to defining them by their condition or disability. Whilst doing so, it is acknowledged that there is no universally preferred way of describing disability and that in some instances identity-first language can be useful in highlighting the way society is disabling. This is explored further in the paper. This paper also describes differences in homelessness experience which are particular to certain types of disability. For ease of explanation, the terms ‘physical disability’, ‘cognitive disability’, and ‘neurodevelopmental condition’ are used to denote general differences relating to physical, cognitive or neurological function, with reference to specific disability labels where relevant. It is recognised that people who adopt certain labels, such as ‘autistic’, may not identify as being disabled. Given the argument that neurological differences, such as autism, are inseparable from a person’s identity, this paper refers to ‘autistic people’.

Endnotes

- 1 Crisis (2022). “I don’t know what the winter’s going to bring”, experiences of homelessness in a cost of living crisis [online] Available at: https://www.crisis.org.uk/media/248519/experiences-of-homelessness-during-a-cost-of-living-crisis_full-report.pdf
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