PROFESSIONAL EVALUATION

Beyond safety to wellbeing: How local authorities can mitigate the mental health risks of living in houses in multiple occupation

Dr Caroline Barratt[1], Christopher Kitcher[2] and Dr Jill Stewart[3].

[1] School of Health and Human Sciences, University of Essex and Tendring District Council, Private Sector Housing
[2] Environmental Services, Tendring District Council, UK
[3] School of Health and Social Care, University of Greenwich

Correspondence: Dr Caroline Barratt, School of Health and Human Sciences, University of Essex, Wivenhoe Park, Colchester CO3 4SQ. Telephone: 07786 661496. Email: barrattc@essex.ac.uk

Abstract

The regulation of houses in multiple occupation (HMOs) by local authorities focuses on ensuring the physical safety of occupants through adequate standards of building quality, safety provision and management suitability. However, it has been suggested that HMOs may also pose a particular threat to the mental health of residents. In this paper we consider the suitability of current regulations to tackle the possible risks to the mental health of HMO residents and then outline how the current public health agenda may present an opportunity for environmental health professionals to tackle these issues in new ways. Using a framework which encompasses the psychosocial processes thought to link residents' mental health with their housing conditions, we describe how local authorities can address some of the mental health risks posed by HMOs but that the current enforcement culture, in which prosecution is seen as a last resort makes decisive action against landlords very difficult. In recognising the many vulnerable households living in HMOs, we argue that local authorities dealing with housing standards and environmental management are strategically placed to be more ambitious and proactive in protecting the health of local residents particularly through the developing public health and wellbeing partnerships. We call for empirical research to look at how local authorities actually use current legislation as well as other strategies to manage HMOs and protect the mental health of tenants.

Key words: Houses in multiple occupation, mental health, local authorities, regulation, shared housing, private rented sector, environmental health

Introduction

One of the statutory roles of local councils in the UK is to maintain housing standards both in social housing and the private rented sector (PRS). Good housing standards make a valuable contribution to public health and wellbeing and the relationship between housing and health is well documented (Pevalin 2008, Pollack *et al.,* 2008, Shaw 2004). The relationship between mental health and housing does not have the same body of evidence or long history of research as housing and physical health. However, interest in the connection between mental health and housing has been increasing (Evans *et al*., 2003). In 2010 suitable housing was identified by the UK government as a key component for mental health (Department of Health 2011) and factors such as overcrowding, small room sizes and high rise buildings among other factors have all been shown to impact upon the mental health of residents (British Medical Association 2003, Evans *et al.,* 2003, Page 2002).

The PRS in Britain is becoming an increasingly important source of housing provision with an estimated 30% increase since 2005 of households in England living in the PRS (Department of Communities and Local Government 2011). The housing strategy for England published in 2011 emphasises the importance of investment in the PRS and praises the high standards generally found in the sector (Department of Communities and Local Government 2011). However, there is recognition of the need to take a harder line on 'rogue landlords' (Department of Communities and Local Government 2010a). The Parliamentary Office of Science and Technology (2011) reported that the PRS highest proportion of non-decent homes (compared with other housing tenures), short tenancy agreements and general lack of secure tenure may contribute to mental health problems and discourage tenants from seeking home improvements, reporting problems to landlords in case of eviction and investing in rented homes.

Of all housing types in the PRS, HMOs can prove a particularly difficult for local authorities to tackle. They fulfil an important role in the UK housing market especially for those who are unable to access other tenures resulting in many vulnerable individuals suffering some of the worst landlords. However, not all HMO landlords are of a poor standard and equally not all tenants are vulnerable. For example, in some contexts HMOs offer accommodation to students and young professionals who wish to live in central locations they would not otherwise be able to afford. HMOs nonetheless frequently comprise the bottom end of the sector and it is this type of HMO that this paper focuses upon.

Previous research has highlighted the relationship between mental health problems and HMOs. Shaw *et al*., (1998) note that HMO residents are eight times more likely than the general population to suffer from mental health problems as well as having other problems:

> *'These groups [living in HMOs] are more likely to be drug or alcohol-dependent, many have spent their early lives in care, or are ex-prisoners, and have nowhere else to go' (Shaw et al., 1998: 67).*

HMOs have also been linked to increased antisocial behaviour and a decline in owner occupation in the communities where they are situated (Hubbard 2008).

Furthermore HMOs may pose a greater threat to the mental health of residents than other forms of housing tenure because of greater insecurity, less control and poorer social networks (Barratt 2011).

The need to improve the management of HMOs and to ensure that they are a safe and healthy housing option is made all the more urgent by the expectation that demand for HMO accommodation is going to increase. The effect of the downward pressure on housing benefit payments will mean that those living in the PRS are likely to be looking for cheaper accommodation options. In particular the increased age at which a person is entitled to the full one-bedroom local housing allowance rate, from 25 to 35 years, is expected to result in approximately 88,000 extra people (McCann 2011) between 25-34 years now requiring lower cost and possibly HMO accommodation. However, legal processes to bring HMOs up to required standards are frequently lacking suitable resources and can be frustrating and lengthy for the local authority enforcer and tenant alike (Rugg and Rhodes, 2008). It can also lead to cases of rental increase, and retaliatory eviction (Crew 2007) with tenants sometimes suffering harassment and feeling powerless about their situation improving, and many are unaware of the services available to help them (Emanuel 1993).

This paper discusses the options available to local authorities to manage Houses in Multiple Occupation (HMOs) and how wider use of various regulations and other public health and wellbeing interventions may help protect and enhance tenants' mental health. We start by presenting a framework for understanding how HMOs may influence the mental health of tenants.

Housing and mental health

A review of literature regarding the relationship of housing and mental health by Evans *et al*., (2003) looked at the impact of overall housing quality on mental health, including 27 studies from 1983-2001, and concluded that mental health was positively correlated to housing quality. A more recent review of literature relating to unhealthy housing in the UK (Pevalin *et al.,* 2008) identified studies looking into different aspects of housing and mental health concluding that pollution, noise, poor building design, infestation and living in unpopular areas and high rise flats can contribute to mental illness and in some cases drug and alcohol abuse. Page (2002) reaches similar conclusions but also emphasises how overcrowding and residence in temporary accommodation have been shown to adversely affest mental health, especially among children whose long term development can be affected. Adults living in temporary accommodation have been shown to suffer from increased levels of depression, domestic violence, alcoholism, family stress and relationship breakdown (Shaw *et al*., 1998). Page (2002) adds that HMOs offer a similar type of accommodation to more temporary living arrangements in hostels or bed and breakfast accommodation, but with a lack of alternate accommodation, households frequently stay longer than anticipated. Rugg and Rhodes (2008) emphasised how behaviour and housing are closely interlinked socially and economically, and 'slum' rentals at the bottom end of the PRS tend to target those with already chaotic lives and as such, anti-social behaviour from those with addictions or existing mental health problems is more likely in this sector.

Understanding mental health in HMOs

The Evans *et al*., (2003) framework details five psychosocial processes that link housing and mental health providing a useful model to consider the possible mental health impact of living in a HMO.

HMO accommodation is potentially problematic in relation to each of these factors (Barratt 2011). We now outline why:

Identity

Evans *et al*., (2003) point out that a person's identity and their self-esteem may be influenced by the house and community that they live in. They note "The house is a symbol of self, reflecting both inwardly and outwardly who we are, what we have accomplished and what we stand for" (Evans *et al*., 2003: 492). Forchuk *et al*., (2006) carried out a study with men and women who had received psychiatric treatment. Respondents emphasised how important it was for them to be proud of where they lived and that this was a central element of being well. The poor quality of many HMOs may result in declining self esteem among residents who may feel embarrassed about where they live.

[1] The legal definition of a HMO is complex and includes some types of self-contained accommodation. However, this paper uses a narrower definition of a HMO: a building in which unrelated occupiers of the building share basic amenities such as kitchens, bathrooms or toilets.

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Control
Good housing should offer protection to residents. Evans *et al*., (2003) note that this should not just be from the elements but also from unfavourable social conditions and that it is within our houses that we should be able to control who enters and what takes place. An inability to control circumstances within our own home may lead to feelings of low self efficacy. Page (2002) identified that forced social interaction can pose a threat to mental health. HMOs by their definition include some element of shared space, which instantly reduces the control that individual residents have over the space in which they live. Furthermore, the close proximity of other residents means that the choices of other residents impacts greatly on individuals. HMOs therefore offer significantly less control compared with other types of housing.

Insecurity
Good housing should be a source of security to tenants; however, Evans *et al*., (2003) point out that poor quality housing has been shown to lead to insecurity through repeated problems with maintenance, having to engage with people from bureaucratic organisations and high rates of involuntary relocation, all of which can lead to psychological stress. Illegal evictions and tenant harassment by landlords contribute to the insecurity felt by tenants, some of whom are already transient (Stewart *et al*., work in progress). Another aspect of insecurity is potential danger from the accommodation or other residents' behaviour, particularly for families.

Social support
Housing and the neighbourhood in which people live play an important role in defining the social support a resident can access. Evans *et al*., (2003) note that the way in which buildings and roads are laid out, including details such as the door orientation, can influence patterns of social interaction. In one of the earliest studies on this topic women living in high-rise flats found that they experienced a high degree of isolation attributed to the building's verticality and lack of garden (Fanning 1967). Furthermore, housing can influence who people interact with. For example, living in an area with high property prices may provide access to neighbours with knowledge about jobs. Within HMOs the shared facilities and the close proximity of residents may lead to increased levels of social interaction, although we have already noted that this may not always be desirable, especially owing to the high vulnerability of some HMO tenants.

Parenting
Evans *et al*., (2003) establish that parenting styles are influenced by the circumstances in which families live. Parents are likely to become more restrictive if the housing quality is low and the neighbourhood thought to be dangerous. Additionally, parents' self-esteem and feelings of self efficacy might be affected by housing problems that they are unable to solve. A lack of privacy may prevent parents from building close intimate relationships with their children. Page (2002) notes that the lack of control parents have over the internal environment of shared accommodation results in greater parental anxiety and limits the control parents have over the people and behaviours their children are exposed to. Living only in one room would severely limit space to play and would be a source of stress for the parent.

These five processes do not exist distinct from each other; they are closely related and some issues fall under more than one process. However, this brief consideration of the framework suggested by Evans *et al*., (2003) helps demonstrate why HMOs may pose a greater threat to the mental health of HMO residents than other, self contained housing tenures. We will now explore the regulations that are used by local authorities to manage HMOs as well as wider planning, public health and wellbeing provisions and consider how they can help to mitigate the impact of HMOs on the mental health of residents, basing our discussion around the five psychosocial processes identified above.

Current HMO legislation and its impact on the mental health of residents

Houses in Multiple Occupation are currently regulated under the Housing Act 2004 and the Management of Houses in Multiple Occupation Regulations 2006. The Housing Act 2004 (Part 1) introduced the Housing Health and Safety Rating System (HHSRS), to replace the previously outdated statutory standard of fitness, as well as mandatory licensing for larger HMOs. This includes HMO properties that are three or more floors and house five or more people from three or more households. Licensing was introduced in recognition of the potential danger these properties pose to residents as well as attempting to deal with the growing challenges being posed by HMO properties, especially in cities with large student populations and seaside towns (Department of Communities and Local Government 2010b, Agarwal and Brunt 2006, Department of Communities and Local Government 2008). Overall, these changes in HMO legislation were seen as a progression from previous

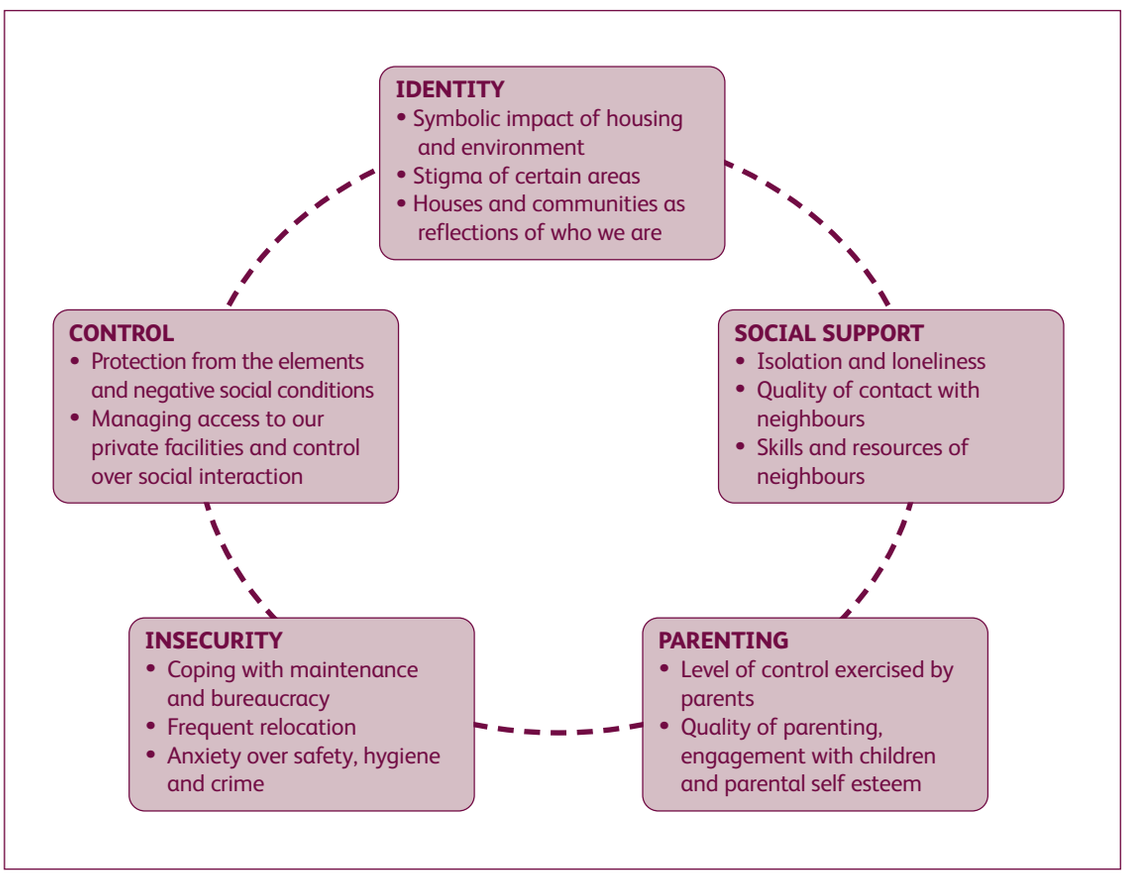

Figure 1.0
Psychosocial processes thought to link between housing and mental health (Adapted from Evans *et al*., 2003)

reactive measures (Stewart 1999; Stewart 2001) to a more dynamic and evidence-based approach.

The Management of Houses in Multiple Occupation Regulations 2006 apply to all HMO properties in which facilities are shared, irrespective of whether or not they are licensable. These regulations make the manager responsible for ensuring that their contact information is available to residents; that fire safety measures are in place and that common parts are properly maintained. Essentially, they cover basic health and safety requirements aimed at protecting against injury and disease. However, in terms of the psychosocial framework previously outlined these regulations could protect the mental health of residents by making them feel safe, reducing insecurity and increasing their sense of control as they are able to contact the landlord and deal with problems in the property when they arise. Although the word 'maintain' is ambiguous, if the property is maintained to a high standard, this could help to boost the self esteem of residents, giving them a positive sense of identity.

Additional requirements must be met for HMOs requiring a licence and each landlord or HMO manager of a licensed property must be considered 'a fit and proper person' to manage the property; factors such as a past criminal record are taken into account when making this judgment. Any previous history of poorly managing HMOs would be considered although in effect checks are limited. While the licence may provide reassurance for the tenant that certain standards are adhered to and the knowledge that the manager or landlord was a 'fit and proper person' may contribute toward a greater feeling of security for tenants, the extent of checks actually made in practice remains uncertain. It is also unclear to what extent tenants are aware of the licensing system or the impact it has on property and as a result the impact

of the licence on mental health may be limited despite tenants being physically much safer if the licence conditions are met.

The Housing Health and Safety Rating System and mental health

The Housing Health and Safety Rating System (HHSRS) is used in England and Wales (with separate standards for Scotland and Northern Ireland) to assess risk in residential properties including HMOs in conjunction with other applicable legislation. If a sufficiently serious risk is identified, legal action can be taken against a landlord to ensure that potential hazards are addressed. HHSRS requires that 'psychological' hazards that pose a threat primarily to mental health are considered: crowding and space; entry by intruders; lighting; and noise. The importance of being able to regulate these hazards is emphasised in the earlier framework (Figure 1.0). Protecting against entry by intruders, for example, will increase a resident's sense of security and control as they are able to keep unwanted influences out of the home environment. The lack of privacy caused by overcrowding can lead to increased levels of stress and aggression among individuals (Hopton and Hunt 1996). Growing up in overcrowded conditions has been shown to affect the healthy emotional development of children, making this particularly stressful for parents. Regulating for light and preventing accommodation from being too dark can help to improve mental health as sunlight has been linked to the prevention of and recovery from mental illness (Rosenthal *et al*., 1984, Beauchemin and Hays 1996). The conversion of properties into HMOs may result in some rooms having limited light sources, making this issue particularly pertinent. The property's outlook could influence whether or not the view from the room reinforces a positive or negative sense of self. Furthermore, the only private space available to HMO residents is their own room. Therefore, if the view from their room is poor or the light compromised, it is not possible to spend time in another, brighter part of the house, making protection from this hazard particularly important in this housing tenure.

As well as risks to mental health being identified under psychological requirements, the potential for hazards usually associated with physiological harm to affect mental health are also identified within the health effects of other hazards. In relation to mould and damp it is recognised that this can cause embarrassment and contribute to social isolation and one hazard, 'flames, hot surfaces etc' identifies 'acute psychological distress' that victims of scolds and burns, as well as the parents of children that are burnt, can suffer for many years after the incident is recognised (Office of the Deputy Prime Minister 2006).

The links between housing and mental health therefore feature in the hazards identified. However, the system for assessing the severity of potential harm from any particular hazard makes it difficult to account for threats to mental health and some concerns were expressed in the developmental stages of HHSRS in respect of how mental health (e.g. stress, depression) issues would be incorporated (Stewart 2002). The system of harm classification as well as the paucity of data regarding the impact of housing on mental health limit the capacity of HHSRS to adequately incorporate a psychological dimension. For each hazard identified, details are provided regarding the probability of an individual being affected and the extent of harm likely to be caused. Harm is defined as 'an adverse physical or *mental* effect on the health of a person' (Office of the Deputy Prime Minister 2006: 11). Four classes of harm are identified under HHSRS – Class I being the most severe and Class IV the least. For all the hazards detailed under 'psychological requirements' the vast majority of those who are affected are thought to suffer Class IV harm (the lowest class of harm) resulting in relatively minor health effects. However, it is noted that there is a paucity of data in relation to psychological impacts of these hazards, making it difficult to accurately attribute a class of harm.

Being unable to accurately identify the level of potential psychological harm attributed to any given hazard means that individuals utilising HHSRS are then unable to meaningfully calculate whether the hazard is defined as a Category I or II hazard. The significance of this is that local authorities are obligated to take action against a landlord if the hazard is considered to be Category I. If the risk is considered to be a Category II hazard, a local authority can take action if it is deemed serious enough. Alternatively if there are numerous hazards, which would not necessitate action individually, these can all be combined, enabling the local authority to take action given the overall hazard score of the property. However, owing to the low class of harm associated with psychological hazards, it is unlikely that the hazard score would be high enough to enable the local authority to take action. Therefore, it is very unlikely that action could be taken against a landlord based on consideration of

psychological hazards alone. In the HHSRS Operating Guidance (Office of the Deputy Prime Minister, 2006:16) it is explained that this process of hazard scoring enables very different hazards to be compared and 'enable(s) hazards which may result in physical injury to be compared with ones which could cause illnesses or affect mental health'. But this is doubtful as the paucity of data does not enable such comparison to be made despite the potential of the hazard scoring system. Further development in application and enforcement of the HHSRS may bring forward new ideas in how mental health can be more highly rated.

HMO regulation and the problems of sharing

Having looked at the most common legislation used to regulate HMOs, we now discuss how sharing facilities and living in close proximity to individuals from different households impacts on mental health and outline how current legislation can tackle this.

Within HMOs some of the greatest threats to the mental health of tenants come from the actions of other tenants. Landlords currently have a duty to ensure that the behaviour of tenants in the property does not impinge on the surrounding community but it is not specified that tenants should be protected from the behaviour of other tenants. However, some protection is provided to HMO tenants through the legislative provision for dealing with anti-social behaviour in the PRS. Residents can make complaints about antisocial behaviour to the landlord of the perpetrator. If the landlord fails to take action and the complaint is sufficiently serious but the landlord does not take steps to rectify the issue, a special interim management order can be put in place by the local authorities under section 103 of the Housing Act 2004. This facilitates the intervention of the local authorities in tackling the problems arising from that property. Furthermore, under the HMO licence conditions the local authority is able to specify additional conditions, for example how the landlord will deal with the behaviour of tenants. This may be through detailing expectations of tenant behaviour in the tenancy agreement, keeping records of all ASB incidents or fitting security cameras in properties with a history of ASB. In an area where anti-social behaviour has become a significant problem and there is a high proportion of properties not being managed properly, selective licensing for all private landlords within that area can be introduced under part 3 of the Housing Act 2004. This could help protect HMO tenants as well as the wider community. In terms of mental health, preventing ASB behaviour in the property will make tenants feel safer and more secure, especially for parents who wish to protect their children from negative behaviour. Minimising the impact on the wider community of ASB from HMOs may result in improvements in the local area, boosting the esteem of those living there and reducing stigmatisation.

As it stands, both the HHSRS and the HMO management regulations fail to consider enforcing steps that provide greater privacy and security for HMO residents, which could help tackle the problems of sharing. For example legislating for the sound insulation properties of partition walls, floor and ceilings would make it much easier for individuals in the property to live together by preventing noise pollution. The Building Regulations 2010, Part E (Government of England and Wales 2010) outline sound insulation requirements when the property goes through a change of use but this cannot be enforced retrospectively so there is no recourse to tackle poor sound insulation in older properties. Currently, landlords may be asked to take action such as improving insulation or the provision of double glazing in order to reduce the impact of ambient noise levels. However, guidance for noise hazard assessment states *'noise from unreasonable behaviour of neighbours should not be included in the assessment'* yet nothing is specifically stated regarding HMO properties when a tenant's neighbours live *within* the same property (Office of the Deputy Prime Minister 2006: 105). This would make enforcement of greater noise insulation difficult using HHSRS. There is provision for dealing with excess noise caused by tenants in the Anti Social Behaviour Act 2003 (Government of England and Wales 2003) (although issues with noise are not necessarily examples of ASB) or through the Noise Act 1996 if noise is being emitted from a '*dwelling*' exceeds the permitted level.

A further optional condition of the HMO licence is that the landlord attends a suitable training course. If done well, this could lead to better conflict management within the property, increasing the sense of security for all tenants and helping to reduce stress and anxiety. The licence conditions for HMOs and guidance for tenants experiencing ASB in the PRS emphasises the role of the landlord in tackling many of these issues. Therefore, if landlords are more able to deal with them effectively the burden on the local authority would be reduced. Additionally, landlord accreditation schemes are becoming more widespread in the UK and it is becoming an increasingly professionalised industry. This provides a

good opportunity to inform landlords about the links between mental health and housing and develop management practices that reduces the stress of living in shared accommodation.

Other regulations and the challenges of enforcement

There are other criminal and civil remedies under non-housing legislation that can also be considered, although the extent to which they are successfully used, or even used at all, remains unclear (Stewart 1999, Stewart 2001), particularly since the introduction Housing Act 2004 and its wider coverage of hazards than the earlier statutory standard of fitness.

The status of the HMO as a business means that the Health and Safety at Work etc Act 1974 could be used to enforce improvements in common parts, for example if lighting or security was thought to be inadequate. Page (2011) listed several different pieces of legislation that he has used in relation to HMO regulation over the course of his career including the Prevention of Eviction Act 1977; Landlord and Tenant Act 1985, Section 11; Sections 27 and 28 of the Housing Act 1985; and Defective Premises Act 1972, the later two being civil proceedings. Therefore current powers do enable environmental health enforcement officers to take action for hazards that may negatively affect the mental health of HMO residents but it may require using legislation in more creative ways than is currently observed in typical day-to-day practice. However, Hutter (1988) noted that actions are sometimes 'controlled' by how discretionary powers are used and although this was over two decades ago this observation is felt to be relevant in practice today.

Although the legislation seems to provide a variety of tools to use to maintain HMO standards and therefore protect the mental health of tenants, enforcement in the PRS and HMOs in particular proves problematic and may account in part for the low numbers of prosecutions. In a review of legislative approaches to controlling housing conditions, Burridge and Ormandy (2007) note that the power of individual tenants to ensure that landlords maintain housing standards has traditionally been very limited, pointing particularly to the weak regulatory impact of the tenant landlord contract. In light of this the state has become increasingly involved in lawful intervention on behalf of tenants in the PRS. Cowan and Marsh (2001) point out that a compliance-based strategy has developed with regards to the PRS, meaning that prosecution is used only as a last resort. They highlight that the emerging perception of the PRS as 'partners in local housing strategies' (Cowan and Marsh 2001: 853) has resulted in legislation that appears set to punish poor landlords. However, in reality officers are constrained by the objectives of their local authority, financial realities and judicial attitudes.

The situation is also complicated when a property may be deemed an HMO under housing legislation, but not under planning or building legislation. Close organisational working is therefore necessary to seek the highest standards, for example in proactive application of building controls on conversion to multiple occupancy, in requirements for noise insulation and fire safety, although there are many cases where housing legislation is applied reactively, which sometimes generates difficulties for tenants and landlords alike.

Despite a plethora of legislation and regulations, informal action – i.e. where no legal notices are served – remains the main means of securing housing improvements. There are calls for a more strategic approach to using the HHSRS (Chartered Institute of Environmental Health 2008) and this could help inform the local evidence base on successful interventions. Even though the PRS presents some of the worst housing conditions for some of our most vulnerable tenants, there is still relatively low importance granted to interventions in this sector (Audit Commission 2009). Therefore, despite the range of legislative powers available to local authorities, significant barriers prevent their effective use. We now consider how a very different approach on the part of environmental health professionals could help to find alternative solutions to promoting mental health among HMO residents

Developing wider partnerships to enhance mental health

In order to deliver more effective mental health and wellbeing outcomes, those charged with delivering housing enforcement also need to look more widely, particularly within the field of public health, for emerging opportunities to work in ways that bring housing and health together more closely than seen in recent decades. The Local Government and Public Involvement in Health Act 2007 required Primary Care Trusts (PCTs) and local authorities to produce Joint Strategic Needs Assessments (JSNA) of the current and future health and wellbeing of their communities. This demands wide stakeholder involvement with identified links to other

strategies and it needs to be founded on a local evidence base to have credibility (Emanuel 2011). With regard to mental health it was noted:

> *'Local government will play a central role in ensuring that local partnership arrangements can deliver the shared mental health objectives. Partners will include social care, education, the police and criminal justice system, housing, the environment, employers, charities and voluntary organisations, as well as health' (Department of Health 2011).*

This develops potential roles for environmental health professionals in wider public health and wellbeing partnerships including health and wellbeing boards and recognises that HMO enforcement alone cannot address the multiple causes and effects of mental health in its relationship with housing.

Local community-based projects in areas of high HMO concentration highlight the importance of combining enforcement of regulations to maintain housing standards while also engaging other agencies with the aim of tackling some of the underlying socio-economic issues in these areas. The successes of these projects reflect the comment in the Rugg Review that some issues seen as 'housing' issues are in fact 'wider policing' issues (Rugg and Rhodes 2008).

The award winning 'Operation Jupiter' (2006), at Weston-super-Mare is a good example of a multi-agency partnership that tackled the effects of problematic HMOs in a spatially concentrated area populated by a transient community. The local community was concerned about the number of vulnerable people moving to the area with drug and alcohol problems and the effect this was having on community stability, nuisance and anti-social behaviour. Central to the approach was strong enforcement of legal housing standards, closer inter-agency working and appropriate support for the community. In particular, the strategy sought to prevent an influx of potential tenants to unsuitable accommodation which would further aggravate their need and a gradual withdrawal of the more unsuitable accommodation (Grant 2008). Approximately 18 months into the project seven HMO premises had been sold, redeveloped or were subject to a 'change of use' application. Three further premises were proposed for sale to a Registered Social Landlord and forty nine Housing Standards enforcement notices had been served (Operation Jupiter 2006). The possibility of residents ending up in poor quality accommodation was therefore reduced and options were also explored to increase the supply of self-contained accommodation by working with private sector landlords and housing associations. This is likely to have beneficial effects on the mental health of people that are now living in improved accommodation and on the community more widely as the environment of their neighbourhood improves.

In another seaside town, the Margate Task Force has provided great impetus in drawing together agencies (including environmental health, housing, children's services, police, environmental health, children's services, probation service, primary care trust and drug and alcohol rehabilitation services) in tackling a similarly vulnerable and needy community characterised by multiple deprivation. The programme is based around strong private sector housing enforcement of HHSRS and HMO licensing conditions to address unsatisfactory HMO accommodation while offering substantial social support to the local and transient community (Stewart *et al*., work in progress). Programmes such as these protect mental health among HMO tenants very directly – not only through ensuring the HMO is of the correct standard but by tackling some of the underlying issues that may also contribute to mental health problems.

The need for evidence

Yet even these approaches currently face significant challenges owing to the lack of evidence to demonstrate the effectiveness, particularly the cost effectiveness, of housing and health interventions. Housing must be seen as a public health and wellbeing priority for this to change (Davidson *et al*. 2011). The Building Research Establishment (2008) and Chartered Institute of Environmental Health (2008) partly address this by demonstrating the value of private sector housing to public health. Specifically, they describe the HHSRS Cost Calculator, which calculates the health costs that arise from particular hazards and compares this with the cost of intervention. The calculator tool concentrates on physical rather than mental health impacts but the report does provide examples of how mental health has been included in some private sector housing strategies. The CIEH online Private Sector Housing Evidence Base aims to address knowledge gaps in this area and make information on effective housing and health interventions more available including that which tackles HMOs and mental health specifically. Rugg and Rhodes (2008) emphasised the importance of making best practice examples widely available and the database is an attempt to achieve this. Sound evidence will be of growing importance in securing resources from the emerging Health and Wellbeing Boards

(Emanuel 2011). Furthermore, local authorities need to be able to effectively demonstrate the effect their work will have on addressing mental health, a priority area for government (Department of Health 2010; Dunning 2010; Department of Health 2011). Understanding how the work of environmental health professionals and the management of private sector housing can contribute to the public health agenda could be an important component of this.

Conclusion

How housing affects mental health is a complex and under researched issue, particularly in HMOs. Using the framework developed by Evans *et al*., (2003) we have shown that current legislation has the potential to contribute significantly to the safety and quality of housing and this is likely to positively affect the mental health of tenants, through creating a sense of safety and security. However, we have also outlined how the current regulations and enforcement culture make it difficult for those working in private sector housing enforcement to take action against landlords, especially where the threat is to mental rather than physical health. The paucity of data regarding the impact of housing conditions on the mental health of residents adds to this difficulty. If the HHSRS is to be effectively used to protect mental as well as physical health, the lack of evidence of the relationship between housing and mental health needs to be urgently addressed so that this can be fully incorporated in the risk assessment framework of HHSRS.

In addition to regulatory action we have also emphasised the importance of interagency working so that HMO regulation is not tackled in a vacuum divorced from the socio-economic drivers that can fuel the issues in areas of high HMO concentration in low income settings. We have described two case studies where interagency working is delivering positive outcomes for HMO tenants as well as the wider community. If support for this type of intervention is to grow, and attract the funding and local mobilisation necessary for their success, documentation of their achievements needs to be forthcoming. This needs to be backed up by examples of best practice and learning points from private sector housing teams, which should be widely shared rather than local authorities tackling very common issues in separate silos. Furthermore, the involvement of local authorities in health and wellbeing boards and the creation of JSNAs should include officers involved in private sector housing regulation as well as environmental health professionals more widely so that the public health role of housing regulation and environmental health is fully recognised.

HMOs are going to become an increasingly important form of housing which is expected to attract increasing numbers of vulnerable tenants. Effective management of HMOs by local authorities is likely to include broader approaches that utilise appropriate legislation within wider public health and wellbeing strategies to help protect and enhance mental health. Before this can happen, however, the significant knowledge gap about how local authorities actually regulate and police HMOs needs to be addressed; otherwise progress in this area will remain in the theoretical rather than practical domain.

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