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Control and care: landlords and the governance of vulnerable tenants in houses in multiple occupation

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ABSTRACT

Houses in multiple occupation (HMOs) in which tenants share facilities are housing an increasing proportion of vulnerable adults who have limited affordable housing options. However, knowledge about how these types of property are managed is limited. In this paper, we examine the governance function of HMO landlords from the perspective of landlords/landlord agents and the tenants that live within their properties. The landlord exercises control through formal and informal risk assessment of tenants and close surveillance of them. These control mechanisms may also involve direct or indirect provision of support and care to some tenants. This illustrates the complex relationship between care and control and the extent to which both are integral to the housing management of vulnerable tenants living in HMOs. We suggest that this dual function calls for a critical examination of what constitutes a 'good landlord'.

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Houses in Multiple Occupation (HMOs); landlords; tenants; bedsits; surveillance

Whilst the governance function of social housing landlords has received significant research attention, the role of the landlord as an agent of control and care has received less attention in the private rented sector (PRS). In social housing, there are mechanisms for social landlords to exercise control to modify tenants' antisocial behaviour as well as a responsibility to promote well-being among tenants (Carr *et al.*, 2007; Flint, 2006). In the PRS, landlords have a responsibility to deliver safe and secure housing to tenants which reaches appropriate standards established in law and are also legally obliged to take action if their tenants behave in antisocial ways (Crook & Kemp, 2011). However, there is little research about how PRS landlords control vulnerable tenants' behaviour in houses in multiple occupations (HMOs).

This is a salient issue as the number of people living in the PRS in the UK is growing in less prosperous areas and an increasing proportion of tenants are those who would previously have lived in social housing (Gray & McAnulty, 2008; Houston & Sissons, 2012). The PRS thus plays a disproportionate role in housing those living in poverty (Kemp, 2011) and an increasing number of vulnerable people are being forced into the cheapest, least desirable PRS accommodation such as HMOs.

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HMOs are residential properties with common areas, such as kitchens or bathrooms, which are shared by more than one household. In the UK, the concept of HMOs emerged in the Housing Act 1985 section 345, which defined them as 'a house which is occupied by persons who do not form a single household' (HMSO, 1985). Subsequently, the Housing Act of 2004 refined the definition and introduced the requirement for some HMOs to be licensed. Given the devolved structure of the UK, the definition and regulations vary a little in each of the four constituent countries. HMOs (in England) are defined as accommodation let to three or more tenants who form two or more households and who share kitchen, bathroom or toilet (Crook & Kemp, 2011).

HMOs can take different forms, from large shared student houses to individual bedsits with shared facilities and are mainly accessed by individuals unable to afford self-contained accommodation as well as by those waiting for, or excluded from, social housing. In areas such as seaside towns, former holiday bed and breakfast accommodation readily lends itself to such change of use and poor quality bedsits in HMOs can be found in coastal towns throughout the UK (Smith, 2012; The Centre for Social Justice, 2013). This provision of cheap accommodation has acted as a draw for state benefit claimants and others seeking low-cost housing (Beatty & Fothergill, 2003; Office of the Deputy Prime Minister, 2006; Stewart & Meerabeau, 2009). HMOs in these areas house a disproportionately high number of vulnerable people (Smith, 2012) whose situation qualifies them for social housing but who are not able to access it because of long waiting lists (Crook & Kemp, 2011). HMO tenants are often very disadvantaged with multiple markers of social exclusion and associated challenging behaviours (e.g., drug and alcohol misuse) (Page, 2002), and are somewhat similar to the so-called 'problematic populations' living in social housing described by Flint (2004, 2006) with the important caveat that HMO residents are generally single people, whereas social housing caters for families. HMOs have been linked to increased antisocial behaviour in the communities where they are situated (Hubbard, 2008).

Low-cost HMOs are linked to social exclusion as they attract disadvantaged social groups in receipt of Housing Benefit into seaside towns with limited employment opportunities (Ward, 2015) where opportunities for upward social mobility are highly constrained (Smith, 2012). They are thus a key factor in the reproduction of socioeconomic decline in some coastal towns (Beatty & Fothergill, 2003; Smith, 2012). They nevertheless fulfil an important role in the UK housing market especially for those who are unable to access other tenure. The governance function of HMO landlords is likely to be challenging but there is little evidence about how this operates. This is particularly pertinent in the current climate given the dwindling stock of social housing as well as the coalition government's (2010–2015) welfare reforms which have increased the age at which single adult Housing Benefit recipients are entitled to self-contained accommodation (Smith, 2012), which has resulted in increasing numbers of young and vulnerable people living in HMOs.

In this study, we examine the range of mechanisms, specifically the relationship between landlord and tenant, which are used to monitor tenants living in three diverse HMOs in a seaside town in the South-East of England. We identify mechanisms used by landlords/landlord agents to manage properties and consider how these are experienced by the tenants who live there. In particular, we are interested in how a richer understanding of this relationship would shift perception of what constitutes a 'good' landlord and the roles that this relationship plays in the management of 'problematic populations'.

Surveillance, legislation and governance

Monitoring everyday life has been increasingly prevalent in what Lyon (2001) terms our 'surveillance society' and is a key mechanism to control antisocial behaviour. Foucault (1979) discussed mechanisms, such as Bentham's panoptic design, for keeping 'problematic populations' under observation and control. A central idea of Foucault's panopticism concerns the systematic ordering and controlling of human populations often using subtle and unseen forces. There are currently a growing number of technological surveillance mechanisms such as closed-circuit television (CCTV) as well as legislation and self-surveillance (Vaz & Bruno, 2003).

One key mechanism to control tenants has been via legislation and licences. Valverde (2003) examines how licensing is used as a mechanism through which the government delegates the surveillance and control of 'certain spaces, activities and people' (p. 236). She specifically examines how pub licensing has been a mechanism whereby licensing effectively delegates the management of disorder by obligating publicans to manage drunkenness and other risks associated with their business. Making this a condition of licence is pragmatic and facilitates governmental need to ensure security and order. In the social housing sector, it has been noted that landlords have recourse to an increasing legal armoury designed to contain and control antisocial behaviour (Papps, 1998). Recent research suggests that landlords are increasingly using these instruments to control and punish tenants exhibiting antisocial behaviour (Hunter & Nixon, 2001) and to ensure that social problems are 'contained' geographically, thus insulating more affluent and powerful populations from such behaviour (Flint, 2006).

As lower quality dwellings in the PRS, such as HMOs, increasingly house the overspill from social housing, much of this responsibility for containing the behaviour of 'problematic' tenants has been transferred to private landlords (Carr *et al*., 2007) via licensing conditions and management regulations. The challenges inherent in the management of HMOs and evidence of poor management have resulted in considerable legislation which governs the establishment of HMOs, safety standards and management responsibilities of HMO landlords (Crook & Kemp, 2011). There is an expectation that landlords of HMOs have a governance function which goes beyond that expected for other property types in the PRS reflecting the increased risk they are assessed to pose to both tenants and local communities. Details of the establishment and licensing of HMOs are discussed in the methods section below to provide contextual understanding of the parameters within which HMO landlords operate.

Landlord–tenant relations: control and care

If the legal framework of HMO management is studied in isolation, the true complexity of landlord–tenant relations is missed as tenancy relationships are primarily based on social interactions characterised by inequalities between landlord and tenant rather than legal principles (Lister, 2005). For all landlords in the PRS, there are tensions between the rights of control to the property as,

> Both landlord and tenant represent conflicting claims to possession, one based on ownership and the other based on the hire of the commodity, residential space … [which] …, may draw certain landlords into close surveillance of the use of the property. (Allen & McDowell, 1989, p. 46)

This tension may be exacerbated in HMOs due to the enhanced governance function in the legislative framework which encourages landlords' close surveillance of the behaviour of tenants.

Lister (2005) shows how landlords use the social relationship with tenants to establish internal controls, and this is often framed as caring. She found that surveillance of young tenants was used extensively by landlords as a management technique to ensure their compliance with the norms of expected behaviour. She conducted semi-structured interviews with 15 landlords and 15 tenants and reported widespread use of surveillance and 'overtly intrusive approaches to monitoring tenants in their homes' (p. 517). The landlords' level of surveillance threatened tenants legal rights, e.g., uninvited visits were commonplace which interfered with tenants' rights to 'exclusive possession' and 'quiet enjoyment' (Lister, 2006).

The relationship between landlord and tenant has been likened to that of a parent and child (Bierre *et al*., 2010; Lister, 2005, 2006) with landlords acting in 'loco parentis', e.g., visiting frequently to keep an eye on tenants. Such behaviour is rarely appreciated by the tenant (Atkinson, 2008) and it 'highlights the delicate balance between "informal" and "friendly" encounters with tenants and interference and control' (Lister, 2005 p. 522), and the indeterminate boundary between a social and a business relationship. Lister (2005) reports that some of the young tenants felt that the landlords were more interested in keeping control of their property rather than their tenants' welfare.

There may though be a caring aspect to surveillance and Lyon (2001) refers to the two faces of surveillance or 'watching over', which 'involves care and control' (p. 3). A report for the housing charity Shelter (Reynolds & Smith, 2009) noted that some landlords were 'performing a valuable support role for their tenants, in some cases signposting them to support agencies or offering them some flexibility in their rent payments' (p. 7). This type of support was most evident among landlords of HMOs.

The coexistence of control and care is highlighted in DeVerteuil's (2012) 'critique of current grammars of urban injustice'. He demonstrates that punitive aspects of control to contain vulnerable groups within urban spaces often coexist with more supportive responses of sustenance and care. One example he uses is that of safe drug injection sites in a number of cities. These serve as a measure of control to reduce injecting drug use occurring on the street but are also a harm-reduction technique as they provide a safer space in which to inject and possibly a route into therapeutic treatment for injecting drug users. He also provides broader examples of urban spaces in which the punitive and supportive are combined in order to contain, sustain or support the vulnerable. Indeed, he argues, there is not only a coexistence but also often a codependency between the punitive and the supportive. This study reports on whether this more nuanced understanding of a coexistence of care and control at the level of city scape is also apparent in the microcosm of the landlords' governance of HMOs. To what extent can this be categorised as control or care and how are the two linked?

Rogue landlords and 'problematic populations'

A more nuanced understanding of tenant surveillance by HMO landlords also has implications for the categorisation of HMO landlords. The housing strategy for England published in 2011 recognised the need to take a harder line on 'rogue landlords' in the PRS (Department of Communities and Local Government, 2010). Kemp & Rhodes (1997) note

that 'private landlords are commonly portrayed as rather seedy characters, who exploit their tenants by charging exorbitant rents for poor quality accommodation' (p. 118). Their research on private landlords in Scotland, however, revealed a more complex picture and also considerable variation in management standards and professionalism among landlords. Nevertheless, they reported that many HMOs are owned by 'rogue landlords incapable of managing properly and sometimes operating outside of the law' (Crook & Kemp, 2011, p. 42). Thus, some HMO landlords perhaps conform to the negative landlord stereotype. This study seeks to critique the stereotype of the rogue landlord in the light of the control and care nexus.

A subsidiary question the paper addresses relates to the notion of 'problematic populations' and 'responsible tenants' identified by Flint (2004). These categories have been prominent in UK housing debates in connection to antisocial behaviour. Policy discourse about social problems associated with social housing tends to focus upon 'individual moral deficiency' of the tenants (Flint, 2004). As a result, emerging forms of housing governance are based upon what Flint (2004) terms 'technologies of the self' in which power works through the self regulation of subjects within constructed norms of responsible and ethical conduct. To what extent is such self-surveillance, which has been identified among tenants, often families, living in social housing evident among single people living in HMOs?

This study thus addresses the following questions, which link to key theoretical discussions highlighted in previous research about vulnerable and/or surveilled populations.

- To what extent is surveillance of tenants' behaviour by HMO landlords motivated by control or care and are these two functions linked?
- If control and care are linked, how can HMO landlords be categorised and, specifically, what constitutes a 'rogue landlord' in the governance of 'problematic populations'?

Methods

Research setting and the legislation and governance framework of HMOs

In common with many other coastal resorts, the town in which the research was carried out has a stagnating economy and a number of buildings previously used as tourist accommodation, such as bed and breakfasts, have been turned into HMOs (The Centre for Social Justice, 2013). In terms of the local housing stock, the town has a lower proportion of HMOs than other UK seaside resorts such as Margate, Hastings or Blackpool (Smith, 2012). There is, however, a concentration of privately rented accommodation in the centre of the town which has 79 HMOs. In this area, 54 per cent of people aged 16–64 are on out-of-work benefits—the fifth highest percentage in England, and the local food bank reported that the majority of their clients are males aged 25–45 who may be staying in bedsits (The Centre for Social Justice, 2013). This area therefore fits the profile reported in studies in similar settings (Shaw *et al*., 1998) of having a high proportion of vulnerable groups in HMOs such as care leavers, people who misuse substances, those with mental health problems and ex-prisoners (The Centre for Social Justice, 2013). A needs assessment notes that:

> Many of these houses [bedsits] provide a safe environment and a place to stay until the person is able to find their feet. However, many are simply *dumping grounds* [their emphasis] for some of the most vulnerable members of a community. (Tolchard & Speed, 2010, p. 44)

One of the statutory roles of local councils in the UK is to maintain housing standards in social housing and the PRS including HMOs. This research was motivated by the concerns of the local council regarding the welfare of vulnerable people living in HMOs and was supported by a multi-agency group including statutory and non-statutory health, housing, social care and law enforcement agencies. The area has several community-based voluntary organisations that run a soup kitchen, often frequented by HMO tenants as well as drop in events at local community buildings and churches. There is a local community safety partnership which has representatives from local police, crime commissioners office, the fire authority, district council, probation service and the NHS who work together to reduce antisocial behaviour in the area.

Nationally, HMOs are 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 which is used to measure risk in all PRS properties, including HMOs, and provides the framework for enforcement action against landlords whose property exposes tenants to high levels of risk. Under Part 2 of the Housing Act 2004, mandatory licensing was introduced for large HMOs 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 (Agarwal & Brunt, 2006; Department of Communities and Local Government, 2008, 2010).

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. The regulation of HMOs thus focuses on ensuring the physical safety of occupants through adequate standards of building quality, safety provision and management suitability.

Licence conditions can be varied to suit the requirements of a particular location or building. This allows local authorities the flexibility to add licence conditions which reflect the context in which the HMO is located and the tenants it houses. The Department of Communities and Local Government (2007, p. 13) states 'The council may also specify conditions such as those relating to the facilities in the HMO, its condition and the management of the building, including how the licence holder deals with the behaviour of occupiers'. Although the licences of individual properties were not read during the research, conversations about particular licensed properties included in the research revealed that some had been asked by the local authority to install CCTV in public areas as a means of managing tenants' behaviour as part of their licence conditions. In the local authority in which the study was carried out, inspections of all licensed HMOs took place every 12 months but where the properties were considered to house tenants at high risk of causing antisocial behaviour, they were inspected bimonthly (this is the policy of the local authority and not a statutory requirement). If a sufficiently serious risk is identified, legal action can be taken against a landlord to ensure that potential hazards are addressed.

The person applying for the licence for an HMO, usually the landlord, must be deemed a 'fit and proper' person who should not have relevant convictions or have acted in a way that would make them unsuitable to manage the property (Housing Act, 2004). Any previous

history of poorly managing HMOs would be considered although the extent to which checks are actually made in practice is uncertain.

The licensing process of HMOs illustrates that although the central concern of HMO management is in the standard of the property through local authority enforcement of the Housing Act 2004 and the Management of Houses in Multiple Occupation Regulations 2006, there is some provision to ask landlords of licensed HMOs to take steps to manage tenant behaviour so that the impact of the property in the community is minimised. There is also legislative provision for residents to complain about antisocial behaviour to the landlord of the perpetrator. The licence conditions for HMOs and guidance for tenants experiencing antisocial behaviour thus emphasise the role of the landlord. The use of licences and the onus on the landlord to control disorder in HMOs is thus a good exemplar of government delegation of the management of disorder noted by Valverde (2003).

Despite a plethora of legislation and regulations to maintain HMO standards, enforcement may be problematic. 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 & Rhodes, 2008). In a review of legislative approaches to controlling housing conditions, it was reported 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 (Burridge & Ormandy, 2007). Informal action rather than legislation often remains the main means of securing housing improvements.

Research design

Semi-structured in-depth interviews were carried out with landlords/managers and tenants of HMOs about their experiences of living in and managing a HMO as well as the landlords/tenant relationship. The interviews with landlords asked about the history of property ownership, the selection of tenants and their relationship with them and the challenges of management particularly of tenants with mental health or substance misuse problems. The interviews with tenants took a more narrative approach in order to chart their housing career in the context of their life history. They were also asked about the experiences and challenges of living in a HMO. This study focuses upon the experiences of HMO management from the perspective of both landlords and tenants and the relationship between them. The research was reviewed and given ethical approval by the local university.

The landlord sample was achieved by writing to all licensed HMO landlords in the most deprived ward of the town who were registered with the local council. Sampling of tenants was primarily guided by the need to include HMO tenants who were vulnerable in terms of their background (e.g., from a care home or abusive childhood), recent history (e.g., recently released from prison) or mental health (e.g., in receipt of secondary mental health care or substance misuse treatment). Voluntary agencies working with vulnerable people in the town (e.g., a local housing charity and a food bank) were asked to approach potential participants, and if willing, their details were passed on to the research team. In addition, we aimed to interview at least some landlords and tenants linked to the same HMO to include as case studies. Seven participants were approached by their landlord or managing agent to see if they wished to take part. Three sets of landlord/tenant interviews were identified as case studies in that they included interviews with both the landlord/manager and some

of their tenants. All the case studies were licensed HMOs and subject to inspections by the local authority at least every twelve months. In two cases, the tenants were approached by the landlord, but in the third case, the fact that both landlord agent and tenants from the same property were interviewed was coincidental (the landlord responded to a written invitation to participate, the tenants were recruited at a local food bank).

All of the interviews with tenants took place in neutral settings with which the participant was familiar (e.g., a community centre). Landlords were interviewed in their office, a community centre or the council offices and one was by phone. All interviews with tenants and landlords were tape recorded and transcribed. Seven landlords/managers (including one caretaker) and twenty tenants were interviewed between November 2010 and August 2011. The landlord sample included two resident landlords, a caretaker and manager of a HMO with an absentee landlord, the manager of HMOs that were owned and/or managed by a social enterprise organisation and two absentee landlords. In total, twenty tenants were interviewed, eighteen of whom were current HMO residents and two who had moved out of HMO accommodation within the last six months. There were sixteen men and four women and the age range was 19–82 (four ≤ 30, eleven aged 31–49 years and five aged 50+). All but one was unemployed and in receipt of state welfare benefits and seven had spent time in prison. Seven were in receipt of secondary mental health care at the time of the interview, and 14 reported mental health issues often related to drug and/or alcohol use. On the basis of these criteria, we therefore adjudged them to be a vulnerable group.

Data analysis

The data presented in this study have emerged from thematic analysis of interview data that focused on living in and managing a HMO. The transcripts were entered onto MaxQDA (a software package to assist analysis of qualitative data). The relevant data were coded and initially analysed by two of the authors using standard thematic analysis. Having independently identified key themes in the data for both the landlords/managers and tenants separately, we reviewed and discussed the themes at length with a focus on identifying commonalities and differences across the data set within the context of the diversity of HMOs and comparing landlord/manager and tenant perspectives. The case study HMOs provided the richest data for exploring landlord/manager–tenant relationships and the results focus upon these interviews, which include four landlord/managers and thirteen tenants.

Results

Case study A

Case study A is based on an interview with a private landlord (L1) who lives in his HMO property and three of the tenants (T18, 20 and 23). All the tenants were initially approached by the landlord to take part in the study. Brief details of each participant are in Table 1.

The landlord (L1) bought the property twenty years previously intending to make a profit through a quick sale as it was a time of escalating house prices in the area but found himself in negative equity as prices declined. His motivation for letting rooms is clearly financial but he classifies himself as, 'one of the better landlords', committed to providing tenants with a reasonable standard of accommodation. Central to his management strategy

Table 1. Participants in case study A.

L1: male resident landlord	Been a landlord for over 20 years. Rents for financial reasons and notes 'I've ended up stuck there'
T18: male tenant aged 82	From the local area. Lived with relatives and when they died moved to the current HMO where he has been living for 28 years noting that 'Being here got everything I want'. Has a pension
T20: male aged 70	Moved into HMO after separating from his wife. Depressed when first moved to HMO but is now accustomed to it having lived there for 18 years
T23: male aged 30	From the local area. Lived in current HMO for 2 years. He is working as chooses to live in a HMO as the rent is cheap and affordable on a low wage

are the selection of what he calls 'better tenants' and processes for ensuring quick eviction of those who do not live up to this standard. He prefers to advertise vacant rooms through word of mouth and selects those who he believes are most likely to pay the rent. He avoids those who are on out-of-work benefits, saying, 'If someone knocks on the door saying they are claiming then I'm not interested, they don't get in my building'. He also selects tenants according to their appearance and demeanour:

> Generally people that have tattoos across their fingers, anyone with tattoos, yep, they are not allowed in my building. Erm … Anyone who looks generally scruffy. (L1)

He claims to operate using his own rules and reports an ongoing conflictive relationship with the local council due to their enforcement of government regulations. He is dismissive of written contracts with tenants (although it is a legal requirement) and does not take a deposit in order to avoid the associated bureaucracy when the tenancy comes to an end:

> I don't take deposits because that means I don't have to get involved in this rent deposit scheme, it's aggravation and my experience is that deposits are a bit meaningless … Erm I just find it's an argumentative point it's just not worth the aggravation … And if they are a nuisance tenant and I want them out they then flit away easier without aggravation. (L1)

He aims to have a relatively stable tenant population, and two of the tenants interviewed had lived there for over eighteen years. He deliberately keeps rents 'below the market rent' so that those on a low wage or pension can afford to live there and uses this as an example of being a 'good landlord'. Whilst he takes pride in his perception that he is running the HMO well, he feels little if any responsibility to support vulnerable tenants commenting 'I'm not a warden as such I just rent to them'.

His response to challenging behaviour from the tenants is in his own words, 'harsh', a management style which he reports contributes to a lack of problems in the HMO, with few complaints from neighbours or recourse to police intervention. He gave many examples of his 'harsh' response to a number of 'nuisance' tenants including throwing a sound system out of a window and physically throwing tenants out of the HMO. He perceived that such behaviour had 'done me good because it's built me a reputation' and he told stories about how he cultivated this reputation in order to intimidate any tenants that are 'giving me nuisance'.

The tenants who were interviewed (all of whom had been recruited by the landlord) corroborated the picture of management that the landlord provided. T18, a man in his 80s, felt protected by the landlord's aggressive behaviour towards tenants who behaved badly saying that the landlord 'threw out … a young fella [who] broke into my room [and] took a lot of my stuff'. T20 described him as 'a good landlord' and all tenants reported that the landlord attended promptly to repair faults and never entered the room without permission.

All of the tenants confirmed the landlord's description of tenant selection and felt that this resulted in less antisocial behaviour with tenants generally living in close proximity fairly amicably. There were examples of tenants borrowing small items from each other, offering to run occasional errands and feeling sufficiently secure to leave room doors open when going to the bathroom. In comparison with other HMOs he had lived in, T23 (a 30-year-old working man had lived in at least four different HMOs over a six-year period) described the HMO as:

> a lot quieter than most … erm … other bed-sits. I mean, it's not one of these bed-sits where you get … plenty of the drug users and the drugs, you haven't got any of them here … The landlord's very picky in what he has in and stuff, so … that's good …

The tenants reported that there were many cameras in the property and that this added to their sense of security. Even though the cameras were not requested under the property licence terms, it is legal for the landlord to use CCTV in public areas both inside and outside the house provided it is for security purposes (Information Commissioners Office, n.d. accessed 8 June 2015). As T23 explained, 'there's cameras everywhere. As you walk out of a room, if you just look up on your left, there's a camera there, there's a camera on every level … So it's well secured … the cameras are there for everyone's safety really'. None of the tenants reported that they felt the cameras invaded their privacy.

Case study B

Case study B is a HMO that is run as a social enterprise providing a range of HMO accommodation for homeless people. Details of the participants are set out in the Table 2. None of the tenants were recruited via the landlord/manager but they were part of the community sample, and thus, it was only *post hoc* that this was designated a case study.

Case study B is run by a charity motivated by philanthropic rather than financial considerations. Many referrals come from a night shelter or direct from prison and the manager acknowledges that the tenants include 'very risky, very vulnerable, very dangerous clients' whose behaviour can be challenging.

The manager (L3) describes the organisation as being 'an ethical landlord' with a 'moral obligation' to offer 'people that have got very complex needs … a platform to change'. Tenants are provided with all basic equipment for their room and those who want it are in addition offered support such as counselling, assistance with benefit claims or gym membership.

Table 2. Participants in case study B.

L3: male manager	Describes the organisation as an 'ethical landlord'. Not motivated by money but by supporting vulnerable clients
T3: male tenant aged 47	From the local area. Lived in HMOs for 18 years. Has been in receipt of secondary mental health care
T5: male tenant aged 42	Moved to area to be nearer to his children. Lost his social housing when in prison. Has history of drugs and prison and has been in receipt of secondary mental health care
T12: male tenant aged 41	Has lived in many areas and experienced many periods of homelessness since separating form partner. Claims to have 'no roots anywhere' and is keen to leave area and find work
T13: male tenant aged 27	Raised in the county. Homeless after separating from partner and directed to HMO. Keen to find work and move on but struggling to do so, saying he is 'sort of stuck here at the moment where I am'
T14: male tenant aged 22	Formerly in foster care. Came to HMO when discharged from prison. Has relatives locally but doesn't feel he belongs in town or the HMO but can't find a way out
T15: male tenant aged 31	Raised and lived in London. Struggled since losing work 2 years previously and ended up in the area. Desperate to move on

The organisation thus has as overt mission to reintegrate needy tenants and 'teach them responsibility' by providing a base from which they can try to find work and eventually self-contained accommodation. However, the views of the tenants who were interviewed rarely alluded to the support functions of the HMO outlined by the manager. Rather, they focused on negative aspects of the accommodation, complaining about the lack of private facilities (T3, T5, T12). All tenant participants found that sharing accommodation with people whose behaviour may occasionally be challenging (e.g., alcohol-related violence) was problematic. There were complaints from T14 and T15 about the cleanliness and noise of communal areas. T12 described the HMO as, 'basically a hell hole really. It's … it's where they just dump anybody who's got some kind of addiction'. T15 described how problematic he found the other tenants commenting that 'there's no normal people around here'. All participants stated their eagerness to move elsewhere but recognised that their choices were constrained.

The manager described a complex system of governance and surveillance, which he justified by the need to 'set boundaries' (L3) to assist the client's journey towards reintegration. For example, the organisation carries out a risk assessment on all their clients in order to 'know the risks to the charity and the individual' (L3), reportedly to link them to the most appropriate support agency and allocate them to the most appropriate HMO. All of the HMOs run by this landlord have rules which vary in accordance with the risk profile of tenants. These include regulations about who may visit the tenant (e.g., no visitors under 18) and there is a zero-tolerance policy relating to the consumption of alcohol or illegal drugs.

In order to enforce the rules, there is a team who patrol the properties and those housing the tenants with the most risky behaviour have CCTV which the manager acknowledged was 'a little bit "Big Brother"'. Unlike case study A, the installation and proper functioning of CCTV cameras in public areas inside the property as well as at the front were a condition of the HMO licence. The fact that the accommodation is 'all camera-ed up' (T3) was noted by tenants and all spoke about the constraints imposed by 'loads of rules [which] you don't necessarily agree with' (T3). As one tenant noted:

T12:	There's enough cameras there, yeah. But the cameras aren't there to deter people from breaking in, the cameras are there so they can nosey on everything that's going on.
Interviewer:	So it doesn't necessarily feel that they're for security, it feels more they're prying?
T12:	Oh yeah. Yeah, definitely. They watch everything you do.

The manager (L3) felt CCTV and other surveillance measures were necessary for safety reasons given the risk profiles of the tenants:

> So what I would say to someone is they say why can't I have visitors in this house and why is it on CCTV I say that because at a time in your life where you need more intense support to make sure that you are safe.

Despite close monitoring of tenant behaviour, the organisation tries hard not to evict tenants as it contravenes their mission to be supportive. As L3 said, 'we have put people on notice but we don't evict them it's a kind of a wakeup call'.

Case study C

Case study C is owned by a private absentee landlord who owns a number of HMOs. The HMO is run by a manager (L6) and a resident caretaker (L5). Four of the tenants (T7, T8,

Table 3. Participants in case study C.

L5: male caretaker	Resident in the property
L6: male manager	Non-resident. Manages a number of properties in the town
T7: male tenant aged 38	Has lived in many areas describing himself as 'a traveller'. Has long-standing mental health issues. Lots of experience of living in HMOs. Feels supported in the current property and that he has 'landed on my feet'
T8: male tenant aged 40	Moved to the area with partner and children but lost partner and house was repossessed when he went to prison. Has long-standing mental health issues. Speaks highly of the support from manager/caretaker and feels that 'they do care'
T9: female tenant aged 44	Moved to area with parents as a child. Has a learning disability and described the bedsits as 'depressing'. Feels trapped in bedsits having lived in them for twenty years
T10: male tenant aged 56	Moved to area with girlfriend. Has long-standing mental health issues and is also disabled. Has been in prison. Feels supported in current HMOs

T9, T10) were also interviewed all of whom were suggested by the manager or caretaker. Details of the participants are set out in Table 3.

The motivation for the landlord in case study C is clearly financial but the ethos of its governance is upon efficient management and surveillance through a combination of control and care of tenants. The manager (L6) sees himself as the intermediary between landlord and tenant saying, 'I mean, from an agent's point of view, although we work for the landlord, we're kind of on the tenants' side'. This is reaffirmed by the caretaker (L5) who notes that he acts as 'the primary liaison between the police and other emergency services and this place'. The caretaker is physically big and according to the manager, 'He's well-trained in terms of protection, defence, etc., you know, he's ideal for this role. So he does maintain a much better level of control of this building'. (L6)

The tenants who were interviewed were all 'vulnerable' in terms of their mental and/or physical health, largely conforming to the caretaker's description:

> If I was asked to characterise the type of person we get in this establishment, it's the vulnerable the very vulnerable, on Job Seekers, can't get a job or don't want a job, heavy drinkers, drug users, previous criminal conviction … I would say, without a doubt, that we have a good 40% here that have depression problems … 85/90% of our client base are … what you would consider to be of a vulnerable nature (L5).

Prior to being offered accommodation, tenants undergo an extensive character assessment. The manager justifies this vetting on the grounds that it gives information to provide appropriate support:

> The more information we know about someone, the better we are to … put them in the right spot within the building … And it certainly allows us to be more supportive of certain tenants. (L6)

Along with careful selection of prospective tenants, there is also surveillance of their behaviour through CCTV (which is requested as a condition of the property's HMO licence) and from the resident caretaker who notes most tenants are 'easy to control' (L5), saying they 'don't piss around, because they know that I'm going to storm out of my flat, come up, bang on their door' (L5). The rationale for this control was linked to the provision of care and support and both the manager and the caretaker spoke of their desire to be supportive to vulnerable tenants. The caretaker described in some detail the support for tenants which he said had evolved but 'was certainly not on my Job Description' (L5). Likewise, the manager noted that '… we're both happy to help out [tenants], provided it's appreciated and warranted' (L6). They both reported how they had kept a room open for a tenant whilst he

was in hospital although the manager acknowledged that this also had financial benefits as they continued to receive the tenant's Housing Benefit.

The level of surveillance, control and support was described by the tenants as an aid to their security and well-being. For example, T7, who has a long-standing mental health problem and has also experienced being abused by other residents in a former HMO, highlighted the sense of security he gets from the CCTV and the value he gets from the manager and caretaker's support, saying: 'O Colin [pseudonym of caretaker] is a star … He's the best guy we've got 'cause he lives here as well so we're safe … I've got the support here'.

Other tenants, notably T8 and T10, both of whom also had a long history of mental health problems, also spoke positively about the care provided by the manager and caretaker. T8 described how they kept a caring eye on him:

> They do care yeah, … it's nice when I first came here it felt like nobody cared but now yeah people do care and erm … I've sat down with Col a couple of times and explained my history and erm and he does understand he he is one in a million, he is a top chap and he he doesn't put you in categories just 'cause you've been in prison. (T8)

This was echoed by T10, described by the caretaker as 'an ideal tenant', who said that they would knock everyday when he was not well to see if he needed anything, kept his place open when he was in hospital and also moved him into a room with en suite facilities which took account of his disability. He described the HMO as, 'more like of a community type thing, yeah?' (T10). T9 was less effusive about the support she received but compared the HMO favourably to previous HMOs she had lived in noting, 'I got lucky with this place'. (T9)

Discussion

This study is based on three very different case studies of HMOs in a deprived coastal area and is therefore not representative of the HMO sector as a whole and results cannot be generalised. The method of selection of landlords and case study properties will in all likelihood have excluded the worst landlords. Another important qualifier is the extent to which comparison between the case studies is meaningful due to bias associated with the different methods of selecting tenant participants (via landlord/landlord agent in case studies A and C and incidental in case study B). However, this small study nevertheless clearly highlights the high level of surveillance exercised by some HMO landlords and the complex relationship between control and care in the management of vulnerable tenants.

Governance through control and care

It is clear from our results that control was used by landlords to manage potentially problematic tenants. Such control was evident prior to commencement of tenancy through careful selection of tenants supporting the findings of Allen and McDowell (1989). This process was described in detail by L1 (case study A) who excluded tenants who were in receipt of Housing Benefit and priced the accommodation as cheaper than average so that those on low incomes (e.g., a pension or working for a minimum wage) could afford to live there. Conversely, the rooms in the HMO of another landlord interviewed (L7 whose property was not one of the case studies) were priced higher than average but included all bills and broadband as he purposefully tried to be 'slightly up-market' in order to attract dependable working tenants. Pre-screening of tenants also occurred in case studies B and

C both of which actively catered for vulnerable tenants. Both conducted a formal assessment of potential tenants, reportedly for the purpose of offering them the most appropriate accommodation and support, although for case study C, it was also used to try and screen out those most likely to exhibit antisocial behaviour.

All the case study HMOs made extensive use of CCTV to monitor tenants' behaviour. For the properties in case studies B and C, CCTV installation was a condition of their HMO licence whilst the landlord in case study A chose to do this. In addition, having a resident landlord, manager or caretaker also provided a level of surveillance and all the HMOs had rules to moderate the behaviour of tenants and their visitors. This included rules about who could enter the property, how much time visitors could spend there and prohibiting the use of alcohol or illegal drugs.

Despite the high level of surveillance and control, the case studies reveal how the governance function can also be caring. Case study C is an exemplar of the interdependence of care and control. Although this HMO is run as a business venture to make money, both the caretaker and the manager report being overtly supportive to vulnerable tenants and this is recognised and valued by the tenants who were interviewed. In addition, there is surveillance at many levels to prevent and contain antisocial behaviour. Key to this arrangement is the selection of tenants who the managing agents feel can be managed and supported even though many have complex and long-standing problems.

Each of the case study HMOs exhibited a wide range of surveillance measures to control tenants, but this was often combined with and defined by both landlord and tenant as 'care'. The line between control and care was not clear-cut, and there were examples of vulnerable and the most powerless tenants being more easily controlled by establishing a caring relationship. One tenant, in case study C, was described as 'ideal' because he was malleable and dependent on the caretaker's support. Ironically, the tenants in case study B, which has a mission to provide support and housing solutions for vulnerable tenants, were least likely to perceive surveillance as caring rather than controlling. This difference perhaps reflects the different recruitment method of tenants in case study B compared to the other two cases.

'Rogue' landlords and problematic tenants

Too much surveillance and monitoring by landlords has been described as intrusive and disempowering (Lister, 2006) but it was not generally perceived as such by tenants in our case studies. The widespread use of CCTV provoked diverse responses. In case studies A and C, the tenants reported that this enhanced their sense of security rather than feeling it invaded their privacy. However, three of the tenants in case study B were resentful of it and found it intrusive. This highlights the tension of balancing individual privacy against the security of others (Macnish, 2011). Some tenants clearly prioritise security over privacy and value surveillance by the landlord as a means to moderate antisocial behaviour of other tenants.

This is well illustrated by case study A as the landlord has many systems in place for monitoring tenants' behaviour (being resident himself, CCTV throughout the building and assertive treatment of troublesome tenants). As a result, there is little antisocial behaviour in this property and the tenants report feeling relatively safe and content. It is interesting that the landlord clearly stated that he feels no responsibility for providing support to vulnerable tenants and some of the behaviours he reported could be considered illegal. He thus has many of the characteristics of a stereotypical 'rogue landlord', and yet, this was not how his

tenants described him. Admittedly, the role of the landlord in interviewee selection will have influenced the tenants chosen for interview. Furthermore, the worst landlords in the sector are unlikely to have volunteered to take part in our study.

In contrast, case study B has a central mission to be supportive to tenants and exercises governance primarily to ensure tenant safety and to enhance the provision of care. It aims to be a good landlord, yet none of the tenants interviewed felt that the environment was supportive. This was largely related to the behaviour of other tenants and their own wretchedness about having no option but to live there. It should also be noted that the more critical comments of these tenants may be related to method of their recruitment which was through a community agency and unlike the other cases, not via the landlord or landlord's agent. Nevertheless, our case studies suggest a mismatch between tenant perception and popular characterisations of rogue and good landlords. The fact that many of the tenants interviewed felt protected by the surveillance measures suggests that they subscribed to the notions of self-discipline and tenant responsibility noted by Flint (2006) and, in the main, supported the landlords' standard of acceptable tenant behaviour. For many HMO tenants, a good landlord is one who contains antisocial behaviour within the HMO.

There is clearly variation in the appetite that HMO landlords have for assuming responsibility for managing (controlling and/or caring for) 'problematic populations'. The landlord/managing agents in our three case studies were more active than the other landlords we interviewed who adopted a more laissez-faire approach leaving the police and the local council to assert control if the behaviour of tenants became unacceptable to other tenants or residents in neighbouring properties.

What is clear, however, is that as Hunter & Nixon (2001) point out in relation to social landlords, few HMO landlords will have the appropriate specialist training, skills or resources to manage their properties efficiently or to support vulnerable tenants. As a result, the obligations to accommodate risks and resolve problematic behaviour are often left with the tenants themselves. HMO tenants rarely have the resources to assume responsibility for problematic behaviour of others as they are often struggling to control their own lives. They thus find themselves in a housing situation which may expose them to a range of antisocial behaviour, yet they have neither the skills nor emotional or practical resources to influence it. The governance of the property is therefore particularly important.

Conclusions and practical implications

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 January 2012, there was an increase in the age at which a person is entitled to the full one-bedroom local housing allowance rate, from 25 to 35 years meaning that Housing Benefit will no longer cover the cost of self-contained accommodation for this age group. It is estimated that this will have affected 88 000 people (McCann, 2011). More stringent caps on Housing Benefit are also likely to displace low-income people from areas such as London with very high rents to low-cost HMOs in coastal areas (Smith, 2012). The governance of such properties is likely to become more challenging as occupancy and demand increases.

Our study suggests that the governance of the three case study HMOs in many ways mirrors the management of 'problematic populations' in social housing described by Flint (2004) and Atkinson (2006). In a rather haphazard and often informal way, all three HMOs in this deprived area in a coastal town served to manage and discipline marginalised tenants according to normative expectations of wider society (Brown, 2004).

Current attempts to improve the standard of HMO management tend to concentrate on the mechanism of licensing but our study suggests that licensed landlords act with a lot of autonomy. Regular property inspections by the local authority are an important way of ensuring property standards but they are unlikely to reveal how a landlord treats his tenants or how effective the landlord is at managing antisocial behaviour in his property. What appears important to tenants and local communities is the ability of landlords to control tenants' behaviour within and around the HMO. Our small-scale study suggests that the provision of appropriate care can form an important part of this management strategy. Care and control may be codependent and both are often welcomed by vulnerable tenants. Whilst landlords are not 'carers', some of the challenges they face in tenant management may be more effectively tackled through a caring lens. Landlords could be better supported to provide assistance to tenants by the local authority, particularly with regard to issues of tenant behaviour and signposting tenants to local services and organisations.

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