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Working Together to Address Multiple Exclusion Homelessness

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This article draws on preliminary findings from a two-year exploratory study to describe how different agencies and professionals work together to identify and manage the intersections between homelessness and other facets of deep social exclusion. We assess the extent to which current practice is informed by policy frameworks for 'personalised and integrated care planning' focusing in particular on the 'coordinating' and 'sign-posting' role of the housing support worker. We conclude with some initial thoughts as to how policy and practice might be strengthened in this area to ensure more 'joined-up' and continuous support for people with experience of multiple exclusion homelessness.

Introduction

The concept of multiple exclusion homelessness alerts us to the potential for complex interplay between many different professional or occupational groups. There is evidence that experience of drug or alcohol dependencies, severe mental health problems, domestic violence, local authority care and prison and participation in 'street culture' and 'survival activities', such as sex work, begging, street drinking and street-level drug dealing frequently (but not always) intersect with homelessness (Fitzpatrick *et al.*, 2010). There are questions as to how support might best be organised across these professional boundaries and the need to identify more concretely the advantages and disadvantages of spending time working collaboratively. According to Ehrlich *et al*. (2009) a more pressing problem is that a common understanding of coordinated care is often assumed when in reality the concept is neither clearly defined nor completely understood.

In England and Wales, the statutory framework that underpins interagency and interprofessional working for adults is outlined in Section 47 of the NHS and Community Care Act 1990. Under this Section, if during an assessment it appears that the person may have health or housing needs, the local authority must invite the NHS or housing authority to participate in the assessment. There is, however, no statutory obligation on

the NHS or the housing authority to cooperate (Mandelstam, 2005). The early guidance which accompanied the 1990 Act introduced to the United Kingdom (UK) the concept of 'Assessment and Care Management' (Social Services Inspectorate/Scottish Office Social Work Services Group, 1991a and 1991b). The central task of the care management process is to coordinate a holistic assessment of need (a community care assessment) which draws together findings from a range of specialist assessments. Thereafter the task becomes one of coordinating the different professional inputs and services into an overarching (integrated) care plan; delivering a 'seamless service' in which the boundaries between primary health care, secondary health care, housing and social care are invisible to service users and carers (DH, 1990, s.1:8/1:9).

In the community care guidance, assessment and care management are envisaged as worthwhile services in their own right. This was established in a legal challenge relating to a fifty-two-year old woman who was suffering from anxiety and depression. She was unintentionally homeless, but had rejected an offer of accommodation under the Housing Act 1996, and sought an assessment for provision of accommodation from social services. Social services refused to assess her, partly on the basis that it would be futile and a poor use of resources to do so where there was no hope of meeting the need. The Court rejected this, stating that resources were irrelevant to the statutory duty to assess and that in any case assessment served a useful purpose even if services did not follow (*R* v *Bristol CC, ex parte Penfold,* reported in Mandelstam, 2010).

Successive guidance issued by the Department of Health has served to reinforce the 'practice principles' associated with assessment and care management. However, Hudson (2010) alerts us to a shift toward adult social care increasingly being seen as the 'handmaiden' of the NHS with a consequent loss of a distinct perspective. The latest guidance on care management opts for the term 'personalised and integrated care planning' (DH, 2009a). This is seen as a 'professionally led' process targeted at managing long-term conditions in the community. Long-term conditions are to be understood as 'non-disease specific' and as relating to people who have an intricate mix of health and social care difficulties and who may be vulnerable, which means that simple problems can make their condition deteriorate rapidly, putting them at risk of hospital admissions or long-term institutionalisation (DH, 2005).

At the heart of personalised and integrated care planning is the 'Common Assessment Framework' (CAF) (DH, 2006). More usually associated with children and families, it is proposed that CAF should become a generic approach to assessing the health, social care and wider support needs of individual adults (DH, 2009a). From a commissioning perspective, CAF is intended to ensure that in any given geographical locality there is shared understanding and agreement among different agencies and professionals around procedures for information sharing and coordination. Indeed, the only significant difference between this and the earlier community care guidance is that it erodes the lead role of the local authority social worker as the 'care manager'. It is now acknowledged that the 'lead worker' might be a single person or possibly a multi-disciplinary team of professionals who convene to coordinate the individual's care and support needs (DH, 2009b).

In the policy guidance, the expectation is that everyone with a long-term condition and social care needs will have an integrated and personalised care (support) plan if they so wish (DH, 2006). With the advent of 'personalisation' (HM Government, 2007), emphasis is shifting away from professionally dominated approaches towards

'self-assessment', 'co-production' and 'self-directed support', which will require much more concerted effort to work in partnership with service users and carers. The guidance is clear that vulnerable groups such as 'homeless people' should not be excluded from these processes as integrated care and support planning are key mechanisms whereby the multiple health and social care needs of 'adults with chaotic lives' can be planned, coordinated and delivered (DH, 2006).

In this article, we begin by exploring how these policy frameworks are working to support people with experience of multiple exclusion homelessness. We outline current practice approaches with particular regard to the role of the housing support worker, and discuss some of the problems that can arise at the boundaries between services and different professional territories. Finally, we explore what might be done at a strategic level to promote 'joint working' over the longer term to ensure more continuous support for people with experience of multiple exclusion homelessness.

Methodology

The study on which this article draws was carried out as part of the Economic and Social Research Council's Multiple Exclusion Homelessness Research Programme. It commenced in July 2009 and was due for completion in June 2011. The study comprised a fieldwork phase and a practice development phase. The fieldwork (now completed) involved three different localities across England. The fieldwork sites were selected purposefully on the basis of applications put forward to Homeless Link (the coordinating body for the Multiple Exclusion Homelessness (MEH) Research Programme). The three organisations which hosted the fieldwork were: a housing support and homeless prevention service for offenders (serving a geographically remote and sparsely populated rural area), a rent deposit (bond guarantee) scheme (based in a metropolitan town) and a non-direct access hostel (based in inner-London).

In each fieldwork site, the researcher 'tracked' a minimum of ten cases over a six-month period. This included five referrals made to each of the partner agencies (closest to the date of the researcher's arrival on site) and a further five cases where the person was about to 'exit' the service or 'move on' or where the 'key worker' felt that a case might be particularly illustrative of the challenges of interagency and interprofessional working. Tracking involved participant observation in the workplace, shadowing workers, study of case files, reflective interviews with the 'key worker' and interviews with 'experts by experience' (people with first hand experience of multiple exclusion homelessness) shortly after their referral to the agency and then again six months later. First interviews were carried out with thirty-two people and six months later we were able to contact and carry out a second follow-up interview with nineteen people.

In addition to tracking participants' journeys through the system, we undertook interviews ($n = 15$) and focus groups ($n = 15$) with different groups of professionals, including social workers and mental health professionals, drug and alcohol workers, local authority housing staff and criminal justice staff. We also undertook interviews with service managers and commissioners ($n = 15$). Rather than discussing individual cases known to workers, interviews and focus groups employed a case study 'vignette' to generate discussion around the different practice approaches to working with people with experience of multiple exclusion homelessness

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The second stage of the study (currently on-going) includes an action research or development phase. Throughout the life of project, the three host projects have met together regularly as a 'learning set', visiting each others projects, acting as advisors to the researchers, discussing the emerging findings and exploring how the findings can be best developed for practice, including piloting innovations within their own services (for example, one project is looking at the value of developing 'interprofessional supervision'). The overall methodological and analytical approach is grounded in the traditions of realistic evaluation (Pawson and Tilly, 1997) and can be summed up as follows:

> [Exploratory research means] unpicking and unpacking things that are commonly accepted to encourage new viewpoints, perspectives, ideas and actions to emerge. Through this process we aim to generate new insights which offer opportunities to not only advance understanding of the nature of phenomena, but can provide the ability to comprehend old and sometimes entrenched challenges with a fresh set of eyes. (Reeves, 2010)

We would stress that the findings presented in this article are preliminary. An earlier version of this article was presented to the 'learning set' as a means of generating ideas for the development phase. The 'learning set' concluded that the findings strongly resonated with their own practice experiences and throughout the article we draw on other research findings to either support or challenge this emergent perspective.

Collaboration on the ground

In this section, we begin with a description of how different agencies and professionals currently work together to support people with experience of multiple exclusion homelessness. Across all three sites, 'tracking' commenced from the point of referral to the housing support provider and it is from this point that we begin our description of practice.

When the housing support provider receives the referral, the person is first assessed in terms of their need for support with practical aspects linked to successfully managing a tenancy (e.g. securing benefits and paying bills) and whether or not they will need a referral for any *specialist* help with matters such as drugs, alcohol and their own mental health. Once referrals to other agencies have been made, each agency develops its own 'holistic' support plan, which is rarely shared with other agencies. Each agency sees itself as at the centre and invests some effort in coordinating activities. However, once the person leaves a particular service this support plan effectively becomes null and void, with the consequence that there is little continuity and on-going support. Each time the person presents to the service, he or she is treated as a 'new referral'. Practitioners often have only very limited access to the person's history as documented by other agencies and professionals. Overall, practice is best described as multi-professional rather than interprofessional in that agencies and professionals are mostly working in parallel (Soubhi *et al*., 2010). As this worker described:

> Everyone has got little snippets of an individual but no one is collating it. (Housing Support Worker)

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Case study

One participant left the hostel to set up a new life with his wife and children down south. His children were living with his wife's mother. On moving down south, the planned hostel accommodation fell through, which meant he and his wife had to live in a tent for five weeks 'battered by Atlantic winds'. His wife was on probation, which ensured some degree of continuity, meaning that she was able to access her methadone while he was unable to access a prescription for his. Living this way got too much, so he and his wife took the decision to return to London. On their return, the tenancy at the hostel had been rescinded and he was told 'to go to the day centre which had dumped me months and months before and they would redo me' [in terms of putting in a referral to the hostel as there is no self-referral]. He had to sleep on his mate's floor before being reaccepted. This took two days and then they were in 'straight away'. When he got back into the hostel, they gave him a different key worker to the one he had had previously: 'It was a bloke and I said I am not seeing anybody until I get my [other] key worker back . . . She has been with me all those months and you just stick with the person you know. She likes me and I like her and I won't see anyone else apart from her.'

During the fieldwork we found one example of personalised and integrated care planning, which lived up to the expectations of the policy guidance described earlier. It related to a woman with alcohol problems. She was very well known in the locality among different agencies and professionals and had been 'sofa surfing' (staying with friends having no place of her own) for most of her adult life. She had a son aged fifteen years who had until recently lived with his father and older brother. When her former partner died and her oldest son was sent to prison, her younger son was potentially living on his own. A multi-agency team led by a social worker from social services (Children and Families Services) was already involved in supporting her younger son. On hearing what had happened, the social worker sought special permission from a local housing association for the woman to temporarily take over her former partner's tenancy. A new support plan was put in place with the overall aim of providing very intensive support so that woman could 'learn to be a mother' to prevent her son being taken into the care of the local authority. This team included a wide range of professionals: the Youth Offending Service's drug worker, a young person's counsellor from a local voluntary organisation and the Family Support Service, which was to be the mainstay of day-to-day support for the family. A housing support worker was also recruited to the team to support the woman in managing her tenancy. Regular meetings were held at least monthly. Although each agency undertook its own assessment and care plan, the social worker produced an overview plan integrating the different elements. The detail of the care plan was fine-grained and encouraged flexibility and 'moving across' professional roles. So, for example, when the Family Support worker was on leave, the housing support worker agreed to visit and provide support on those days when she was away. This approach was underpinned by much goodwill whereby the different partners were willing to stretch their own organisational boundaries and rules, for example all getting together to decorate the boy's bedroom.

In services for children and families, there has been a much greater political imperative to implement the Common Assessment Framework (CAF) following a number of child deaths where a lack of joined-up working was implicated (Children's Workforce Development Council, 2009). However, in relation to adult services, the Department of

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Health acknowledges that the cultural change needed to embed good practice locally has not benefited from the senior management support and leadership and that as a consequence, personalised and integrated care planning is still not widespread and barriers persist (DH, 2009a). Across all three fieldwork sites, housing support workers and their managers found it extremely difficult to draw on the support of social workers and their employing authority. In one case where a person had a learning disability and social workers were involved, this did not lead to integrated care planning in that there was no overview plan bringing together the different aspects of support. Here, the housing support worker reported poor information sharing and described feeling forgotten when review meetings were being arranged. In terms of primary care, while many participants with homeless experiences described the important role their GP had played in sign-posting them to different services, this did not, in any of the cases we observed, lead into case managed support for a long-term condition. Accessing mental health support was reported as a very significant problem by housing support workers across all three sites, especially for people with dual diagnosis. One worker highlights what can happen to a person who is excluded from the different parts of the system simultaneously:

> There is a man who has a long-standing alcohol problem … He has suffered a head injury and fits. He also has a chronic infection in one of his legs. He is street homeless and has been ASBO'd[1] out of one (local authority). He was recently on remand for assaulting a policewoman and when he came out of prison he came into one of the hostels. The hostels felt they couldn't manage him and then very shortly after that he threatened one of the hostel staff and he was evicted, so he is back on the street. He doesn't want any help with his substance misuse, so he doesn't meet their (substance misuse services') threshold. He has a degree of physical disability, but he won't meet the threshold for ordinary residential care. He has a degree of cognitive impairment, but we are not sure how much, probably not too much so he doesn't fit the mental health criteria and he is a very difficult person in his behaviour. So if you parcel it up, he has got multiple needs but there isn't actually a service … he remains on the street. (Housing Support Worker)

So, with each agency closely guarding its own territory and without the unifying function of the CAF to open-up the possibilities of 'collaborative advantage', Rosengard *et al.* (2007) point to what they describe as the 'inverse care law' where those in greatest need can fare worst because they fall between the service cracks. This echoes the findings of a report produced by a coalition of major charities who are campaigning under the banner *Making Every Adult Matter* (Clinks *et al.*, 2009), highlighting how adult services might benefit from adopting the approaches being advocated for children and families.

However, it is important to keep in mind that exclusions ('gate keeping') rooted in ever-tightening eligibility criteria and high case loads extend across adult social care and are not restricted to people with experience of multiple exclusion homelessness. In relation to older people's services, for example, there is growing evidence to suggest that few local authorities are able to operate intensive care management schemes thereby translating into practice the interdisciplinary care management approach described in the policy frameworks we outlined above (Jacobs *et al.*, 2009).

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Professional protectionism

The process of compartmentalising needs in terms of specialist referrals for drugs, alcohol and mental health problems is a central feature of much 'joint working' in multiple exclusion homelessness. However, it is a particularly problematic way of working especially for housing support workers. While housing support workers feel that they must 'hand over' responsibility for the 'drink problem', 'the drug problem' or the 'mental health problem', because these are areas which are perceived to be outside their professional expertise, they can subsequently find themselves working in isolation to manage the 'combustion effect' or interplay between multiple and complex needs. In practice, this is often referred to as 'chaotic behaviour':

> [Researcher: so tell me about Sam's (anonymised name) support plan?] With Sam you have got the behaviour, the paranoia . . . the family dynamics or history . . . and the addiction which always seems to be the stumbling block, alcohol use and the rent [arrears] as usual . . . All the indicators, that someone is having a chaotic lifestyle . . . Last time he was here [in the hostel] he lost the bloody plot and was dressed as a vampire most of the time . . . So there was so much wrong with him really and the relationship [with his girlfriend where there were issues of domestic violence] on top of that which it made it even more confusing and even more difficult to work with. (Housing Support Worker)

What is emerging from this research is that in most cases housing support workers are providing much more than what might be described as low intensity 'housing related support'. Cameron (2010) argues that with the rise of care management, housing support workers are effectively filling the vacuum that has been left by the retreat of social workers from 'direct work' with many adults, and that the full implications of the reconfiguration of social care services have not been fully considered, particularly the impact on the wider workforce. Acknowledging that there is a mismatch between the assumed and real 'job role' of the housing support worker raises important questions about what constitutes appropriate preparation and training. Amid a climate of tight resources, where there is little time for multi-disciplinary meetings and case conferencing (making uniprofessional working sometimes inevitable), there would seem to be enormous scope for much more interprofessional training and education. Cameron (2010), for example, describes a pilot whereby some of these issues outlined above were addressed by ensuring that housing support workers were able to access 'interprofessional supervision' from agencies other than their own (e.g. a manager from a local drug agency) alongside 'managerial supervision' from their own managers. There are, however, significant cultural barriers, which often lead managers and workers to shy away from these kinds of inter-disciplinary activities for fear of treading on the toes of other professional groups.

Indeed, when 'referring on' to other agencies, there is an important question to be asked about what is the disciplinary or 'specialist expertise' that is being sought? The tracking we carried out as part of the fieldwork phase suggests that 'referring on' triggers many additional veins of assessment and care management and so-called 'sign-posting'. Furthermore, nearly all the assessment tools being used purport to provide a 'holistic', 'person-centered' approach with the consequence that there is much duplication, because they cover much of the same ground (e.g. housing, health, well-being, employment etc.). Very often, the impact of the 'professional lens' is to determine the order in which

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these different issues will appear on the assessment schedule. Best (2010) captures this when describing the findings of an audit of specialist drug treatment services in Birmingham, which set out to assess what typically occurs in treatment sessions. The majority of clients in this study were seen fortnightly and they were typically seen for forty-five minutes in each session. In an average session, typical initial tasks were case management activities, around prescription management, drug testing and results, compliance and signposting. There was then very little time available to deliver evidence-based psychosocial interventions (i.e. specialist disciplinary support):

> In other words, what is called treatment for the majority of clients on substitute prescribing is, in fact, a 'script' (prescription) and a chat. (Best, 2010)

Discussion

In this article, we have explored 'joint working' around multiple exclusion homelessness and how some people can find themselves bounced between different services or left out in the cold. The more difficult discussion lies in deciding what needs to be done to remedy this situation?

In terms of already 'on the ground' solutions, there has been a proliferation of specialist schemes specifically designed for 'homeless people'. These have sought to bridge the gaps between different services and very often try to recreate the wider system in microcosm (in-house) (Queens Nursing Institute, 2008). Evans (2007), for example, describes the benefits of integrating housing and drug treatment services under one roof and how this has worked to overcome deficiencies in mainstream provision whereby knowledge about the drugs sector by the homeless sector is limited and *vice versa*. While service evaluations often suggest that these kinds of specialist multi-disciplinary projects are highly acceptable and much sought after by 'homeless people' (Whiteford, 2008), there is considerable geographical unevenness of provision (so-called 'post code lottery') and a fine balance to be drawn between promoting access by providing specialist services and creating the conditions for further marginalisation and reinforcement of stereotypes (Daly, 2007). For people who may experience multiple exclusion homelessness, the key issue is that:

> Some people have got the lot: mental illness, addiction, homelessness . . . There are some good services but not enough have got all the elements together. (Gould, 2009)

We would argue then, that while these schemes do play an important role in meeting some (but not all) unmet needs, they should not overshadow the need for leadership and commitment at the very highest levels to ensure the implementation of the 'Common Assessment Framework' (CAF) and the opening-up of the 'whole system'. This should be seen as a means of reducing duplication (as regards reducing the number of assessments undertaken) and freeing-up resources, and something which is therefore entirely consistent with work programmes designed to produce efficiency savings. As the NHS Chief Executive Sir David Nicholson points out, many of the most significant 'productivity opportunities' depend on organisations working together in local systems of care to explore ways of sharing services, costs and reducing duplication (quoted in Ham, 2010).

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Furthermore, we would suggest that when implementing CAF, local homeless forums will need to campaign to ensure that local processes are accessible to all adults, including those with experience of multiple exclusion homelessness. While the 'Making Every Adult Matter' (Clinks *et al.*, 2009) campaign suggests that local authorities should 'define the group' (which it sees as a potentially small group of individuals who will be well known to local services), it may be more prudent to demonstrate how (some but not all) people with experience of multiple exclusion homelessness will meet the 'Fair Access to Care' eligibility criteria in regard to having needs which pose a critical or substantial risk to independence (Department of Health, 2010). Given the absorption of Supporting People funds within mainstream local authority budgets, the danger is that people with experience of multiple exclusion homelessness might be assessed out of services altogether, since few local authorities will meet needs defined as low to moderate (Mandelstam, 2010).

Our research would also seem to point to the importance of re-evaluating the job role of the housing support worker, ensuring that training and management practices reflect how the role has extended beyond the provision of low intensity support. Such a move toward 'professionalisation' would mean that housing support workers will be in a much better position to lead multi-disciplinary teams of professionals where housing and homelessness issues predominate. This is an important consideration because in opening-up personalised and integrated care planning to this previously excluded group, there is potential for increased case load pressure on other 'care managers' (social workers, community nurses, mental heath nurses, etc.).

The final challenge however, will be to secure the conceptual shift from multi-professional to interprofessional ways of working, especially as it relates to the reintegration of 'homeless people' as part of the adult (social care) population.

> Interprofessional working is not about fudging the boundaries between the professions and trying to create a generic care worker. It is instead about developing professionals who are confident in their own core skills and expertise, who are fully aware and confident in the skills of fellow health and care professionals, and who conduct their own practice in an non-hierarchical and collegiate way with other members of the working team, so as to continuously improve the [well-being of individuals and communities]. (McGrath, 1991, quoted in CAIPE, 2007)

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Note

1 Has an anti-social behaviour order which means that if he enters a borough he may be arrested.

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