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Rethinking Multiple Exclusion Homelessness:

Implications for Workforce Development and Interprofessional Practice

Summary of Findings

University of Cumbria

SOCIAL CARE WORKFORCE RESEARCH UNIT

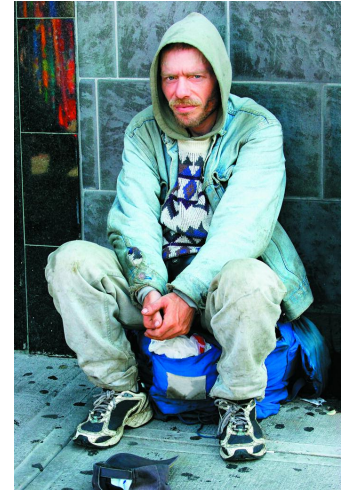KING'S College LONDON

University of London

E·S·R·C ECONOMIC & SOCIAL RESEARCH COUNCIL

complex lives

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With CASS, Look Ahead London and Calderdale Smartmove

Introduction

In February 2009, the Economic and Social Research Council launched the 'Multiple Exclusion Homelessness Research Programme' with the aim of informing government policy and practice and finding solutions to bring the most vulnerable 'homeless people' in from the margins of society. The concept of 'multiple exclusion homelessness' alerts us to the potential for complex interplay between many different professional or occupational groups, reflecting how 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, Johnson and White, 2010).

As part of the Programme, the 'Social Care Workforce Research Unit' at King's College London was commissioned to undertake a two year exploratory study exploring how different agencies and professionals work together to support people with experience of multiple exclusion homelessness. The study commenced in July 2009 and is due for completion in June 2011. The objectives of the study were threefold. First, to conceptualise and describe the workforce as it relates to multiple exclusion homelessness. Second, to enhance understanding of how interprofessional collaboration works to identify and manage the intersections between homelessness and other facets of deep social exclusion. And thirdly, to make recommendations as regards for whom and when, and in what respects, interprofessional collaboration might work best to prevent multiple exclusion homelessness.

What did we do?

Exploratory research means unpicking and unpacking things that are commonly accepted to encourage new viewpoints, perspectives, ideas and actions to emerge. Interagency and interprofessional working lends itself to this kind of analysis because these practices are often tacitly understood rather than explicitly conceptualised or defined (Ehrlich et al., 2009). Throughout the life of the project the researchers worked closely with frontline practitioners across housing, health, criminal justice and social care agencies to arrive at a 'thick description' and understanding of practice. Research methods included observations of practice, interviews (n=101) and focus groups using a case study vignette (n=17). To further test these descriptions and understandings we also carried out interviews (on two separate occasions) with thirty people with direct experience of multiple exclusion homelessness, 'tracking' their journey through the system over a six month period. The project team met quarterly throughout the life of the project and employed a 'learning set' methodology to ensure continuous reflexivity between research and practice. The project team brought together academic researchers from different disciplines including nursing and social work, 'experts by experience' (that is, people with direct experience of 'multiple exclusion homeless') and practitioners and service managers from three 'partner agencies' (Cumbria Action for Social Support, Calderdale Smartmove and Look Ahead based in London).

In the final six months of project we worked closely with our three partner projects to develop the research findings for practice. Projects included the development a 'Community of Practice' in West Cumbria, developing a programme of 'Interprofessional Group Supervision' in Halifax and a pilot project in Westminster to develop interprofessional protocols for 'personal budgets'.

The problem

The development of specialist services *for* 'homeless people' such as those designed to address intermediate health care needs has seen different agencies and professionals come together to work in integrated teams. However, these services are sparsely scattered across the UK and much of what might be termed mainstream collaborative practice surrounding 'multiple exclusion homelessness' takes place at the boundaries between different services and agencies. Such activity is most often initiated where it is perceived that the person's needs are beyond the scope of a particular service, leading to 'sign-posting' and 'referring on' as a means of securing additional expertise and resources for the service user. Collaborative practice is also targeted at securing 'sequential handovers' where practitioners seek to enable service users to progress through the system (for example, from 'temporary' to 'permanent' accommodation). Overall, we found much evidence of and commitment toward collaboration in ground level practices however this was targeted at these quite specific areas. There was very little evidence of strategic commitment to integrated working as a means of promoting shared assessment and coordinated support planning. Each agency undertook its own 'holistic' assessment of need and set out its own goals and objectives of care/support. One 'housing support worker' summed up the current situation in that 'Everyone has got snippets of the individual but no one is collating it'.
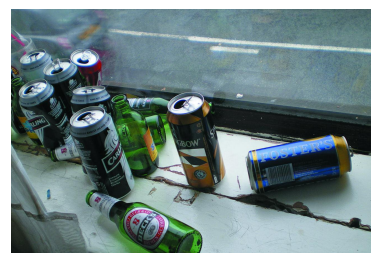
For people using services, the limitations of current 'joint working' are exposed where needs are identified which are perceived to go 'beyond' the scope and remit of existing provision. Such situations often cause intense frustration and conflict between different professionals and agencies as each seeks to avoid taking on responsibility for the most vulnerable and 'chaotic'. For the person themselves, such disputes often lead to a 'revolving door' in which they might be offered a service (reluctantly) with some seemingly impossible goals attached (such as remaining abstinent after a life time of alcohol abuse). This increases the likelihood of eviction or abandonment ('voting with your feet') and further periods of homelessness, imprisonment and/or hospitalisation. The following example illustrates this:

'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)

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[1] Has an Anti Social Behaviour Order which means that if he enters a certain local authority area he may be arrested.

In terms of finding solutions to bringing in the most vulnerable 'homeless people' from margins of the society, securing greater access to statutory community care assessment is one potential way forward. In ground level practices, 'homeless people' are often excluded from community care assessment because this seen as the preserve of older and disabled people seeking access to personal care ('social services'). However, the 'Fair Access to Care' (DH, 2010) eligibility criteria is clear that where a person's needs pose a substantial and/or critical risk to their independence and well-being (e.g. where underlying health needs may mean that staying on the street might lead to hypothermia and death) then they are likely to be eligible for community care services and a 'differentiated' response based on more resource intensive and interprofessional forms of case management.[2] With the advent of 'personalisation' (still a relatively new policy in implementation terms) this should also afford scope for more imaginative and flexible responses whereby the person and his or her multi-professional team might access an 'individual' or 'personal budget' to arrive at a uniquely tailored solution if, as in the case above, there is a poor fit between the person's needs and available services. However, as Mandelstam cautions,

> **'Personal budgets will only be available to those deemed eligible under the fair access to care policies of local authorities. The trend over the past decade is that fewer people are treated as eligible.'**
> **(Mandelstam, 2010 p114)**

Delivering person centred care and securing improvements in assessment and case management have been the holy grail of community care policy for well over twenty years. In their article *'Despite all we know about collaborative working why do we still get it wrong?'* Williams and Sullivan (2010) caution that it is perhaps inevitable that collaborative working is not the first call on an organisation's core business but a 'bolt-on' activity with few resources. In the face of predicted service cuts they see this trend as intensifying and agencies withdrawing even further into their primary purposes and statutory roles. So, because of likely implementation difficulties the solution itself needs to be seen as a significant part of the problem.

Looking beyond traditional 'top down' approaches to case management, there is growing interest in more 'bottom-up' approaches which pay closer attention to the everyday social relationships of 'joint working' and the means by which learning and caring (so called transformational learning) can be implemented in everyday practice. 'Communities of Practice' are one example of this approach which we piloted as part of the research (see box 1 below). Feedback from practitioners

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[2]Case management is currently being reviewed by the Department of Health in terms of new practice guidance for 'Integrated Care and Support Planning' which includes proposals for a 'Common Assessment Framework' (2009a, 2009b). In terms of right of access to community care assessment, people should not be discriminated against because they are homeless. This was established in R v Bristol CC, ex parte Penfold, 1998 (reported in Mandelstam, 2010) which concluded that assessment should be seen as an important service in its own right.

taking part in this pilot reported very positive outcomes especially as regard promoting opportunities for more collegiate ways of working which could mitigate against constraints of the 'system'. We do not propose 'communities of practice' as the silver bullet but one means of demonstrating that 'implementable' solutions to everyday practice challenges can be found by nurturing so called 'collective capability' (Soubhi et al., 2010). This involves ensuring that there are dedicated (even relatively small amounts of) resources to service and co-ordinate collaborative processes, encouraging boundary spanning and networking activities to build collaborative cultures, brokering to bring people together, promoting systems for reward and incentivisation, ensuring space for entrepreneurial activities to promote innovative solutions to 'wicked issues', and having mediation processes to align the different cultures, viewpoints and aspirations of diverse stakeholders (Williams and Sullivan, 2010).


Research into Practice Box 1

In West Cumbria we established a 'community of practice' (COP) as a means of improving joint working around the issue of multiple exclusion homelessness. This brought together different practitioners who had a real 'passion' for the topic (not 'organisational' representatives). The initial pilot ran for four sessions and the COP is now being continued by its members (a social worker, a probation officer, a housing support worker, an advice worker, a mental health worker, a drugs worker and a researcher from this project). Members bring practice challenges and anonymised 'cases' to each session and seek support and help from the community. Although not common practice, this COP has actively sought to promote the inclusion of former 'service users' by virtue of their status as 'experts by experience'. While still only in the early stages of development, the COP has been described by its members as a 'light house' for practice values and principles and a means of achieving real changes in approaches to 'joint working' which are of direct benefit to people who use services.

Implications for Workforce Development

In medicine it is recognised that the interplay between complex and multiple needs (so called 'multiple-morbidity') poses quite specific challenges for service delivery and workforce development, requiring 'case management' and highly evolved forms of interprofessional practice, education and supervision (Soubhi et al., 2010). However, in the orbit of homelessness, the combustion effect or interplay between complex and multiple needs is often written off as '*chaotic behaviour*' and does not generally trigger any kind of differentiated or enhanced response from service providers. Furthermore, the

practice of compartmentalising needs in terms of 'housing', 'mental health', 'drug and alcohol' etc, and then handing over ('referring on') responsibility for those areas that are perceived to be
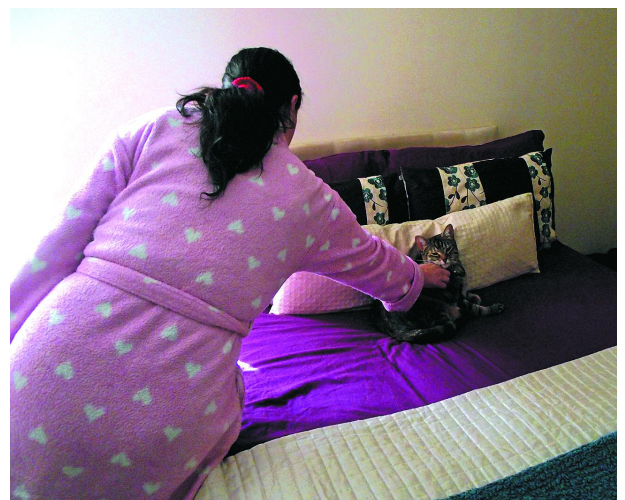
outside of your remit or expertise can leave front line workers feeling isolated. Practice challenges and uncertainty around 'job role' arise because as in the case below, it becomes almost impossible to separate the need for 'housing related support' from the wider mesh of presenting issues:

'[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… 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)

Cameron (2010) argues that 'housing support workers' are effectively filling the vacuum that has been left by the retreat of social workers from 'direct work' with adults which was one of the key changes of the 1990 NHS and Community Care Act. This suggests the need for more appropriate forms of training and education which better befits the *reality* of the 'housing support workers' current 'job role'. Indeed, 'housing support workers' are especially disadvantaged because, unlike many other groups of (non-professionally qualified) support staff, they do not generally have access to 'professional' (rather than managerial) supervision in the same way that a 'physiotherapy assistant' would always have access to a qualified physiotherapist if not a much wider multi-professional team. Finding new ways to support 'housing support workers' in their 'job role' is a key recommendation of this research (see Box 2 below).

Research into Practice Box 2

In Halifax, we piloted a programme of 'interprofessional group supervision' to provide housing support workers with the opportunity to discuss their case load with a range of different professionals (a social worker, a mental health worker and a drug and alcohol recovery specialist). Feedback from participants indicated that this directly impacted at the level of practice (arming workers with new knowledge and understanding which they could take out into the field) including a passion for seeking out more interprofessional collaboration.

There is also the need for more fundamental debate which might, for example, consider the need for increased 'professionalisation' of the housing support worker role and/or 'integration' of the housing support function within new kinds of multi-disciplinary teams. Firth (2010) for example, describes how in one new psycho-social mental health service geared toward 'recovery', housing support workers are co-located alongside many other professional and support worker functions. With moves to 'personalisation' (micro commissioning) there is also the issue of whether the 'housing support worker' role will survive at all as support functions are reconceptualised in terms of 'navigators and brokers' and 'personal assistants'. There is a clear message from the 'experts by

experience' in this study that the 'personal assistant' role is certainly not something that should be shied away from. The scope for **flexibility and person centred ways of working** within the current 'housing support role' (which allows *your* worker to phone the utility companies on your behalf, accompany you on trips to the doctor and to provide a bit 'radical advocacy' to get through red tape) is something that is highly valued and sought after. Again this lends further support to the need to move away from compartmentalised and organisationally driven approaches (which try to delineate between 'housing' and 'care') to more individualised approaches where people are able to self-direct their own support and to determine the size and scope of their own 'personal workforce'.

Research into Practice Box 3

In Westminster we piloted an innovative approach to personalisation and interprofessional support planning. While interprofessional processes are usually driven by professionals, we put hostel residents 'in control' by allowing them to decide who they wanted to share their 'personal plans' with and also what in-put/advice they wanted to 'include' and 'exclude' from their plans. In addition to their friends and hostel key worker a number of the people in the pilot wanted to share their plans with their 'doctors and shrinks'. This meant working with local GP practices to raise awareness of personalisation and the new process whereby GPs would be asked to contribute to a support plan (rather than just keeping their own notes and records). Although the evaluation of the pilot is still underway the implication seems to be that this opens up the potential for more meaningful interprofessional collaboration. For example, while one resident initially felt that spending his 'personal budget' on Complan drinks would a good way to gain weight and get fit, the 'sharing process' highlighted a much a better strategy (seen from the perspective of the person themselves) which was based on providing support with healthy eating and accessing fitness training.

Conclusion

We have argued that opening-up access to community care assessment is one potential way forward in terms of bringing 'homeless people' in form the margins of society. However, this requires a subtle conceptual shift in which the objective becomes one of achieving outcomes for people rather than designing services and responses around 'client groups'. Some people, especially those with very complex and multiple needs, do not fit neatly into these 'compartments'. They become recycled around the system because they are at one and the same time 'the homeless person', 'the drug addict', 'the mental health service user' meaning that they are everyone's and no one's responsibility. Access to assessment is the key to accessing the resources that allow for outcome based and individualised responses. More importantly, access to a shared or common assessment framework is vital if we are to prevent a 'retrench to silos' where each service sector evolves its own approach to personalisation meaning that people end up with multiple budgets, one for health, one for care and one for housing support. Already the 'next system' is starting to feel frighteningly complex and engineering it so that many different professional groups can work together with 'personal budgets' will be an enormous challenge. We conclude that small steps that encourage good quality social relationships and collective learning at the front line may prove to be the best stepping stone.

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