

Tackling homelessness and exclusion: Understanding complex lives

Round-up
Reviewing the evidence

September 2011

The overlap between homelessness, mental health problems, drug and alcohol dependency, street activities like begging, sex work or shoplifting, and experience of institutions such as prisons, has been an unknown quantity. What can research tell us about this overlap? How can services respond to complex lives where homelessness is one issue amongst many?

This paper:

- summarises findings from four projects examining the interaction between homelessness and other support needs.
- looks at services for people with complex needs and suggests ways that policy and practice can more effectively tackle homelessness.

Key points

- There is a strong overlap between experiences of more extreme forms of homelessness and other support needs, with nearly half of service users reporting experience of institutional care, substance misuse, and street activities (such as begging), as well as homelessness.
- 'Visible' forms of homelessness – including the use of services like hostels or applying to the council as homeless – commonly happen after contact with non-housing agencies, for example mental health services, drug agencies, the criminal justice system and social services. They also occur after periods of 'invisible' homelessness such as sofa-surfing.
- Traumatic childhood experiences such as abuse, neglect and homelessness are part of most street homeless people's life histories. In adulthood, the incidence of self-harm and suicide attempts is notable.
- Most complex needs were experienced by homeless men aged between 20 and 49, and especially by those in their 30s.
- Where homelessness and housing support agencies take on primary responsibility for supporting people with multiple and complex needs, workers can often feel isolated and out of their depth. It has been suggested elsewhere that housing support workers are now filling the gap left by the retreat of social workers from direct work with adults.
- People with complex needs are at serious risk of falling through the cracks in service provision. There needs to be an integrated response across health, housing and social care.

Author

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Introduction

For some people, homelessness is not just a housing issue but something that is inextricably linked with complex and chaotic life experiences. Mental health problems, drug and alcohol dependencies, street culture activities and institutional experiences (such as prison and the care system) are often closely linked with the more extreme experiences of homelessness.

This Round-up looks at evidence collected as part of the Multiple Exclusion Homelessness (MEH) Research Programme. The programme provides a statistically robust account of MEH in seven UK cities, alongside evidence from the life histories and accounts of people with first-hand experience of MEH and reflections from front-line workers, managers and commissioners.



The research

Four research projects were commissioned as part of the MEH Research Programme, which ran from February 2009 to September 2011:

Fitzpatrick *et al.*, Heriot-Watt University.

Multiple exclusion homelessness across the UK: A quantitative survey.

A multi-stage quantitative survey conducted in Belfast, Birmingham, Bristol, Cardiff, Glasgow, Leeds and Westminster (London).

Cornes *et al.*, King's College London.

Rethinking multiple exclusion homelessness: Implications for workforce development and interprofessional practice.

In-depth fieldwork exploring joint working around MEH in Cumbria, Halifax and inner London, including a development stage to put the research findings into practice.

Dwyer *et al.*, University of Salford and Nottingham Trent University.

The support priorities of multiply excluded homeless people.

Parallel qualitative interviews with people who have experienced MEH and key service provider/commissioning informants in three London Boroughs and Nottingham.

Brown *et al.*, University of Salford and University of Lincoln.

Losing and finding a home: A life course approach.

A study of the life histories of MEH people and homelessness agencies in Stoke on Trent.

The findings from these projects:

- provide new evidence and insight into the complexities and vulnerabilities that go hand in hand with extreme forms of homelessness;
- suggest where preventative efforts might best be targeted; and
- suggest what might be done to ensure more comprehensive ways of working that are better able to meet people's needs and aspirations for recovery and well-being.

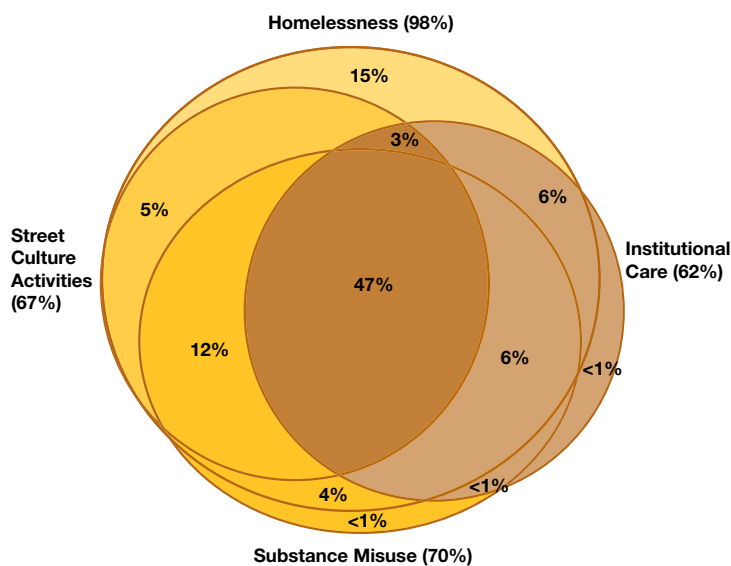
Overlap between homelessness and other social issues

The Fitzpatrick study provides a statistically robust account of the nature and patterns of MEH in the UK. The study took a three-stage approach:

1. A wide range of homelessness and other 'low threshold' services (e.g. drug and alcohol services, services for ex-offenders and street sex workers) were randomly sampled in the seven cities.
2. A census questionnaire survey was conducted with all of the users of these services over a two-week period.
3. An extended interview survey was conducted with a sample of service users whose census responses indicated that they had experienced MEH.

The census survey analysis examined four types of experience: homelessness, substance misuse, street culture activities and institutional care. All four issues were widespread amongst service users. Whichever service they were using at the time of the survey, almost everyone (98%) had experienced homelessness at some point, 70% had experienced substance misuse, 67% street culture activities, and 62% institutional care (Figure 1). The degree of overlap between these experiences was therefore very high, with almost half (47%) of service users reporting all four experiences (Figure 1).

Figure 1 Overlap between experiences of homelessness and other social issues



(Base: 1,286)

Source: Fitzpatrick et al. Census Questionnaire Survey, 2010

Table 1 Experience of homelessness by type of service

Indicator	Homelessness service	Other service	All
Stayed with friends, relatives or other people because had no home of own	78%	87%	80%
Stayed in a hostel, foyer, refuge, night shelter or B&B hotel because had no home of own	83%	82%	83%
Slept rough	80%	69%	78%
Applied to the council as homeless	70%	84%	73%
(Base)	1,112	174	1,286

Source: Fitzpatrick et al. Census Questionnaire Survey, 2010

Homelessness was a particularly prevalent form of exclusion, being widespread amongst those recruited to the study from services aimed at other dimensions of deep exclusion, such as drug misuse (Table 1).

Table 2 shows the extent of specific MEH relevant experiences within the sample selected for extended interview. The most prevalent individual experiences included all of the forms of homelessness specified,

mental health problems, alcohol problems and street drinking. The least prevalent experiences – affecting less than one fifth of all MEH service users – were having been in local authority care, having been the victim of sexual assault as an adult, having had a partner who had died, engagement in survival sex work, repossession and bankruptcy.

Table 2 MEH relevant experiences and median age of first occurrence

<i>Experience</i>	<i>Per cent</i>	<i>Median Age*</i>
Stayed at a hostel, foyer, refuge, night shelter or B&B hotel	84%	28
Had a period in life when very anxious or depressed	79%	22
Stayed with friends or relatives because had no home of own	77%	20
Slept rough	77%	26
Applied to the council as homeless	72%	27
Had a period in life when had six or more alcoholic drinks on a daily basis	63%	20
Involved in street drinking	53%	18
Went to prison or young offender institution	46%	21
Used hard drugs	44%	19
Divorced or separated	44%	32
Were a victim of violent crime (including domestic violence)	43%	20
Shoplifted because needed things like food, drugs, alcohol or money for somewhere to stay	38%	20
Attempted suicide	38%	-
Thrown out by parents/carers	36%	17
Begged (asked passers-by for money in the street or another public place)	32%	28
Engaged in deliberate self-harm	30%	-
Admitted to hospital because of a mental health issue	29%	26
Injected drugs	27%	22
Charged with a violent criminal offence	27%	-
Evicted from a rented property	25%	28
Made redundant	23%	26
Abused solvents, gas or glue	23%	15
Left local authority care	16%	17
Victim of sexual assault as an adult	14%	-
A long-term partner died	10%	43
Had sex or engaged in sex act in exchange for money, food, drugs or somewhere to stay	10%	17
Home was repossessed	6%	34
Experienced bankruptcy	6%	29
(Base)	452	-

Source: Fitzpatrick *et al.* Extended Interview Survey, 2010

*Note: No data was available on age of first occurrence of four of these experiences as they were asked about in the self-completion section of questionnaire.

Pathways to multiple exclusion homelessness

The median age at which these experiences first occurred provides some general sense of likely routes into and through MEH (Table 2). However, the sequencing of experiences was looked at in more detail, since a better understanding of how multiply disadvantaged people become homeless is necessary to inform the design and delivery of effective services. Four broad phases within individual MEH experiences were identified:

Stage 1 – Substance misuse: The experiences that tended to happen earliest, if they happened at all, were: abusing solvents, glue or gas; leaving home or care; using hard drugs; developing a problematic relationship with alcohol and/or street drinking.

Stage 2 – Transition to street lifestyles: There was then a group of experiences that, if they occurred, tended to do so in the early–middle part of individual MEH sequences. These included: becoming anxious or depressed; survival shoplifting; engagement in survival sex work; being the victim of a violent crime; sofa-surfing; and spending time in prison. These experiences seem indicative of deepening problems bringing people closer to extreme exclusion and street lifestyles. Also featuring in this early–middle-ranked set of experiences was one adverse life event: being made redundant.

Stage 3 – Confirmed street lifestyle: Next, there was a set of experiences that typically occurred in the middle–late phase of individual MEH sequences, and seemed to confirm a transition to street lifestyles. These included: sleeping rough; begging; and intravenous drug use. Being admitted to hospital with a mental health issue also tended to first occur in this phase, as did two of the specified adverse life events: becoming bankrupt and getting divorced.

Stage 4 – ‘Official’ homelessness: Finally, there was a set of experiences that tended to happen late in individual MEH sequences. These included the more ‘official’ forms of homelessness (applying to the council as homeless and staying in hostels or other temporary accommodation) and the remaining adverse life events (being evicted or repossessed and the death of a partner).

Troubled childhoods

A key finding from the Fitzpatrick, Dwyer and Brown studies is how frequently the roots of many people's experiences of MEH in adulthood lay within very troubled childhoods. While it does not follow that all people who experience troubled childhoods will have complex lives or become homeless, childhood experience has a pervasive impact on an individual's life course. Events such as abuse, bullying, witnessing alcoholism, domestic violence, as well as – as is often the case – experiencing these factors in combination, affects the way a child comes to perceive their world and their place within it. Such events not only affect childhood well-being, they echo throughout adulthood in the development and maintenance of self esteem and the ability to form meaningful relationships.

When I was six years old, right, I was on the park, kind of thing. This is the day that I died. This is why I don't care about nothing and this is it. I was – hold on a minute, I'm getting dead emotional about this – right, I was on the park and if you can imagine like a little park down the bottom of Salford. On the other side there used to be like a cricket pitch and all that kind of thing and there was this guy, 'David', and I looked at him, like. "Your dad says you can wash my car for me" and all that kind of thing. I says, "Yeah, I'll wash your car" and all that kind of thing. Me and his mate, they took me in his house and they raped me and all that kind of thing. That's the day that I died.

(51-year-old male, Brown *et al.*)

My mum's aware, well I know she was aware of what was going on and she didn't want the truth to come out. Basically, yeah, I don't think she wanted my dad to know; she didn't want anybody know. So I was the one saying, "I want to go live with my Nana, I don't want to live with you no more." and it was her way out, doing that. Did we ever discuss it when I went back, when I was 14? No, we never, never discussed it with her, but that was the way it went and that was it.

(37-year-old female, Brown *et al.*)

The quantitative study underlines the fact that most MEH service users had experienced a range of trauma, distress or exclusion as a child. In all, 78% of service users reported at least one of the experiences listed in Table 3. These experiences were somewhat less prevalent amongst service users who had migrated to the UK as an adult: 57% of migrant service users reported at least one of these experiences, compared with 85% of non-migrant service users. There was a strong age gradient, whereby many of these experiences were most commonly reported by MEH service users under 25, and least commonly reported by over 50s. There was less distinction by gender, though female MEH service users were most likely to report not getting along with their parents/carers and to have had parents with mental health problems. Experience of childhood sexual abuse was also concentrated amongst female respondents.

Table 3 Experiences in childhood (under 16 years old)

<i>Experience</i>	<i>Per cent</i>
Truanted from school a lot	50%
Didn't get along with parent(s)/step-parent/ carer(s)	38%
Suspended, excluded or expelled from school at least once	36%
Ran away from home and stayed away for at least one night	34%
Violence between parents/carers	27%
Parent(s)/step-parent/carer(s) had a drug or alcohol problem	24%
Badly bullied by other children	22%
Physically abused at home	22%
Brought up in workless household	21%
Family was homeless	16%
Spent time in local authority care	16%
Sexually abused	16%
There was sometimes not enough to eat at home	15%
Neglected	15%
Parent(s)/step-parent/carer(s) had a mental health problem	15%
(Base)	452

Source: Fitzpatrick *et al.* *Extended Interview Survey*, 2010

Experiences of multiple exclusion homelessness

People's experience of MEH clustered around five different levels and types of complexity. The statistical patterns identified by Fitzpatrick *et al.* in their extended interview survey are graphically illustrated by the personal accounts given in the Dwyer and Brown studies.

Box 1 Case study: Ahmed

Ahmed is a Syrian Kurdish asylum seeker, aged 32. He was a member of a banned political party in Syria and used to distribute leaflets from his shop. He was forced to flee Syria following a tip-off that security forces had raided his shop in his absence. He feared a long imprisonment or worse. He arrived in England after several days hidden in the back of a lorry. He eventually found his way to Liverpool, where he was fed by the Kurdish community and where he reported to the Home Office who furnished him with an ID card. He was transferred first to Leeds, where he applied for asylum, and then to National Asylum Support Service (NASS) accommodation in Sunderland, where he stayed for a year, before being evicted when his asylum claim was refused. From that point on, he has been sleeping rough. He came to Nottingham to seek out the Kurdish community, who have given him occasional help, along with a refugee organisation, but otherwise he has been sleeping rough in a park ever since, where he has experienced considerable harassment.

(Dwyer *et al.*)

Cluster 1 – Mainly homelessness: This cluster accounted for nearly a quarter of those who participated in the survey and was the least complex overall (five experiences on average). Cluster 1 cases were less likely than the MEH population as a whole to report experiences additional to homelessness, and were overwhelmingly male (84%) and mainly aged over 35. Notably, a disproportionate number of Cluster 1 cases had migrated to the UK as adults (35%) and so are likely to have restricted access to UK welfare benefits. The majority (53%) were located in Westminster, which attracts people as one of the busiest parts of London, but has an exceptionally tight local housing market.

Cluster 2 – Homelessness and mental health: This cluster accounted for over one quarter of the survey population, and its members displayed moderate complexity (nine experiences on average). A key feature of Cluster 2 cases was experiences associated with mental health problems: 86% reported experience of anxiety or depression and 51% had attempted suicide. Cluster 2 was disproportionately female.

Cluster 3 – Homelessness, mental health and victimisation: This was a smaller group (9% of the survey population), which may be viewed as a much more complex and severe version of Cluster 2 (15 experiences on average). Mental ill health was a defining characteristic: experience of anxiety or depression was reported by 100%; suicide attempts by 91%; being admitted to hospital with a mental health problem by 89%; and 75% had self-harmed. Cluster 3 members had also experienced exceptionally high levels of victimisation – 71% had been a victim of violent crime and 40% had been a victim of sexual assault as an adult. Nearly half (48%) had been in local authority care as a child. This group was slightly younger than the MEH population average.

Box 2 Case study: John

John was 24 when interviewed at a hostel. He attributes the start of his extreme temper fits, anxiety and depression to a time when he was a teenager and his father was arrested under suspicion of sexually abusing his older sister. He regularly attended a specialist mental health facility for about a year. The allegations were not upheld, as a result of which his sister was ostracised by the family, with the exception of John, who left home at 16 to be with his sister. He became homeless when she threw him out. After some time in hostels, he managed to get his own accommodation, but lost it through non-payment of rent and became homeless again. After various attempts to stay with his sister and his parents, during which he was hospitalised following one violent altercation, he finally ended up in his current hostel.

(Dwyer *et al.*)

Box 3 Case study: Billy

Billy was 57 when interviewed, living in supported accommodation for older people. He was from Northern Ireland, and spent most of his childhood in a Dr Barnardo's children's home after his parents split up. He then spent 12 years in the Navy. He attributes his drinking to the period after he came out of the Navy, when he could not settle, moving between seamen's missions and subsisting on casual employment. He settled with his wife in Northampton for a while, but she was unable to tolerate his drinking and left him. His drinking then became heavy and chronic. He came to Nottingham with a friend who told him there were places to stay, but he ended up sleeping rough for a long time, with occasional nights in a night shelter. He was taken to hospital with hypothermia and got a place in a Salvation Army hostel, but the regime reminded him too much of his childhood, he swore at staff and was asked to leave, after which he returned to rough sleeping. He eventually got his current accommodation through help from a day centre.

(Dwyer *et al.*)

Cluster 4 – Homelessness and street drinking: This was also a smaller group (14% of the sample), and comprised a moderately complex set of cases (eleven experiences on average). The defining experiences of this older, mainly male, group was street drinking (100%); rough sleeping (98%); and problematic alcohol use (96%). Other indicators of street culture activities were also common. Membership of this cluster was most common in Glasgow.

Box 4 Case study: Sharon

Sharon was 34 and living in shared accommodation with support when interviewed. She was kicked out when she was 12 after the man her mother had married sexually and physically abused her. She stayed with a street sex worker for a while, before being taken into local authority care. By the time she was 14, Sharon was a sex worker herself and on drugs, moving between squats, punters' flats and rough sleeping, with brief periods in hostels. She started sniffing gas and glue, but she was groomed by a pimp who got her on to crack cocaine. Other drugs quickly followed.

Sharon had four children by various men, all of them taken into care and three now adopted. Relationships were brief affairs, normally ending in her being subjected to violence and needing to leave for her own safety. There might then be a period in accommodation before she was drawn back into her street lifestyle of drink and drugs, maintained by sex work. There were periods of imprisonment when, for instance, she was violent to a social worker trying to take one of her children into care. It was the prospect of getting custody of her fourth child that eventually led Sharon to seek help to stabilise her life and get a place in supported accommodation.

(Dwyer *et al.*)

Cluster 5 – Homelessness, hard drugs and high complexity: This accounted for one quarter of MEH service users and was the most complex (16 experiences on average). The defining experience was use of hard drugs (100%), understood by most MEH service users to denote drugs such as heroin and crack cocaine, with very high scores generally on the substance misuse and street culture domains. Although involvement in survival sex work was uncommon across service users as a whole (at 10%), 21% of this group reported this experience (almost all of them women). Anxiety/depression was almost universally experienced (95%), and rates of attempted suicide and self-harm were also high (56% and 47% respectively). Experience of prison was very prevalent (77%), with a strong theme of violence as both victim (56%) and perpetrator (51%). Cluster 5 members tended to be in the middle age range; most were in their 30s.

Box 5 Case study: Scott

Scott was 41 at the time of the interview. He is part of a large family with around six siblings in total. Scott's biological father sexually assaulted him when he was four or five years old. His father was arrested for this. Scott's siblings do not talk to him and he thinks they are ashamed of him. He says he was out of control when he was young and that he smoked and drank alcohol early in life. His mother's attempts to discipline him were ineffective and Scott was put into care, but his behaviour did not improve. He attributes his challenging behaviour to his family's unwillingness to believe his account of his father's abuse. Following an accident at school, Scott had a year out of education to recover. Upon his return, he felt apathetic about school work and 'couldn't be bothered'.

Scott was raped when he was 16 years old, though it is unclear by whom. He travelled to London, where he expected to obtain employment and accommodation but this did not work out as planned; instead, he slept rough and begged for money. Scott became involved with 'the wrong crowd', including older and more experienced rough sleepers, and continued to drink alcohol and use drugs heavily. He remained in London for nine years, briefly returned to his parents' home, spent around a year sofa-surfing and then went back to live with his mother when she became ill.

Recently, both Scott's mother and step-father died within a short time. He turned to heavy alcohol use. He returned to London to live with his sister but this lasted for one year until she asked him to leave on Christmas Day on account of his excessive drinking. He now has no contact at all with his family. He returned to his home town and began to sleep rough and use drugs again. Scott has a number of health problems including a heart condition and arthritis. It was clear that he had had several girlfriends but he did not elaborate on these. He has also had seven spells in prison due to crimes to fund his drug habit, but this was not elaborated upon either.

(Brown *et al.*)

Statistical analysis showed that factors associated with more complex MEH experiences were:

- being male;
- being aged between 20 and 49 years old (especially 30s);
- having experienced any of the following as a child: physical abuse or neglect, there sometimes not being enough to eat at home, or homelessness;
- having had parents who experienced drug, alcohol, domestic violence or mental health problems;
- having had poor experiences of school (i.e. truancy, exclusion);
- having lived on welfare benefits for most of your adult life;
- being recruited to the study from a drugs or other 'non-homelessness' service.

Factors associated with less complex MEH experiences were:

- being female;
- being young (under 20) or older (over 50);
- being an adult migrant to the UK (but this was not so true of migrants from Central and Eastern Europe);
- being a Westminster (London) respondent;
- being in steady work for most of adult life;
- being recruited to the study from a homelessness service.

Demographic factors

Gender

The impact of gender was more modest than might have been expected, except for the particular association between mental health issues and women's experience of MEH (see Cluster 2 above). The only other notable gender distinctions were with respect to experience of sexual assault and/or abuse, and survival sex work, which were heavily concentrated amongst female respondents. The Dwyer study found that women without dependent children are likely to have similar experiences to men in securing help.

Migrants

The Fitzpatrick study investigated the specific experiences of MEH service users who had migrated to the UK as adults, including 'A10' migrants from Central and Eastern Europe, refugees and asylum seekers and irregular migrants. Migrants were more likely than other MEH service users to have slept rough but were less likely to have stayed in hostels or other temporary homeless accommodation, or to have applied to a council as homeless (these findings are likely to relate to the ineligibility of many migrants for housing or welfare assistance in the UK).

Migrant service users' experience of the other (non-homelessness) issues was significantly lower than that of non-migrants:

- 51% of migrants reported some form of substance misuse, compared with 82% of non-migrants;
- 51% of migrants had engaged in street culture activities of some kind, compared with 74% of non-migrants; and
- 32% of migrants reported at least one form of institutional care experience, compared with 72% of non-migrants.

These findings point to a lower 'threshold' of personal problems and associated support needs amongst migrants, suggesting that their problems are often more 'structural' and less 'individual' than those of other MEH service users.

That said, there clearly were migrants amongst the MEH population with complex needs and, as the Dwyer study found, this was especially true with respect to A10 migrants from Central and Eastern Europe, many of whom had serious problems with alcohol and associated street activities.

The first day in London I'm working, maybe [for] three weeks, maybe after one month, I've no money. I must sleep on the street ... too much free time, I'm alcoholic. I must drink. When I'm working, no drink ... when I stopping work, come back to garage and to alcohol. This is problem.

(Polish man, Dwyer et al.)

Service provision

How do services respond to such complex needs?

Providing effective services for people with such complex needs is a huge challenge. There is a plethora of programmes, strategies and advice to providers of services on issues central to people with high-level needs. How could all the effort and resources be more effective? The research focused on two issues:

- comparison between the perceptions of service users and those of providers; and
- the extent to which service delivery takes account of how needs are interrelated.

Differing perceptions

Exploration of the different priorities of users and providers of homeless services is the core of the Dwyer study. People's priorities evolve with changing circumstances and experiences. On becoming homeless, many initially prioritise street survival needs – safety, food, personal hygiene – above securing accommodation or seeking help with other problems. For significant numbers, meeting the demands of drug or alcohol dependency initially takes precedence.

Surviving day by day. Getting accommodation wasn't on top of my list. Top of my list was getting my money for my fix, getting my food and getting warm and stuff ... I was so out of my face. I was high 24/7.

(Service user, Dwyer et al.)

As the priorities of people with complex needs change, securing appropriate accommodation is a key step in finding a way out of MEH. It often becomes a priority when individuals encounter a serious, sometimes life threatening, crisis. More positively, it is also linked to recovering a sense of self-worth or the possibility of renewing valued past relationships. Persistence and flexibility in approach is required by service providers to ensure that as and when the time is right for each individual, suitable accommodation and support is available.

The outreach team nurse people, they were the ones that finally said, "Come on, we'll help you out. You're in a mess". I was in a mess; I'd cut my arm open; I was, like, filthy; I was on drugs. I didn't like it.

(Service user, Dwyer et al.)

Around and around, the outcomes are. Sometimes it sticks. Sometimes it just works. If you get them to the right hostel at the right time and the right state of mind with the right worker in the hostel supporting them.

(Service provider, Dwyer et al.)

Hostel residents in the Brown study in Stoke generally appreciated the benefits provided by hostels and staff. These included meeting people who had similar experiences to themselves, opportunities for voluntary work and other activities and practical support. Some very negative experiences of hostels were reported, but these related to acts of violence and criminality by other residents. Some people had been in hostels before and recognised that you had to learn how to live in a hostel; just as you have to learn how to live generally. They were grateful that hostel staff were working hard to prepare them for resettlement. There were some criticisms of staff being too concerned about money and lacking empathy with the residents. Most interviewees, however, reported that the hostel had effected a big improvement in their lives, and in some cases a real turning point towards a more stable future.

As the Dwyer and Brown studies found, people working in agencies routinely interacting with people with complex lives identify a range of priorities in their work, which may not always converge with the needs of the individual. Although this is an obvious statement, it is an important one, as these varied priorities reflect contrasting remits and policy agendas. Some agencies are very much focused on helping homeless people with complex needs to rebuild their lives; others have responsibilities to address specific issues (e.g. substance misuse and mental health issues). Certain agencies see their primary role as protecting the general public, and other homeless people, from criminal or anti-social behaviour.

Getting people housed really ... it's so difficult working with somebody who is street sleeping – how can they address other issues?

(Service provider, Dwyer *et al.*)

We work with people to increase their independence to give them a sound start again.

(Service provider, Dwyer *et al.*)

You have to focus on the next potential victim ... if we can prevent this happening ... those potential victims may not become victims ... It's offender management.

(Service provider, Dwyer *et al.*)

There was some evidence that commissioning practice can lead to avoidance of some of the people with the most complex needs:

...the people that we used to accept were more chaotic, if you like, whereas now, we've got certain expectations, and there's contractual targets that our funders expect us to meet. So if we feel that somebody is too chaotic then we can't accommodate them, so we would signpost them to other organisations ... the clients have to be more stable and more willing to engage with support, whereas, you know, a few years ago, we would accept anybody really.

(Agency in Stoke, Brown *et al.*)

In relation to the debate about enforcement/interventionist approaches, the evidence suggested some people experiencing MEH avoid agencies perceived to be challenging certain types of behaviour.

Rules and regulations can also lead to exclusion from services. Service users described being unable to sustain the exacting regimes of abstinence that operated at dry or drug rehabilitation hostels. The result of eviction was often another period of rough sleeping.

These boys know you need to have a beer to get the edge off things. This woman threw me and [name] out, banned us for life because we smelt of alcohol. How can you put somebody into the cold and you are a Christian? I can't work that out. They put you on the streets for five days, me and [name], wrapped up in cardboard, bad place.

(Service user, Dwyer *et al.*)

Dwyer *et al.*'s study suggested that more rigid interventionist approaches, that dictated the speed of engagement rather than responding to the individual's own pace, were not appropriate for people with the most complex needs. The result was often the person being excluded through eviction or 'giving up'. However there are real issues about the safety of other residents and staff, drug taking, bullying and theft that cannot be ignored.

He seriously injured another resident ... I thought, I've got to draw a line. I felt he was somebody I was going to ring another hostel and say, "He's not working here, you have a go". He's got to make up his mind if he wants to be off the streets enough that he will toe the line a bit.

(Service provider, Dwyer *et al.*)

Homeless service users consistently reported that the most effective help is offered when agencies and their staff are not constrained by enforcement or conditionality. Many key informants and homeless service users reported that persistent encouragement and support is key to homeless individuals with complex needs committing to meaningful change and successfully overcoming the often formidable barriers they face.

One guy, for example, has been rough sleeping for about six years now, doesn't engage with any services other than the churches ... We've now got him into a B&B ... four months, probably, of regular intervention with me building a relationship with him to get him to go and visit the B&B. Then get him to stay for a couple of nights and then he left again and then he came back and left again. Now he's been there about a month and a half, probably two months full time, which is a fantastic step for that individual ... My focus has been purely with individuals.

(Service provider, Dwyer *et al.*)

Innovative programmes such as the London Rough Sleepers '205' initiative, the Nottingham personalisation pilot and the JRF London-based study of personalised support (Hough and Rice, 2010) illustrate the value of more

flexible approaches to overcoming barriers to tackling the problems of the most entrenched rough sleepers. The Dwyer and Cornes studies support the view that schemes that allow for the relaxation of local connection rules and the creative use of personalised budgets (on terms negotiated between individual rough sleepers and their personal support workers) can be highly effective in reaching out to the most excluded individuals.

All service providers spoke about helping people with complex lives, but many agencies are constrained to varying degrees by other agendas. This is especially true of mainstream statutory services that do not specialise in the needs of this user group, and can only help them if key conditions are met. Such conditions are frequently fixed by statutory priorities, centrally driven targets or constraints on the use of resources. For example, a manager at Jobcentre Plus unsurprisingly prioritised 'getting people jobs' and highlighted the requirement for users to be actively seeking work to retain rights to certain benefits. Similarly, an informant in charge of emergency mental health services was clear that the priority was to ensure that people 'don't remain homeless if they've got mental health problems' but also stated that whether or not someone was homeless was immaterial because 'we're mental health'. This highlights the cracks between individual services and the different policy and practice agendas.

Integrated working

The Cornes et al study found that, with notable exceptions, there was very little evidence of integrated working across health, housing and social care, with each agency undertaking its own 'holistic' assessment of need and setting its own objectives for care and 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'.

In practice, the interplay between the complex needs that go hand in hand with deep social exclusion is often taken as evidence of 'chaotic behaviour' and does not generally trigger any differentiated or enhanced response from service providers. There may be lessons here from the field of medicine which recognises that so called 'multiple morbidity' requires a highly specialised response including enhanced case management and 'interprofessional' education and training.

For people using services, the limitations of current 'joint working' are exposed where needs are perceived to go 'beyond' the scope and remit of existing provision. Such situations can cause intense frustration and conflict between different professionals and agencies as each seeks to avoid taking on responsibility for the most vulnerable and 'chaotic'.

The workforce

Housing support workers can often find themselves working alone to manage challenging and complex situations. A typical scenario is where someone 'moves on' into private rented accommodation and is provided with 'floating support'. When other agencies make referrals to housing support providers, this often comes with promises of further support, however the pressure on case loads across all sectors means that once a person is 'handed over' this generally permits a degree of backing off.

However, the problem with parallel or 'uniprofessional' ways of working is that when people's needs change, for example if a person's mental health deteriorates or they relapse into drug use, it can be very difficult to pull interagency support back in quickly enough to prevent a crisis.

There is also a degree of 'professional protectionism' whereby housing support workers are sometimes made to feel less confident about certain areas of practice. For example, many housing support workers will argue that they do not have expertise in mental health work or drug and alcohol recovery beyond signposting or making referrals for specialist help. However, this tends to overshadow the reality in which it is extremely difficult to separate housing issues from the wider mesh of people's lives.

Box 6 Research into practice: Interprofessional group supervision

In Halifax, the Cornes team 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 that they could take out into the field, including a passion for seeking out more interprofessional collaboration. (Cornes *et al.*)

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 [arrear] 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 made it even more confusing and even more difficult to work with.

(Hostel worker, Cornes *et al.*)

It has been argued that housing support workers are effectively filling the vacuum that has been left by the retreat of social workers from 'direct work' with adults (Cameron, 2010). This suggests the need for more appropriate training, which better fits the reality of housing support workers' current role. 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 is a key recommendation of this programme.

There is also the need for more fundamental debate that might, for example, consider the need for increased 'professionalisation' of the housing support worker role and/or integration of housing support within new kinds of multi-disciplinary teams. 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', 'brokers' and 'personal assistants'.

There is a clear message from the service users 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 to see the doctor and provide a bit of 'radical advocacy' to get through red tape – is something that is highly valued. 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') towards more individualised approaches where people are able to self-direct their own support and determine the size and scope of their own 'personal workforce'.

Box 7 Research into practice: Personalisation and interprofessional support planning

With an agency in Westminster, the Cornes team piloted an innovative approach to personalisation and interprofessional support planning. While interprofessional processes are usually driven by professionals, hostel residents were put 'in control' by allowing them to decide who they wanted to share their 'personal plans' with and also what input/advice they wanted to include or exclude. 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 is 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 nutrition drinks would be a good way to gain weight and get fit, the 'sharing process' highlighted a much better strategy (seen from the perspective of the person themselves), which was based on support with healthy eating and accessing fitness training.

(Cornes *et al.*)

Personalisation

Hostel provision and housing-related support has been delivered largely through the Supporting People programme, which has prioritised delivery based around preventative housing-related support services. As a result, where homelessness is seen as the main presenting 'problem', it is often the case that people will be channelled into these services without having their needs statutorily assessed under the provisions of the 1990 NHS and Community Care Act. At ground level, the common misconception is that community care assessment and adult social care is the preserve of older and disabled people seeking access to a limited range of social care services targeted at personal care and that homeless people are not therefore eligible.

Recent guidance offers the means to challenge this practice. Guidance on eligibility criteria for adult social care (DH, 2010) links the right of access to community care services to an assessment of the risks posed to a person's independence and well-being. So, for example, where sleeping rough on the street could lead to hypothermia and death then it might be argued that this person is eligible for services because their situation poses a critical risk to their independence and well-being.

Importantly, the menu of resources that can now be accessed through community care assessment and adult social care has recently expanded to include new forms of interprofessional case management (currently being reviewed by the Department of Health in terms of a 'Common Assessment Framework' and integrated care and support planning) and the advent of 'personalisation'; individual or personal budgets that are intended to encourage more imaginative ways of working and uniquely tailored solutions, especially where there is a poor fit between the person's needs and available services. However, Mandelstam (2010) cautions that '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.'

Delivering person-centred care and securing improvements in assessment and case management have been the holy grail of community care policy for over 20 years. Collaborative working has not been the first call on an organisation's core business. In the face of predicted service cuts, agencies are likely to withdraw even further into their primary purposes and statutory roles.

Services are in competition ultimately in terms of money. We're about to head into a period of time where they're screaming "There is no money and actually the money you've got won't be there" ... And not just third sector agencies, but all agencies, statutory and third sector, are all going to have funding cuts and I think sometimes people are a little bit fearful of getting together and coming up with a solution.

(Service provider, Brown *et al.*)

Looking beyond traditional top-down approaches to case management, there is growing interest in more bottom-up approaches, which pay closer attention to the social relationships of joint working and the means by which learning and caring can be implemented in everyday practice. 'Communities of practice' are one example of this approach, which King's College London piloted as part of the research (see Box 8). Practitioners taking part in this pilot reported very positive outcomes, especially as regards promoting opportunities for more collegiate ways of working which could mitigate against the constraints of the 'system'. Communities of practice are not a silver bullet, but one means of implementing solutions in everyday practice. The challenge is to ensure that there are dedicated resources (even small amounts) to service and co-ordinate collaborative processes. Small steps that encourage good quality social relationships and collective learning at the front line could be the best initial step towards improved outcomes

Box 8 Research into practice: Community of practice

In West Cumbria, the Cornes team 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 in the early stages of development, the COP has been described by its members as a 'lighthouse' for practice values and principles and a means of achieving real changes in approaches to joint working that are of direct benefit to people who use services.

Recommendations for policy and practice

Prevention

- *Increase recognition of the childhood experiences that lead to MEH:* Recognition of the early signs of a transition towards MEH provides a key to more effective prevention. Problematic childhood experiences are very prevalent among those with the most complex needs. This suggests a need for improved understanding within children and family services of routes into MEH. A key issue is homelessness in earlier life and more support needs to

be given to families experiencing homelessness to break this pattern. More targeted work with children who are experiencing other issues that relate to later homelessness would also be welcome.

- *Understand the critical intervention points for prevention:* This programme has highlighted the critical points in a person's journey into multiple exclusion homelessness. Help could be targeted at these points to prevent people ending up on the streets. Key services such as mental health and drug treatments are crucial to this approach and should acknowledge the prevention of homelessness within their remit.

When prevention has not worked

- *Recognise a forgotten group:* Services and support have not yet addressed the specific needs of the group this research indicates to be in the majority in the MEH cohort – men over 30 with substance/alcohol use and anxiety/depression issues. Whilst there has been a lot of investment in recent years in specialised provision for groups identified as having specific needs, such as women and young people, men are often placed in 'general needs' provision with little reference to their particular experiences. Childhood sexual abuse figures highly in the backgrounds of men with the most complex support needs, but little attention has been given to creating a support system to assist men through such trauma.
- *Address acute mental distress:* Psychologically informed services and environments are vital to deal with the high incidence of acute mental distress in people's lives and the frequent history of troubled childhoods. This may involve more specialist support to facilitate more reflective practice within services.
- *Ensure better access to coordinated support:* The current review of social care offers an opportunity to explore whether homeless people with the most complex lives could and should fall within the remit of adult social care. There are different patterns of need within the MEH population. Some individuals require low-level support. However, for those with the most complex needs it becomes impossible to separate the need for housing-related support from wider issues. In these complex cases, at best, services work in parallel, without properly addressing the acute overlap of needs; at worst they work in conflict with one another. Access to the coordination provided through community care assessment could help ensure that all agencies play their part in the provision of a holistic package of support.
- *Provide coordinated support to move on:* Coordination must continue as people move away from homelessness. Practical routes out of homelessness need to include appropriate stable accommodation underpinned by a range of flexible and integrated support drawn from across health, housing and social care. The process may start in a high support environment, moving to lower levels of support.
- *Help professionals to learn from each other:* Interprofessional education and training provides a route to integrated care and personalised support planning and a shared understanding of underpinning processes such as the Community Care Assessment and Fair Access to Care Services.
- *Recognise and develop the coordinating role of support workers:* The research demonstrated the importance of the support worker within homelessness services. However, there is a need to review this job role, which in reality often goes far beyond the provision of housing-related support. Evidence suggests the need for a support worker/mentor/advocate who is truly cross-sector.
- *Improve positive social networks and relationships:* The existence of positive social networks and relationships that are flexible, supportive and continuous is critical to addressing MEH. This can often be provided by a member of an individual's wider family network, especially if they receive support to address substance misuse or other issues that have put pressure on these relationships in the past. However, specific support to enable individuals to re-establish and sustain appropriate and safe relationships with family members may be necessary in many cases.

Conclusion

While the challenge of developing more effective services for MEH people cannot be denied, progress is being charted on several fronts. The Brown study found a more positive picture of hostels than earlier research painted and is some testimony to the contribution of the Hostels Capital Improvement and Places of Change programmes. The excellent work being undertaken by peer support groups and other user-led organisations is a force for positive change.

Concern over public finances and cuts in public spending will act as a real constraint on service improvements but there is growing awareness that such complex support needs are very costly to society as a whole. Providing tailored services for this group may therefore be a cost-effective strategy. The evidence of this programme will shortly be matched by evidence from the Multiple Disadvantage Local Inclusion Laboratory Areas and from the Making Every Adult Matter (MEAM) local pilots. Both of these initiatives focus on finding better ways of coordinating services to deliver for the whole person. Consolidation of all these findings will offer a platform for innovation at a time of change.

The recent report of a cross-Whitehall Ministerial Task Force tasked with preventing and tackling homelessness (DCLG, 2011) offers a framework to consider MEH issues more broadly. Two of the six commitments – helping people to access healthcare and helping people into work – are highly relevant to the people in these studies. While the focus is clearly on rough sleeping, there are some references that promise later attention to the complex needs of people who feature in these studies, including: recognition of complex multi-faceted problems, a call for better prevention and reference to ‘invest to save’. The report announced a £20 million Innovation Fund to be administered by Homeless Link and one of the purposes is to improve prevention.

Evidence from the MEH research programme strongly supports the argument that there is a very high degree of intersection between homelessness and other complex social issues. Some people, especially those with very complex and multiple needs, do not fit neatly into existing service compartments. A shift is needed to focus on outcomes for the whole person rather than designing services and responses around client groups.

About this paper

This *Round-up* provides key findings from four projects that make up the Multiple Exclusion Homelessness Research Programme. The programme, a partnership between the Economic and Social Research Council (ESRC), JRF, Homeless Link, Tenant Services Authority and the Department for Communities and Local Government (DCLG) was set up in 2008 and managed by ESRC. DCLG funding was approved by the previous Government.

The findings in this report are those of the authors and do not necessarily reflect the views of the partners in this programme.

More information on the projects can be found at:
www.homeless.org.uk/esrc-programme

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