

Multiple Exclusion Homelessness and adult social care in England: Exploring the challenges through a researcher-practitioner partnership

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Abstract

This paper describes the early progress that is being made to implement the Care Act 2014 in England with regard to the care and support needs of people who are homeless. It outlines exploratory discussions that were generated through a series of interprofessional 'community of practice' meetings. These meetings highlighted practice challenges and emerging strategies to overcome them, from the perspective of both local authority social workers and homelessness practitioners. Three main themes emerged and we discuss these under context related headings: (i) legal change, (ii) homelessness and (iii) the local authority as an organisation. In summary, homelessness practitioners spoke about efforts to become legally literate in order to support people who are homeless to access adult social care. They reported that they often encountered barriers or fragmented responses. Statutory social workers spoke about encountering homelessness as an atypical form of vulnerability and grappling with how their needs relate to the new eligibility framework alongside significant budgetary pressure. The findings link strongly with theoretical strands around the nature of legal literacy, constructions of vulnerability and the impact of austerity on 'street level bureaucracies'.

Keywords: Homelessness, social work, Care Act 2014, community of practice

Background

Multiple Exclusion Homelessness (MEH) describes how the experience of homelessness often overlaps with other areas of extreme marginalisation including early childhood trauma, experiences of the care and criminal justice system and 'street activity' involvement (Fitzpatrick *et al.*, 2011; McDonagh, 2011). MEH is characterised by 'tri-morbidity' and is associated with impairments which arise from the combination of mental ill health, physical ill health and drug or alcohol misuse. It is an independent risk factor for premature mortality, with the average age of death of a long-term homeless person being between 40-47 years (Medcalf & Russell, 2014). Because of this underlying complexity, addressing MEH requires a shift in focus from 'rooflessness' towards a more appropriate health and welfare-oriented iteration (Maseele *et al.*, 2013). However, evidence suggests this is yet to be achieved in practice with a number of studies highlighting the particular difficulties facing homeless people in accessing more personalised support through adult social care (Cornes *et al.*, 2011; Cameron *et al.*, 2016).

A key objective of the Care Act 2014, which was implemented in England from April 2015, is to make the law fair and consistent by removing the anomalies which treat particular groups of people differently (Department of Health, 2013). In their review of these changes, Cornes *et al.* (2016) argue the Care Act is potentially 'good news' for people experiencing homelessness. First, the Care Act 2014 removes reference to 'eligible' and 'ineligible groups' so that any adult with any level of need will have a right to an assessment. This means that certain vulnerable adults (including 'homeless people') who were previously excluded on the grounds that they did

not come within a certain user group defined in legislation, will in future be included. Second, the new eligibility regulations are also potentially more inclusive of the needs of people who are homeless as they do not prioritise outcomes linked to physical assistance (e.g. help with washing and dressing) over and above those for social inclusion. Third, the Care Act 2014 simplifies the rules for how the local authorities will determine 'ordinary residence' which is welcome considering that transience and mobility across geographical patches is often associated with homelessness. More recently, emerging case law (*SG v Haringey* [2016]) has also shown a requirement to consider if care and support needs are accommodation related, in other words, contingent on the environment in which they occur.

Taken together, these changes do not necessarily mean that the Care Act 2014 contains a 'new deal' for homeless people, but that it may help clarify some of the 'grey areas' which led to inadequate responses from adult social care in the past. Furthermore, the extent to which the Care Act 2014 will be implemented in the spirit of the legislation is contingent on a number of other factors. First, in times of austerity there are questions as to the capacity of social workers to absorb the increased workload, especially with regard to the new duty to assess. Second, there is uncertainty surrounding the end of the Supporting People Programme. This provided ring-fenced grant funding for 'housing related support' and was the main funding source for homeless organisations. In order to fill this funding gap, homeless organisations may start to advocate more strongly for 'personal budgets' (cash for care) on behalf of their clients. This could in turn lead to increased budgetary pressures on already overstretched local authorities and tighter gate keeping of resources at the frontline (Cornes *et al.*, 2016).

In this paper we report on a series of four 'community of practice' meetings which were designed to explore how the Care Act 2014 is being implemented in the 'street-level bureaucracies' which underpin the organisation and delivery of care and support for people experiencing MEH. The meetings were held across 2016 and 2017 and brought together local authority social workers and homelessness practitioners from across England. The meetings were convened by academics from different universities who wanted to build a network of interest in order to scope future research in this area. The scoping exercise was funded in part by seed funding from one of the participating universities.

In the discussion that follows, we situate the views of local authority social workers and homelessness practitioners alongside each other to highlight the interprofessional challenges and opportunities that are emerging. Indeed, an unanticipated benefit of the 'researcher-practitioner' partnership was that it led to some immediate 'practice development' as practitioners and researchers exchanged knowledge and shared their resources and ideas. This confirms the potential of 'communities of practice' as both spaces for collegiate reflection and action.

Method

To bring academic and frontline practitioners together in a safe and constructive environment we drew upon 'community of practice' methodology, emphasising the important connections between research and practice (Fouché, 2015). 'Communities of practice' bring together people who share an interest or concern about a topic and seek to extend their knowledge through interacting together (Wenger, 2002). They have already been used to work through practice challenges associated with Multiple Exclusion Homelessness (Clark *et al.*, 2015; Cornes *et al.*, 2013).

In the early stages of developing the 'community of practice', we asked a number of homeless organisations to identify frontline practitioners with an interest in homelessness and adult social care. This recruitment strategy was then extended into statutory adult social care, using the professional networks of the participating academics. This enabled us to make contact with a number of local authority social workers with direct experience of working with people who are homeless and who were interested in developing their knowledge and understanding. We set

up four 'community of practice' meetings to explore the most salient issues arising in practice. This comprised 12 hours of discussion and debate. These sessions were attended by 4 academic research practitioners, 18 local authority social workers from 3 English local authorities (2 in London, 1 in the West Midlands) and 16 homelessness practitioners from 8 homelessness organisations (4 from London, 1 in the South West, 1 from the West Midlands and 2 from the North of England). Homelessness organisations included voluntary sector day centres, outreach programmes, specialist hospital discharge schemes and social enterprises. The consent of participants to report on the meetings was secured at the outset.

Detailed notes were taken at each meeting and these notes were then read and analysed, adopting a thematic approach. This involved identifying recurrent themes within and across participants' comments, as well as in their interactions with one another (Attride-Stirling, 2001). The focus was on identifying commonalities in practitioners' experiences of negotiating tensions in and beyond their institutional settings, as they related to the implementation of the Care Act 2014. Emerging themes from the study groups were shared with participants for comment and review.

The main limitation of this paper is that the findings are not based on empirical research. However, as Care Act 2014 implementation is still in its infancy, with little published research available, we thought these discussions would be of interest to other stakeholders and researchers keen to begin scoping this new field of collaborative practice.

Findings

A number of recurring themes emerged from the 'community of practice' discussions with local authority social workers and voluntary sector homelessness practitioners. The findings can be grouped under three key contextual areas: (i) legal change, (ii) homelessness and (iii) the local authority as an organisation.

The context of legal change

A) The homelessness practitioners' perspective

The Care Act 2014 and accompanying statutory guidance (Department of Health, 2016; 2017) were central to the 'community of practice' discussions. Homelessness practitioners reported frustration and powerlessness when making referrals and navigating adult social care systems. They attributed this to a lack of knowledge and formal training about the Act as well as being unclear about the remit of local authority social workers. Yet this group also discussed innovative ways of taking responsibility for their learning, while citing examples of using the Act to advance homeless people's needs. Homelessness practitioners outlined two key ways in which they did this.

First, homelessness practitioners spoke about harnessing the language and terminology of the Care Act 2014 to optimise the likelihood of their referrals being accepted by statutory adult social care. One participant reflected that their referrals had previously focused on narratives of vulnerability and difficult life circumstances to construct need, likening their referrals to 'an East Enders storyline' (referring to the UK soap opera). When they mapped this 'storyline' to the Care Act's terminology regarding eligibility outcomes and aspects of wellbeing, they found that they recorded fewer referrals that did not result in an assessment from adult social care. To build on this success, one participant described how he had designed a 'toolkit' (Ornelas & Meakin, 2016). This was designed to guide practitioners and service users through the relevant elements of the Act, with a particular focus on how to work with the new eligibility regulations. It was felt that the 'toolkit' helped staff to better frame their advocacy and articulate care and support needs with greater structure and clarity, thus improving communication with adult social care. While it was reported that there had been some initial concern among social workers that

the toolkit was a 'competing' assessment tool, when it was established that it was intended as a communication and training aid then most of these fears were allayed.

The 'toolkit' was subsequently shared with the community of practice and other members agreed to pilot this in their own areas. In later meetings, similar results were reported with regard to this innovative practice development having resulted in more positive outcomes from referrals. This engendered a growing sense of confidence and proficiency in navigating referral and assessment processes for adult social care.

Second, homelessness practitioners reported that the Act's reconfiguration of safeguarding was helpful in ensuring referrals were taken on by the local authority. The Care Act 2014 places safeguarding on a statutory footing and has formulated safeguarding as being inclusive of 'self-neglect' in its statutory guidance (Department of Health, 2017). Braye (2016) has argued that this will enhance governance around practice in this area and this appeared to be borne out in discussions. Homelessness practitioners spoke about how previously rejected referrals were often subsequently accepted by adult social care when self-neglect was explicitly mentioned. They believed the concept of self-neglect helped them to underpin care and support needs with risks, particularly when related to addiction, acquired brain injury, severe mental health issues or other people who may be unable to make decisions around their care and support needs.

Although both of these approaches suggest homelessness practitioners adapting to adult social care's terminology and processes, these practitioners remained critical about the power asymmetry inherent in having to make such modifications in order to be considered for care and support. They argued that the adult social care system continued to be configured around how people could fit into the system, rather than how the system could meet people's needs.

B) The statutory social workers' perspective

The local authority social workers had all received training from within their organisations on the Care Act 2014. They reported anecdotally that people who are homeless were being referred to them at higher rates than in previous years and this was attributed to an increase in homelessness and cuts to homelessness services rather than changes to the law, though the discussion led to reflections and acknowledgement of this as a possible factor.

Despite the greater levels of familiarity and confidence in working with the Care Act 2014 amongst these participants, there was some debate as to how certain aspects of the Act were being rolled out. For example, recent case law (SG v London Borough of Haringey [2016]) regarding 'accommodation-related support' was discussed but those attending were unclear how their local authority would respond. A hypothetical case study was discussed involving someone who was able to complete their personal care independently but struggled to achieve eligibility outcomes linked to social inclusion (for example, accessing and engaging in work, training, education and volunteering). Social workers agreed that the person in this case study appeared to be technically eligible, but accepted that it was uncertain whether this person would be considered eligible in practice. There was also uncertainty as to how people who were homeless could be supported to meet outcomes linked to inclusion.

Social workers agreed that the new safeguarding regime had brought clarity around responsibilities and that they were managing self-neglect in different ways to the previous community care regime. A number of social workers agreed that self-neglect could be a useful way to conceptualise the needs of homeless people. However, this was often experienced in a 'threatening' way in referrals from the voluntary sector. For example, they spoke about the language of safeguarding being conflated with risk and blame. This meant that referrers sometimes explicitly told social workers that the local authority was now aware of a safeguarding issue such that it would be 'their problem' if anything happened to the person. Not only was this experienced as an unwelcome and defensive threat, social workers also explained that this was not in keeping with the ethos of the Care Act or safeguarding which

sought to balance risk with the principles of independent living, choice and control. It was also asserted that the existence of a safeguarding concern did not mean that services could be forced upon a homeless person. This provoked some tension among the participating practitioners around whether autonomy was being given primacy by social workers without respectfully challenging why the person was refusing care and support. In other words, homelessness practitioners suggested the emphasis on autonomy and freedom to refuse care and support could result in an effective abandonment of the vulnerable homeless person by social workers.

At the same time, it is important to note that social workers generally spoke about the Care Act 2014 in positive terms, equating it to their ability to practice in a way that was more consonant with social work values. For example, social workers found alignment with terms like 'person-centred' and 'strengths-based'. This finding builds on Cornes *et al.*'s (2016) thesis that the Act may allow for homeless people's access to more personalised forms of adult social care. However, caution is required when using the vocabulary of personalisation (Beresford, 2016) and strengths-based practice (Slasberg & Beresford, 2017) in terms of whether this represents participatory or, conversely, 'top-down' iterations of personalisation. Further research will help clarify this particular issue.

The context of homelessness

A) The homelessness practitioners' perspective

Encountering the experience of homelessness was part of the day-to-day work of the practitioners in this sector. They were intimately aware of how homelessness could have a deleterious impact on an individual's physical and mental health and social care needs. They spoke about how homeless people's vulnerability was often perceived by social workers to be a 'housing problem' to be dealt with under housing legislation and departments and therefore not accepted as a social care referral (Whiteford & Simpson, 2015; Maseele *et al.*, 2013). Participating homelessness practitioners viewed the loss of ring-fenced Supporting People funding as a regressive step and openly questioned whether the Care Act's implementation could compensate for this.

Homelessness practitioners spoke about the importance of building trusting relationships with homeless people, who had often experienced multiple losses and rejections. They noted the high turnover of social work staff (see, for example, Research in Practice, 2015) and the problems this posed in terms of establishing stable and meaningful interprofessional practice, and thus in helping homeless people to agree to referrals. The lack of consistent social work engagement was seen to undermine (and marginalise) the support needs of people affected by homelessness.

A key obstacle in accessing adult social care for people who are homeless was the difficulty in establishing ordinary residence. This manifested itself in three distinct ways. To begin with, local authorities often disputed whether they had a responsibility to accept a referral. This was particularly problematic if the person had changed address or sleep site regularly and across local authority borders or had difficulty evidencing their address history. Related to this, several practitioners noted that local authority housing departments often placed homeless people in temporary accommodation 'out of area' (i.e. outside of the person's 'local connection'). This housing solution then led to a social care dispute between the original local authority's adult social care team and their counterparts in the receiving local authority. Third, and finally, release from prison represented another problematic issue. The Care Act stipulates that the local authority in which the prison is situated should assess a person's needs. However, practitioners noted that people who were being released from prison often had networks in other local authorities and they often ended up with unpredictable living arrangements post release. This led to difficulty when formulating social care plans.

B) The statutory social workers' experience

Social workers emphasised their genericism in the sense that they are not specialists in housing and homelessness. Indeed, most social workers acknowledged that homeless people are commonly viewed and understood as an 'atypical' group in terms of mainstream social work practice. At the same time, social workers said that they sometimes had trouble interpreting the referrals that they received from homelessness organisations. They described referrals with impenetrable jargon or narrative accounts of vulnerability, which did not specify a physical or mental health problem (the first requirement in the new eligibility rules). One example was the use of street names for certain substances in referrals (e.g. 'Monkey Dust'). This account also validates the efforts of homeless practitioners to develop a toolkit as an aid to improve interprofessional communication.

Social workers described receiving referrals for homeless people who said that they were not aware of the referral, were unhappy the referral was sent and did not agree with its content. There were also examples of referrals for homeless people who could not be contacted. Often social workers spoke about their difficulties engaging with people who are homeless. Some debate emerged in the 'community of practice' when discussing cases where a homeless person who may demonstrate some cognitive problems (perhaps an acquired brain injury or suspected learning disability) refused support from local services. Some social workers felt that not enough may be known about an individual's situation for a worker to form decisions about their capacity in a snapshot assessment. However, such an assessment might be required, for example, when it is not known where this person is going to be living after discharge from hospital.

Social workers acknowledged that ordinary residence may be an obstacle raised within local authority settings and this linked closely with gatekeeping and the organisational context, which we will look at next.

The organisational context of the local authority

A) The homelessness practitioners' perspective

Homelessness practitioners spoke about the local authority as a 'gatekeeper' of resources and felt that the system was set up in a way that required people to fit its requirements rather than the system being set up to meet individual needs. They acknowledged cuts within the statutory sector, but noted these were also having a significant impact on the voluntary sector's ability to effectively respond to the support needs of people experiencing Multiple Exclusion Homelessness.

One common observation was the perceived lack of coordination between the housing department and the adult social care department (particularly in London, where local authorities hold both functions), despite the Care Act's emphasis on integration. Some homelessness practitioners reported being asked by local authority adult social care or housing departments to mediate between these arms of the local authority who seemed to have limited communications. Homelessness practitioners also claimed that these arms often operated in adversarial or 'gaming' ways with one another, a process described by Whiteford & Simpson (2015) as services 'looking for ways in which individuals fall outside their eligibility criteria' (p.130). This was cited as a source of frustration for those working in homelessness organisations.

Another key theme around staffing and high turnover has already been addressed in this article. This was important in terms of how the homelessness practitioners perceived the local authority as offering a lack of continuity and a fragmented response to homelessness, which frequently exacerbated the problem of engagement given many homeless people's poor experiences with statutory services.

B) The statutory social workers' perspective

Austerity, particularly in the form of local authority budget cuts, recurred as a theme for social workers, who outlined various ways that local authorities were monitoring and attempting to reduce what was being spent, including through increased management oversight and incrementally lower cost thresholds for panel authorisation. Social workers spoke about how this directly affected what they could reasonably offer and how this often fell short of what they felt was required. There was evidence that homelessness practitioners perceived that social workers exercised high levels of discretion at street level. In contrast, social workers thought that in fact the space for practitioner discretion was shrinking on the basis of this organisational climate. One way that this manifested itself was having less time to build relationships with service users. This perhaps responds to claims by homelessness practitioners that social workers were not proactive about engaging hard to reach populations.

As already noted, social workers described the Care Act 2014 as enabling 'good social work practice' with its references to 'person-centred' and 'strengths-based' practice, but felt that the implementation of such an ambitious piece of legislation in times of austerity was extremely challenging.

Discussion

Having outlined three key themes, which emerged from the communities of practice approach, it is useful to consider how these fit with broader theoretical debates, and how they contribute to what is known about the implementation of the Care Act 2014 and interprofessional working in this area. We will also consider how all of this can support future research agendas.

Legal literacy is a theme that has gained increased attention in the field of social care in recent years and can be defined as the ability to connect 'legal rules with the professional priorities and objectives of ethical practice' (Braye & Preston-Shoot, 2016, p.4). Local authority social workers spoke about the Care Act's requirement to think about wellbeing and eligibility in new ways. Working with people who are homeless and other previously excluded groups constituted a developing area of practice where these new rules were being operationalised and tested. Social workers often reported a lack of clarity and ambiguity around how this new set of legal rules would be applied, especially the eligibility outcomes linked to social inclusion. Meanwhile, the homelessness sector has had to grapple with the withdrawal of ring-fenced Supporting People funding and the need to understand how the Care Act 2014 might apply to their client group. This has been experienced as significantly challenging in the context of homelessness practitioners' limited understanding of, and formal training in, adult social care law. The aforementioned toolkit represents one innovative way that homelessness practitioners tackled this gap in their knowledge and, in doing so, found a way to link the presenting needs of people who are homeless with the law. This served the dual purposes of helping to enhance homeless practitioners' knowledge of the law and their ability to apply this by using the tenets of the law to advocate for the person they were working with.

This appears to demonstrate these practitioners coping with legal change by seeking to become legally literate, building the skills, knowledge and professional values associated with understanding and interpreting the law (Preston-Shoot, 2014).

Increased contact with homeless people was cited as a source of difficulty for some social workers, in terms of encountering their relatively atypical and diverse forms of 'vulnerability' and navigating how these would fit the eligibility systems of social care provision. Vulnerability is a contested concept and its usage is changing in both adult social care and housing sectors. In housing law, vulnerability has been connected with 'priority need' and 'full' housing duties, but recent case law has brought the relative nature of this concept and the existence of degrees of vulnerability into focus (Loveland, 2017). Its use in connection with local authority housing duties may explain its use by homelessness practitioners in the context of adult social care.

However, the adult social care sector has shifted away from the use of the term 'vulnerable adult' (Department of Health, 2017), due to the inherent suggestion of a lack of agency and the term is otherwise problematic in associating vulnerability with membership of 'othered' marginalised groups (e.g. people experiencing homelessness) (Herring, 2017). It is often theorised in social work literature alongside 'risk', using the concept of 'resilience', which can be uncritically bound up with the politics of neo-liberalism and individualisation (Garrett, 2016). This was interesting as some of the homelessness practitioners noted that social workers in adult social care would often point to the 'resilience' of rough sleepers who 'presented well', correlating this as a type of heuristic process indicating a lack of eligible care and support needs.

'Presenting well' seemed to refer to a range of factors, including good levels of mobility and maintaining normative levels of personal care. However, homelessness practitioners repackaged this as a performative strategy to survive and a survivalist attitude adopted to manage the adverse nature of rough sleeping in particular. This was strongly gendered as it was mostly associated with male rough sleepers. Homelessness practitioners reported that this presentation often belied an inability to achieve a range of 'inclusion' type eligibility outcomes, as outlined earlier. They said this was sometimes not picked up by social workers who constructed this as 'independence' and consequently decided the person was ineligible. Social workers noted that independence, choice and control are central principles in the delivery of adult social care, especially in situations where homeless people did not wish to accept care and support from the local authority. However, homelessness practitioners often argued that social workers gave primacy to the principle of autonomy as an orthodox position, and at the expense of 'respectful challenge' around things that homeless people were not coping with.

As discussed briefly in the introduction, the concept of MEH may be a helpful intervention in this regard. For example, this tension was less likely when focused around discussion of specific vulnerabilities, such as acquired brain injury. Practitioners from both groups tended to agree on the complexity of mental capacity assessments and decision-making in this 'grey area', consistent with Holloway & Fyson's (2016) outline of the challenges faced by social workers working with this group.

It should be noted that there is some concern that the Act's implementation alongside the concurrent budget cuts and the context of austerity will stifle the progressive elements of the Care Act 2014 (Whittington, 2016). Local authority social workers noted that although the Act appears to offer renewed consistency with social work values (e.g. strengths-based practice and person-centred care), the significant fiscal cuts to local authority budgets are likely to undermine the potential for change (Slasberg & Beresford, 2017). Social workers' accounts of increased management oversight and requirements for panel ratification of care and support plans that previously could have been agreed at team level are consistent with debates around the changing nature of discretion and 'street level bureaucracy' (Ellis, 2011). Having said this, homelessness practitioners argued that some inconsistent responses to referrals signalled that discretion continued to be alive and well (Dobson, 2015; Evans & Harris, 2004).

Linked to this, as well as our earlier observation about social workers welcoming the consonance of aspects of the Care Act with their professional values, the organisational climate in local authority social work teams in the wake of financial cuts was described as demoralising (see also Whittington, 2016). Social workers linked this to an inability to implement care and support plans that they felt were appropriate due to resource insufficiency, strongly echoing the conditions for moral distress amongst frontline practitioners (Mänttari-van der Kuip, 2016). However, this also seemed to create positive attitudes for participating social workers about a commitment to working with homeless people. This seemed to reflect practitioners' ability to effect change in the form of empathetic attitudes to homelessness and critically self-reflective practice in spite of difficult circumstances (Fantus *et al.*, 2017).

Before concluding, it is worth briefly discussing the community of practice approach and its implications for interprofessional practice. Specifically, this intervention is not a 'magic bullet' (Cornes *et al.*, 2014) and does not necessarily eliminate conflict or adversarial communication, but it did appear to harness the positive aspects of shared learning. This resonates with Engestrom's (2001) activity theory around the productivity of sharing concerns and differences in interprofessional settings. It certainly appeared to help break down some of the barriers between different practice groups through practitioners' shared concern to address the care and support needs of people who are homeless in the context of the changes made possible through the implementation of the Care Act 2014.

Conclusion

The use of a community of practice approach as an interprofessional practice development has yielded a number of interesting themes which will be studied further through a formal research bid. It seemed important, however, to share the immediate themes arising in the context of limited research evidence in this area following the implementation of the Care Act 2014. We have provided an illustration of how 'communities of practice' can break down the barriers between practitioners from different organisations through shared learning and professional development. We have also shown how this approach can be used to support the development of research and scholarship as well as academic practitioners helping to inform and support practice in this field.

Having outlined a number of emerging themes and illustrations of practice dilemmas as well as emerging strategies, it remains to be seen if these relate to pockets of practice or whether these reflect a wider picture. This will be assessed by means of future research. In the meantime, it is anticipated that the themes discussed in this article will help to contribute to the emerging knowledge base around the challenges and opportunities that people who are experiencing Multiple Exclusion Homelessness encounter when accessing adult social care in England.

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