Homelessness and Adult Social Care Workforce: Scoping Study

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Skills for Care is the employer-led strategic body for workforce development in social care for adults in England. It is part of the sector skills council, Skills for Care and Development.
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Executive summary

Introduction

1. This research project was undertaken between January and September 2014 and explored the interactions between the Adult Social Care (ASC) and homelessness workforces. In doing so, it has considered whether Skills for Care should develop interventions, activities or resources that could enhance the skills of those members of the ASC workforce who come into contact with people who are homeless or facing homelessness.

2. The work has concentrated on five specific points at which the interface between the ASC and homelessness workforces appears to be relatively prominent. Termed ‘transition points’, these are ‘leaving prison’, ‘experiencing domestic abuse’, ‘leaving hospital’, ‘leaving care as a looked after young person’ and ‘leaving the armed forces’.

3. The research method has included a review of relevant literature, consultations with 30 national stakeholders from the ASC and homelessness sectors, three local authority case studies (which explored the transition points in more detail) and an online survey (83 responses) aimed primarily at people working in ASC in local authorities.

The Existing Evidence Base

4. Very little research has previously been undertaken on the interactions between the ASC and homelessness workforces, and less still which looks at workforce development and skills needs. Instead, research has tended to focus mainly on different models of service integration and the integrated support needs of specific client groups.

5. Where previous work relevant to the topics covered by this study has been undertaken (e.g. Reeve et al, 2006 and Tischler et al, 2007), it has identified ‘core areas’ of knowledge that staff in each workforce should have about the other (largely around who provides specific services and how to engage with them) and has stressed the importance of joint commissioning and effective information sharing agreements. These points have also arisen during this study, although an important finding is that most ASC consultees feel confident that they have an appropriate (although not necessarily comprehensive) level of knowledge of homelessness processes and providers, and vice versa.
Interactions and Overlaps

6. The research has shown that while multiple support needs are very common, only a very small proportion of people have homelessness issues and support needs of a nature and severity which qualify them for ASC support. This is true across each of the five transition points that have formed the focus for the research. As a consequence, interactions between the two workforces are relatively infrequent.

7. That is not to say that interactions do not exist at all – they do and the main body of this report provides a range examples taken from the local authority case studies (see appendices E-G for more detail). These include a project set up specifically to provide support to ex-members of the armed forces with a range of needs including housing and ASC; specialist healthcare teams providing services to people in temporary accommodation; and an education support project for people in supported housing after they have left prison.

8. However, these are the exceptions rather than the norm. While each appears to have had some success and has involved effective interactions across the workforces (and may therefore be suitable for replication elsewhere), it was much more common for consultees to report that on a day-to-day level, and across all five transition points, the extent of the interaction is limited.

Opportunities for Skills and Workforce Development Interventions

9. The consultee feedback on this subject is very clear. Regardless of whether they have a national or a local remit, and regardless of whether they work in ASC or homelessness, they were not able to identify any evident skills-related areas of need or market failure on a scale that would justify Skills for Care’s intervention.

10. This was also echoed in the ASC workforce survey, the responses to which suggest that when staff from the two sectors do work together, then referrals, information sharing and signposting all operate reasonably well and do not require skills or workforce development activities (beyond those which already exist) to be more effective.

11. In the few cases where consultees did identify opportunities for new skills or training programmes, they tended to be unspecific about what they should involve, talking instead in generic terms about “understanding what we/they do”, “understanding legislation” and “getting referrals right” (similar comments were made in the ASC workforce survey). Those making more specific suggestions were evidently referring to local issues that do not require a national response.
12. That is not to say, of course, that the workforces do not encounter challenges or barriers to joint working. It is very clear that they do (for example, issues relating to budgets and resources were regularly cited during the research) but the resolution of these challenges – where indeed there is a resolution – does not fall within the remit of Skills for Care.

Concluding Remarks on the Transition Points

13. This research has looked at five specific transition points and in each of these has identified the main types of organisations involved and the nature of the interactions between the ASC and homelessness workforces. In doing so, it adds new evidence to an area where relatively little previously existed and concludes that there is no immediate need for any Skills for Care-led intervention, be that in the form of workforce development programmes, new resources or aware raising activities.

14. The reason for this centres mainly on the issue of supply and demand. While it is generally agreed that the risk of homelessness increases at most of the transition points, it is still (and thankfully) relatively rare even then. Clients that are at a given transition point, that have a genuine risk of homelessness and have an ASC need and are eligible for ASC support are rarer still. Throughout the research, consultees said that while it was by no means unheard of for them to work with people in these circumstances, it did not happen regularly.

15. This raises the question of whether the transition points were the right focus for the research. Insofar as they provided a definitive scope for the study and are acknowledged points where the risk of homelessness can increase, then their selection was justified. What is clear, however, is that the transition points on their own are not necessarily the triggers of homelessness, nor of ASC need, hence the supply and demand issue. To this end, it is not recommended at the current time that further research be undertaken by Skills for Care, nor that any activities or resources be developed, that focus specifically on the transition points.

16. The fact that the research results in these conclusions is not bad news. On the contrary, it should be welcomed that representatives from both national and local organisations, covering all five of the transition points, said that there are no systemic skills or workforce development issues that require specific intervention. Skills for Care should be commended for undertaking what has essentially been a market testing exercise as this will help them to channel their resources into areas where they can have a more significant impact.
1. Introduction

1.1 Research Overview

Skills for Care, in its role as the Sector Skills Council for Adult Social Care (ASC) in England, has been keen to explore the interactions between the ASC workforce and the homelessness sector. This interest stems from early stage research, undertaken in-house by Skills for Care, which suggested that:

- There is or may be a lack of expertise in ASC on homelessness issues;
- There is or may be a lack of understanding of how ASC works with the homelessness sector;
- Hostels should have good links with ASC safeguarding co-ordinators, but the extent to which this happens is not clear;
- ASC tends to group around areas of need, e.g. mental health and the elderly, yet because homeless people often do not fit into any single ‘category’, there is a risk of their needs not being fully identified and met.

Skills for Care also identified certain points at which the interface between the ASC and homelessness workforces appears to be relatively prominent. Termed ‘transition points’, these include:

- Leaving prison;
- Experiencing domestic abuse;
- Leaving hospital;
- Leaving care as a looked after young person;
- Leaving the armed forces.

In December 2013, Skills for Care commissioned this research project to inform the parameters and scope of any future work that they may wish to take forward involving the two workforces. The specific objectives of the work were to understand more fully:

- the range of stakeholders interested in the overlap between the workforces, focusing specifically on the five transition points listed above
- the extent of work already established in the field and the nature of any overlap between ASC and other staff.

The project was intended to culminate in an options appraisal of potential interventions that could enhance the skills of those members of the ASC workforce who come into contact with people who are homeless or are facing homelessness.
1.2 Research Method

The project took place between January and September 2014 and involved the following activities:

- **Evidence review**: a structured review and synthesis of evidence (academic and non-academic) on ASC and homelessness interactions. Google and Google Scholar were key sources, and the ekosgen team also worked with colleagues at the Centre for Regional and Social Research at Sheffield Hallam University to ensure that all relevant evidence was identified. The team took a structured approach to the review which included sifting out evidence that was of poor quality and only including evidence that had relevance to the key lines of enquiry covered by the research.

- **National stakeholder interviews**: 30 consultations (face-to-face and telephone) with representatives from national organisations operating in the homelessness and ASC sectors. The consultations covered the scale and types of interactions across the two workforces and the associated skills and workforce development needs. Appendix C lists the organisations involved.

- **Case studies**: three local authority case studies explore the ASC and homelessness workforce in more detail. Reports from the case studies have been submitted to Skills for Care separately but summaries can be found in Appendices E-G. Findings from the case studies have informed much of this report.

- **Workforce survey**: an online survey, aimed at people working in ASC who have some involvement with homelessness issues or homeless clients. The survey was distributed via Skills for Care’s e-news and generated 83 responses. Key findings have been included in this report and a summary of the responses to each question has been provided in a separate annex document. The questions included in the survey can be found at Appendix D.

1.3 Reflecting on the approach

This study is one of relatively few that has explored the interactions between the ASC and homelessness workforces. In that regard, it provides an up-to-date perspective, specifically against five transition points. It should be noted, however, that as the study progressed it became evident that fully meeting the research objectives would be challenging, especially in terms of identifying a valid options appraisal for future Skills for Care interventions. This topic is revisited at various points in the report, but at this stage it is worth noting the following:
Transition points: the research has explored workforce interactions focusing on an agreed list of transition points. Consultees were however consistently in agreement that the number of people at each transition point who have an ASC need is typically quite small, which has limited both the breadth and depth of the findings. That is not to suggest that the transition points are not valid, and simply looking at homelessness per se would have made the scope of the research too large, but focusing on the five transition points in question has influenced the extent to which authoritative conclusions can be drawn. It may be the case that at other transition points, the interactions are more common.

Local variations: beyond statutory provision, the scope and scale of services for people with multiple needs varies locally depending on a number of factors that include funding, local demographics and the strength of cross-organisation working. The three local authority case studies (see appendices E-G for more detail) therefore provide very useful insight, and have verified many of the messages obtained from the national consultations, but they will not necessarily reflect practice the country over.

Other influencing factors: reflecting Skills for Care’s remit, the study has set out to identify elements of ASC and homelessness interaction that could potentially be improved or made more efficient by workforce development related activities. In summary, and as explained later in the report, no such elements were identified on a scale that would warrant Skills for Care’s involvement. However, both local and national consultees regularly identified issues relating to budget reductions and contracting constraints and spoke of the strains that these place on service provision. So while the report concludes that there are no evident inter-workforce skills/training issues to be addressed, that should not imply that the two workforces are satisfied with the service they are able to provide for their clients, be that in isolation or collectively.

1.4 Terminology

The following definitions have been adopted for this research:

Homelessness: includes rough sleeping, staying with friends or family (often referred to as hidden homelessness) and temporary accommodation (e.g. hostels and refuges).

ASC workforce: social workers, care workers and personal assistants, community outreach and support workers, people working in employment support, occupational therapists, nurses and allied health professionals, youth offending support workers, counsellors, advocacy and guidance service workers, educational support workers.
- **Homelessness workforce:** a broad definition has been used to capture the diversity of the sector. This includes outreach support, floating tenancy support, hostels and refuges, temporary accommodation with support and wider housing-related services.

- **Interaction:** where both workforces are involved in supporting a client. This might include referrals, joint working and/or case management.
2. Policy and Evidence Review

2.1 Policy Evolution and Recent Developments

Policy developments in the 1970s saw local authority departments become increasingly focused on single client groups. Included in these developments was the 1977 Housing Act, which transferred responsibility for homelessness from social services departments to housing departments. What followed, critics argued, were insufficient interactions between ASC and homelessness services (and indeed between different departments in general), in some cases resulting in poor access to support, especially where people had both housing and long term ASC needs.

More recently, the focus has been on service integration. The report Social Justice: Transforming Lives (Department of Work and Pensions, 2012), for example, proposed a new approach to addressing poverty and disadvantage that focuses on prevention and early intervention. The report recognises that there are many adults living chaotic lives and experiencing multiple forms of disadvantage which can impact on their life chances, and these people’s needs are unlikely to be adequately met without a new approach.

“We cannot hope to tackle multiple problems in a sustainable way unless we continue to establish new approaches to delivery for this group, including better preventative services, multi-agency approaches, and the provision of key workers to provide long term tailored support”. (Department of Work and Pensions 2012 p.11)

The 2012 Health and Social Care Act has placed new health inequalities duties on the NHS Commissioning Board and Clinical Commissioning Groups, and a greater emphasis on service integration. Health and Wellbeing Boards have been charged with driving better local co-ordination of services for individuals with multiple needs, while programmes such as the Department of Health’s Integrated Care Pilots have also tested new approaches to supporting people facing multiple health issues.

In addition to integration, there has been a move towards preventative measures. Within the homelessness sector, for example, a greater focus has been placed on supporting people at risk of homelessness (previously the emphasis tended to be on addressing homelessness once it had happened). The report, Making Every Contact Count (Department of Communities and Local Government, 2012) endorsed this and advocated a joined up approach to preventing homelessness, calling on local authorities to adopt a corporate commitment. Predating this was the 2003 Audit Commission report, Homelessness Responding to a New Agenda, which identified three features of effective homelessness prevention:
• **Accessible service**: ensuring individuals know how and where to find help. This includes raising awareness about services, enabling different forms of access or developing one-stop needs assessments.

• **Providing effective housing advice**: enabling people to stay in their existing accommodation and ensuring clear routes into, and links between, services to help them obtain advice.

• **Support to maintain housing**: ensuring that support agencies are proactive in helping people to sustain their accommodation in order to combat the ‘revolving door’ of repeat clients.

“Some services have made little attempt to systematically address applicants’ support needs, which may be particularly important for repeat applicants….case files offer little evidence of systematic onwards referrals from homelessness services to other services when clients need help from these services but are not in touch with them. Homelessness staff should play a pivotal role in support……staff will need up-to-date contact information and an understanding of eligibility criteria in order to make appropriate onward referrals”. (Audit Commission 2003, p30)

At an operational level, and importantly in the context of this study, the Audit Commission found that some people, particularly young people leaving care and those with mental health or drug and alcohol problems, have been prone to ‘falling between the gaps’ of service provision due to a lack of specific protocols and local variations in the level of need that is necessary to trigger intervention.

The movement of policy towards integration has been designed, in part, to tackle these issues and to better respond to the needs of those members of society facing multiple challenges. As a consequence, job roles and responsibilities are changing, and will continue to change as integration becomes more embedded, with many ASC workers in particular expected to have a broader base of knowledge and skills than was the case in the past.

### 2.2 The Causes of Homelessness

It is widely recognised that a range of interrelated issues can cause or increase the risk of homelessness. Research by the Joseph Rowntree Foundation (2000) categorises these into ‘structural’ and ‘individual’ factors:

• **Structural factors** relate to macro- social and economic processes such as housing and labour markets, government policy, welfare policy and trends in family structures.
• **Individual factors** are those related to a person’s own circumstances such as poverty and unemployment, relationship breakdown, abuse and harm, isolation and loneliness, mental and physical health, substance misuse, experience of local authority care and time spent in prison.

The above leads to the identification of specific triggers which, either individually or combined, can result in homelessness. These include:

- ‘Transition points’ such as leaving hospital, prison or care, or arriving in a new country as an immigrant or asylum seeker.
- Family or relationship breakdown, including that which involves abuse or harm, bereavement or young people running away from home.
- Financial hardship leading to poor housing standards or eviction.
- Deterioration in mental or physical health or increased drug and/or alcohol use.

In practice, combinations of the above are likely to be involved. Consequently, the Joseph Rowntree Foundation has suggested that strategies to prevent homelessness are most successful when the full range of factors can be taken into account and addressed in a holistic and joined up way.

Following on from this, the concept of ‘multiple issue homelessness’ has been the focus of recent research. Cornes et al (2011b, 1) suggests that this concept “alerts us to the potential for complex interplay between many different professional or occupational groups, reflecting how drug and alcohol dependencies, severe mental health problems, domestic violence, local authority care and prison, and participating in street culture and survival activities such as sex work, begging, street drinking and street-level drug dealing frequently (but not always) intersect with homelessness.”

The Cornes et al (2011b) research explored the interaction between the agencies involved in supporting people who experience multiple issue homelessness. It found that, while there is evidence of signposting and referrals, it is often the case that support plans are not shared amongst agencies, which in turn reduces the continuity and effectiveness of the support that clients receive. The research also found only limited evidence of strategic integrated working involving shared assessment and co-ordinated support planning.

### 2.3 Interaction between the ASC and Homelessness Workforces

Very little research has been undertaken on the interactions between the ASC and homelessness workforces, and less still which looks at workforce development or skills...
needs. Instead, the research has tended to focus mainly on different models of service integration or the integrated support needs of specific client groups.

The needs of older people, for example, have been the focus of several pieces of work, including Homeless Link’s *Older Homeless Project*. This looked at older people’s needs specifically in relation to adult social services departments and highlighted hospital admission and discharge as a point where housing issues can come to light. The work suggested that in some cases, a lack of expertise within ASC on homelessness issues, and a lack of understanding of how ASC works in the homelessness sector, can result in poor access to services. It also highlighted specific areas where understanding and joint working across agencies could be improved (Homeless Link 2013a). These include joint assessments and adult safeguarding.

Homeless Link has now begun looking at the expertise required in different sectors to address the needs of the older homeless population. In doing this, they are considering the role of different structures of partnerships to facilitate the pooling of knowledge and expertise. Multi-agency steering groups is one of their recommendations.

“Project workers need to understand more about how ASC works, and how and when to access a community case assessment. ASC need to understand more about hostels and the level of support they can provide. ASC will be invited to run a session to develop this mutual understanding; hostel workers will offer reciprocal training on understanding the needs of homeless clients.”

**Specialist Homelessness Post within Adult Social Care (Homeless Link 2013b)**

The London Borough of Camden has appointed a social worker whose role it is to work exclusively with hostel residents. This is intended to:

- improve communication between ASC and hostel staff
- improve understanding across the two workforces of each other’s roles and remits
- engender a more joined up way of working, thus delivering better outcomes for clients
- result in a more proactive approach to early intervention.

All referrals from hostels in the borough are allocated to this social worker. Clients will also be in receipt of a care package which is then monitored by the social worker to ensure it is working effectively. The social worker also works closely with hostel staff to help build better relationships and improve their understanding of ASC. When the social worker visits one of their clients at the hostel, they also met with key workers and attend relevant meetings. The social worker also contributes to the assessment and move-on stages of the support.
A recent study (Manthorpe et al. 2013) has explored the role of social workers within statutory and voluntary agencies that work with people at risk of and experiencing homelessness. It found that social workers have, in the main, responded well to the homelessness support needs of their clients and have made concerted efforts to minimise the homelessness risks that they face. They have also been effective at arranging appropriate social care support, where eligibility criteria permit, for those experiencing homelessness.

In addition, the following examples of the approaches being taken to improve integration are also worthy of note:

- **Contracting the Voluntary Sector to Provide Assessments of Homeless People (Homeless Link 2013c).** In Nottingham, the Mental Health Support Team (MHST) carries out community care assessments on behalf of adult social services for homeless people who require residential or home care services. The MHST is considered an appropriate organisation to undertake the assessments due to its familiarity with the client group. The MHST carries out assessments, acts as advocates for homeless people to help them access a range of services, offers ongoing support to those who find it difficult to access mainstream services and have a key worker system for individuals who remain socially excluded.

- **Hospital Discharge Project for Older People (Homeless Link 2013d).** Willow Housing is the main housing provider for older people in the London Borough of Brent. They have a floating support service for older people to enable them to live independently. Within the floating support team are hospital discharge support workers who work specifically with older people returning home after a stay in hospital and who need help and support during this period of transition. The floating support lasts for up to six months, during which time referrals are made to longer term care and support services where necessary. The intention is that the service enables older people to remain in their own homes, reduces ‘delayed discharge’ fines for social services (which are levied if older people are not able to leave hospital when ready), frees up hospital beds, reduces hospital re-admissions and reduces the number of referrals made to residential care.

### 2.4 Implications for Workforce Development and Skills Needs

The ongoing move towards service integration will have (and is already having) implications for both ASC and homelessness workers in terms of the need to develop a clearer awareness of each other’s roles and the issues they commonly face. Research undertaken to date in this area has tended to focus on multiple health-related issues, and has been more about ways of working than measures to upskill the workforce(s), but they nonetheless provide pointers which may be relevant to housing/homelessness and social care. The evaluation of the Integrated Care Pilots (RAND Europe and Ernst
& Young LLP, 2012), for instance, highlighted the importance of bringing together a range of different skills sets to effectively help individuals with complex needs, an example of which is provided in the box below.

**Integrated Care Pilot: Norfolk**

The integrated teams in Norfolk identified their target populations through use of a combination of clinical judgement and a predictive risk tool to identify people at risk of unplanned hospital admission, developed common assessment processes and provided patients and service users with a key worker or case manager as a primary contact point. Joint assessments by health and social care staff were carried out with patients placed on a shared case list. Some teams had an integrated care liaison officer who was provided with access to multiple IT systems containing patient data and referrals, and who could relay this information quickly to relevant health and social care colleagues. Monthly multidisciplinary meetings at GP practices were the primary means through which the teams discussed individual patients with primary care staff. In one sub-pilot social workers spent one day a week in GP surgeries. Additionally, two sub-pilots included rapid response teams—groups of health and social care clinicians who have been taught generic care skills in order to respond to patients within four hours, with the aim of preventing hospital admission.

The Integrated Care Pilot evaluation also noted that as a result of the different ways of working, staff roles had changed, mainly in terms of a broadening of their responsibilities. However, only a small proportion of the staff involved said that they had been given enough training to meet their new responsibilities effectively. This lack of formal training was criticised in the evaluation and was said to hinder the ability of the staff to deliver a better support service. Some staff also reported feeling disempowered as a result.

Other evidence is more specific to the topics within the scope of this research project. For example, the policy briefing ‘Prevention of Homelessness: the role of health and social care’, published jointly by the Department of Health and the Housing Learning and Improvement Network (2009), sets out the rationale for joint working to prevent homelessness and how this can be achieved. In doing so it specifies the broad knowledge areas that the health and social care workforce should have of homelessness and vice versa. These are summarised below (note that they refer to health and social care rather than ASC exclusively). The policy briefing goes on to stress the importance of joint commissioning and service delivery, as well as effective information sharing agreements.
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Multi-agency training is seen as an important way of enabling joint working and understanding, which can be enhanced by distributing updates about local services for homeless people. This is also supported by Reeve et al (2006) and Tischler et al (2007) who argue that more joined up service provision and greater understanding of homelessness would benefit homeless women.

Finally, the literature highlights the need for social workers to understand the risks and trigger points of homelessness and to be able to identify the signs of this amongst their clients. To this end, a homelessness prevention checklist was developed by Sheffield Institute for Studies on Ageing (a revised version is available via Homeless Link (Homeless Link 2013d)). This can be used by health and social care professionals where they have some concern that a person might not be managing in their home. It contains prompts about daily living and household management skills, debts, and problems that might be causing unsettledness. The checklist is provided at Appendix B, although note also that the vast majority of ASC consultees that participated in this research said that they and/or their staff were very confident that they would be able to identify the risks of homelessness without the need for additional guidance.
3. An Overview of the Service Provision Landscape

3.1 Generic and Transition Point Specific Provision

There is clearly a broad and extensive range of organisations and individuals providing support to people that have housing/homelessness issues and/or who may have an ASC need.

To list or map these comprehensively would be a near endless task, especially given the variety that is present at a local level and the many permutations that exist in terms of people’s needs, circumstances and where they fit against eligibility thresholds.

At a high level, however, the services can be grouped into ‘generic support’ and ‘transition point support’:

- **Generic support** includes organisations that serve a wide population base, such as GPs and Jobcentre Plus, alongside specific services that support clients who may lead chaotic lives and have multiple needs, such as substance misuse services. The majority of these are statutory services (see the diagram below). The housing and homelessness support and the local authority led ASC support referenced in the diagram is that which is not specific to a transition point.

- **Transition point support** is tailored to the specific needs of individuals who are at a given transition point. These are a great many organisations providing these services (for example, it is estimated that some 2,000 charities exist with the aim of supporting ex-service personnel alone) and the local authority level case
studies provide a more detailed picture (see appendices E-G). In summary, however, they include, although are by no means limited to:\1:

- **Support organisations**: typically in the voluntary sector, these organisations provide services such as mentoring, advice and guidance and counselling. They may also offer short term or, in some circumstances, long term accommodation for their clients (across the transition points covered by the study this is most common for domestic abuse and leaving the armed forces). They have an in-depth appreciation of their clients’ circumstances and support needs.

- **Statutory services** such as the police and probation services in the case of those leaving prison (this highlights the point that statutory or generic services can also be transition point specific).

- **Employment and education services**: a range of organisations exist to provide education and employment to, or arrange it for, people at the transition points (most commonly leaving prison and leaving the armed forces).

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Note that in the diagram that follows the bullet points, the 'leaving hospital' transition point is not included. This is because the services involved in that transition point are, in the vast majority of cases, statutory or generic services rather than having a remit that is specific to that transition point.
It is difficult to say conclusively whether the support landscape, both generic and transition point specific, is fit for purpose, as to do so with any certainty would require a much larger study. However, not losing sight of the fact that some consultees gave examples of gaps in provision, and recognising as well that challenges can exist when clients come to access certain services, the study has found that in the main, services are available to meet the needs of individuals at each of the study’s transition points. A recurring message throughout the research has been that where market imperfections exist, e.g. where clients are not able to access services promptly, the root of the issue tends to be limited resources (financial and personnel) rather than shortcomings in skills or knowledge.

3.2 Transition Point Routes

The following sub-sections show, at an intentionally high level, an indicative route through each of the five transition points covered by the study. Each route will in practice have many variables and permutations dictated by the needs, abilities and choices of the individuals concerned. The local authority case studies look at these permutations, and the transition points as a whole, in more detail, but the intention here is to illustrate the main components involved in each transition point (see appendices E-G for more detail).

Before doing so, it is important to acknowledge the following two points:

- The proportion of people at each transition point who actually become homeless is small. In the vast majority of cases, the route through the transition point does not result in homelessness, due at least in part to the good work done by the support agencies, both statutory and non-statutory.

- The risk of homelessness varies by transition point. As above, it is low in each, but would seem to be lowest at the point of leaving hospital or leaving care and highest when leaving prison.

Leaving Prison

For those facing homelessness on release from prison, pre-release support is made available to help source suitable accommodation. This is provided by prison accommodation officers and voluntary sector providers, as well as by social services where the prisoner is already attached to a social worker.

Referrals are made to hostels, accommodation and support providers and housing associations. On leaving prison, voluntary sector providers will often offer ‘through the gate support’ and continue to work with their clients while they are in temporary accommodation. Clients are then supported, either by the accommodation key workers or by the support provider, to access other services depending on their needs and circumstances. Further detail is provided in ‘leaving prison and domestic abuse’ case study report.
Domestic Abuse
When domestic abuse is disclosed, a risk assessment is undertaken by the police and social services (who will remain involved if there are safeguarding issues). Those experiencing the abuse are offered counselling and support from a voluntary sector provider and, where it is not safe for them to stay in their home and they choose to leave, a referral is made to a refuge. Clients are then supported, either by key workers at the refuge or by the voluntary sector support provider, to access other elements of support as appropriate. Further detail is provided in ‘leaving prison and domestic abuse’ case study report.

Leaving Hospital
Ensuring that all patients have a safe and appropriate environment to return to after leaving hospital is an integral part of the hospital discharge process. When leaving hospital, medical and nursing staff will review the housing and other medical/care
support needs of all patients and will refer patients onto social services where additional (non-medical) intervention or support is required. Social services sometimes have dedicated social workers based within hospitals to manage these cases.

Where a patient already has a social worker, it will be the social worker’s responsibility to co-ordinate any wider support that is required to facilitate the discharge. Where the patient is not known to social services and support needs are identified, medical staff will refer to social services who will attend the hospital and take over the management of the individual’s case. The patient’s social worker will refer to other support agencies and departments in order to help the individual access an appropriate package of support. Where a patient is facing homelessness, this will include a referral to local authority housing teams, third sector providers and providers of temporary accommodation. Further detail is provided in the ‘leaving hospital and leaving care’ case study report.

Leaving Care
Leaving care is designed to be a gradual transition process, and as such care leavers receive ongoing support from a local authority Leaving Care Support Worker. This support is offered as part of the authority's Corporate Parenting role: each care leaver will have a Pathway Plan which identifies the support that they need to help them make a successful transition to adult life. The Pathway Plan will consider a wide range of support needs such as housing, social care, education and training, employment and financial assistance. It will be the responsibility of the Leaving Care Support Worker to refer and liaise with the relevant agencies and departments to help the young person access the services they require.

It is important to note that it is highly unlikely that a young person will become homeless at the point at which they leave care. The risk of homelessness is more likely to arise once they are no longer receiving the above support (research by the Who Cares Trust,
for example, shows that 30% of homeless people have been in the care system) or if they are classed as having made themselves intentionally homeless. Further detail is provided in the ‘leaving hospital and leaving care’ case study report.

Leaving the Armed Forces
Around 20,000 service personnel leave the armed forces every year. This can be due to a natural end to their commission, redundancy or medical discharge. Each of these individuals has access to tailored support and advice in advance of being discharged, the intention being that they are as well prepared for civilian life as possible. The Career Transition Partnership – a partnering agreement between the Ministry of Defence and Right Management – is key to this and provides resettlement services that cover the job market, housing, health and education, benefits (which where appropriate could also incorporate ASC) and pensions.

Each service leaver has a Personal Resettlement Plan which, while focused primarily on employment and training, can also cover issues and actions relating to housing and ASC where necessary. The Career Transition Partnership is available to ex-service personnel up to two years after they have been discharged (assuming that certain eligibility criteria are met).

There are, in addition, a range of national and local support agencies whose remit, in full or in part, is to assist ex-service personnel with various aspects of civilian life. Some of these – Veterans Aid and the Royal British Legion being two – have hostels, care homes or other forms of accommodation which ex-service personnel can reside in on a short or long term basis. The research shows that staff in these organisations tend not to have prescribed or formal processes in place for identifying ASC needs amongst their clients, relying instead on observations regarding their clients’ physical and mental health. Referrals are relatively rare, although they do occur. A UK-wide provider of rental housing for ex-service people explained that, where appropriate, they signpost
their residents on to occupational therapy services (although the same provider also noted that local authority resources for that kind of support is typically very limited so they also regularly signpost to other charities and help people to access the Army Benevolent Fund and the Navy Benevolent Fund). Another charity helping ex-service personnel, this time based in the south of England, will act as an advocate and advisor for their clients when they are engaging with social services.
4. Workforce Interactions

4.1 Understanding the Workforces

Homelessness sector
People working in the homelessness sector who were consulted for this research tended to say that their sector was rather siloed, an issue which stems in part from the historic separation of local authority service areas discussed in Chapter 2. They also identified the diversity of the sector (and its clients) and the absence of regulation as influencing factors. The regulation issue, in particular, was said to make the sector harder to define than many others.

Frontline homelessness workers, especially those that are not specific to a transition point, tend to be seen (perhaps unfairly given the skills they require), as ‘generalists’ who have a broad range of relevant knowledge but few in-depth specialisms. This can be frustrating for the workers themselves, some of whom argue that their role is not regarded with the credibility that it should be. Compounding the issue is a lack of recognised formal qualifications for key workers in the homelessness sector and the fact that homelessness services often fall outside statutory provision.

“*The workforce doesn’t have a representative body and regulation as social workers or nurses do. It’s so diverse and so difficult to place under one umbrella.*” – Housing and support charity (national stakeholder)

“As it’s not statutory provision, homelessness support is seen by some people to be almost marginal or less important.” – Housing and support provider (national stakeholder)

“*Other professions need to recognise that a generalist is still an expert.*” – Housing and support provider (national stakeholder)

The research suggests that the homelessness workforce’s understanding of ASC is rather narrower than the definition used by Skills for Care and outlined in Chapter 1 of this report (given the relatively small scale of the research versus the size of the workforce, this is something of a generalisation but it did arise consistently throughout the consultations).
ASC was considered by the majority of homelessness consultees to include:

- local authority led social care (residential and domiciliary)
- social work
- care and support worker job roles.

Very rarely did any of the homelessness consultees cite people working in employment support, occupational therapists, nurses and allied health professionals, youth offending support workers, counsellors, advocacy and guidance service workers or educational support workers as being in their definition of ASC.

It is difficult to say whether this narrow view of ASC amongst the homelessness workforce gives rise to any problems. It is certainly not the case that homelessness staff are unaware that these other roles exist, nor do they appear badly informed about what they involve, so how they are categorised could be largely inconsequential. That said, if in the future Skills for Care is looking to design interventions that involve both ASC and homelessness, it is worth noting that the full breadth of ASC does not seem to be accurately understood within the homelessness sector.

**ASC sector**

Perhaps more surprising is that some workers consulted for the evaluation, who are in roles that fall within Skills for Care’s ASC ‘footprint’, do not recognise themselves as being part of the sector. This is especially true of those in nursing, education support and NHS resettlement officer roles, who associate themselves much more closely with the health and housing sectors. This is likely to be linked to the fact that the definition of ASC is itself becoming more complex as a result of the integration agenda. Anecdotal feedback gathered during the research suggests that workers are finding it increasingly difficult to identify themselves in a single sector, but rather see some elements of their job as belonging in ASC and other elements belonging in different sectors.

Members of the ASC workforce consulted for the research, both in the case studies and the online workforce survey, claimed to have a reasonable understanding of the homelessness sector and didn’t identify any evident gaps in their knowledge. There is, however, the risk of “not knowing what they don’t know” and while rare, a small number of consultees did identify some issues. These are conveyed via the quotations in the box on the following page.
"It would be good for some of our staff to know more about the causes and effects of homelessness and it’s important to know about the associated legislation.” – Local authority social services department (local case study)

“In one case, social services were not willing to provide a package of personal care because they felt it was our role – we provide housing support, not support to help people have a shower.” – Housing and support charity (national stakeholder)

“At the moment, when we are working across professions we find there is a lack of understanding of what we do......including amongst some people in social care” – Housing and support provider (national stakeholder)

Examples such as these were far outweighed by the view that each workforce has an appropriate understanding of what the other does, the organisations that provide local services and how to contact them (the excerpt in the blue box below on this topic is from the armed forces case study but it conveys a finding that is common across all five transition points). However, it is important here to make the distinction between an ‘appropriate understanding’ and ‘a comprehensive understanding’, as the former does not necessarily imply the latter. That said, while none of the consultees would argue that having more knowledge of what the other workforce does, and how it does it, is a bad thing, neither do they consider it essential.

Excerpt from the Armed Forces Case Study

The vast majority of the stakeholders with a national remit that were consulted for the armed forces case study agree with the following two assertions:

- The homelessness workforce that has ex-service personnel amongst its client base understands the eligibility criteria for ASC and knows how/who to refer on to relevant services.

- ASC staff working with ex-service personnel do not necessarily include housing or homelessness in their formal assessments, but they are clear about who they would refer onto if they had concerns about a client’s housing situation.
4.2 Interactions and Overlaps

The consultations with stakeholders have shown that while multiple support needs are very common, only a very small proportion of people have homelessness issues and support needs of a nature and severity which qualify them for ASC support. As a consequence, workforce overlaps are relatively rare.

It is worth noting here that just under a quarter (22%) of the respondents to the ASC workforce survey undertaken for this study stated that they work with people on a regular basis who are homeless or at risk of homelessness. This is a considerably higher figure than the rest of the research suggests is true across the sector as a whole, but the survey was specifically promoted as being about ASC and homelessness crossovers, so it is not surprising that staff who work in this space will be overrepresented in the results.

Interaction at the transition points

There are some clear commonalities in the research findings regarding transition point specific workforce interactions. The first, and the main one, is that the interactions are relatively infrequent. That is not to say they don’t exist at all, they do and examples are provided in the boxes below. However, these represent the exceptions rather than the norm.

Leaving the Armed Forces

A disabled person’s organisation in a North West local authority was consulted for the study and spoke of how they had run a six month pilot that was specifically aimed at supporting ex-service personnel with a range of needs including housing and adult social care. The pilot had gone well, but in the six months it had run, it had only supported three ex-service personnel.

That is not to detract from the very positive impact that it had, but it helps to show why the homelessness/ASC ‘transition point’ of leaving the armed forces tends not to be regarded by stakeholders as a particularly pressing issue.
Mental health and healthcare for people experiencing homelessness

In a local authority in Yorkshire, there are specialist healthcare teams providing services to people in temporary accommodation. This comprises a mental health team which treats approximately 10% of homeless people in the city. Patients include those with psychological support needs, personality disorders and bipolar disorder. Many tend to be subject to a ‘revolving door’ of homelessness. There is also a healthcare team which provides health services in hostels and women’s refuges.

These teams are funded by the local NHS Health and Social Care Trust and are recognised as providing both a health and social care service. The teams include ASC roles (social workers and nurses), as well as health service roles.

Education support for people in supported housing having left prison

A voluntary sector education support provider was consulted in a Yorkshire local authority. They often support people who have been housed in supported accommodation having left prison homeless. The support provides engaging, creative activities as well as functional skills with a view to helping the clients progress to a position where they can access further learning opportunities or employment.

Young persons supported housing provision

A housing provider accepts referrals from leaving care teams, probation services and social services for young people and single parents at risk of homelessness or who have become homeless. They provide supported housing with access to specialist workers able to advise on and manage a range of support needs, including those relating to ASC.

4.3 Opportunities for Skills and Workforce Development Interventions

In considering this topic, the issue of scale needs to be kept front of mind. Given that cases of adults requiring homelessness and ASC support (both generally and within the specific transition points) are, in relative terms, infrequent, it is difficult to make a strong case for new skills or workforce development activities.

The consultee feedback on this subject is very clear. Put simply, regardless of whether they have a national or a local remit, and regardless of whether they work in ASC or homelessness, none of the consultees identified any evident skills-related areas of need or market failures on a scale that would justify Skills for Care’s intervention. This was also echoed in the ASC workforce survey, the responses to which suggest that when staff from the two sectors do work together, then referrals, information sharing and
signposting all operate reasonably well and do not require skills or workforce development activities (beyond those which already exist) to be more effective.

In the few cases where consultees did identify opportunities for new skills or training programmes, they tended to be unspecific about what they should involve, talking instead in generic terms about “understanding what we/they do”, “understanding legislation” and “getting referrals right” (similar comments were made in the ASC workforce survey). Those making more specific suggestions were evidently citing local issues that do not require a national response.

That is not to say, of course, that the workforces do not encounter challenges or barriers to joint working. It is very clear that they do, but the resolution of these challenges – where indeed there is a resolution – does not fall within the remit of Skills for Care. For example:

- **Chaotic lifestyles**: consultees spoke of their frustrations at clients being “passed between organisations unwilling to support them” due to their chaotic lifestyles and the range (sometimes a complex range) of needs that they have.

> “It’s a Catch 22 situation: they can’t access mental health support because of their substance misuse but can’t access support for their addiction because of their unstable mental health.” Key Worker (homelessness sector)

For some consultees, a significant challenge lies in getting a client correctly diagnosed when they have a range of issues. Anecdotal examples were provided of where clients had reportedly been given inappropriate packages of support as a result of inaccurate diagnoses.

- **Resources and targets**: linked to the above, where funding is assigned to an organisation rather than an individual, consultees gave examples of where (in their opinion) statutory services had been reluctant to support their clients due to budgetary pressures and the presence of multiple needs, resulting in clients being passed between agencies. There was also a feeling amongst some consultees in the homelessness sector that, more generally, a lack of resources can limit the extent to which other stakeholders engage in partnership working and joint case management.

- **Meeting the threshold for support**: there are cases where consultees in the homelessness sector feel that their clients would benefit from ASC support but are deemed ineligible.
• **Suitability of accommodation**: specific to the armed forces case study, consultees voiced concern about the suitability of flat/house sharing arrangements for ex-service personnel, although they also recognise that in the vast majority of cases this is dictated by housing availability (or lack of) rather than any shortcomings in the skills or knowledge of the housing officers.

• **Working relationships**: several consultees working in the homelessness sector noted that the effectiveness of the working relationships with local authorities, including those working in ASC, can vary quite significantly from authority to authority. This, according to some homelessness stakeholders, is down to experience and personalities. The quote below is from the armed forces case study but is representative of comments made by numerous national and local stakeholders:

  “We work in 68 local authorities. With some of those we have a fantastic relationship whereas in others it seems a lot harder to get things done and to be kept up to date with progress.......that’s down to who we’re working with in the authority.” Representative of a homelessness national ex-service personnel charity, referring specifically to working with housing officers/teams in local authorities.

4.4 **Examples of Service Integration**

The research has uncovered a small number of examples where providers who support people with an ASC and/or homelessness need are working more closely together, or sharing information in a more structured way, than in the past. Two such examples are provided on the following page and others are included in the local authority case study reports. It cannot be claimed that these are representative of activities taking place in other parts of the country, but they do suggest that the ASC and homelessness workforces, in some settings, are coming into contact in a more formal way than they may have done previously.
Multi-Agency Adult Risk Service: North West Local Authority

A North West local authority has established a Multi-Agency Adult Risk Service, which includes representation from the following:

- adult social care;
- children’s social care
- housing
- floating support providers (e.g. Nacro and Threshold)
- alcohol, drugs and mental health services
- Age Concern
- leaving care team
- Police and Community Safety.

The Multi-Agency Adult Risk Service was established in recognition of local authority resources becoming in shorter supply and that a more joined-up approach to supporting adults with multiple needs was required. It is a case-based approach, and therefore representatives from many of the organisations listed above will only attend for specific cases. In most of the cases, ASC will not be relevant or the individual will not meet the eligibility threshold, but they will often be known to local services, e.g. as frequent users of Accident and Emergency units. At the time of writing the new service is still in its infancy, but it is hoped that it will lead to improved communication between agencies and, of equal importance, the pooling of resources to provide more tailored and more prompt assistance for adults at risk.

“The idea behind it is that the different organisations ‘muck in’ financially to ensure support for these in need is not jeopardised by funding issues.” Multi-Agency Adult Risk Service Member
Multi-Agency Risk Assessment Conferences (MARAC): Yorkshire and Humber Local Authority

A Multi-Agency Risk Assessment Conference (MARAC) is a multi-agency meeting, which has the safety of high risk instances of domestic abuse as its focus. It involves key statutory and voluntary agencies who might be involved in supporting people who experience domestic abuse. The purpose of a MARAC is to reduce the risk of further assault and injury to people who have experienced domestic violence and have been assessed as being at high risk of further abuse.

Key attendees include:

- police
- probation
- Independent Domestic Violence Advocacy Service
- local authority - children, young people and families service
- local authority – safeguarding adults
- NHS
- substance misuse support providers
- housing and refuge providers
- community youth teams
- youth justice service.

The objective is to share information, establish a multi-agency support plan and make links with other public protection procedures where not already in place, particularly safeguarding children, vulnerable adults and the management of offenders.

Partnership links between the agencies involved in MARACs are reported to be very strong.
This research set out to inform the parameters and scope of any future work that Skills for Care may wish to take forward involving the homelessness and ASC workforces. In doing so, it has looked at five specific transition points and in each of these (via local authority case studies and national stakeholder consultations) has identified the main types of organisations involved and the nature of any interactions across the two workforces. It has added new evidence to an area in which relatively little research has previously been undertaken and concludes that there is no immediate need for any Skills for Care-led intervention, be that in the form of workforce development programmes, new resources or aware raising activities.

The reason for this centres mainly on the issue of supply and demand. While it is generally agreed that the risk of homelessness increases at most of the transition points, it is still (and thankfully) relatively rare even then. Clients that are at a given transition point, that have a genuine risk of homelessness and have an ASC need and are eligible for ASC support are rarer still. Throughout the research, consultees said that while it was by no means unheard of for them to work with people in these circumstances, it did not happen regularly. In addition, and perhaps because of that irregularity, no suggestions were put forward for skills development activities that went beyond improving one workforce’s understanding of the other at a local level\(^2\).

This raises the question of whether the transition points were the right focus for the research. Insofar as they provided a definitive scope for the study (‘homelessness’ as a universal topic would have been too broad on this occasion) and are acknowledged points where the risk of homelessness can increase, then their selection was justified. What is clear, however, is that the transition points on their own are not necessarily the triggers of homelessness, nor of ASC need, hence the supply and demand issue.

To this end, it is not recommended at the current time that further research be undertaken by Skills for Care, nor that any activities or resources be developed, that focus specifically on the transition points. It may be that social, political or economic circumstances change such that the number of people at the transition points requiring (and qualifying for) ASC support increases significantly, in which case Skills for Care’s intervention may be more appropriate, but for now the research would suggest that Skills for Care should keep more of a watching brief.

This should not suggest that the interactions between the homelessness and ASC workforces, where they do exist, are without difficulty. It is made clear in this report, and covered in more detail in the case studies (see appendices E-G), that resource constraints can have a negative impact on the efficiencies and effectiveness of cross-

\(^2\) This largely tallies with the work undertaken by Homeless Link (see Chapter 2), which identifies several areas of ‘core knowledge’ that each workforce should have about the other.
organisation working, but this issue is not going to be resolved, nor significantly improved, through additional skills or workforce development activities.

The fact that the research results in these conclusions is not bad news. On the contrary, it should be welcomed that representatives from both national and local organisations, covering all five of the transition points, said that there are no systemic skills or workforce development issues that require specific intervention. Skills for Care should be commended for undertaking what has essentially been a market testing exercise as this will help them to channel their resources into areas where they can have a more significant impact.
Appendix A: References


Homeless Link (2013) http://homeless.org.uk

Homeless Link (2013a) http://homeless.org.uk/older-homeless-adult-social-care

Homeless Link (2013b) http://homeless.org.uk/ASC-specialist-social-work-post-hostel-residents

Homeless Link (2013c) http://homeless.org.uk/MHST-community%20care%20assessments-homeless-people

Homeless Link (2013d) http://homeless.org.uk/sites/default/files/Homelessness%20prevention%20Questions%20for%20community%20nurses.doc


## Appendix B: Prevention Checklist

[http://homeless.org.uk](http://homeless.org.uk)

<table>
<thead>
<tr>
<th>Questions</th>
<th>Responses</th>
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<tr>
<td>1  How are you managing in your accommodation?</td>
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<tr>
<td>2  Are you having problems with rent or bills or other debts?</td>
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<td>3  Have you been asked to leave or considered giving up your housing?</td>
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<tr>
<td>4  Do you have problems with the general condition of your housing?</td>
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<tr>
<td>5  Do you have the things you need to live here, e.g. a bed, a cooker?</td>
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<tr>
<td>6  Are the gas, electricity and heating working okay?</td>
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<tr>
<td>7  Are you having problems with Social Security or Housing Benefits?</td>
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<tr>
<td>8  Are you having difficulties at home with cooking, laundry or cleaning?</td>
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<tr>
<td>9  Are you having any difficulties with the people who you live with or with neighbours or local people?</td>
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<tr>
<td>10 Are health or mobility problems causing you difficulties at home?</td>
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<tr>
<td>11 Does alcohol or drug use cause you problems at home?</td>
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<tr>
<td>12 Have you lost anyone that you shared a home with in the last two years?</td>
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Q1 How are you managing in your accommodation?
This opening question is intended to start discussion about a person’s housing and any problems that they are experiencing without raising any anxiety.

Q2 Are you having problems with rent or bills or other debts?
To find out whether the person has rent arrears, or debts for utilities and service charges, including council tax and water rates. Also if they are having problems budgeting generally or being harassed for debt.

Q3 Have you been asked to leave or considered giving up your housing?
Intended to find out whether a landlord is threatening or has begun to take action against the person, or whether the person has considered giving up the accommodation. The reasons should be determined.

Q4 Do you have any problems with the general condition of your housing?
Intended to get information about the physical condition of the accommodation and whether it is in a bad state, or repairs are required, e.g. infestation or severe damp.

Q5 Do you have the things you need to live here?
To find out whether the person has essential furniture, if not they may need help with a community care grant or application to a charity.

Q6 Are the gas, electricity and heating working okay?
Intended to investigate whether there are problems with the utilities.

Q7 Are you having problems with Social Security or Housing Benefits?

Q8 Are you having difficulties at home with cooking, laundry or cleaning?
Intended to find out whether there are problems around household tasks and the reasons.

Q9 Are you having any difficulties with the people you live with or neighbours or local people?
The question investigates whether the client is being threatened or harassed by marital partners, other tenants, household members, friends, or neighbours, or is the perpetrator of nuisance behaviour.

Q10 Are health or mobility problems causing you difficulties at home?
Intended to find out whether physical health problems and disabilities, or depression or other mental health problems is affecting how the person is coping.
Q11 Does alcohol or drug use cause you problems at home?
Intended to find out if they might need support around drinking or drug use.

Q12 Have you lost anyone that you shared a home with in the last two years?
Bereavement of a partner or parent can be a trigger for homelessness, this question is intended to finds out if a bereavement has left them unsettled.
### Appendix C: Consultation List

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<tr>
<th>Organization</th>
<th>Notes</th>
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<td>Action for Children</td>
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<td>Association of Directors of Adult Social Services</td>
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<td>Blackburn with Darwen Borough Council</td>
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<td>Brighter Futures</td>
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<td>Care South</td>
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<td>Haig Homes (2 consultations)</td>
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<td>Homeless Link (3 consultations)</td>
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<td>Homes 4 Heroes</td>
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<td>Housing Authority of Thurston County</td>
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<td>Independent consultant specialising in looked after children leaving care</td>
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<td>Independent consultant specialising in skills programmes in the homelessness sector</td>
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<td>National Association of Social Workers</td>
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<td>Porch Light</td>
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<td>Prison Reform Trust</td>
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<td>Respect</td>
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<td>Revolving Doors Agency</td>
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<td>Single Person’s Accommodation Centre for the Ex-Services (2 consultations)</td>
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<td>Sitra</td>
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<td>St Mungos</td>
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<td>Unlock</td>
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<td>Veterans Aid (2 consultations)</td>
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<td>Veterans UK</td>
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<td>Women’s Aid (2 consultations)</td>
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<td>Women in Prison</td>
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Appendix D: Online Survey Questions

SECTION 1: INTRODUCTION

1. In which part of the adult social care sector do you predominantly work?

2. Which of the following best describes your role?

   Social worker, care worker, personal assistant, community outreach and support worker, employment support worker, occupational therapist, nurse or allied health professional, youth offending support worker, counsellor, advice, advocacy and guidance service worker, educational support worker, manager, director, other.

3. How many years' experience do you have in adult social care?

4. How often, if at all, do you work with clients that are homeless? (E.g. you provide services in hostels; homeless people are sometimes referred on to you by other support services etc.)

5. How often, if at all, do you work with clients that are at risk of homelessness (but who have not yet become homeless)? (E.g. your caseload brings you into contact with people facing eviction or rent arrears; people at risk of homelessness are sometimes referred on to you by other support services etc.).

SECTION 2: WORKING WITH HOMELESS PEOPLE

6. In the course of your work, how often do you come into contact with:

   - Local authority housing or homelessness services
   - Voluntary/third sector housing or homelessness services
   - Other voluntary/third sector providers working with homelessness people

7. Overall, would say you that the ways in which you work together with the people providing these services are:

   - Excellent – highly productive/supportive
   - Good – productive/supportive
   - Ok – quite productive/supportive but with scope for improvement
   - Poor – unproductive and unsupportive
   - Don’t know

8. Are there any skills, knowledge or training issues which, if addressed, would enable this to be more effective? This could apply either to your own role or to the people working in the homelessness sector.

9. How often, if at all, do you work with clients that are at risk of homelessness (but who have not yet become homeless)? (e.g. your caseload brings you into contact with
people facing eviction or rent arrears; people at risk of homelessness are sometimes referred on to you by other support services etc.)

SECTION 3: WORKING WITH PEOPLE AT RISK OF HOMELESSNESS

10. How confident are you that you know which organisation, agency or department to refer on to when one of your clients is at risk of homelessness?

11. (‘Quite unconfident’ or ‘very unconfident’ only): Why is this?

- It happens so infrequently that I would need to check who I should refer them on to
- I have referred people on in the past but been told they that were ineligible for support
- I don’t know who provides housing/homelessness support in this area
- The number and types of support organisations in this area seems to be changing all the time
- Other – please specify

12. Are there any skills, knowledge or training issues which, if addressed, would enable you to feel more confident that you were helping your clients with housing or homelessness issues in the best way that you could?

SECTION 4: FINAL COMMENTS

13. Overall, how well do you think the adult social care and homelessness workforces work together in terms of:

- Sharing information
- Referring service users
- Understanding each other’s roles and responsibilities
- Understanding the constraints within which the other workforce is operating

14. Is there anything else you would like to add for the purposes of this survey?
Introduction

This case study was undertaken as part of a research study to explore the interaction between the adult social care (ASC) and homelessness workforces. The research was commissioned by Skills for Care and was undertaken between February and August 2014.

The case study took place across a local authority area in the north of England and looked at two specific ‘transition points’: i) when people are leaving prison; and ii) when people are experiencing domestic abuse. The case study was been based upon a programme of qualitative interviews with 15 individuals working in either the ASC or homelessness sectors.

Although the circumstances for people at each of the two transition points will often be very different, the research has found that the workforce interactions tend to be similar. Unless otherwise stated, the findings in this report should therefore be interpreted as being applicable to both transition points.

Homelessness and Leaving Prison

Leaving prison is a time when people may experience an above average risk of homelessness. It is estimated that 30% of people released from prison have nowhere to live, with particular concentrations amongst people that have served long sentences, are single and/or have mental health support needs. People leaving prison often have multiple support needs which, alongside housing, can include substance misuse, mental health, finance, benefit and debts, education, training and employment support.

Homelessness and Domestic Abuse

The cross-government definition of domestic abuse is any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to psychological, physical, sexual, financial and emotional abuse. In taking action to escape domestic abuse, survivors and their children can become homeless. Often people who experience homelessness will have encountered domestic abuse, even if it is not a key precipitator of their homelessness. Experience of domestic abuse is also often associated with other support needs, the most common of which are mental health and substance misuse.

Mapping the Support Landscape

There is a range of support in place for ex-offenders and people experiencing domestic abuse that are at risk of, or are experiencing homelessness, including: housing and accommodation, mental health and healthcare for people experiencing homelessness,
support providers (e.g. mentoring), education support and other mainstream support. This is shown in the figures overleaf.
Referrals

In the local authority case study area, there are very few referrals for ASC support from the homelessness workforce and vice versa at each of the two transition points. This is due primarily to there being only a small number of clients that are at risk of homelessness and who reach the threshold to qualify for ASC support. The research suggests that it is not due to inefficiencies or failures in the referral process, nor to any significant skills or knowledge gap on the part of either workforce.
That said, the case study did identify isolated examples where key workers at an accommodation and support provider for people leaving prison had referred clients to ASC services (particularly mental health) and felt that their observations of their clients’ wellbeing had not been given due weight. They put this down, in part, to the lack of recognised professional qualifications and regulation in the homelessness sector, which, they feel, can give the perception that they lack expertise and specialist skills.

**Partnership Working**

Partnership working across the two workforces at each of the transition points is also relatively rare in the case study local authority area, although some examples were found. For example, hostel key workers and an NHS Health and Social Care Trust mental health team have fortnightly meetings to discuss individual cases, the common view on which is that they are very effective.

>“The meetings that we have with the hostel workers are really good – I would consider them to be good practice. It helps us to provide a better service, we make sure that we are not duplicating efforts and we can help to plan their support for when they move on.” – Nurse

Partnership working also occurs where there is a local authority social worker involved for disability or safeguarding reasons. In these instances, the interaction tends to be less structured and is often done via email or telephone rather than formal meetings. Information sharing appears more sporadic and the success of joint working is largely determined by the amount of time and resources that individual members of the workforce are able to dedicate.

**Supporting the Workforces**

While the case study consultees were unanimously supportive of workforce development per se, there appears to be little in the way of specific or systemic skills or information gaps that are currently hindering the way in which the two workforces interact. Instead, consultees spoke more generally about ‘improving their knowledge and understanding’, with examples including a better understanding of the causes of homelessness, the statutory regulations around housing eligibility and the scope of ASC roles. These are all important in the context of workforce interactions, but they were not raised with any regularity or consistency and, as such, would seem best addressed at a local level rather than through intervention from Skills for Care.

That said, the system is clearly not perfect. Consultees, more on the homelessness than the ASC side, expressed some frustrations about communications and eligibility
criteria, although these are in part down to an incomplete understanding of ASC processes and regulations. But it would be wrong to suggest that these frustrations are widespread or that those working in the two sectors are regularly calling into question the quality or completeness of support that their clients are receiving as a result.
Case Study Report: Leaving Care and Leaving Hospital

October 2014
**Introduction**

This case study was undertaken as part of a research study to explore the interaction between the adult social care (ASC) and homelessness workforces. The research was commissioned by Skills for Care and was undertaken between February and August 2014.

The case study took place across a local authority area in the Midlands and looked at two specific ‘transition points’: i) when people are leaving hospital; and ii) when looked after young people are leaving care. The case study was been based upon a programme of qualitative interviews with 15 individuals working in either the ASC or homelessness sectors.

**Homelessness and Leaving Hospital**

There is a clear link between homelessness and health. For example, people who are homeless are six times more likely to visit accident and emergency departments than people with stable housing and re-admission rates amongst the homeless population are significantly above average. Recognising this, measures have been introduced nationally with the aim of ensuring the effective and safe discharge of homeless patients. In 2013, for example, the Government awarded £10 million to 52 projects around the country in order to improve the quality of care that homeless people receive when leaving hospital, while in 2012 the H2H (Hospital 2 Home) project was introduced to provide a coordinated response between homelessness service providers and hospital discharge teams.

**Homelessness and Leaving Care**

Young people that have experienced care can be especially vulnerable to homelessness. Research has shown it to be amongst their most pronounced fears and there can sometimes be a shortage of suitable accommodation for them to move into. However, it is not just the fact that they have experienced care that places them at risk. There can be a wide range of other influences also at play, including learning difficulties, mental health issues, drug/alcohol problems, their ability to secure employment and their financial management skills (amongst others).

In terms of leaving care as a ‘transition point’, young people will already be known to Social Services when they leave care and should have a Pathway Plan designed to help them achieve sustainable, independent living. As such, they are a client group where housing/homelessness and ASC services/workforces may interact. However, with local authorities having a duty of care towards care leavers, it is significantly more likely that the risk of homelessness will arise when post-care support is reduced or withdrawn than at the point when they actually leave care.
The Support Landscape: Leaving Hospital

Housing will be considered by staff whilst an individual is in hospital and, where necessary, the appropriate agencies will be engaged. In such cases, a referral(s) will usually be made to the local authority’s Acute Discharge Team in Social Services, or, if the individual is already known to Social Services, to the relevant social worker. There are, of course, a range of variables and permutations within this, depending on whether the discharge is classed as ‘simple’ or ‘complex, whether or not the individual is able to return home immediately after their discharge, and what other types of support they may need. Beyond the initial interaction between hospital staff and Social Services, a range of different support staff may therefore be involved, including other healthcare professionals, housing and accommodation workers and specialist support providers, including those working in ASC.

However, in both relative and absolute terms, the number of people who leave hospital and are homeless is very small. It is also the case that leaving hospital does not give an individual priority for housing support.

The Support Landscape: Leaving Care

In recent years there have been several changes in homelessness policy which have seen a greater priority placed on prevention, especially for young people. The statutory duty placed on local authorities has also expanded, with care leavers becoming a priority need client group for housing support. Pathway planning procedures have been extended for care leavers which has increased the length of time local authorities perform a Corporate Parenting role for young people in care.

These changes create a predetermined route or offer to young care leavers which is standardised throughout the country. It is led by Children’s Social Services via the Leaving Care Teams who engage with other agencies and providers, including housing support, based on the young person’s needs. Referrals may be made to ASC where there are safeguarding or social care issues.

Understanding the Workforces

The case study consultations suggest that those working in the homelessness (and housing) sector have a reasonably good understanding of ASC, although their definition tends to be somewhat narrow and focuses on local authority led social work, domiciliary care and residential care. That is not to suggest that they do not recognise or have the requisite understanding of the other elements of ASC that are included within the formal definition, but they did not routinely class them as being ASC.

There was no suggestion amongst the front line homelessness consultees that the ASC needs of individuals would go unnoticed or ignored. Rather, they said that clients would either a) be referred to them with a care package already in place; b) already have a social worker; or c) if hostel/housing staff identified an ASC need, be referred to Social
Services for a social care assessment. The findings also suggest that front line housing workers are accustomed to dealing with individuals who have a range of support needs and as such they have to be aware of the different support agencies that may be able to assist, although some consultees did acknowledge that communications across the two workforces could be improved.

The ASC staff consulted for the case study showed a good level of awareness of homelessness issues and did not feel that at a local level there were any significant knowledge or skills gaps. They did agree, however, that housing can be one of the most challenging aspects of their clients’ support needs, particularly in terms of timelines and the time it can take for some issues to be resolved. They also spoke about the difficulty of finding suitable accommodation for all care leavers.

**Workforce Interactions**

The case study consultations suggest that in this local authority area, there are, at both transition points, relatively few cases where individuals will be homeless (or at risk of homelessness) and have an ASC need. As such, workforce interactions are relatively limited.

There is a statutory responsibility on Leaving Care Teams to find accommodation for care leavers, as a result of which there should, in theory, be no increased risk of homelessness. At the leaving hospital transition point, while some people find themselves in a situation where their accommodation becomes unsuitable and requires modification due to their health issues, the consultees said that it was very rare for them to have no accommodation to go to at all, and even rarer still for them to be in this situation and need (and qualify for) ASC. Where interaction does occur, this tends to be because an individual has been referred from a provider or agency in one sector to a provider or agency in the other.
**Example: Interaction between Health and Social Services following Unplanned Acute Episodes**

Where an individual is not known to Social Services and experiences an unplanned acute episode resulting in hospitalisation, health professionals will lead on assessing their needs. Through the discharge planning process, discussions regarding housing and care support needs will be considered. If there are housing needs, a Section 2 notification will be sent to Social Services following which a social worker will visit the individual in hospital to discuss their needs.

Whilst there will be liaison between health and Social Services regarding the timing of the patient’s discharge, both agencies will push for hospital discharge as soon as the patient is medically fit. From this point the Social Services department will lead and co-ordinate the patient’s care. This may include finding short term care, e.g. a residential nursing placement or rehabilitation unit, as well as referring onto the local authority’s housing department to address any longer term housing needs.

**Example: Interaction between Children and Adult Social Services**

The leaving care process is managed by Children’s Social Services. A referral will only be made to Adult Social Services if there are ongoing safeguarding or learning disability issues. Similarly, housing services will only be engaged where they are specifically needed (it may be that a young person will return to the family home or is able to find accommodation independently in the private rented sector, thus negating the need for any specific housing support). Again therefore, the level of level of interaction depends on the particular support needs of the young person, but during leaving care this will be managed by Children’s Social Services which reduces the extent of any direct interaction between the ASC and housing/homelessness workforces.

The general consensus then is that individuals’ needs are well considered, although that is not to suggest (in the views of those consulted for this case study) that the optimal outcomes are necessarily achieved. A shortage of resources (financial and personnel) is seen to hinder – in some cases quite significantly – the extent to which an individual’s journey through and beyond the transition points can be considered ideal. Importantly in the context of this study, however, consultees very clearly highlighted this as a resourcing issue rather than one relating to the skills or knowledge of staff in either the ASC or homelessness workforces.
Appendix G: Homelessness and the Adult Social Care Workforce: Scoping Study. Case Study Report: Leaving the Armed Forces

Case Study Report: Leaving the Armed Forces

October 2014
Introduction

This case study was undertaken as part of a research study to explore the interaction between the adult social care (ASC) and homelessness workforces. The research was commissioned by Skills for Care and was undertaken between February and August 2014.

The case study took place across a local authority area in the north west of England and looked specifically at the ‘transition point’ when service personnel leave the armed forces. It has been based upon a programme of qualitative interviews with 12 individuals working in either the ASC or homelessness sectors.

Homelessness and the armed forces

The transition from military to civilian life can, for some people, increase the risk of homelessness. This is typically influenced by drug and alcohol misuse, unemployment, health and mental health issues, the availability of suitable local authority accommodation and relationship breakdown. In practice a combination of these factors is often present.

However, ex-service personnel are actually under-represented in the homeless population and are no more likely to be unemployed than other members of the public. The Department for Communities and Local Government has stated that there are around 2,300 rough sleepers in England, approximately 4% of which claim a military connection (which would equate to around 90-95 individuals).

The Support Landscape for Ex-Service Personnel

Nationally, around 20,000 service personnel leave the armed forces each year, all of whom have access to tailored support and advice in advance of being discharged. The Career Transition Partnership – a partnering agreement between the Ministry of Defence and Right Management – is key to this and provides resettlement services that cover the job market, housing, health and education, benefits (which could incorporate ASC) and pensions. The Career Transition Partnership is available to ex-service personnel for up to two years following their discharge.

There is also a range of national and local support agencies whose remit, in full or in part, is to assist ex-service personnel with various aspects of civilian life. Some of these, e.g. Veterans Aid and the Royal British Legion, have hostels, care homes and other forms of accommodation.

In the case study local authority area, ex-service personnel can be prioritised for social housing if they are classed as having an ‘urgent need’. In cases where someone has been seriously injured in the armed forces and needs an adapted property, the works are agreed and carried out in conjunction with armed forces welfare officers and occupational therapists.
The local authority also has an Armed Forces Community Covenant – a voluntary statement of mutual support between the local civilian community and the armed forces community. The Covenant covers a broad range of topics, including the aforementioned additional preference for ex-forces personnel with urgent housing needs, and a commitment to meeting the ASC needs of those presenting with more complex issues.

**Understanding the Workforces**

People working in homelessness in the case study area tended to hold a rather narrow view of ASC, comprised mainly of local authority led social work and domiciliary and residential care. Occasionally they also mentioned occupational therapy but this was rare. Roles such as nurses, education support workers and NHS resettlement workers were not seen as being in the core ASC footprint.

The ASC consultees feel that they understood who provides housing and homelessness services in the case study area, although this is helped somewhat by there being two main social housing providers, so the landscape in that sense is relatively ‘simple’. There is no evidence of a knowledge, skills or information gap.

**Workforce Interactions**

The homelessness workforce that supports ex-service personnel does not have prescribed or formal processes to identify ASC needs amongst its clients, relying instead on observations regarding their clients’ physical and mental health. The common view from those working in homelessness is that they have the skills and knowledge to do this effectively, although in practice it is relatively uncommon for homelessness organisations supporting ex-service personnel to need to refer their clients on for ASC. The main reason for this is that relatively few ex-service personnel with homelessness issues also need ASC, and those that may do often do not reach the statutory threshold to qualify for ASC support. Furthermore, where there is a need, this is often identified and addressed before the homelessness services become involved.

That is not to say referrals don’t take place, but they are the exception rather than the norm. For example:

- A UK-wide provider of rental housing for ex-service people explained that, where appropriate, they signpost their residents on to occupational therapy services (although they also noted that local authority resources for that kind of support is typically very limited).

- Another charity helping ex-service personnel will act as an advocate and advisor for their clients when they are engaging with Social Services.

- Specifically in the case study area, anecdotal feedback was provided of “very occasional” cases where a homelessness organisation would refer to the local authority for ASC purposes.
ASC staff reported that it is very rare for their clients to be homeless, or to be at severe risk of homelessness, at the point of referral. Where this is the case, options include referring on to tenancy support within the local authority and/or securing support from voluntary sector providers.

Nonetheless, cross-organisation working more widely does occur in the case study area, a notable and recent example of which is the establishment of the Multi-Agency Adult Risk Service. This includes representation from adult social care, children’s social care, housing, floating support providers, alcohol, drugs and mental health services, Age Concern, the leaving care team, the police and community safety.

The Multi-Agency Adult Risk Service was established in recognition of the need for a more joined-up approach to supporting adults with multiple needs. It takes a case based approach, and in most of the cases ASC will not be relevant or the individual will not meet the eligibility threshold, but they will often be known to local services, e.g. as frequent users of Accident and Emergency units. At the time of writing the new service is still in its infancy, but it is hoped that it will lead to improved communication between agencies and the pooling of resources to provide more tailored and more prompt assistance for adults at risk.

**Supporting the Workforces**

Relatively few ex-service personnel are referred for ASC support from the homelessness workforce and vice versa. This obviously limits the extent of the interaction between the two workforces at the ‘leaving the armed forces’ transition point, especially at a local level. Where there is an interaction, the majority view is that the networks, referral processes and joint working arrangements operate, in most cases, as well as can be expected.

The case study consultees tended to speak in positive terms about workforce development per se, but none identified a need for any new learning materials, training courses or other workforce development interventions that would fall within the remit of Skills for Care.

With the number of ex-service personnel likely to grow substantially over the coming years, it may be the case that there is an increase in the number and proportion requiring ASC, and in that instance then Skills for Care’s intervention may be more appropriate. But at this stage the advice would be to keep more of a watching brief.
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