Working Together Locally to Address Multiple Exclusion

Homeless Link Conference Workshop
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Rethinking Multiple Exclusion Homelessness: Implications for Workforce Development and Interprofessional Practice

2 Year Exploratory Research Study
Due to report September 2011
Workshop Aims

● To explore how workers from different sectors work together to address multiple exclusion homelessness

● To explore how we can improve interprofessional and interagency working
  - Strategic solutions
  - Innovations from practice

● How to deliver better value for money
Methods

- Fieldwork in Cumbria, Calderdale and Inner London
- Interviews (n=48) and focus groups (n=17) with stakeholders from a wide range of agencies across health, housing and social care including housing support workers/hostel staff
- Interviews with ‘Experts by Experience’ [following their journeys through the ‘system’ over a six month period] (32 first interviews and 22 follow-up interviews)
22.12.10
REFERRAL: Bob is admitted to an acute in-patient mental health unit. Diagnosis: mental and behavioural disorder due to multiple drug use, and social anxiety problem. Depression and attempted suicide.

Because is homeless and is referred to a housing support project. A locum consultant psychiatrist supports the referral with a letter which is intended to "expedite the tenancy".

PROMISES In the letter it is noted that any discharge plan will include initial support from the Crises Resolution and Home Treatment Team. His CPN will then provide regular monitoring and review. It is noted that the drug and alcohol team are involved and that he has a drugs worker allocated to him.

Accepted onto Supported Housing Scheme but there is a waiting list...

Discharged self from hospital and Housing Support Worker supports Bob to get accommodation in a local hotel. "It was horrible there I didn’t feel comfortable"

Readmitted to hospital

8.3.10 Discharged to local hotel for four nights before accessing supported housing
10.3.10 (CRISIS) Bob has bad shakes face and legs. Housing Support Worker calls doctor and is told to take Bob to A&E. Was told medication needed changing.

Ongoing often daily support...
Bob’s Journey Continued…

**6.5.10** Not engaging with drug and alcohol services anymore… Locked up last night – bought some Temazepam to ‘calm down’

**23.10.10** Probation officer reports that Bob had taken overdose of anti-depressants. Said it was an impulse thing as he felt bad about shoplifting… food parcel given.
15 minutes discussion

How can we promote better joint working in frontline practice?

Could improved joint working deliver better value for money? If yes, how?
Strategic Solutions - Common Assessment Framework (CAF)

Community Care Assessment → Case Management

GP & Community Health Services

Mental Health Services

Drug and Alcohol Services

Care Plan

Support Plan

Support Plan

Support Plan

Supported Housing Provider

Personal Care

Employment/Training Big Society etc,

Integrated Personal Plan Identifying Outcomes to which all Agencies and Professionals Agree to Work Towards Achieving Together

Individual Budget

Monitor & Review... Ensuring Continuity
“There is a man who has a long-standing alcohol problem... He has a chronic infection in one of his legs... The hostels felt they couldn’t manage him and then very shortly after that he threatened one of the hostel staff and he was evicted so he is back on the street. He doesn’t want any help with his substance misuse so he doesn’t meet their threshold... **He has a degree of physical disability but he won’t meet the threshold for ordinary residential care.** He has a degree of cognitive impairment but we are not sure how much, probably not too much so he doesn’t fit the mental health criteria and he is a very difficult person in his behaviour. So if you parcel it up he has got multiple needs but there isn’t actually a service... he remains on the street”.

(Housing Support Worker)
Critical risks to independence are when:

- life is, or will be, threatened; and/or
- significant health problems have developed or will develop; and/or
- there is, or will be, little or no choice and control over vital aspects of the immediate environment; and/or
- serious abuse or neglect has occurred or will occur; and/or
- there is, or will be, an inability to carry out vital personal care or domestic routines; and/or
- vital involvement in work, education or learning cannot or will not be sustained; and/or
- vital social support systems and relationships cannot or will not be sustained; and/or
- vital family and other social roles and responsibilities cannot or will not be undertaken.
“Some of the money taken out of Supporting People schemes is being redirected into the Council’s social care budget for people who need higher levels of support”

Cumbria News and Star
13th June 2011
15 minutes discussion

Would you feel confident in referring a person with experience of multiple exclusion homelessness to your local social services?

What do you think would happen?

How could any barriers to access be overcome?
Obtaining seamless care

Some other solutions from practice
Managing transitions

Solution: greater flexibility in working

- We are already starting the relationship between key worker and client before we take them in [to the hostel]. Then once they are in we can be there every day just making sure, five - ten minutes, longer if necessary, and looking at helping the hostel manage the behavior because it can be so chaotic and what you don’t what is for something huge to go off and they are immediately out. What you need to say is “See that behaviour? There you need to stop it now otherwise in two days time it is going to be too risky and you are at danger and your staff are at danger”. Now that may happen five or six times a week and then the following week it may happen only four times and then gradually the hostel start taking over. [Specialist Outreach Team - Urban Site]
Dual diagnosis: whose responsibility?

Solution: specialist workers

Our key aim is...to develop an integrated approach to work with dual diagnosis patients in mental health services. And in practice what that means is for people with higher levels of need who meet the threshold for entry into community or inpatient mental health services we provide support to sort of mainstream care coordinators or clinicians working in adult mental health services. In practical terms that means anything from direct clinical work that we undertake ourselves on an individual or a group work basis. So from time to time for example we run relapse prevention management groups, or we might do individual bits of support work with people who are wrestling with issues linked to their substance uses.

We have got - we are like - sort of water, we sort of get everywhere and fill in the cracks, but we are a very sort of thin resource if you like, very small budget and small staff. (Dual Diagnosis Clinical Lead - Urban Site)
Working in rural areas

Solution: network building

- there is no official networking forum in [this area], when I worked [elsewhere] there was a homelessness forum where people met quite regularly, but the statutory bodies never turned up although they were invited, but here there is nothing…

- yeah, there is no linking up [across this rural area], they are trying to get the [rural] Advice Network off the ground, now they have got a little bit of funding…and they ring, they have [a champion] in each area, and they ring the details of their own organization and what they do and they are trying to build up a picture of what is available in each area, who does what how do they do it, how you access them. (*Homelessness Advice Charity - Rural Site*)

- Solution: developing communities of practice
15 minutes discussion

How can seamless services be provided when people move out of an area?