

# Policy responses to ‘Rough Sleepers’: opportunities & barriers for homeless adults in England

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## Abstract

In the winter of 2018, high profile debates about ‘rough sleepers’ intensified following reports about men who died in freezing conditions. Government since pledged to cut the number of rough sleepers by half by 2022 and eliminate it by 2027. This commentary reviews two pieces of legislation, which could support this target: the *Care Act 2014* and *Homelessness Reduction Act 2018*. It argues that policies offer opportunities to improve outcomes for rough sleepers, given historic failings to provide for this social group. However, financial and institutional barriers remain.

**Key words:** homelessness, institutions, complex needs, housing support, legislation, adult social care, rough sleepers

## Introduction

Homelessness in England is increasing. In 2017, nearly 58,000 people were assessed ‘statutorily’ homeless, 44% above a 2009-10 low point (Fitzpatrick et al., 2017). Comparatively, the last official count estimated ‘rough sleeping’ at 4,751 people, but the problem receives popular attention. This recently intensified through media reports that homeless men died while sleeping on the streets. While deaths are not new for winter months, reports gained traction given a doubling of rough sleepers since 2010 under a Conservative government (Comarty and Strickland, 2018). Speaking in March, prime minister Theresa May (2018) said this was a ‘*source of national shame*’ for a leading global economy. May pledged to cut rough sleeping in half by 2022 and eliminate it by 2027. Homelessness minister Heather Wheeler said she will resign if rough sleeping worsens during her tenure but added she does not know why the problem has increased (BBC Radio 4, 2018). Critics are clearer, citing financial cutbacks under post-2008 ‘austerity’ and institutional barriers. The government has developed initiatives to reduce rough sleeping, but these are considered ‘light-touch’ without an effective safety net and long-term homelessness strategy (Wilson,

2018). In this context, this commentary reviews two pieces of legislation, which offer opportunities to improve outcomes for rough sleepers: the *Care Act 2014* and *Homelessness Reduction Act 2018*.

First, it is important to clarify the term ‘rough sleeping’. This refers to people who sleep on the streets, reside in temporary accommodation and supported housing, and experience long-term ‘revolving door’ homelessness (McDonaugh, 2011). It describes people who are repeatedly excluded and re-housed, with intermittent/ongoing contact with social welfare services (Adamson et al., 2015).

Rough sleeping and associated services (accommodation projects, day centres, night shelters) are mediated by intersections of social identity such as gender, sexuality, age, ‘race’ and ethnicity. Some social identities are more visible than others. Services are often male-dominated, and may represent spaces of fear *and* support for homeless people (Johnsen et al., 2005). Evidence shows young queer and trans people are reluctant to access services that are faith-based, where there is risk of misgendering from staff/peers and they must choose between binary gender options (i.e., male/female only accommodation projects). The latter is triggering where non-binary/fluid gender identity has been a cause of homeless due to familial rejection, for example (McNair et al., 2017). Generally, women will conceal homelessness through comportment, dress, and fitting into public spaces (e.g., libraries, train stations). Gendered responses may enable women to reside in ‘hidden’ spaces (e.g., permitted to sleep in public toilets by male security-staff) (Casey et al. 2008). Women and LGBTQI people are prone to transactional ‘survival’ sex/relationships, to achieve housing (McNair et al., 2017).

BAME people are disproportionately overrepresented amongst homeless people but there are limited analyses about causes of, and service responses to, homelessness amongst these social groups (Netto, 2006). Of the ‘official’ 4751 rough sleepers, 14% were women, 20% were non-UK nationals and 8% were under 25 years old (Ministry of Housing, Communities & Local Government, 2017). ‘Race’ and ethnicity are not discussed in these data. This problem is recognised in practice debates, with grassroots initiatives developing support for BAME people specifically (see *Big Lottery* funded project ‘*Fulfilling Lives*’ (Moreton et al., 2016)).

One implication is that debates about rough sleeping are often conversations about homeless white men. Indeed, this is reflected in contemporary homelessness research about rough sleepers with ‘complex needs’. This approaches rough sleeping as a care and support need, social problem and public health crisis. It is estimated that 58,000 largely white men aged 25-44, experience problems of homelessness, mental ill-health, substance misuse and offending (Bramley et al., 2016). ‘Complex needs’ reflect formative, systemic (e.g., socio-economic marginalisation) and biographical problems (e.g., early childhood trauma, difficult family relationships) (Adamson et al., 2015). They give rise to physical and/or mental impairments, with implications for multimorbidity (Cornes et al., 2013). Life expectancy for rough sleepers is 30 years below the national average, at 47 for men and 43 for women (Thomas, 2012).

### **Financial & Institutional Barriers**

Financial barriers include a lack of affordable housing and ‘austerity’ reforms, instituted by a Conservative government, and typical of post-industrial Western nation-states following the 2008 financial-crash. National homelessness charities argue that reforms are incompatible with rough sleepers’ need for affordable housing and flexible support (CentrePoint et al. 2017). Two measures restrict housing availability in high-demand/unaffordable locations: *Local Housing Allowance* (the formula used to assess *Housing Benefit* entitlement), and *Shared Accommodation Rate* for 25-34 year olds (the maximum entitlement to *Housing Benefit* for a room in shared house). Penalty-sanctions under *Jobseekers Allowance* and *Employment and Support Allowance* have expanded, resulting in loss of income for non-compliance with benefit conditions, i.e., not attending JobCentre appointments. In future, *Universal Credit* will replace *JobSeekers* and *Housing Benefits*. It emulates salaried employment via monthly payments. There is a 4-week application process, which may be ameliorated by an advanced payment loan where financial resources are unavailable (i.e., savings, family support). However, money management skills are needed to bridge the application/payment gap and achieve monthly rent and debt payments. These pressures represent *causes* of homelessness and detract focus from rough sleepers’ ‘recovery’ (CentrePoint et al. 2017).

Local cutbacks affect homelessness services specifically. Charity *Homeless Link* (2017) report real-term reductions to services of 21% since 2010 and drops of 10% in bed spaces and 9% in day centres between 2014-2017. Cutbacks are contrasted to *expansion* of services in the 2000s under a Labour government when coordination across services helped improve outcomes for rough sleepers (Dobson, 2016; Buckingham, 2009). From 2003, *Supporting People* was implemented. This aimed to move homeless adults with low/medium support needs towards independent living, within a set timeframe. It required that authorities commission homelessness services based on area-audits of local needs. Commissioned providers, primarily specialist voluntary sector accommodation projects, were regulated by authorities to ensure compliance with programme aims. This sustained resourcing led to innovations for homeless adults with mental ill-health and drug/alcohol dependencies. Commissioned services did not have a remit to respond to acute care and support needs, but people *presented* to services with these issues (Cornes et al., 2011). This positioned the homelessness sector as best placed to respond to vulnerable homeless adults, and limited financial burdens on health and social care agencies (Crane *et al.*, 2006). Funding afforded occupational status to a traditionally under-resourced sector (Scullion et al., 2014). Nevertheless the *Supporting People* programme lost its ‘ring-fence’ in 2009 and experienced a 40% drop in funding between 2010-2016. There is presently no budget allocation for *Supporting People* as funding was rolled into the single 'Formula Grant' given by central government to local authorities (Homeless Link, 2013). Homeless hostels may still achieve funding from residents’ housing benefit entitlement, but this does not cover support functions and is under threat following roll-out of *Universal Credit* (Blood, Copeman & Finlay, 2016). Consequently, homelessness organisations are asked to do more with less (Cockersell, 2012). Because homelessness providers cannot ‘catch’ rough sleepers, they increasingly present at emergency services such as hospitals, policing, courts and social services (Adamson et al., 2015), or ‘drop through the cracks’ and receive no provision.

Although financial cutbacks offer compelling explanations for increases in rough sleeping, institutional barriers are also significant. First, evidence shows some *Supporting People*-funded agencies excluded homeless adults who were ‘*too hard to help*’. This describes judgments that their needs were ‘*too high*’ given remits to ‘move-on’ clients

rapidly. Explanations for ‘gatekeeping’ included limited capacity to respond to ‘complex needs’ due to skills shortages (Scullion *et al.*, 2014; Buckingham, 2012) and exclusions and evictions where service users were ‘non-compliant’ – a term which describes informal practices that constructs clients in pathologising terms: demotivated, challenging, disorderly (Cornes *et al.*, 2014; Scanlon & Adlam, 2012).

Second, homeless adults have historically struggled to achieve statutory entitlements (temporary accommodation, re-housing) under a *Housing Act 1996* part VII assessment (*as amended 2002*). Two thresholds for achieving entitlement under the Act are to establish vulnerability (‘priority-need’) and ‘intentionality’. Regarding vulnerability, housing authorities may lack understanding about physical, mental and behavioural effects of ‘complex needs’. Moreover, effects of formative pain, trauma, mental ill-health and addiction are challenging to evidence/treat using traditional ‘medical-model’ diagnostic labels (Scanlon and Adlam, 2012). Rough sleepers are sometimes called a ‘shadow population’ because they are unknown to health services. Where they attend, professionals may have limited understanding of conditions like ‘dual-diagnosis’, which are a feature of ‘complex needs’. Substance misuse and mental ill-health risk being treated as distinct/causal factors, with claims that mental-ill health will improve if substance misuse ceases (and vice-versa). This is despite evidence that ‘recovery’ approaches to substance misuse are inappropriately applied to rough sleepers, with abstinence regarded as an ‘end-stage’ outcome (Moreton *et al.*, 2016). Even if appropriate medical diagnosis is available, this may not be accepted by health professionals if authorities have taken diagnostic assessment ‘in-house’. This refers to ‘independent’ checks by state-contracted firms, consistent with controversial practices in unemployment services (Mills, 2017).

Regarding ‘intentionality’, authorities establish if an applicant caused their homelessness through an act/omission. However, known causes of rough sleeping may be used to establish ‘intentionality’ and limit entitlement under the Act. Examples include eviction/abandonment due to money management or offending problems, linked to substance mis-use or a physical or mental health condition (Dwyer *et al.* 2014). Coupling needs with problem behaviours has constructed rough sleepers as vulnerable *and* transgressive in the legislation (Dobson, 2011).

Given institutional and financial barriers, two pieces of legislation provide opportunities to improve outcomes for rough sleepers: *Care Act 2014* and *Homelessness Reduction Act 2018*.

### **Care Act 2014**

The *Care Act 2014* is not principally about housing. It makes recourse to provision available to adults on the basis of individual wellbeing (s.1) and criteria that recognise physical and emotional health, and personal and environmental risk factors. Stages to establishing entitlement assess if: 1) an adult's *needs* arise from/are related to a physical/mental impairment/illness; 2) as a result, an adult is unable to achieve two or more of ten *outcomes* (e.g., maintaining personal hygiene, able to make use of the home safely); 3) as a consequence there is likely to be *significant impact* on any of nine *wellbeing* criteria (e.g., physical/mental health, emotional wellbeing, participation in work, education, training/recreation) (Department of Health & Social Care, 2018). Regarding stage 1) an assessing authority must establish if an adult has a condition as a result of '*physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury*' (s.6.104). The condition must not be caused by other '*circumstantial factors*' (i.e., rough sleeping) but formal diagnosis should not be required. If entitled, adults are provided with a personal budget to pay for their care. Described as '*personalisation*', and contested (Needham, 2013), this represents movement away from institutional care.

Proponents argue the legislation *must* assist rough sleepers because its provision of support on epidemiological grounds recognises their 'complex needs' (Cornes *et al.*, 2014). However, there is variable knowledge about the Act, and it is unevenly implemented because of ongoing institutional and financial barriers. The Act introduced a national minimum eligibility threshold for adult social care services, i.e., the level/type of need which must exist before services are provided. Prior to this, every local authority exercised power to set its own eligibility criteria for adult social care services. When budgets were limited - or being cut - authorities tended to raise eligibility criteria. Subsequent variations in spending led to what is sometimes called a 'postcode lottery'. This means services depend not simply on needs but also location. However, the Act does not straightforwardly overcome this issue. Many rough sleepers with lower-level but very complex needs *still* may not meet national

minimum eligibility thresholds. And even if rough sleepers do achieve entitlement, local authorities struggle to meet statutory obligations in a context where demand for adult social care is increasing but budgets are reducing.

Mason et. al's (2018) empirical study of the Act's implementation is prescient. It explored relations between a voluntary sector homelessness organisation and adult social care department, where referrals from homelessness practitioners achieved entitlement for rough sleepers. Social workers said it was challenging to receive referrals where rough sleepers 'presented well', because they appeared more resilient compared to their 'normal' clients (i.e., older people). Homelessness practitioners described successful referrals as adopting relevant legal terminology and avoiding 'soap opera storylines' to explain needs. In other words, practitioners challenged institutionally-bound constructions of rough sleepers to achieve outcomes under the Act. However, resourcing still mattered. Social workers thought authorities were monitoring and attempting to reduce spending through increased management oversight and incrementally lower cost thresholds for meeting care needs. This affected what workers could reasonably offer and often fell short of what was required. Given reports that 'even' Conservative authorities are demanding tax increases to resource adult social care (Savage, 2018), financial cuts will continue to impact outcomes under the Act.

### **The Homelessness Reduction Act 2018**

The Act started as a Conservative MP's private members bill, but achieved support from cross-party politicians and campaigning organisations. Consistent with developments in Scotland in 2012 and Wales in 2014, its main duties require that local authorities take '*reasonable steps*' to prevent homelessness and work to secure accommodation (s.195). This applies to *all* people where they are eligible due to homeless/threatened with homelessness, and regardless of evidence of priority-need or intentionality. A '*Personalised Housing Plan*' ('PHP'), completed under assessment duties (s.189A), sets out actions authorities and applicants agree to take to secure accommodation. This process is supported by extension of period '*threatened with homelessness*' from 28 to 56 days. During this time, a '*relief duty*' (s.189B) is owed to those with a priority-need, with interim accommodation provided. A '*main housing duty*' is owed if after 56 days, homelessness is not relieved, an applicant has a

priority-need and is unintentionally homeless. However, an authority may ‘discharge its duties’ if a person has ‘*deliberately and unreasonably*’ refused to cooperate with their *PHP*, for example by refusing an offer of accommodation.

The *Code of Guidance* accompanying the Act advises priority-need can be established through ‘*combining factors*’ (e.g., mental-ill health, drug/alcohol problems, history of sleeping rough) which taken alone may not establish vulnerability (s.8.39). It warns against ‘*checklist*’ approaches to assessment, cautions that applicants may need ‘*sensitive encouragement*’ to disclose needs (s.11.11) and recommends the *PHP* be ‘*holistic*’ (s.11.11) and ‘*realistic*’ (s.11.20). It recommends authorities take into consideration that rough sleepers’ non-cooperation with a *PHP* may be due to difficulties managing communications when street-homeless and if care needs are unsupported (s.14) (Ministry of Housing, Communities & Local Government, 2018a).

Authorities are obliged to work toward eliminating rough sleeping (s.2.68). The *Code* recommends this is achieved through strategic coordination between health, social care, criminal justice and voluntary/third sector providers because housing services ‘*cannot tackle rough sleeping alone*’ (s.2.69). Coordination also features in s.213B ‘*Duty to Refer*’. This requires that named public bodies refer individuals (with their consent) to an authority of their choosing where they think a person is homeless/threatened with homelessness. Such ‘integrated’ responses claim to reduce the risk that rough sleepers ‘fall through the cracks’, and limit pressures on services by lessening emergency callouts (s.2.29). The Act will be resourced by £72.7 million additional ‘implementation’ funding. There is a £30 million immediate fund for 2018-2019 (with further funding agreed for 2019-2020) for 83 councils with the highest numbers of rough sleepers, to finance bed spaces and specialist practitioners. A *Rough Sleeping Team* with expertise in ‘complex needs’ will advise these authorities (Ministry of Housing & Local Government, 2018b).

In the absence of empirical evaluation, three observations can be made at this early stage. First, housing authorities have responsibility and flexibility for operationalising the legislation. This presents opportunities and challenges. For example, the *Code* permits authorities to outsource key duties. If housing departments lack capacity to manage the *PHP*,



specialist voluntary sector providers may fill this gap (as under *Supporting People*). However, responsabilising authorities highlights gaps. For example, multi-agency responses are discussed in vague terms; authorities ‘*will wish to*’ agree arrangements with relevant authorities (s.4.10) and should be ‘*mindful*’ of duties under the *Care Act 2014* (s.11.12). This does not address institutional challenges of joint-working (Milbourne, 2009) or specific processes, like impacts of *Care Act* personalisation for a rough sleeper’s *PHP*.

Relatedly, given everyday contact with street-homeless people, and the *Code*’s recommendation that housing authorities reduce rough sleeping by working with agencies to tackle ‘*street drinking, begging, drug misuse and anti-social behaviour*’ (s.2.70), it is surprising that Police are not a ‘*referring public body*’. Although, Police take-up of ‘*Public Space Protection Orders*’ against street-homeless people arguably work against the Act’s aim to eliminate rough sleeping, because enforcement measures fail to tackle root causes (Comarty and Strickland, 2018).

Second, assessing ‘*combining factors*’ has potential to overcome institutional barriers to establishing vulnerability under the Act. However, under the present system, some service users (and advocates/professionals) have found psychiatric diagnostic categories useful for evidencing their need for support in ways that enhance institutional and state legal protections (Gask, 2018). Resultantly, movement away from diagnostic labels does not ensure increased entitlement and could risk loss of protections. This is because the Act is implemented in a socio-cultural climate still subject to the power of a medical-model, and assessments of entitlement to social welfare demonstrate hostility to human suffering (Mills, 2017). In short, the Act’s move away from diagnostic labels should not be conflated with a progressive ‘social model’ approach.

Third, *PHP* guidance warns against penalising rough sleepers, which challenges pathological constructions of rough sleepers as non-compliant. This challenge is extended through the *Code*’s recommendation of models of support for rough sleepers: ‘*Psychologically Informed Environments*’ (*PIEs*) and ‘*Housing First*’ (*HF*). *PIEs* aim to generate personal change in rough sleepers by creating an emotionally safe environment. This is achieved by applying non-prescriptive psychological principles to practitioner training and agency design (e.g.,

‘trauma-informed care’) (Haigh et al., 2012). *HF* re-houses rough sleepers immediately without using resettlement accommodation projects to ensure their ‘readiness’ for independent living. Accommodation and support are separated out to different providers, such that housing is not conditional upon compliance with support. In its original US-based formulation, rough sleepers received intensive support from a team including health, welfare and ‘psy’ practitioners, which is flexible insofar as it is led by client choice and needs (e.g., abstinence not a condition of support) (Tsemberis, 2010).

Inclusion of these models in the *Code* reflect their growing popularity across the homelessness sector for approaches based in *relations*- as opposed to behaviour-management (Cockersell, 2011). This can be interpreted as a response to the historic exclusion of rough sleepers from services where their needs are regarded as too high or their behaviours too disorderly (Scanlon & Adlam, 2012). Both models have enthusiastic supporters. *PIEs* feature increasingly in local commissioning and government has pledged £28m to pilot *HF* in three areas. Overall though, they are not commonly practiced across England, and it remains difficult to appraise their effects (Moretone et al., 2016). Anecdotal evidence suggests *PIEs*’ popularity amongst commissioners risks a ‘faddish’ approach that detracts from its commitment to flexible, creative and service user-led practice (Johnson, 2018). Early findings of *HF* demonstrated increased sustained tenancies amongst rough sleepers (Tsemberis, 2010). However, care over housing (e.g., location, co-habitants) and support practice are fundamental to its ability to improve outcomes (Parkinson and Parsell, 2017).

Interestingly, both the *Care Act 2014* and *Homelessness Reduction Act 2018* promote approaches that challenge the sustainability of homelessness services in their present forms. *Personalisation* and *HF* represent shift from residential/collective provision (i.e., funding allocated to providers as block grants) to individual budgets and independent housing (Cornes et al., 2013). However, movement away from institutional provision should not be straightforwardly conflated with improved care and support for rough sleepers. Feminist ‘ethic of care’ approaches demonstrates that power dynamics are central to how ‘care’ is prescribed, taken-up, practiced and achieved, for different contexts, locations and identities (Barnes et al. 2015). Critical exploration of policy and practice in situ is needed.

## Conclusion

Cuts and institutional barriers provide explanations for increases in rough sleeping. The *Care Act 2014* and *Homelessness Reduction Act 2018* offer an opportunity to overcome barriers by committing authorities to key duties, and challenging pathologising constructions of rough sleepers. However, varied local implementation and the enduring power of the medical-model will structure how far legislation improves outcomes for rough sleepers, and evolved construction of rough sleeping as a care and support need. Overall, the Acts and associated resourcing appear piecemeal without a sustained country-wide homelessness strategy accompanied by long-term and meaningful support, and a supply of secure and affordable housing (Wilson, 2018). Without this, rough sleepers risk falling through the cracks of *both* adult social care and homelessness legislation, and cuts will mean they fall faster and harder.

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