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Increasing access to Care Act 2014 assessments and personal budgets among people with experiences of homelessness and multiple exclusion: a theoretically informed case study

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Abstract

Purpose – The purpose of this paper is to present a case study describing the progress that is being made in one city in England to increase access to Care Act 2014 assessments and personal budgets among people with experiences of homelessness and multiple exclusion.

Design/methodology/approach – A case study employing a “study group” to describe and reflect on local development work.

Findings – The authors focus on the "systems change" activity that was undertaken by one voluntary sector partnership project to address issues of referral and access to adult social care. This included the development of a “Multiple Needs Toolkit” designed to support voluntary sector workers to communicate more effectively with adult social care around the application of the new Care Act 2014 eligibility thresholds. The authors discuss the role of “persistent advocacy” in increasing access to assessments and also the limitations of this as regard the potential for poorer joint working.

Originality/value – Throughout, the authors draw on the “ambiguity-conflict” model of policy implementation to assess if the learning from this single case study might be applied elsewhere.

Keywords Personalization, Care Act 2014, Eligibility, Ambiguity-conflict model, Homelessness, Hospital discharge, Intermediate care, Medical respite, Transition of care, Realist systematic review, Systems change

Paper type Research paper

Introduction

Integrated care is central to overcoming the problem of fragmented and uncoordinated services. It is of particular importance for excluded groups who may have difficulty in advocating for their own needs (Faculty for Homeless and Health Inclusion, 2013). While government initiatives such as the “Homeless Hospital Discharge Fund” (Department of Health, 2013a) have prioritised ways of improving integration between health and housing sectors, less attention has been paid to the interface with adult social care. It is timely to redress this because a key feature of the Care Act 2014 was removal of reference to “eligible” and “ineligible groups” so that any adult with any level of need for care and support has a right to an assessment.

The Care Act 2014 was introduced in England from 1st April 2015. It rescinds much legislation, including the NHS and Community Act 1990, with the aim, inter alia, of creating a single consistent route to establishing entitlement to publically funded care and support. To make the...
law fair and consistent, the government aimed to remove anomalies which treated particular groups of people unjustifiably differently (Department of Health, 2013b, p. 1). As a consequence some people who were frequently passed over by adult social care on the grounds that they did not come within a certain user group as defined in legislation, for example, “homeless people” will no longer be excluded (Mandelstam, 2013, p. 80).

The Care Act 2014 places personalisation on a statutory footing for the first time. It substitutes to some extent individual funding for a system of block commissioning of services from the private and voluntary sectors (Ellis, 2015). Under the Act everyone eligible for non-residential care and support is entitled to a “personal budget”. The guidance stipulates that a “direct payment” (a cash payment in lieu of services) should be the preferred option (Department of Health, 2017, s12.2). However, personal budgets can also take other forms such as an “Individual Service Fund” (ISF). With an ISF the service user can appoint an organisation of their choice to both manage the personal budget and use its own employees to deliver any direct care or support. This model is designed to enable people to exert influence, without having to take on the responsibilities that come with a direct payment such as having to employ staff (Tomlinson et al., 2014) or manage the money. The other option, and the one that remains most commonly used in England for around 95 per cent of service users (Slasberg and Beresford, 2015), is where the local authority manages the personal budget on behalf of the service user, often providing regulated personal and domiciliary care services in much the same way as in the past. This has been described as “phantom personalisation” (Slasberg and Beresford, 2016).

In a review of the implications of the Care Act 2014 for people who are homeless, Cornes et al. (2016) suggest that homeless organisations need to rapidly increase their knowledge of personalisation as it is conceptualised within the new care and support system. This is because as block contracts and grants for services diminish, negotiating the new “cash for care” system through mechanisms such as ISFs may be key to organisational survival. Importantly, the Care Act 2014 guidance is clear that personal budgets can encompass expenditure on both care and support (and items), including housing and tenancy-related support (Department of Health, 2017, s15.55).

Given these changes, this paper explores the progress that is being made in one city in England to implement the Care Act 2014 with regard to meeting the needs of people with experience of homelessness and exclusion. We begin by describing the method through which the case study was generated. We then explore the wider background to the case study in terms of the voluntary sector’s increasing role in “systems change” and how this can be understood in terms of the wider literature on “managerial domination” in policy implementation processes. The case study then describes the different steps that were implicated in making some scale progress towards increasing access to Care Act 2014 assessments and personal budgets. This encompasses discussion of “persistent advocacy”, the development of a “multiple needs toolkit, shared learning and a community of practice. Finally, we explore how transferable this approach may be to other areas in England, mindful of the unique position of this voluntary sector organisation as a charitably funded project rather than a local authority commissioned service.

**Method**

Because implementation is still in its infancy, there is no formal research reporting on the impact of the Care Act 2014 on the health and wellbeing outcomes of excluded groups. With a view to scoping future research on this topic, the Policy Institute at King’s College London along with social work colleagues from the “Faculty for Homeless and Inclusion Health” convened a series of study group meetings comprising academics, local authority social workers and practitioners working in the field of homelessness and multiple exclusion. Four study group meetings were held across 2016 and 2017. Three sessions were held in London and one in Stoke-in-Trent. In attendance at one or more of the meetings were: four academic researchers, 18 local authority social workers from three local authorities (two in London, one in the North of England), 16 homelessness practitioners from eight homelessness organisations (four from London, one in the south west of England, three from the north of England) and one “expert by experience”.

The case study presented here was generated through these study group meetings. At the first meeting, a presentation was given on the work that was taking place in the case study site. Using a simple “Plan-Do-Study-Act” methodology (Reed and Card, 2015), progress was then tracked.
by the study group over a period of one year. This did not constitute any formal evaluation activities such as interviews or focus groups. Rather the study group was used as a “sounding board” for the main stakeholders involved in developing the work. The main stakeholders were the director and senior manager from the voluntary-sector organisation leading the work, along with a senior social worker from the local authority. Alongside the main stakeholders, academic and other members of the group became actively involved in the development work itself. This included making visits to the case study site to learn more about the work or contributing their interdisciplinary knowledge and expertise (e.g. sourcing relevant literature, designing and participating in local training events, and helping with note taking and writing-up activities). The meetings generated over 12 hours of discussion and debate. Permission was secured from participants to report on these discussions. Mason et al. (2018) provide more detail about the study group format and an overview of the range of topics that were discussed.

The main limitation of this approach is that the findings presented in this paper are not based on empirical research. There is also the potential for bias towards a more positive view of the work given that all the authors of this paper (albeit to different degrees) were actively involved in designing and delivering the work. Nevertheless, the paper was written to achieve “critical reflexivity” (Girbich, 2017). We also think it is potentially valuable to report this work as it provides early learning which may be useful for other areas developing similar work and also offers recent insights for other researchers interested in scoping this topic.

**Challenging “systems failure”**

In a critique of personalisation and personal budgets, West (2013) draws attention to the evangelical way in which these concepts are promoted by key policy makers and local authority officials despite the near impossibility of implementing them in “progressive forms” due the current financial climate. She locates these observations in the wider discourse on “managerial domination” suggesting that institutions will seek to efface critique by reiterating the “symbolic frame” through which a situation is to be interpreted (e.g. “making it personal” or “offering choice and control”). In what follows, we further develop this critique of “managerial domination” by drawing on Matland’s (1995) “ambiguity-conflict model” in public policy implementation. In doing so, we want to explore what happens when the voluntary sector takes on a grass roots activist role, not only questioning the “symbolic frame” but also seeking to take some ownership of the transformation or “systems change” process.

Abercrombie et al. (2015) have drawn attention to the fact that “systems change” is increasingly being adopted by a range of progressive charities and funders as a means of addressing the root causes of social problems. They conceptualise “systems change” as an intentional process designed to alter the status quo by shifting the function or structure of an identified system with purposeful interventions. They see an important role for charitable and voluntary sector organisations in “challenging systems that don’t work and showcasing better alternatives” (Abercrombie et al., 2015, p. 3) but also caution how:

> It is easy to characterise government as the problem – and there are plenty of places where the public sector’s behaviour is frustrating and creates challenges – but voluntary sector actors can sometimes be guilty of a lack of curiosity and empathy with government colleagues, which can, in turn, limit the understanding and ability to engage and influence decisions (p. 29).

In 2013, the Big Lottery launched the “Fulfilling Lives Programme”, investing £112 m over eight years in 12 areas of England with high concentrations of people experiencing multiple needs (Adamson et al., 2015). An individual is said to have “multiple needs” where they have concurrent experience of at least two of the following: experiences of homelessness, reoffending, substance misuse and mental ill health. An important ambition of the “Fulfilling Lives” programme is that it should lead to sustainable changes to the wider systems of services used by people with multiple needs, and that participating projects should evidence new ways of working which will influence the future commissioning of services (Adamson et al., 2015).

In a review of the systems change literature commissioned by the Gateshead Fulfilling Lives Project, Hough (2013, p. 27) identifies personalisation as an example of a “systems failure” and an area where systems change work might usefully be targeted. Referencing Duffy (2014), she
describes how the aspiration for a more flexible system has become distorted by austerity or public sector spending reductions and how, as a result, personalisation has become an “excuse for abandonment”. Seeking to tackle these kinds of exclusionary practices through “innovation in referral and access to services” features as key change objective in the Big Lottery Fulfilling Lives Programme (Moreteon et al., 2016, p. 37). We now turn our attention to theorising about the potential for conflict where “systems change” led by the voluntary sector is targeted at flagship government policy, that is the dominant “symbolic frame”.

The ambiguity-conflict model

Matland (1995) hypothesises that when public policy is enacted by government, the task of implementation is to translate symbolic ideas and aspirations (high ambiguity) into clearly specified goals and objectives. This might take the form of detailed policy guidance. The next task for government officials is to design the most appropriate control mechanisms which can secure the compliance of frontline actors. This can be achieved through marketisation and managerialisation and might include, for example, frameworks for quality monitoring and contract compliance or the introduction of a local authority “panel” to review proposed personal budget expenditure plans. As guidelines develop and become more specific, Matland sees the potential for conflict increasing as competing interest groups begin to see more clearly the threat to their own “turf” (p. 159). Thus, “symbolic implementation” is characterised by “high ambiguity/high conflict” whereas “political implementation” is characterised by “low ambiguity/high conflict”. For Matland, a key attribute of “political implementation” is that it reduces the scope for “street-level bureaucracy” to influence outcomes:

The central principle in political implementation is that implementation outcomes are decided by power [...] The “bottom-up” argument that policies are decided at the micro level fails because it does not take account the considerable forces and power than can be brought to bear upon an issue when it is unambiguously and explicitly formulated (Matland 1995, p. 165).

Ellis (2015) argues that personalisation does not fit neatly into Matland’s characterisation of “political implementation”. This is because prior to the Care Act 2014, personalisation was implemented largely in a legislative vacuum. As result, she suggests that early policy guidance remained highly ambiguous which made it difficult for local authorities to lever sufficient control to close the “enduring spaces for and influence of street-level discretion” (p. 245).

Like West (2013) and Hough (2013), Ellis sees the transformational aspirations of policy on personalisation as having been constrained by the challenge of retaining the ethos of “self-directed support” whilst experiencing severe funding cuts. She suggests that the more social workers are under pressure to manage excessive demand relative to resources, the more social work discretion will be used defensively. Thus, while controls such as new managerialism “have affected a qualitative shift in the governance of front line discretion, the assumptions and practices of paternalism and deservingness appear remarkably impervious to change” (Ellis 2015, p. 251).

In the case study that follows, we explore two questions in particular arising from this theoretical exposition. First, to what extent is the Care Act 2014 reducing ambiguity by filling the legislative vacuum surrounding personalisation? Second, and with regard to the first, what is the role of charitable and voluntary sector “change agency” in mediating between government control and the “professional discretion” of the front line social worker?

Case study – the golden ticket

[Roald Dahl’s writing is characterised by his anarchic spirit and spikily, gruesomely satisfying resolutions to his problems (Mangan, 2014, p. 1).]

VOICES is one of the 12 “Fulfilling Lives” partnership projects and works across one city in England. The overall aim of the project is to empower people with multiple needs to change their lives and to influence services. VOICES employs a team of service coordinators who work intensively to build relationships with customers (the term used in preference to client, service user or user)
and achieve an integrated response to their needs from local services. Coordinators help customers to navigate complicated access points to services, act as persistent advocates in order to secure entitlement to resources, and provide a continuous source of support that is not contingent on behavioural conditions. For example, customers are not excluded from the service if they fail to attend an appointment.

At a more strategic level, VOICES aims to facilitate partnerships across a wide range of local stakeholders. This includes: senior commissioners from the NHS and local authority; representatives from the police; local charities; and people who have lived experience of multiple needs. One of VOICES’ key objectives is to:

Seek opportunities for systems change by challenging the ways in which systems of all kinds, such as in commissioning, communities and policy, inadvertently reduce the [life] chances of people with multiple needs (VOICES, 2016, p. 9).

Based on co-production with people with lived experience of multiple needs, VOICES’ aspiration for systems change was initially conveyed through Roald Dahl’s popular tale “Charlie and the Chocolate Factory”. The aim was that the most vulnerable and excluded citizens will have a “Golden Ticket”. “The intention is that being accepted as a Golden Ticket holder [a customer of VOICES] will provide registration with a GP and a full health MOT, acknowledgement of vulnerability for social services, housing, health, mental health and criminal justice services” (VOICES, 2013).

Securing the golden ticket

VOICES’ work to lever change with regard to “referral and access” in adult social care emerged iteratively. It can be conceptualised by way of the diagram shown in Figure 1. The diagram highlights the process through which “systems change” was achieved by moving away from “persistent advocacy” (High Conflict) towards a more collegiate or collaborative approach (Low Conflict). The collaborative approach employed shared learning and Communities of Practice as a means of managing the ambiguities inherent in the Care Act 2104.

Persistent advocacy

For the VOICES coordination team, issues quickly came to light as regard access to adult social care. Coordinators found it difficult to negotiate the initial customer services screening processes.
and to secure an assessment for their customers. Situations occasionally arose where coordinators felt that they had no option but to provide care themselves. In one case, a VOICES coordinator reported that she had used her own washing machine to meet the needs of a customer who was disabled and doubly incontinent having failed to secure what she perceived to be the necessary help through adult social care.

In order to improve access to adult social care, the initial approach employed by VOICES coordinators centred on practices which they conceptualised as “assertive” or “persistent advocacy”. This approach is legitimised within the systems change literature on the following grounds:

Practitioners analysis of systemic social problems often emerges from their experience and dissatisfaction, rather than a formal diagnosis or study, and they are likely to agitate for change from within a system (Abercrombie et al., 2015, p. 12).

Persistent advocacy involved VOICES coordinators directly challenging the decisions of social work colleagues where they perceived exclusionary practice. The case study shown in Box 1 illustrates this approach as described from the perspective of a VOICES coordinator. It was recognised that as “unqualified workers”, it was not always easy for VOICES coordinators to challenge “professionals”. However, customers were often appreciate that someone was “on their side”. In turn this enabled VOICES coordinators to build the relational capital that was needed to engage with people previously identified as “hard to engage”.

Persistent advocacy was also sometimes backed-up through management support for the use of formal escalation (and complaints) procedures. Another strategy used by VOICES was to establish interprofessional alliances which invoked medical and professional hierarchies. Typically, this might involve securing a letter of support from a senior NHS doctor in order to challenge the grounds on which particular needs had been deemed ineligible by the local authority. For example, clinical evidence might be introduced to argue that in a particular case, chronic homelessness and alcohol misuse were a result of a brain injury and not poor or unwise lifestyle choices (which as illustrated in the case study was a common argument put forward by the local authority for disputing eligibility).

Box 1: Case study recounting the use of persistent advocacy

Steve is in his 50s having been in and out of prison for more than two decades. He has struggled with a heroin addiction and poor mental health for most of his adult life. Steve was in hospital receiving treatment for an infection when he was introduced to VOICES. He was later admitted to a Mental Health Ward for further assessment. Steve informed his VOICES Service Coordinator that he did not want to return to the hostel where he was living. He felt that an environment where heroin was easily accessible was not going to help his recovery.

Steve was supported by VOICES to make a request for a Care Act assessment. However, the outcome of the assessment was that Steve was ineligible for support. This was justified on the grounds that he “had capacity” was therefore “making a lifestyle choice”. Steve was later discharged from hospital to a B&B. He remained there for 5 weeks.

Steve was readmitted to hospital due to his ongoing physical health problems. A request for another Care Act assessment was put through by a Community Matron. Again, Steve was deemed to be making a “lifestyle choice” and deemed ineligible for care and support. Steve’s physical health was deteriorating and mobility worsening. He became doubly incontinent and unable to address his own care needs.

To secure another Care Act assessment for Steve, the VOICES coordinator visited the local authority in person and refused to leave until she had spoken to a social worker. Following this assessment, Steve was found to be eligible for care and support. He spent ten weeks in a respite facility before moving into his own specially adapted home. Through a “managed personal budget” Steve receives five daily visits from care workers with wider interprofessional input from occupational therapy, community nursing and VOICES.

Note: *Anonymised – written by a VOICES coordinator*
In terms of delivering systems change, an independent evaluation report of the VOICES initiative (Rice, 2017) identifies assertive advocacy on a casework basis to be a powerful tool for enabling fair access, concluding that:

It may be that part of VOICES legacy is recognition that a small team working flexibly with small caseloads of people is an ongoing need to sustain and progress fair access systems change (p. 8).

However, while improving access to assessment on occasions, this assertive approach was also characterised by “high conflict” and poorer working relationships in which social work colleagues own pressures and organisationally defined roles may have been disregarded. Furthermore, as illustrated in the case study above, “arguing the case” could take place over extended periods of time. This could potentially lead to poor interim outcomes for service users with increased expenditure upstream, including repeat admissions to hospital and the need for potentially more costly care and rehabilitation packages. Thus, while VOICES staff and management recognised the gains from “persistent advocacy” in cases like these there was a clear imperative to move towards more collegiate ways of working (i.e. to lower the conflict level).

Multiple needs tool kit. An early lesson to emerge from VOICES’ work centred around the importance of communicating with adult social care practitioners in their own language. It was recognised that where referrals provided a narrative account of customers’ circumstances (described by one VOICES manager as being comparable with a soap opera storyline) these were rarely acted upon by social workers. What worked from an advocacy perspective, was ensuring that referrals clearly specified how presenting needs mapped onto the new “eligibility regulations” contained in the Care Act 2014. Eligibility is important because it triggers a legal duty for the local authority to meet a person’s needs.

To assist coordinators in their advocacy work, VOICES designed the “Multiple Needs Tool Kit” (Ornelas and Meakin, 2016). This provides a “step by step” guide to working through the Care Act 2014 eligibility regulations. The tool kit is a powerful advocacy aid as it records different viewpoints side by side: that of the person being assessed, that of the support worker (or advocate) and that of the social work assessor. One outcome of presenting information in this way is that it renders any discretionary judgement (both professional and non-professional) explicit and therefore open to much greater scrutiny and challenge. For example, hypothetically, the social work assessor might support the VOICES customer’s perspective that they are managing their “personal hygiene” well, while the view of the coordinator may be that the customer is unkempt and self-neglecting. Here, the social worker might argue the VOICES coordinator is being paternalistic, while the support worker might see the social worker as saving resources by not probing why the customer is declining care and support. The customer meanwhile can potentially find themselves stuck between both these professional judgements which might then be played out in terms of an assessment of his or her capacity. Thus, one limitation of the tool is that while it gives expression to the customer’s perspective, it does not necessarily lead to increased “choice and control”.

Initially, social workers and their managers in the local authority expressed concerns about the tool kit on the basis that it duplicated a “self-assessment” tool that was already being developed. However, VOICES addressed these concerns by making the aims of the tool kit clearer in the introductory section, providing reassurance that it was not intended to replace the formal assessments of professional social workers. This dialogue between the two parties marked a potentially important “first step” in moving towards a more collegiate and less combative relationship. The tool kit’s negotiated aims are:

- to ensure that people with “multiple needs” can record and communicate their needs as effectively as possible;
- to increase confidence among VOICES and other voluntary sector workers in working with the Care Act 2014;
- to support social workers (who may be unfamiliar with this “client group”) to explore how “multiple needs” impact on the need for care and support; and
- to enable relationships and information exchange between these two groups of workers who may not have worked together previously.
How the tool kit was working in practice was then regularly reviewed in a specially convened meeting (a community of practice) which brought together social workers and VOICES co-ordinators. Both VOICES co-ordinators and social workers agreed that the tool kit was helpful. For VOICES co-ordinators its main value was in promoting greater knowledge and understanding of how to work with the complexity inherent in the Care Act 2014 eligibility regulations or thresholds. For social workers who had little previous experience of working with people with multiple needs, it was acknowledged as being helpful in enabling them to ascertain a better understanding of the seriousness and gravity of risks associated with situations such as “rough sleeping”. It was also considered helpful in enabling social workers to understand the impact of fluctuating needs linked to behaviour driven by substance use and mental ill-health. One social work team manager said that it had transformed her own and consequently her team’s understanding of the vulnerabilities and difficulties facing this group of people.

Indeed, the tool kit appeared to be something of a Golden Ticket. This was because when the needs of VOICES’ customers were documented through its “lens” it was nearly always the case that they appeared eligible for care and support. This is because of the close parity between the consequences of “multiple needs” and the eligibility regulations (DH, 2017). For example, a very high proportion of VOICES’ customers have: impairments linked to physical and mental ill-health including substance misuse; associated difficulties with achieving two or more of the outcomes listed in the regulations, especially with regard to maintaining a habitable home environment and those outcomes linked to social inclusion (e.g. making use of necessary facilities or services in the community); and with consequent significant impacts on their wellbeing (e.g. as evidenced through high utilisation of hospital resources). Of the 16 tool kits completed (at the time of writing this paper) all triggered a Care Act 2014 assessment.

Outcomes of the assessments were:

- Eight customers receiving a “personal budget”. In all cases these were managed by the local authority. In seven cases the local authority organised regulated services (providing a package of domiciliary (home care) and personal care into customers’ own homes) and in 1 case a Personal Assistant was organised for the customer.
- Six customers being supported in Extra Care sheltered accommodation because of needs requiring residential care.

**Masterclass and community of practice**

When the Care Act 2014 was implemented in April 2015, VOICES requested that the local authority deliver some introductory training. However, during the session the trainers acknowledged that they could not answer many of the questions the Act raised for VOICES’ customer group as the training was designed with older people and people with learning disabilities in mind. It was therefore recognised that this was uncharted territory, and that a joint training venture or Masterclass might help pave the way. Importantly, the Fulfilling Lives projects have a healthy budget for learning initiatives, while local authorities received few dedicated resources for Care Act 2014 implementation. The Masterclass was delivered as an interprofessional educational initiative in Autumn 2016 and brought together VOICES’ staff with two social work teams. This was followed-up in early 2017, with a session which brought together a wider range of local stakeholders including representative from housing and health. The sessions were led by academics who gave an overview of the policy field and who could also act as independent brokers to facilitate the subsequent discussion. VOICES was able to tap into this academic consultancy because it was linked to a shared study group.

The Masterclasses were well received by participants and generated a strong desire to continue learning together. This led to the formation of a Collaborative Working Group. The group was practitioner-led and adopted a “community of practice” methodology (see Cornes et al., 2013; Hennessy et al., 2013 for an outline of the model employed). Communities of practice are specially facilitated sessions which bring together different groups of people who want to deepen their knowledge and understanding of a particular topic. Through the use of anonymised case studies, the aim was to provide a “safe space” in which to discuss ethically challenging practice issues.
Progress to date

Reflecting back on the work that had taken place in the city around the early implementation of the Care Act 2014, key stakeholders from VOICES and adult social care who were engaged in the study group agreed that working together through the Multiple Needs Toolkit had enabled significant progress to be made with regard to “referral and access”. It was however acknowledged that relationships between VOICES and adult social care had been strained while cases were initially “argued”. Coming together through shared learning and the “community of practice” was seen as having been especially important in managing this conflict by enabling greater understanding of each other’s roles and pressures. While it was recognised that there was still much work to do locally to fully implement the Care Act 2014, there was a sense that this would be taken forward as a shared, collegiate endeavor. The perceived outcomes of working together were summarised in a blog in which was written by the Senior Social Worker involved in the study group. The outcomes were:

- increased knowledge, skills and confidence among social workers when engaging with people with multiple needs;
- increased knowledge, skills and confidence among VOICES coordinators when working within the legislative framework of the Care Act;
- more open sharing of knowledge and increased appreciation of the priorities of other organisations;
- development in working relationships with an increase in joint working between organisations; and
- smoother referral process between organisations leading to less defensive practice and improved outcomes for the individual.

Discussion

This case study lends further weight to Ellis’ (2015) argument that personalisation is an atypical form of “political implementation”. While the Care Act 2014 has closed a number of loop holes, for instance, clarifying the position of “homeless people” with regard to accessing the new care and support system, ambiguity remains high. For example, what constitutes an acceptable level of “personal hygiene” is not defined in the legislation and is therefore open to dispute. According to Mandelstam (2017, p. 17), the Care Act 2014 legislation and guidance contain many “short cuts and escape routes” that will inevitably be used by hard pressed local authorities to constrain customers entitlement to resources.

However, what this case study adds to the understanding of atypical “political implementation” is the importance of exploring not just the relationship between “top-down” and “bottom-up”, but also the interplay that can exist between different kinds of “bottom-up” change agency. In this case study, the interplay between the local authority “street level bureaucrat” and the voluntary sector “advocate-activist” was able to lever some quite significant transformational change. This was with regard to the assumptions and practices of deservingness, leading to innovation in access and referral. These are areas which Ellis (2015) describes as being remarkably resistant to change.

To understand how this “bottom-up” collaborative was able to lever change, two overarching factors seem important. First, VOICES was able to position itself as the “trouble maker” (Hough, 2013) within the systems change process because it was charitably funded and therefore outside the control of the local authority’s finance and contracts management systems. These are recognised as powerful transactional technologies for securing the compliance of “providers” (Ellis, 2015). Indeed, there are questions as to the potency of voluntary-sector change agency that does not have this freedom.

The second factor that seems to have enabled the transformational change is that VOICES put in place strategies for actively managing the “High Ambiguity/High Conflict” dynamic.

Managing high ambiguity

At the outset, social workers could potentially find themselves metaphorically sandwiched between VOICES “bottom-up” activism and the “top-down” managerialist control of their local...
authority employer. Through persistent advocacy and the “Multiple Needs Tool kit”, VOICES sought to prevent what they saw as the “misuse” of the Care Act 2014. This effectively closed down older “escape routes” and potentially prevented newer ones from emerging. For example, persistent advocacy successfully challenged the view that the poor outcomes experienced by their customers could be explained by poor life choices. This was achieved by invoking the new Care Act 2014 regulations and making the case interprofessionally (clinically in some cases) that poor outcomes were more likely the result of impairments linked to physical and mental ill-health.

Here, the ambiguity level was not reduced, rather the scope it afforded for professional discretion was exposed and potentially constrained by VOICES through the use of the “Multiple Needs Tool Kit”. Indeed, Ellis (2015) alerts us to the tension between the competing imperatives of transformational technologies designed to lever co-production, and the aforementioned transactional technologies designed to manage the threat this level of self-governance would pose to fiscal control (p. 243).

Reducing the conflict level

Seeking to change the system through “persistent advocacy” and technological means did have some adverse consequences. The tool kit initially engendered a sense of professional protectionism around the issue of ownership of the assessment process. Thereafter “persistent advocacy” accompanied by increased use of escalation (complaints) procedures raised the conflict level leading to poorer collaborative working. This could lead to problems such as unnecessary hospital readmission which were symptomatic of a fragmented health and social care system. Thus moving towards less conflictual and more integrative ways of working became imperative to sustain the transformation process. This was achieved through the Masterclass and the Collaborative Working Group. It is well documented how communities of practice can open-up spaces for shared learning and reflection, leading to more ethical ways of dealing with the practice challenges of being stuck between what has been described as “The rock of increasing demand and the hard place of apparently decreasing resources” (Scanlon and Adlam, 2012, p. 75).

In many respects, the Care Act 2014 provided the ideal window of opportunity in which to initiate this relational and cultural exchange as it marked a “symbolic” break from the past. Indeed, it might be suggested that VOICES was successful in engaging and enthusing social work colleagues, because the enterprise was viewed as a new implementation project and not an intervention in “systems failure”. Under the cover of having to do things differently, it was then possible to renegotiate the street level bureaucracy that had previously impacted negatively on people experiencing multiple needs, and indeed, to secure something akin to a Golden Ticket. This is the “gruesomely satisfying resolution”. Slasberg and Beresford (2016) argue that while the government claims to be creating historic change to social care in England through the Care Act, this is not substantiated in the legislation and guidance. Thus, instead of tackling exclusion, the Care Act 2014 might just have easily been used as a “Smoke screen for the continuation of a system that has served short term political objectives well, but has been anathema to the person-centred system that government claims to want” (Slasberg and Beresford, 2016, p. 4).

Conclusion

Matland (1995) suggests that by studying a policy’s level of ambiguity and conflict, testable predictions can be made as to how an implementation process will unfold. He sees “political implementation” as characterised by “low ambiguity/high conflict”. With “low ambiguity” come clear objectives and the possibility of tight government control. This, he argues, reduces the scope for street level bureaucracy to influence outcomes. In applied terms, the implication is that where a social problem is already impacted by “political implementation” processes then progressive charities and funders would be better off targeting their resources at government officials than grass roots voluntary sector alliances.

However, this case study does not support this hypothesis. First, personalisation is an atypical form of “political implementation” characterised by “high ambiguity”. As Ellis (2015) argues this allows considerable scope for professional social work discretion which in times of austerity
serves to dampen the transformational effect. Second, Matland sees only one source of control over the “street level bureaucrat”, that from the government official above. What this case study illuminates is the potential for the “advocate-activist” to intervene from the “bottom-up”, in this case preventing “misuse” of the eligibility regulations in order to secure improved outcomes for people with multiple needs. Third, while Matland views “high conflict” as largely unproblematic, this case study is testament to the importance of lowering the conflict level and moving towards more collaborative or network based forms of governance in order to prevent fragmentation and other systemic issues from arising. Ultimately, this case study would suggest that where there is “high ambiguity” as in the case of the Care Act 2014, then the key to successful “political implementation” may be to release the grip of managerial domination and to foster a vibrant and well-funded independent charitable and voluntary sector.

References
Department of Health (2013a), Homeless Hospital Discharge Fund, DH, London.
Department of Health (2013b), Fact Sheet 2. The Care Bill – Who is Entitled to Public Care and Support, DH, London.
Faculty for Homeless and Health Inclusion (2013), Standards for Commissioners and Service Providers, Faculty for Homeless and Inclusion Health, College of Medicine and Pathway, London.


VOICES (2016), “Hard edges Stoke on Trent reducing the costs of multiple needs to people and services”, Financial Analysis of VOICES, Voices, Stoke-on-Trent.


Authors bibliography

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On the news today: challenging homelessness through participatory action research

Bruno De Oliveira

Abstract

Purpose – How can people with lived experience of homelessness actively participate in contesting their marginalisation? The purpose of this paper is to suggest that involving people who are homeless in participatory action research (PAR) is one such strategy. This paper shows that such an approach can have a significant impact on empowering people with direct experience of homelessness to challenge prevailing social discourses, particularly in terms of the way in which the local media presents homelessness as a social issue.

Design/methodology/approach – A PAR approach informed the design, development and dissemination of the study on which this paper is based. Analytically, it is underpinned by Foucauldian discourse analysis (FDA). FDA, with its focus on power relations in society, is noted to be particularly useful for analysing local media representations of homeless people.

Findings – The research reported here found that academic practitioners and homeless people can work together to challenge media discourses, which serve to marginalise people affected by homelessness.

Research limitations/implications – The research reported here served to challenge some of the ways in which homeless people are victimized and stigmatized.

Practical implications – The research reported here has the potential to inform future research concerned with understanding media presentations of homeless people. It can be seen as a model for how people affected by a particularly pernicious social issue can contribute to research in ways that go beyond researching for the sake of research.

Originality/value – The research reported here provides evidence of the emancipatory value of research that seeks to bring academic practitioners and homeless people together in a partnership to challenge vital social issues such as the power of the local media to frame understandings of homelessness.

Keywords Media, Participatory action research, Foucauldian discourse analysis, Homelessness, Emancipation, Brighton and Hove

Paper type Case study

Understanding homelessness

Homelessness can be understood as a moment of extreme crisis for individuals and families (Breese and Feltey, 1996). It is also closely associated with deep social exclusion and profound health inequalities (Breese and Feltey, 1996; Burki, 2010). For example, the average age of death for homeless people is just 47 years old, while the average life expectancy for the general population is 77 years old (Breese and Feltey, 1996; Burki, 2010). Homeless people are eight times more likely to suffer from mental health problems and 35 times more likely to commit suicide (Burki, 2010). Research on homelessness indicates that there is a wide variety of reasons why people become homeless. Relationship breakdown, debt, domestic violence, problematic gambling and experience of institutional care have been identified as risk factors for homelessness (Wright and Tompkins, 2006). This has led Sayce (2002) to suggest that homeless people are among the most marginalised, disempowered and voiceless groups in society.
Homelessness in the UK: how complex is the problem?

Homelessness in the UK has soared by 65 per cent since 2010 (Barker, 2017). More than 300,000 people in Britain – equivalent to one in every 200 – are officially recorded as homeless or living in inadequate homes (Shelter, 2017). The year-on-year rise in homelessness has coincided with a period of sustained welfare reform under the Coalition government and (2010-2015) Conservative administrations (2015-2018). The current age of austerity has been termed “radical fiscal retrenchment”. The consequence of this is that housing and welfare spending has fallen to its lowest level in over 60 years (Nevin and Leather, 2012).

According to the Rough Sleeping Statistics England – Autumn (2016), in Autumn 2015 there was a total of 4,134 rough sleepers estimated in England. This number is up 565 (16 per cent) from the autumn 2015 total of 3,569. London had 964 rough sleepers in 2015, which is 26 per cent of the national figure. Brighton, the site of the research reported here, has similarly witnessed a steady rise in homelessness (The Brighton and Hove City Council: Homelessness Strategy 2014-2019, 2014). More particularly, Brighton and Hove City Council sees approximately 4,500 people a year and gives advice and assistance in an effort to resolve housing-related problems. Nearly 1,000 people receive a case prevention/casework service, and a further 1,000 people make a homeless application each year (The Brighton and Hove City Council: Homelessness Strategy 2014-2019, 2014). The city’s street services teamwork with more than 1,000 cases each year – this equates to 20 rough sleepers’ every week. Nevertheless, in November 2015, a snapshot of a single night estimated 78 people were sleeping rough in Brighton & Hove (Brighton and Hove Sleeping Rough Strategy, 2016).

In the news today: reframing homelessness frames

An established research literature exists on the role played by the media in framing homelessness as a social issue (Caeiro and Gonçalves, 2015; Devereux, 2015; Hodgetts et al., 2006; Schneider, 2011). Critical scholars have argued that mainstream media accounts are often incomplete, misleading and driven by political agenda (Caeiro and Gonçalves, 2015; Devereux, 2015; Hodgetts et al., 2006; Schneider, 2011). The effect of this is essentially twofold. One the one hand, homeless people are rendered passive and/or disruptive. On this theme, Chauhan and Foster (2014) have observed that newspapers not only provide a platform for informing readers but also foment public understanding of often complex, and sometimes divisive, social issues. The media has the power to frame contested events in society into easily digestible narratives for public consumption (Iyengar and Kinder, 1987; Iyangar, 1991). Going further Chauhan and Foster (2014) contend that such media accounts largely fail to give critical consideration to the wider political economy of homelessness. Consequently, blame is shifted away from socio-economic factors and towards the imputed moral failings of people who are homeless. Bruce and John (2012) make a similar point in in the observation that society categorises people who are homeless as no longer “useful” and “functional” members of their community because they are seen as people who do not actively work and support their communities (Bruce and John, 2012).

Hodggets et al. (2005) point out that the media’s framing of homelessness relies on simple, one-dimensional and stereotypical characterisations of homeless people, in situations that fit public expectations, and do not draw on facts. Homeless people are encouraged to conform to or ascribed stereotype (Hodggets et al., 2005). As such, the media works to frame homeless people according to “what they lack”, rather than their capabilities and aspirations (Wright, 2000). Lyon-Callo (2000) argues that these dominant discursive practices encourage homeless people to learn to look within themselves, and not to wider social relations and economic forces, for the cause (and continuation) of their homelessness. Central to such discursive practices is an absence of space for homeless people to speak beyond such frames and constructed roles (Caeiro and Gonçalves, 2015; Devereux, 2015; Hodgetts et al., 2006). Hodgetts et al. (2005) note that the lack of engagement with homeless people on their own terms raises important questions as to whose needs are being met.

This paper asks: how can people experiencing homelessness contest their marginalisation? It approaches this task by first arguing that homelessness ought to be explored through an
approach that goes beyond the generation of new knowledge. It then advances from the position that research into homelessness is best informed through working collaboratively with people with lived experience of homelessness. Such an approach can, for instance, begin to challenge the way in which homeless people are discursively positioned as passive objects of avoidance and marginalisation (Crane and Warnes, 2001) through engaging in the research process as co-researchers. This paper concludes by suggesting that involving people who have direct experience of homelessness in participatory action research (PAR) has the potential to challenging normative understandings of homelessness.

Home Sacer: critiquing the frames

Homelessness in the context of austerity-led welfare reforms involves more than concepts of accommodation and pathways in or out of homelessness. Seen in this way, a homeless person in the contemporary political climate can be understood through reference to the concept of the “Homo Sacer” (the “accused man”) in Roman law. Homo Sacer is a person who is banned from Roman society and may be killed by Roman citizens and slaves, but may not be sacrificed in a religious ritual having been deemed impure for such ends. Therefore, one may argue that homeless people in the context of austerity politics are comparable to the Homo Sacer – i.e. a group who are punished by political practices and silenced from the political arena (Agamben, 1998; Bullen, 2015; Foucault, 1979; Kingfisher, 2007; Scanlon et al., 2008). Homeless people are moulded by forms of disciplinary power, which operate through political discourse, and thus serve to reinforce existing social arrangements (Agamben, 1998; Bullen, 2015; Foucault, 1979; Kingfisher, 2007).

In a widely discussed theoretical-infused paper, Scanlon (2008) posed a challenge to practitioners, academics and policymakers to reframe the philosophical basis of their work with marginalised communities. This is particularly relevant and important given that recent welfare reforms in the UK have served to further stigmatise and marginalise vulnerable groups such as homeless people. Taking-up this challenge the research reported here adopted PAR in an effort to challenge the way in which the local media in Brighton and Hove framed homelessness (Bruce and John, 2012; Groot and Hodgetts, 2012; Harvey, 2010; Kingfisher, 2007; Patrick, 2014). This paper demonstrates how PAR can enable academic practitioners and people affected by homelessness to act together to disrupt and problematise discourses of marginalisation. Importantly, PAR is a holistic approach that seeks to reclaim meaning and transform knowledge and understanding from the ground-up.

Methods

Participants

Ethical approval was received from Brighton University. The research team was recruited from Emmaus Brighton & Hove via a link created through a previous project with University of Brighton Community University Partnership Programme. Emmaus was clear about their involvement in this project. Emmaus offered a space for the meetings. Emmaus provides a unique and innovative solution to homelessness. The Community provides companionship, a place to live and work. The first Emmaus Community was founded in Paris, in 1949, by Father Henri-Antoine Grouès, better known as Abbé Pierre. Emmaus had been established in France for 40 years before it came to the UK in the early 1990s (De Oliveira, 2015). No two Emmaus communities are the same – each has its own distinct personality and provides a set of services which meet the needs of its local area.

Emmaus Brighton & Hove was contacted about the possibility of recruiting people for research about homelessness. The community leader read the research recruitment blurb to the community. Following this, three people expressed an interest in participating in this study. A meeting was arranged to discuss research ideas and the research process. It was during this meeting that the participants were invited to become co-researchers. The main outcome of the meeting was that the participants wanted to challenge the misrepresentation of homeless people by the local newspaper, The Argus. The co-researcher team featured two British citizens and one European citizen. All the co-researchers’ noted that the cause of their homelessness was relationship breakdown, and all the participants were in their 30s or 40s.
Procedure

The co-researchers had power to direct the research from its early stages through to the writing up stage (Freire, 1970). The research team, formed by a research student and the three co-researchers from Emmaus, met weekly over a ten week period in the Autumn of 2015. In these meetings, the research team discussed homelessness for 30 minutes, and after that, the research team worked for up to two hours on a folder of arts which included paintings, photography and poetry. The research team wanted to recruit more experienced artists to support the group to enhance their art skills in preparation for the art exhibition. Two third-year art students from the University of Brighton were recruited as volunteers through the School of Arts to support the group. The art students met with the group for eight weeks helping the group to explore their art folder. The art students told the research team that they wanted to be part of the discussions about homelessness and the research team not only accepted them to take part in the debate but also asked the art students if they would like to be part of the research team. The art students were admitted and joined the research team. The research team was interested in learning a method of social science inquiry to challenge the local newspaper misrepresentation of homelessness.

The research team discussed possible methods for analysing the newspaper article such as thematic analysis, narrative analysis, Foucauldian discourse analysis (FDA) and phenomenological interpretative analysis. The group decided on a method focused on the power of language. In this case, the research team decided on FDA as it is a method that provides a framework for challenging the power and the construction of passive subjects. The group was interested in learning about FDA, and during a two period the group met after the art classes for one and half hours to discuss FDA. A Senior Lecturer at the University of Brighton was invited by the research team to mediate one seminar session. This session provided an opportunity for people who might not otherwise have had the chance to learn about and use a scientific method of analysis. This process effectively brought the research team into being.

PAR: challenging marginalising narratives preparation

This PAR used the conventional cycle process of action research approach of planning-acting-observing-reflecting (Brydon-Miller, 2004; Best, 2010). First, the research team planned to challenge the local media representation of homelessness by using art as a means of bringing the community together and through that present to the community the FDA on the local newspaper’s article. Second, the research team acted by challenging the issue and presenting homelessness from their point of view to people with lived experience to the local community (Hodgetts and Groot, 2012; Johnsen et al., 2008). Finally, the team reflected on ill frames of homelessness and its impact on the local community. It was agreed from a process of open dialogue and debate that an art exhibition could help the local community develop a deeper understanding of homelessness and homeless people’s lives (Hodgetts and Groot, 2012). This project enabled the co-researchers involved to gain and enhance their artistic skills by allowing the engagement of different actors with distinct skill-set. Throughout the facilitation classes where art skills were shared, the research team collectively selected the media that they wanted to use in the exhibition (Plate 1). The research team shared techniques on collage, photography, acrylic painting and poetry.

Regarding empowerment, in a PAR approach, it is essential that the co-researchers have the opportunity to learn and to develop long-lasting skills. As one of the co-researcher noted:

This is an amazing project, isn’t it? I never thought I would learn to all this with cool people, right? My art will be displayed at the café for two weeks and we are going to have a private viewing that is so nice. We had a difficult time in the past and now we have the opportunity to show our work to others [Sic].

Exhibition

After weeks of preparation, the art exhibition consisted of 15 pieces of art produced by the research team, which taken together set out to explore homelessness. The artwork produced by the research team was displayed at the Brighthelm community Café in the city centre of Brighton for
two weeks in August (Plate 2). The research team designed and produced a flyer for the event named visual arts PAR. The brochure was distributed in various locations in Brighton such as community centres, universities, local council and, cafes. The art exhibition had a private viewing where the community, the local media and many stakeholders where invited to attend. In total, over 500 people saw the art display at the Brighthelm Café, and 51 people attended the private viewing. There were a diverse set of people attending the private viewing with a wide range of professions ranging from CBT trainee, housing manager, psychologist and students from the University of Brighton and the University of Sussex (Plate 3). The research team produced a mural with factual information about homelessness in the UK. The mural was meant to complement the artwork by informing the viewers on the issue. The wall provided context to those viewing the exhibition. Also, the mural included the discourse analysis produced by the research team where the team investigated and challenged how the media, at times, construct homeless people in Brighton.

In the news: perpetuating stories

This paper was a media report of homeless people in Brighton.

Seafront homeless camp moves on

“HOMELESS people who pitched tents on Brighton’s seafront have moved on.

The tents were spotted on Max Miller Walk, above Madeira Drive, last Thursday (19 June). Passers-by reported seeing people urinating on the floor and spitting down on to Madeira Drive. Brighton and Hove City Council investigated reports of many rough sleepers camping along the seafront and said yesterday the numbers were exaggerated. A council spokesperson added: “The city does experience individuals camping in unauthorised places including the seafront. We are grateful for the support and intelligence of the local business community. While we aim to deal swiftly with acts of antisocial behaviour, our actions also reflect the fact that we are also often dealing with vulnerable people with health, mental health and substance abuse problems. "We are keeping the situation under review including stepping up patrols and prosecution where required and practical" (The Argus, 2014).
The research team met to reflect on the entire process and write a critical reflection of the PAR process. It set out to ask what forms of participation and action research are effective. With this in mind, the research team was delighted with the result of the art exhibition. The research team was pleased by the level of critical dialogue with the local community created by the exhibition. The display encouraged people to critically engage with the issue of homelessness. Also, it also challenged some of the misunderstandings that people had about homelessness in the UK.

A particular strength of the project resided in the fact that it was participatory from the planning to the reflection. For example, all the research team got tangible outcomes out of this process such as learning about FDA, enhancing their art and organisational skills by organising an exhibition with space to co-generate knowledge. The research team noted that bringing people to discuss a topic like homelessness is not a simple task. There was a corresponding recognition that art can play a mediating role in critical dialogue. However, it is important to note that it was a small project and the overall impact was limited. This project achieved its aims of raising awareness about the lived reality of homelessness and to challenge negative media.
constructions through the use of FDA. The research team through the use of art acted to demonstrate that homelessness is a topic that needs to be reframed, so as to capture and reflect its complexity. The research team also challenged how the media discursively portrays homeless people in Brighton. The local media wrote an article about it entitled “Exhibition to counter negatives attitudes towards the homeless” (The Argus, 2015). That report presented a more accurate view of homelessness, and the local media itself changed to some extent its opinions on the issue as a result of the research (see extract below):

“The exhibition and he’s talk to us has definitely had an impact. I’ve always been an artist. My main passion is letter work but I am apprenticing as a tattooist now. Making furniture and tattooing are what I want to be doing when I leave here.” and “I accidentally came across Emmaus when I was looking around to see what I could do in terms of volunteering. I really liked their ethos because it’s not just about homelessness here. You earn your way through life at Emmaus, which is what I believe everybody should do” (The Argus, 2015).

The research achieved its primary aim, which was to challenge the misrepresentation of homelessness by the local media. It also provided the co-researchers with a voice in the local community. The research team further noted that the research challenged the media’s perception of homelessness. It opened a space for reflection such as if someone has experienced homelessness for three months, is that three months their life? What about the 40 years beforehand? What about what their previous contribution to society? The research team also reflected on how empowering it was to challenging marginalisation and test the usefulness of PAR as an active approach in enabling seemly powerless individuals and groups to contest seemly powerful institutions such as the media. There is a need for future participatory to scrutinise media based narratives on public policies. There is also a need to for “experts by experience” to scrutinise local and national policies in an effort to ensure that it is better informed and relevant to the needs of people affected by homelessness. Furthermore, Breeze and Dean (2012) have pointed out that homelessness charities regularly use stereotypical images in their fundraising, focussing on the arresting issue of rough sleeping as opposed to other, more widespread experiences of homelessness such as couch surfing. There is, then, a need for more participatory and collaborative research aimed at scrutinising how organisations that are meant to help homeless people are in actual fact legitimising homeless people’s marginalisation and exclusion (Breeze and Dean, 2012).
FDA: the co-production of knowledge

To explore the way in which the local media framed homelessness and homeless people, the research team wanted a method of analyses that was useful to investigate and to challenge local media framed homelessness and homeless people. FDA was chosen for this research because FDA is an epistemological, social constructionist method of qualitative inquiry concerned with interrogating the role of language in the construction of genealogies and archaeology that form a subject (Foucault, 1970, 1994, 1998, 2002). According to Foucault, genealogy is a method of deconstruction of history previously seen as usual and natural. It aims to enable a critic to challenge whether such constructions are normal and natural (Foucault, 1970, 1994, 1998, 2002). The focus of FDA is on the purpose of language in constructing subjects framed and restricted through power relations validated and legitimised by social practices. For example, Foucault (1990) in the History of Sexuality argues that sex is perceived as healthy and natural only in a heterosexual discourse. Thus, other forms of sexuality are constructed as abnormal when compared to the dominant heterosexual discourse. Foucault goes on to link this with forms of institutional power that validates which sexual practices are legal and which sexual practices are not permitted in society. Thus, FDA is a method that helps to investigate how acts are validated, maintained and legitimised in society. Discourse can restrain, frame and limit the action of social subjects. Importantly, though, discourse constructs ways to understand the world (Willig, 2009). Indeed, prevailing discourses privilege those versions of reality that legitimise standing power relations and social structures. The research reported here challenges on a micro scale such prevailing practices in regards to media framing of people experiencing homelessness in Brighton and Hove.

Discussion and conclusion

The original contribution of this research is the involvement of people with experience of homelessness in methodology. The research team used FDA to analyse an article titled “Seafront homeless camp moves on”, taken from the local newspaper, The Argus. The FDA followed Willig’s six steps guide to FDA discursive construction, discourses, action orientation, positioning practice and subjectivity (Willig, 2008). The newspaper article constructed homeless people as a group of people who consciously moved to a location where homeless people supposedly had no right to occupy or be in, namely, the seafront in Brighton (lines 1-2). The article served to frame homeless people as people with limited right to occupy specific places in the city. The article does not give an account of any literature or any context to homelessness in Brighton. A background would enable the reader to position the issue and to have a better understanding of homelessness in the city. The article contends that homeless people have fewer rights to use public spaces especially public spaces that make them visible, this raises another established conversation about visibility (Lyon-Callo, 2000).

The news article states that homeless people are camping in an unauthorised place. It constructs of marginalisation and a struggle for survival as camping and reduces exclusion and a disempowerment to leisure activity (line 8) (Agamben, 1998; Bullen, 2015; Foucault, 1979; Kingfisher, 2007; Scanlon et al., 2008). The article simplistically constructs a scene of the homeless as uneducated and anti-social capable of an un-civilised behaviour, which is a form of dehumanisation (line 4). The article is constructing a clear discourse that action to combat that scene of the un-civilised act is needed (Agamben, 1998; Bullen, 2015; Foucault, 1979; Kingfisher, 2007; Scanlon et al., 2008). The article constructed homeless people at the seafront as a motive of public concern without providing a context in which people end up living on the streets and in open spaces (lines 5-6). The article does not give numbers for what it perceives to be an adequate number of homeless people at the seafront. This discourse acts to position people that the seafront is not a place to be occupied by the homeless and thereby encourages a positioning that intensifies the marginalisation of homeless people. The article quotes a council spokesperson about the importance of businesses in monitoring the homeless people at the seafront (Agamben, 1998; Bullen, 2015; Foucault, 1979 and Kingfisher, 2007).

The article uses a council spokesperson as a mechanism of power and validation (lines 9-12). The council is policing homeless people and the physical environment. The news article does not mention of support to people but an administrative maintenance of the issue which legitimises the marginalisation of people experiencing in the city (Cloke et al., 2010). The article does not quote a homeless person or an organisation that works with homeless people, which produces a
problematic, uneven and imbalanced account of the event. That is, the homeless people are not given a space to voice their side of the story. Also, the quote from the council spokesperson to some extent constructs homeless people as anti-social and deviates even though they are being oppressed and marginalised blaming them and not the political and social structures of society for not acting to end homelessness (lines 14-22). The council spokesperson does not offer an evidence-based solution for that complex social problem. This act leads to a normative view that homeless people should be in places that they cannot be seen, and the homeless people should not be visible. Also, instead of offering policies, the council spokesperson makes a point that the situation was under review with increased patrols and persecution (lines 23-24). That is, the article constructs homeless people as criminals who need to be punished for their acts. The article does not give the humanised account of people’s experience using its power to communicate to construct a discourse of criminality. The subjectivity emerging from such discourse influences people reading that paper to think of homeless people as people who should not be in certain places. It misses the opportunity to inform people about homelessness as a complex social issue (Agamben, 1998; Bullen, 2015; Foucault, 1979 and Kingfisher, 2007).

To summarise, this research worked with people with experience of homelessness to interrogate the impacts of the dehumanising framing of homeless people by the local media. The impact of this study can be seen in the way in which it allowed people impacted by a social issue to collaborate on a research project that allowed the local community to engage an open a dialogue. This work was vital a resource in allowing homeless people to challenge processes of victimisation and stigmatisation (Crane and Wames, 2001). As the research reported here indicates, people who have direct experience of homelessness are not passive objects of avoidance and marginalisation but critical agents of transformation and dialogue. The article has sought to demonstrate the emancipatory potential of a PAR to challenge critically the power of the media to (mis)represent marginalised groups.

References


Further reading


Department for Communities and Local Government (2012a), *Statutory Homelessness October to December Quarter 2011*, Department for Communities and Local Government, London.


Please, N. et al. (1999), Access to General Practice for People Sleeping Rough, Centre for Housing Policy, University of York, York.


Sennett, R. (2003), Respect in a World of Inequality, Norton, New York, NY.


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Gambling-related harms and homelessness: findings from a scoping review

Stephanie Bramley, Caroline Norrie and Jill Manthorpe

Abstract

Purpose – People experiencing homelessness are being identified as a potentially vulnerable group in relation to gambling-related harm. The purpose of this paper is to explore the links between gambling-related harm and homelessness.

Design/methodology/approach – A scoping review of the English-language literature was conducted in 2016-2017 using a wide range of international sources. Qualitative content analysis was employed to code and identify key themes within the literature.

Findings – Five themes were identified: emerging knowledge about why people experiencing homelessness may participate in gambling; emerging knowledge about the prevalence of gambling within the homeless population; the likelihood that gambling-related harm is under-reported within the homeless population; emerging knowledge about the extent that people experiencing homelessness access gambling support services; and limited awareness about the potential impact of gambling participation among people experiencing homelessness.

Originality/value – The paper reviews research concerning the links between gambling, gambling-related harm and homelessness, which may be relevant to those working with people experiencing homelessness.

Keywords Homeless, Scoping review, Homelessness, Gambling, Gambling-related harm, Housing instability

Paper type Literature review

Introduction and background

People experiencing homelessness are sometimes identified as a vulnerable group in relation to the risk of gambling-related harm (Wardle, 2015). Preliminary research suggests that people experiencing homelessness are ten times more likely to have a problem with gambling when compared with the UK population as a whole (Sharman et al., 2015). Another recent study estimated the excess fiscal costs to the UK Government incurred by people who are problem gamblers to be between £260 million and £1.16 billion per year for Great Britain (GB) (Thorley et al., 2016). The same study provided an illustrative estimate of the excess fiscal costs incurred by people who are problem gamblers in relation to statutory homelessness applications as between £10 and £60 million in GB (Thorley et al., 2016).

This population of homeless people at risk from their own or others’ gambling may include people experiencing “multiple exclusion homelessness” (MEH) which is defined as:

[…] people who have been “homeless” (including experience of temporary/unsuitable accommodation as well as sleeping rough) and have also experienced one or more of the following other domains of “deep social exclusion” (i.e. severe and multiple disadvantage); “institutional care” (prison, local authority care, mental health hospitals or wards); “substance misuse” (drug, alcohol, solvent or gas misuse); or participation in “street culture activities” (begging, street drinking, “survival” shoplifting or sex work) (Fitzpatrick et al., 2012, p. 1).

This study was funded by Ridgeway Information Ltd. The views expressed in this paper are those of the authors alone and should not be interpreted as those of the funders.
Such individuals often have complex needs, be vulnerable to different harms and may potentially “fall between the gaps” in policy and services (Cornes et al., 2011). While recent legal changes in eligibility for and the remit of publicly funded social care took place in England under the Care Act 2014 (CA 2014), there is still uncertainty within homeless organisations about referring individuals for assessment under the CA 2014 and some reluctance by social workers to engage with people experiencing homelessness due to a shortage of resources (Cornes et al., 2016). Although gambling is not included within the definition of MEH, other potentially addictive behaviours are (e.g. substance and/or alcohol misuse) and we would argue that gambling problems may be another factor associated with people either experiencing homelessness or experiencing harm as a result of participating in gambling whilst homeless.

Discourses concerning why individuals may experience gambling-related harm have tended to focus on whether “fault” lies in the person (i.e. individual characteristics, e.g., impulsivity), the product (i.e. specific features of gambling activities) or the environment (i.e. opportunities to gamble, availability of gambling, advertising of gambling products) (Orford, 2011, p. 96). Orford (2011, p. 229) argues that gambling products are intrinsically dangerous and addiction is the result of a complex interaction of the person, product and environment. However, the onus is largely on the individual to control their gambling participation through “gambling responsibly” by using gambling management tools, for example, setting their own limits on time and money spent, using blocking software and participating in self-exclusion, and to proactively engage in help-seeking behaviours should the need arise (GamCare, n.d.). Similar discussions have taken place in relation to explanations of homelessness and tended to fall into two categories – “individualistic” explanations and “structural” explanations which highlight broader forces such as housing market conditions, poverty and unemployment, again, similar to gambling, there seems a complex interplay between these explanations, with certain individual, social and structural factors associated with the odds of experiencing homelessness (Bramley and Fitzpatrick, 2018).

Gambling participation could also be considered as a “street culture” activity, given that the Gambling Act 2005 (GA 2005) liberalised gambling in the UK and gambling in the twenty-first century is becoming ever more varied, accessible and visible. Changes in gambling opportunities within the UK are reflected in: the abolition of the so-called “demand test” which previously outlined that gambling should only be meeting “unstimulated demand” and required gambling operators to provide evidence of such demand when proposing new gambling environments (Orford, 2011); new 24 hour online gambling services (Orford, 2011); large increases in gambling advertisements on television, online and social media (Ellson, 2017); the clustering of betting shops in some British high streets where people experiencing homelessness may frequent in order to participate in other “street culture” activities (e.g. begging or food distribution); a 10 per cent increase (between 2008 and 2015) in the number of Fixed-Odds Betting Terminals (FOBTs) (Gambling Commission, 2018a); and local authorities in England and Wales assuming responsibility for the licensing or issue of permits/notification for gambling premises (Local Government Association, 2015).

Concerns about the proliferation of betting shops in local communities have been raised within the media (e.g. Barford and Judah, 2013). A government-funded independent review (Portas, 2011) suggested betting shops should no longer be classified as a financial and professional service but put into their own “use class” so their numbers could be more easily monitored. This recommendation was adopted and betting shops became classified as “sui generis” meaning that planning permission is required for all new betting shops (Hewitson and Denton, 2015).

The number of UK betting shops has fallen recently (Gambling Commission, 2018a); however, concerns have been raised about FOBTs located in betting shops, casinos and bingo halls which currently enable gamblers to stake up to £100 every 20 seconds (Davies, 2017). Expenditure on FOBTs increased from just over £1 billion (April 2008 - March 2009) to over £1.8 billion (April 2016-March 2017) (Gambling Commission, 2018a), accounting for just over half of the profits from betting shops (Ahmed, 2017). Calls for the FOBT maximum stake size to be dramatically reduced have been voiced by some politicians (Davies, 2016), campaigners (Campaign for Fairer Gambling, 2017) and local authorities (Newham London, 2016). A recent government consultation on proposals for changes to FOBTs and social responsibility measures is expected to report in 2018 (Department for Digital, Culture, Media and Sport, 2017).
The Gambling Commission estimates that nearly half (45 per cent) of the adult population in GB participated in at least one form of gambling in 2017 (–3 per cent from 2016) and 18 per cent had gambled online in the previous four weeks (Gambling Commission, 2018b). In 2017, six out of 1,000 (0.6 per cent) (–0.1 per cent from 2016) respondents to Gambling Commission surveys were identified as problem gamblers (its definition of problem gambling is “behaviour related to gambling which causes harm to the gambler and those around them” and was measured using the short-form Problem Gambling Severity Index, Ferris and Wynne, 2001) (Gambling Commission, 2018c). In addition 51 out of 1,000 (5.1 per cent) (–0.4 per cent from 2016) were classified as at-risk gamblers (Gambling Commission, 2018c).

We undertook a scoping review (Arksey and O’Malley, 2005) of the literature relating to homelessness with the aims of examining the extent, range and nature of research about gambling-related harm and homelessness. This was part of a wider research project focusing on the nature and extent of gambling-related harm affecting “adults with care and support needs” as defined in English law under the CA 2014 (Bramley et al., 2017). The CA 2014 states that the “general duty of a local authority […] in the case of an individual is to promote that individual’s wellbeing” (s 1 (1) CA 2014) which includes aspects relating to “personal dignity; physical and mental health and emotional wellbeing; protection from abuse and neglect; suitability of living accommodation” amongst other aspects of an individual’s wellbeing (s 1 (2h) CA 2014). Once a local authority is satisfied on the basis of a needs assessment that an adult has needs for care and support, it must determine whether any of these needs meet the eligibility criteria, namely, that “the adult’s needs must arise from or be related to physical or mental impairment or illness”; “as a result of this, the person is unable to achieve two or more of the outcomes listed in the regulations” (e.g. maintaining a habitable home environment). The local authority then has to decide whether the adult’s needs and their inability to achieve the specified outcomes cause or risk causing a significant impact on their wellbeing (Cornes et al., 2016, p. 216). Some people experiencing homelessness may meet such high eligibility criteria; however, local authority social care resources are limited, social workers may be overworked, have limited experience of working with homeless people and housing officers, and/or homelessness workers may have little experience of working with adult social care which may impact upon homelessness organisations helping their clients to access support (e.g. advice, a care plan covering personal care assistance, reablement support, and other forms of social care) (Cornes et al., 2016).

Under the CA 2014, local authorities can also make safeguarding enquiries where they have reasonable cause to suspect that an adult in its area has needs for care and support (whether or not the authority is meeting any of those needs); is experiencing, or is at risk of, abuse or neglect; and as a result of those needs is unable to project himself or herself against the abuse or neglect or the risk of it (s 42 (1) CA 2014). Data, however, are not generally collected about the numbers of people about whom there are safeguarding concerns who are homeless.

Our synthesis included evidence about people experiencing homelessness who may be affected by, or at risk of, gambling-related harm as a result of their own or others’ gambling participation. Gambling-related harm is defined as “the adverse financial, personal and social consequences to players, their families and wider social networks that can be caused by uncontrolled gambling” (Responsible Gambling Strategy Board, 2009, p. 9). This paper is one of a series of outputs from the adults with care and support needs and gambling study (Bramley et al., 2017). We have presented elsewhere the findings related to social work (Manthorpe et al., 2017a), and on adult safeguarding policy and practice (Manthorpe et al., 2017b).

Aims of this review

We aimed to improve the understanding of gambling-related harm for people experiencing homelessness to inform policy and practice. The following research question is addressed in this paper:

RQ1. What does research tell us about the extent, range and nature of research about gambling-related harm and homelessness?
Methodology

Table I outlines the search strategy which was developed using the mnemonic PICo for qualitative studies: population, phenomenon of interest and context (Glasper and Rees, 2017). Our definition of homelessness was that applied in several studies, namely the situation of people living in accommodation that is intended as only temporary (e.g. hostels) or where people are classed as “legally” or statutorily homeless such as people sleeping rough on the streets (Shelter, 2017). The following list outlines the data sources that were searched and the inclusion and exclusion criteria.

Data sources:
- Electronic databases: Psychinfo, Embase and Scopus, Web of science, Assia, Social Policy and Practice, AgeInfo, Social Care Online, NHS Evidence and British Nursing Index.
- Other sources: reports; legislation; statutory guidance; professional press; books; book chapters; newsletters; briefing papers; and industry statistics.

Inclusion criteria:
- English language, 2007-July 2017
- The experience of gambling-related harm for people experiencing homelessness.

Exclusion criteria:
- Publications that focussed on gambling by children and young people (i.e. under 18s).

Our work focused on the publications that had been published between 2007 and July 2017; this starting date reflecting the timing of the full implementation of the GA 2005. International literature was included as lessons may be learned from jurisdictions with long-standing de-regulation of gambling and high participation rates, as well as other countries’ initiatives to address risks of gambling-related harm; however, only English language material was accessed. EndNote X7 reference manager software was utilised to organise and manage the scoping review data (Figure 1).

The five stages of qualitative content analysis were followed (Arksey and O’Malley, 2005): identifying the research question; identifying the relevant studies; study selection; charting the data; and collating, summarising and reporting the results. For Stages 2 and 3, the first author identified relevant pieces of literature which were reviewed by the co-authors in order to select studies for inclusion within the scoping review. For Stage 4, the first author produced a brief summary of each piece of literature, including the methodology utilised, the study population and

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<th>Search strategy</th>
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<td>&quot;homeless&quot; OR &quot;homelessness&quot; OR &quot;housing instability&quot;</td>
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the important results. For Stage 5, the summaries were reviewed by the co-authors and patterns/themes were identified within the literature which formed the basis of this paper.

In all, 20 pieces of literature were included in this scoping review. Content analysis revealed five themes: emerging knowledge about why people experiencing homelessness may participate in gambling; emerging knowledge about the prevalence of gambling within the homeless population; the likelihood that gambling-related harm is under-reported within the homeless population; emerging knowledge about the extent that people experiencing homelessness access gambling support services; and limited awareness about the potential impact of gambling participation among people experiencing homelessness.

Findings

**Emerging knowledge about why people experiencing homelessness may participate in gambling**

There is limited knowledge about why people experiencing homelessness may participate in gambling. Some studies note that people experiencing homelessness may visit high-street gambling environments because they offer shelter, have extended opening hours (when other venues are closed), offer low-stake gambling, are warm and often provide free sustenance (Sharman et al., 2016; Wardle et al., 2014). Furthermore, rough sleepers may be victims of violence and abuse on the streets (Crisis, 2016). Therefore, individuals may consider high-street gambling environments as places of relative safety where they can seek refuge and escape life on the streets albeit temporarily (Sharman et al., 2016; Wardle et al., 2014).

In many studies, gambling is considered broadly without any acknowledgement of the multitude of gambling activities with which people experiencing homelessness may engage. Two recent studies are exceptions as they provide some insight into the popularity of gambling activities among people experiencing homelessness. Sharman et al. (2015) found that shop-based gambling activities, including electronic roulette on FOBTs, slot machines and sports betting, were the most common forms of gambling, while online and casino gambling were the least
common among homeless problem gamblers. However, Borchard’s (2010, p. 462) ethnographic study of the leisure activities of people experiencing homelessness in Las Vegas, USA, located one participant who gambled whatever money he had left after his day at work on “video” poker indicating the need to take into account new gambling opportunities.

Emerging knowledge about the prevalence of gambling within the homeless population

The prevalence of gambling participation by people experiencing homelessness in the UK is currently unknown, although five studies have highlighted links between gambling and homelessness. Sharman et al.’s (2015) study contained a sample of people experiencing homelessness (456 individuals; 53.9 per cent = male) attending homeless services provided by Westminster Local Council in Central London, UK. The rate of problem gambling within this sample was 11.6 per cent, compared to 0.7 per cent in the general 2010 British Gambling Prevalence Survey and was higher among people sleeping rough compared to hostel residents who also had high rates of low-risk gambling participation (Sharman et al., 2015).

A later UK study conducted by Sharman et al. (2016) examined the extent to which problem gambling was a cause or consequence of homelessness. They recruited 72 mainly male participants (87.5 per cent = male) from homeless centres also in Westminster, London. Nearly two-thirds (61.5 per cent) of participants who had some level of gambling risk (i.e. Problem Gambling Severity Index score > 0) disclosed experiencing gambling problems prior to becoming homeless compared to a sixth (15.4 per cent) who reported only experiencing gambling problems after becoming homeless. Problem gambling was evident among just under a quarter (23.6 per cent) of the sample, of whom most (82 per cent) said that their gambling preceded their homelessness, while 17.6 per cent had experienced gambling problems after homelessness (Sharman et al., 2016).

In a study of FOBT use and problem gambling in Liverpool, UK, “several respondents” stated that they had become homeless, at least in part, due to their gambling problems (Liverpool Public Health Observatory, 2014, p. 35). Roberts et al. (2017) analysed data collected from the “Men’s Health and Modern Lifestyles Survey” which was administered in 2009 to 3,025 men (aged 18-64 years) living in England, Wales and Scotland at their home address. Respondents were asked whether they had experienced homelessness after the age of 18. The authors administered the South Oaks Gambling Screen, a 20-item questionnaire based on DSM-III criteria for pathological gambling (Lesieur and Blume, 1987) to the sample and found that problem gambling (identified in 11.8 per cent of the sample) and “probable pathological” gambling (identified in 15.2 per cent of the sample) were associated with increased odds of homelessness (Lesieur and Blume, 1987).

Evidence of gambling participation by people experiencing homelessness has been gathered internationally. Moghaddam et al. (2015) analysed data collected within the 2001-2002 US’ National Epidemiologic Survey on Alcohol and Related Conditions and found low-risk (14.5 per cent prevalence), at-risk (23.7 per cent prevalence), problem (29.8 per cent prevalence) and pathological gambling (37.3 per cent prevalence) were all associated with homelessness.

Nowber et al. (2015) investigated the prevalence of gambling disorder and comorbid psychiatric disorders among US African-American people experiencing homelessness (n = 275; 73.5 per cent = male). The sample comprised 60 non-gamblers, 152 recreational gamblers and 63 problem gamblers. Their lifetime rates of sub-clinical problem (46.2 per cent) and disordered (12 per cent) gambling were significantly higher than in the general population.

Matheson et al. (2014) examined the prevalence of problem and pathological gambling among 264 clients (98.5 per cent = male) of a homeless service agency in Toronto, Canada. The prevalence of lifetime problem gambling here was 10 per cent and that of pathological gambling was 25 per cent.

In Japan, Pluck et al. (2015) tested the cognitive function of a small sample of homeless men and assessed their problem gambling status. They found that five (31 per cent of the sample; n = 16) were pathological gamblers but found no correlation between cognitive function and gambling participation.
Rota-Bartelink and Lipmann (2007) interviewed 125 people aged over 50 (74.4 per cent = male) and their case/key workers to assess their understanding of the events and states that led to their client becoming homeless and about the use of homeless services in Australia. Less than a third of the respondents (28.8 per cent) reported gambling problems (comprising 37.6 per cent males and 12.6 per cent females). Men were significantly more likely to report having problems with gambling and also more likely than women to self-report their gambling (46 vs 16 per cent, Rota-Bartelink and Lipmann, 2007).

The likelihood that gambling-related harm is under-reported within the homeless population

Some researchers contend that gambling participation is under-reported within the homeless population. One reason for uncertainty is the British Gambling Prevalence Surveys, which are nationally representative surveys of gambling participation and the prevalence of problem gambling in GB, but only collect data from private households (Wardle et al., 2007, 2011). This approach therefore excludes people experiencing homelessness, together with people living in long-term care facilities, prisoners and other population sub-groups from participating in the surveys (Wardle et al., 2007, 2011). Australian researchers have also noted that large prevalence surveys often recruit via landline telephones. Generally they do not include questions on housing tenure making it difficult to include the homeless population and to determine whether there is any relationship between problem gambling and problems with housing tenure or the risk of homelessness (Miller, 2015).

Rota-Bartelink and Lipmann (2007) noted from key/case workers’ perspectives that problematic gambling together with excessive alcohol consumption was often under-reported by their clients. Holdsworth and Tiyce (2012) conducted in-depth interviews with 17 people experiencing homelessness (58.8 per cent/9 = male) who were seeking assistance for housing and related problems, and 18 service providers (staff such as social workers, counsellors, and case workers) in the Northern Rivers region of New South Wales, one of Australia’s most disadvantaged areas. Both clients and service providers identified connections between homelessness and gambling. One practitioner emphasised that discussing matters such as finances and gambling was critically important, not only to uncover “hidden” problems, but also to provide a fuller understanding of each person’s situation and how assistance might best be offered (Holdsworth and Tiyce, 2012, p. 479). However, others noted that some clients were reluctant to disclose private information and rarely admitted gambling problems (Holdsworth and Tiyce, 2012, p. 480).

Another practitioner observed that people experiencing homelessness may only be able to deal with one thing at a time, which meant that some become overwhelmed by accumulating problems that were difficult to disentangle (Holdsworth and Tiyce, 2012). Others remarked that people experiencing homelessness often find it difficult to face up to their problems, especially gambling problems – some may deny that they have a problem or be unwilling to admit to it (Holdsworth and Tiyce, 2012). Staff and clients reported these feelings could be related to identity, self-esteem and honesty, with some staff noting that gambling behaviour was often consciously concealed (Holdsworth and Tiyce, 2012). Staff spoke of the difficulties they faced when making decisions concerning the allocation of extremely limited resources suggesting that policy initiatives that seek only to measure the extent of problems may need to take these factors into account (Holdsworth and Tiyce, 2012, p. 483).

Emerging knowledge about the extent that people experiencing homelessness access gambling support services

Knowledge about the extent to which people experiencing homelessness are aware of, or access gambling support services is also limited. Sharman et al. (2016) found that the majority (76.9 per cent) of their participants who gambled were aware of support services for gambling. However, such awareness was significantly lower than for alcohol services (94.7 per cent) or substance disorder services (95.7 per cent). Furthermore the actual use of treatment services by gamblers was significantly lower than for people with substance or alcohol problems (Sharman et al., 2016). Less than a third of gamblers (26.9 per cent) in the “some risk” group (i.e. PGSI score > 0) had sought help for gambling problems, whereas nearly half (46.2 per cent) of participants who had endorsed one or more DSM-IV alcohol disorder items had sought help for
alcohol problems and 67.9 per cent of participants who scored one or more of the DSM-IV substance disorder items had sought help for substance problems (Sharman et al., 2016).

Rota-Bartelink and Lipmann (2007) found over 40 per cent (41.6 per cent) of the case/key workers they interviewed had suspected a client had a gambling problem or thought that a gambling problem was evident. The majority (85 per cent) of those who reported gambling problems had not sought assistance for them. The authors compared their findings to those of a similar study carried out in England which had found few self-reports of gambling problems (5 per cent) and fewer occasions where case/key workers suspected their client to have a gambling problem or thought that a gambling problem was evident (5 per cent) (Warnes and Crane, 2006) but this was prior to the major expansion of UK gambling.

Guilcher et al. (2016) interviewed 30 men who had experienced problem gambling and housing instability in Toronto, Canada, to capture their perception of and experiences with support services. Participants reported a loss of autonomy with their gambling behaviour and used various strategies to try and regain control. This approach was perceived to be useful because for some participants being “told what to do” and not feeling empowered led them to consider services as less helpful (Guilcher et al., 2016). Empathy, compassion and sincerity during interactions with service providers were also thought to be important to the recovery process. Participants wanted to feel valued and respected while interacting with services or service providers. Services which could support physical and mental health, education, employment, housing, interpersonal relationships and financial management were considered conducive to recovery. More practical support such as mechanisms which facilitated payments for housing and groceries to be taken from social assistance (social security) were also believed to help with money management. Person-centred engagement was a main theme comprising: empowerment and autonomy; empathy, compassion and sincerity; respectful communication; and tailored holistic life plans. Recommendations for service improvement included raising general awareness of services for problem gambling, delivering integrated services via a one-stop-shop to help address people’s complex and multiple needs in one place, addressing mental health problems through psychotherapy and pharmacotherapy, providing timely access to prevention and recovery services, and enhancing life skills by peer support (Guilcher et al., 2016).

**Limited awareness about the potential impact of gambling participation among people experiencing homelessness**

Gambling can affect individuals’ finances, relationships, emotional or psychological state, health and work/study/economic activity (Langham et al., 2016). Not surprisingly, gambling may be a contributing factor to homelessness (Gambling Commission, 2016a), suggesting that a public health approach should be adopted to acknowledge that gambling and social problems affect the nation’s health (The Lancet, 2017).

Homelessness may also be connected with illegal gambling activity (i.e. gambling which is not regulated) and therefore lead people experiencing homelessness to become known to the criminal justice service with its consequent impacts. A US study found that of 601 homeless young adults aged 18-24 (64.1 per cent male), 19.1 per cent engaged in illegal gambling in order to generate income, with young men (14 per cent) being significantly more likely to do so than young women (5.1 per cent) (Ferguson et al., 2016). Furthermore some individuals admitted to committing illegal acts specifically to fund their gambling, mostly theft (e.g. stealing, shoplifting and burglary) (Sharman et al., 2016).

As there are no visible signs and symptoms directly associated with problem gambling, it has been described as an invisible or hidden problem (Johnson, 2017). Although people experiencing homelessness and gamblers can experience physical and/or mental health problems (Cowlishaw and Kessler, 2016; Homeless Link, 2014), such symptoms may be treated at “face value” by practitioners, due to a lack of training and/or awareness resulting in the underlying difficulties remaining unrecognised (George and Bowden-Jones, 2014). Whilst practitioners working with individuals experiencing homelessness tend to ask clients about their alcohol and drug use, practice guidance and policy do not require practitioners to routinely ask people experiencing homelessness about their participation in gambling (Bramley et al., 2017).
Discussion

This scoping review sought to improve understanding of gambling-related harm for people experiencing homelessness and to examine the extent, range and nature of research about gambling-related harm and homelessness. We identified 20 pieces of literature related to this topic. The review outlined research covering why people experiencing homelessness may visit gambling environments, which gambling activities they may engage with, estimates of the prevalence of gambling participation by people experiencing homelessness, the possibility that gambling participation by this population is under-reported, the extent that people experiencing homelessness access gambling support and the impact of gambling-related harm on people experiencing homelessness.

The review found some evidence about why people experiencing homelessness may visit gambling environments. Such environments may help people experiencing homelessness to meet some basic needs such as finding sustenance and shelter, and obtaining social interaction, if only for short periods of time. Although our review did not identify any specific evidence of the risks potentially faced by people experiencing homelessness who gamble, they, together with other adults with care and support needs may be putting themselves at risk of exploitation in gambling environments by being coerced into gambling, or being observed by other gamblers and subsequently taken advantage of because of their vulnerabilities (Bramley et al., 2017). This risk has been little explored in practice or policy; although since 2016 land-based gambling operators in England have been required to outline how they will reduce risks in their local area such as being located near a “homeless shelter” (Gambling Commission, 2016b) and have to comply with requirements set out in the Licence Conditions and Code and Practice (Gambling Commission, 2017). Within the Social Responsibility Code, licensees must put into effect policies and procedures for interacting with customers where they have concerns that a customer’s behaviour may indicate problem gambling and provision for interacting with customers demonstrating signs of agitation, distress, intimidation, aggression or other behaviour (Gambling Commission, 2017, p. 47). Gambling venue staff may therefore be well-placed to identify incidents of possible exploitation or intimidation of people experiencing homelessness and take action such as refusing to serve the alleged perpetrator or asking them to leave the premises. Those working in homelessness services could assist in providing evidence about whether other people’s gambling habits lead to the coercion, exploitation or intimidation of people experiencing homelessness and, if so, how these risks could be managed.

We found some evidence of gambling participation among people experiencing homelessness, although we found no data indicating country-wide prevalence of gambling by people experiencing homelessness in the UK or other jurisdictions. However, some studies did find higher rates of problem gambling for people experiencing homelessness compared to general population gambling prevalence surveys (e.g. Sharman et al., 2015), suggesting that this population group may be a vulnerable group in relation to gambling-related harm and problem gambling. It should be noted that there may be a potential association between the rates of problem, at-risk and/or gambling-related harm experienced by people experiencing homelessness and the number of gambling venues and/or opportunities within the area in which they reside (e.g. Westminster and Las Vegas) compared to other areas of a jurisdiction (e.g. England and USA) which may have lower numbers of people experiencing homelessness and/or gambling opportunities. Wardle et al. (2017) identified areas of the UK where there may be heightened risk of people experiencing gambling problems either because of the types of people who live in those places (e.g. young people, those from minority ethnic groups, unemployed people and people with certain mental health diagnoses), the types of services offered in those areas (e.g. substance abuse/misuse treatment centres, food banks, homelessness shelters, educational establishments and payday loan shops) or a combination of the two. Reflecting the gender profile of homeless populations most samples provided data related to men (e.g. Sharman et al., 2016), indeed more men participate in gambling than women in the UK (Gambling Commission, 2018c). However, a recent study has suggested that the intersection of disordered gambling and homelessness may be especially risky for women whose housing tenure is insecure (Rash and Petry, 2017). Future research and policy and practice development should therefore investigate the extent to which women experiencing homelessness participate in gambling, are affected by the gambling of others, and whether the types of gambling-related harm experienced by people experiencing homelessness differ by gender.
Our review observed that gambling by people experiencing homelessness may be under-reported and hidden for several reasons. Practitioners may be unsure of how gambling participation may impact on clients and therefore unsure of how to spot the signs of gambling-related harm in the context of other problems experienced by people experiencing homelessness or how to determine the extent that gambling is affecting their clients’ health and wellbeing. There is also evidence that many people experiencing homelessness who have multiple and complex needs may be excluded from social work support, which may negatively impact upon this population’s ability to access support that might address current or long-standing problems (Manthorpe et al., 2015). There also appears very little written about mobile and online gambling among this group, such forms of gambling are on the rise in the UK (Stradbrooke, 2018).

Some researchers have recommended that screening for gambling problems should be undertaken by homeless support services (Sharman et al., 2015, 2016; Nower et al., 2015; Matheson et al., 2014); however, in order for screening programmes to be effective support workers and managers should be engaged in debating whether this is feasible and, in particular, if there are sufficient local resources to assist following a positive screen. If screening was introduced, housing and homeless sector practitioners could have much to offer others about how, where and when people experiencing homelessness gamble, they could provide evidence about the potential impact of gambling for this population, the adequacy, availability and accessibility of gambling support services, user experiences and the potential effectiveness of gambling management tools (e.g. self-exclusion). They may also be able to work with others to develop effective and inclusive public health responses to gambling problems.

We found some evidence of the potential impact of gambling participation for people experiencing homelessness in relation to involvement in illegal behaviour. They may take part in illegal gambling and commit illegal acts in order to fund their gambling habits as well as other needs or addictions. However, little is known about whether people experiencing homelessness experience different types of gambling harm compared to other vulnerable groups and the general population, and the extent that gambling-related harm affects their relationships with support services and their housing situation.

It appears that the knowledge base about gambling-related harm and homelessness is small but emerging. For example, new research projects designed to screen for gambling-related harm in the homeless population, develop brief interventions and explore how to support people experiencing homelessness who have gambling problems are being developed (e.g. GambleAware, 2017).

Our review was limited by its inclusion criteria of only drawing on material published in English, within a recent timeframe, and in relation to adults who might be at risk of harm from their own or others’ gambling. In light of the limited evidence, the studies were not subjected to critical quality appraisal. Furthermore, it is noted that much of the literature relating to gambling and people experiencing homelessness was concerned with men and therefore future research may wish to examine the extent that gambling-related harm is experienced by women experiencing homelessness. Furthermore, future research may wish to establish the prevalence of people experiencing homelessness who are experiencing gambling-related harm. This may identify a potential unmet need and provide an indication of the demand for gambling support services which could be accessed by people experiencing homelessness.

Conclusions

People experiencing homelessness may participate in gambling and consequently experience gambling-related harm. Efforts should be made among policy making and practice communities to raise awareness of the potential impacts of gambling for people experiencing homelessness to support workers and housing officers and in the context of public health approaches. Such practitioners may be well-placed to screen for gambling problems with people experiencing homelessness but they may need assurances that there are support options following this intervention. It may be helpful for gambling, addictions, homelessness and housing practitioners to jointly discuss challenges in common in order to mitigate the risk of people experiencing homelessness experiencing gambling-related harm.
References


Further reading


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