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Meeting the needs of homeless people: Interprofessional work in Norway and Scotland

A pilot study

Samarbeidsrapport
NIBR/Diakonhjemmet University college/ University of Stirling 2012

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Abstract: The main theme of the project are: how cooperation between welfare agencies and professions contribute to a better life for homeless people, and the role of housing in interprofessional work. The project is a comparative study between Norway and Scotland.

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Preface

This report is based on the pilot project " Meeting the needs of homeless people: Interprofessional work in Norway and Scotland". The project is a comparative pre-study carried through in cooperation between three institutions: University of Stirling in Scotland, Diakonhjemmet University College and Norwegian Institute for Urban and Regional Research (NIBR). The latter has been project manager.

The project is largely a literature study and review of existing research, but also includes interviews with professionals in both countries. We want to express our gratitude to the interviewees who has contributed with important information and knowledge.

The project is financed by the Norwegian Housing Bank. The project started in early spring 2011 and the draft report was sent to the Housing Bank in May 2012. We want to thank the Housing Bank and in particular our contact, Rune Flessen for support and patience.

Oslo and Stirling, October 2012

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Summary

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Meeting the needs of homeless people: Interprofessional work in Norway and Scotland

Joint Report: NIBR/Diakonhjemmet University college/University of Stirling 2012

Interprofessional cooperation is generally assessed as an important tool for better-adapted services and increased efficiency in the health and social services. The main themes of this report are: how cooperation between welfare agencies and professions contribute to a better life for homeless people; and the role of housing in interprofessional work. This report gives an account of the outcome of a pilot project based on literature and research reviews, supplemented with interviews with professionals working with homeless people.

The aim of the project has been to identify problems that encompass factors that can influence and set conditions for integrating housing into interprofessional welfare work, and to consider what conceptual framework can be applied in a subsequent main project. The pre-project is a comparative study between Norway and Scotland. While Scotland for decades have had a housing education and profession, housing as a subject in welfare educations is a new and emerging issue in Norway.

Interprofessional work is not an unambiguous concept. In this pre-project we have identified and taken into account various definitions of interprofessional working (and other related terms) as proposed in the literature and we have explored the different concepts and theories in the context of the housing question. Interdisciplinary work, multidisciplinary work, coordination, and partnership are all terms used with reference to cooperation in public health, housing and social work. Distinguishing between

these concepts, multi-disciplinarly work could mean that while each professional makes their own contribution, different professional contributions are not linked. Interdisciplinary work may mean that the insights from the various professions are connected together and have an impact on the outcome. The concepts of coordination and cooperation also have different meanings. Interdisciplinary work is ideally different from multi-disciplinary work and cooperation in that the results from interaction between professionals are different than if they had not interacted.

Main conclusions from the literature and research review: The advocacy of joined up working rarely seems to be robustly informed by coherent theories. At a policy level, inter-agency working is promoted as a 'self-evident good' but problems at strategy and operation levels within organisations are still identified and, importantly, service users with the most complex needs still seem to be most at risk of exclusion from housing and from health and social care services. There is a much more substantial literature and evidence base on joint working across health and social care than in relation to housing and homelessness. Housing is rarely addressed as a 'professional role' although some studies have looked at the role of housing support worker. The evidence base suggests that while interprofessional working has very much become the norm in seeking to meet complex needs, its success in doing so has not been rigorously evaluated. Progress has been made, but problems of vulnerable individuals experiencing exclusion from housing, health and support services are still reported.

There remains scope for research which focuses specifically on 'interprofessional working' as opposed to interagency or partnership working to meet the needs of homeless people. There is considerable scope to refine and further test models for the evaluation of interprofessional working.

Main conclusions from the interviews: The data collected from interviews indicates both conducive and inhibiting factors for integrating housing issues into interprofessional work and for the efficiency of this work. The issues highlighted in the interviews are divided in three main categories; 1) Awareness of housing in interprofessional work, 2) Housing expertise in interprofessional

work, and 3) Management, organisational structures and professional boundaries.

The Norwegian informants expressed support for the need for cooperation, however there was little explanation for models and time allocated to housing issues. The degree to which the informants had an understanding of what social housing work involved varied. The interviews indicated that social housing had not become part of mainstream health and welfare services. Joint working across health and social care professions was very much the norm for the Scottish participants. None of the Scottish participants were "housing professionals", but some were specialist homeless case workers and part of their job was joint working to secure housing for their service users.

The Norwegian participants expressed different opinions of housing problems and how housing fits within interprofessional work. Some interviews indicated a clear relation between training in interprofessional work and/or housing issues and an understanding of the services users needs and how their problems could be solved. Others showed little awareness of housing issues and expressed a formal approach, such as knowing who was responsible for providing housing. The understanding both of housing needs and awareness of the contributions from other professions appeared more consistently present among the Scottish interviewees.

Regarding management, structures and professional boundaries, interviews in Norway revealed a lack of strategies, guidelines and routines for interprofessional work on social housing issues. Interprofessional work creates opportunities for innovation, development and changes in professional identity, and thus can strengthen the professional role. Based on the findings in the pre-study, we can ask whether having fundamental theoretical expertise in social housing work could be a central factor in the development of interprofessional social housing work. Rather than revealing possibilities for new methods of co-operation, the Scottish interviews were more indicative of a process of increasingly embedding interprofessional working in everyday working life. There was a near universal recognition it was crucial to fully meeting complex needs.

The overall aim for a subsequent main project is to develop knowledge about models for interprofessional working that also include housing, in order to work with and for people with complex needs. This is very much brought up to date with Cooperation Reform in Norway implemented from 2012. An important aim of the reform is to increase the municipal care and reduce the time in hospital, which calls for increased cooperation between professions and municipal and national agencies.

Sammendrag

Isobel Anderson, EvelynDyb og Siri Ytrehus

Tverrprofesjonelle hjelp til bostedsløse i Norge og Skottland. En forstudie

Samarbeidsrapport NIBR/Diakonhjemmet Høgskole/University of Stirling 2012

Tverrprofesjonell samhandling er vurdert som et viktig virkemiddel for å sikre gode tilpassede og effektive tjenester i helse- og sosialsektoren. Denne rapporten handler om hvordan samarbeid mellom ulike yrkesprofesjoner kan bidra til et bedre liv for bostedsløse mennesker, og om hvilken betydning kompetanse om boligsosiale forhold kan ha i det tverrprofesjonelle samarbeidet. Rapporten presenterer funnene fra et pilotprosjekt basert på gjennomgang av litteratur og eksisterende forskning, supplert med intervjuer med ulike profesjonsgrupper i Skottland og Norge, som arbeider med bostedsløse.

Målet med pilotprosjektet var å identifisere faktorer som kan ha innvirkning på om boligperspektivet blir integrert i det tverrfaglige velferdsarbeid. Videre var målet å utvikle et oppfølgende hovedprosjekt. I Skottland har det i flere tiår vært mulig å ta en egen boligutdanning både som bachelor-, master- og PhD-grad, tilsvarende de norske velferdsutdanningene, for eksempel sosialt arbeid, sykepleie, vernepleie og ergoterapi. Norge har ikke hatt tilsvarende boligutdanning. Imidlertid har det i noen år nå eksistert ettårige videreutdanningskurs innen «boligsosialt arbeid» som kan tas som påbygging etter en bachelorgrad innen et av velferdsyrkene.

Tverrfaglig arbeid er ikke et entydig begrep. I dette forprosjektet har vi identifisert og drøftet ulike definisjoner av tverrfaglig arbeid

(og andre tilknyttede begreper). Tverrfaglig, tverrvitenskaplig, flerfaglig, koordinering og partnerskap er alle begreper som anvendes med henvisning til samarbeid innen velferdstjenestene.

Hovedkonklusjoner fra gjennomgang av litteratur og forskning: Argumentene for ulike former for felles innsats synes sjelden å være støttet av solide og konsekvente teorier. På politisk nivå er samarbeid mellom ulike partnere framholdt som et "innlysende gode", men det er problemer med å få til tverrfaglig arbeid på strategisk og operasjonelt nivå, og, ikke minst, boligperspektivet er ekskludert fra studier av tverrprofesjonell samhandling. Litteraturgjennomgangen viser at det finnes en langt mer solid litteratur og et utviklet kunnskapsgrunnlag for felles arbeidsinnsats på tvers av helse- og sosialtjenestene enn innfor boligfeltet og bostedsløshet. Arbeidet med å sikre en god bosituasjon er sjelden omtalt som et profesjonelt arbeid, selv om enkelte undersøkelser har studert rollen som en booppfølger kan ha. Gjennomgangen av litteraturen indikerer at tverrfaglig arbeid i stor grad er blitt normen i arbeidet med personer med sammensatte behov. Imidlertid meldes det fremdeles om utfordringer med at utsatte personer med behov for tjenester fra mange ulike profesjonsgrupper, opplever å bli ekskludert fra bolig, helsetjenester og andre former for støtte. Det er relativt få solide evalueringer som kan fastslå om man har lykkes med det tverrprofesjonelle arbeidet.

Forprosjektet har avdekket kunnskapshull i forskning om tverrprofesjonell samhandling i arbeidet med å imøtekomme behovene til bostedsløse personer. Det er et betydelig rom for å forbedre og teste ut og evaluere modeller av samhandlingen.

Hovedkonklusjoner fra intervjuene: Flere intervjuer indikerer at det finnes både fremmende og hemmende faktorer for å integrere boligperspektivet i tverrprofesjonelt arbeid og for effektiviteten i arbeidet. Problemstillingene som ble belyst i intervjuene kan deles i tre hovedområder; 1) Forståelse for boligens betydning i tverrprofesjonell samhandling, 2) Kunnskap om hvordan boligperspektivet kan ivaretas i tverrprofesjonelt arbeid og 3) Administrasjon, organisatoriske strukturer og profesjonsgrenser.

De norske informantene uttrykte støtte til behovet for samarbeid, men det var lite som kom fram om modeller og tid anvendt på boligspørsmål. Informantene hadde i varierende grad forståelse for hva boligsosialt arbeid kan innebære. Intervjuene indikerte at det

boligsosiale ikke hadde blitt en integrert del av den generelle helse- og sosialtjenesten. Felles innsats og arbeid på tvers av bolig-, helse- og omsorgstjenester var derimot normen for de skotske informantene. Ingen av de skotske informantene tilhørte "boligprofesjonen", men enkelte informanter var saksbehandlere spesialisert mot bostedsløshet, og en del av jobben deres var samarbeid for å sikre bolig til brukerne.

De norske informantene hadde ulike oppfatninger om hva et boligproblem er, hvordan hjelpen bør være og hvordan boligperspektivet bør og kan være en del av tverrfaglig arbeid. Noen intervjuer indikerte en tydelig sammenheng mellom opplæring i tverrfaglig samarbeid og boligsosiale forhold og forståelse av brukernes boligbehov og løsning på boligproblemene. Andre hadde liten oppmerksomhet på boligspørsmål og ga uttrykk for en formell tilnærming, som for eksempel at de bare henviste til hvem som formelt er ansvarlig for å framskaffe bolig. Forståelsen av både boligbehov og oppmerksomhet om hva andre profesjoner kunne bidra med var mer konsekvent blant skotske informanter.

Med hensyn til administrasjon, strukturer og profesjonsgrenser, avdekket intervjuene i Norge mangel på strategier, retningslinjer og rutiner for tverrprofesjonell samhandling i boligsosiale spørsmål. Tverrprofesjonell samhandling kan skape muligheter for innovasjon, utvikling og endring i profesjonelle identiteter og kan på den måten styrke den profesjonelle identiteten. Basert på funn i forstudien kan vi stille spørsmål om hvorvidt det å ha grunnleggende teoretisk ekspertise i boligsosialt arbeid kan være en sentral faktor i å utvikle et tverrprofesjonelt boligsosialt arbeid. Heller enn å avdekke nye metoder for samarbeid, indikerte de skotske intervjuene en pågående prosess av økende sementering av tverrfaglig arbeid i det daglige virke. Intervjuene viste en tilnærmet universell anerkjennelse av at tverrfaglig boligsosialt arbeid var vitalt for å møte sammensatte behov på en tilfredsstillende måte.

Det overordnede målet for et påfølgende hovedprosjekt er å utvikle kunnskap om modeller for tverrprofesjonell samhandling som også inkluderer bolig, for å kunne arbeide sammen med og for mennesker med sammensatte behov. Dette temaet er også i stor grad satt på dagsorden med Samhandlingsreformen i Norge som ble iverksatt fra 2012.

1 Background and reasons for the study

In Norway, groups with complex problems and where the question of housing is part of the problems are currently being portrayed in political documents as groups that are poorly looked after. The newly implemented healthcare reform involves a transfer of duties from the specialist health service to the municipal health service. The consequences are that the municipal health services will gradually become responsible for the provision of more specialised services, reflecting the increased complexity and diversity in the user groups and in the needs of the user groups. This in turn will lead to an increased need to be able to offer services that also include assistance with housing. Furthermore, an aging population will lead to increased demands for health and social services.

The growth, and anticipated further growth, in the demand for services runs parallel with limits in public budgets and continuous attention on how public service provision can be developed and changed. Discussion about these topics has been linked to how public services can be organised and expertise and resources best used in new and improved ways, as well as ensuring there are enough suitably qualified staff to maintain a good level of service. One of the challenges is to ensure that vulnerable groups with needs for multiple services receive sufficient attention from the appropriate services. Housing needs and the housing dimension in interprofessional work are central in this context. Interprofessional cooperation is an important tool for better-adapted services and increased efficiency in the health and social services. Further innovations in locally-based services can therefore be seen as fundamental to the on-going health reform which has cooperation as its primary tool.

Although complex social and health-related problems where housing also plays a central role have attracted increasing attention, we still have limited knowledge about the complexity of interprofessional work in specific work-related contexts. Furthermore the significance of housing and how social housing issues can be included in municipal practice, interprofessional work and education provision is still inadequately treated in public policies and reports. The parliamentary report entitled "Utdanning for velferd" (*"Education for welfare"*) (White Paper No. 13 (2011-2012) , for example, does not mention housing and social housing education or expertise, in spite of the fact that the groups under discussion have housing needs and the required service provision will demand expertise in housing. If the social housing question is not included, then it will not be possible to meet the needs of the user group in question in a satisfactory way. The report on social housing, "Rom for alle" (*"Room for everyone"*) (Official Norwegian Report 2011:15), proposes that social housing modules and themes be included in the three-year polytechnic programme (health, social, child protection and social education training) but so far this only covers the need for education within the area of social housing, what an education module should contain and what needs it should cover. In Scotland, where a professional qualification in Housing Studies has existed since the 1980s, the housing question remains largely excluded from educational programmes in health and social care. Recent developments in post-qualification Continuing Professional Development programmes may have a more explicit focus on interprofessional working which better embraces the housing question, but this exploratory study was not able to survey the content of such programmes.

In order to develop the field of social housing, it is important to have knowledge and understanding of the underlying factors that can promote good work in social housing. This includes factors that cover the professional groups' motivation and knowledge, management of the work and the framework conditions and the political context. Even though there are a number of Norwegian studies of social housing work, until now no attempt has been made to study this work in an interprofessional perspective: for example, how the work is set up or how different players become involved, evaluate and commit themselves to the work. From the Norwegian side, therefore, there are no studies that have looked at

how the housing field fits into interprofessional cooperation on services to user groups with complex needs. Some studies of interprofessional working which explicitly focused on housing and homelessness issues have been undertaken in the UK and these are discussed in the literature review in section 1.3. However, even the UK evidence base is very significantly dominated by a focus on joint working between health and social care services, with housing relatively rarely an explicit component of substantive research studies.

The aim of this pre-project has been to identify problems that encompass factors that can influence and set conditions for integrating housing into interprofessional welfare work, and to consider what conceptual framework can be applied in a subsequent main project. In this pre-project we have identified and taken into account various definitions of interprofessional working (and other related terms) as proposed in the literature and we have explored the different concepts and theories in the context of the housing question. Definitions, concepts and theories about interprofessional cooperation are explored in section 1.3 below and will be further developed in the larger, main project. The project is a collaborative pilot study between Scotland and Norway. The remainder of this report highlights some of the problems and issues emerging from a review of the existing evidence base on interprofessional working and the exploratory fieldwork in Norway and Scotland. Our initial findings are used to develop proposals for a more substantial study of interprofessional working and service collaboration for those who are homeless or living in precarious housing circumstances.

1.1 Problems

The discussion about responsibility for social welfare tasks and the allocation of tasks highlights the question of education and the role of education. A standard assumption is that the training which is delivered through professional education does not only provide specific expertise but also reflects and contributes to the overall identity of the profession. In Norway, the field of social housing is not linked to a professional group but has developed as a practical field often embedded in social services at the local level.

In Scotland (and the rest of the UK) there is an established housing profession with a Degree or Post-graduate level qualification validated by the Chartered Institute of Housing, but not regulated by the State. The qualification mainly focuses on the development and management of social housing (council and housing association sectors); and on housing law, policy and strategy across all tenures. However, it is not mandatory to complete the qualification in order to practice in housing and a very small proportion of staff working in the social housing sector (probably less than 10%) are professionally qualified. A further proportion have lower level vocational qualifcations in housing. In contrast, housing support workers (providing care and or support directly to a service user within a housing support service) are required to have a vocational qualification as part of the regulation of the social work service, but this is not a professional-level qualification. Nevertheless, qualifications at all levels contribute to the knowledge and skills base of workers within the different welfare services.

The concrete interprofessional work concerning social housing questions is also influenced by organisational processes. Here, however, we have focussed specifically on knowledge and expertise relating to addressing housing issues in interprofessional work and the problems that can be discussed in the light of professional identity, changes in boundaries between different roles and professional expertise. In the Scottish context, while fieldwork focused on interprofessional working to meet the needs of homeless people across health, social care and housing professions, the interviews and discussions also provided some data on organisational processes.

What can we say about the conditions for interprofessional cooperation with respect to housing? This pre-project has looked at interprofessional work targeted at people with major, complex needs for help, where housing forms part of the problem complex. This was the case in both Scotland and Norway. Even though Scotland has a larger social housing sector and a wider definition of homelessness than Norway, the interviews for this study tended to focus on households with complex needs who were homeless, or had experienced homelessness or housing exclusion.

The overall aim for a subsequent main project is to *develop knowledge about models for interprofessional working that also include housing, in order to work with and for people with complex needs*. A key question is how this task is regarded by service providers? How is the aspect of their work which links to the social housing field perceived? How is social housing work discussed between the professions? Some of the problems with interprofessional working to meet complex needs identified in the existing evidence base are considered in the next section.

1.2 Housing and interprofessional working – evidence from the literature

In the pre-project, we reviewed the existing literature on interprofessional working, with a particular focus on homeless people who also have complex health and social care needs. The discussion first considers the types of complex needs associated with homelessness or housing exclusion and the likely need for interprofessional working to meet these needs. Definitions and terms associated with interprofessional working are then examined along with models of interprofessional working and evidence of its effectiveness. Some conclusions on the evidence base on interprofessional working in relation to homelessness and housing for those with complex needs are presented prior to reporting on our pilot study.

Complex needs and the requirement for interprofessional working

When a homeless person also has serious health problems and other social problems it can be difficult to get help and achieve a stable housing situation. The fact that a person needs assistance from many different services, can reduce the chance for getting the help he or she actually needs The professionals that should help may find it difficult to do so precisely because of the complexity of needs and when a number of agencies are involved, no single service may assume lead responsibility. Consequently, in Norway it is generally agreed that interdisciplinary work and integrated working methods should be central in all the municipalities' work with homeless people (Axelsson and Axelsson 2006, Hansen and Fugletveit 2010). Cooperation between different professional

groups is perceived as the best solution to help with complex housing, social and health problems. A growing body of literature shows that successful intervention focuses on the users' overall situation and the idea that cooperation benefits service users, has been supported by authorities, professionals and research for some years. Cooperation is necessary to overcome the fragmentation, differentiation and complexity of services and to ensure contact between various actors, both private and public (Røiseland and Vabo, 2008; Lewis and Surender, 2004, p. 71; Danermark and Kullberg, 1999; Baldwin and Walker 2005). Collaboration to provide a seamless service can save time for the service user, contribute to more efficient use of services, and enables those who are working to learn from each other. Cooperation should also ensure the user access to all necessary services and prevent duplication.

In the UK, joint working across welfare professions, service providers and government departments to improve services has been a feature of the 21st century and can be traced back to the 1980s and 1990s. For example, the National Health Service and Community Care Act of 1990 legislated for a policy shift away from institutional care towards the integrated delivery of health and welfare services in community settings. In a study of youth homelessness in the early 1990s, the UK Government readily acknowledged a lack of integrated working across departments, which prohibited effective working with marginal or hard to reach groups such as young unemployed or homeless people (Anderson and Quilgars, 1995). Subsequently, joint working quickly emerged as a feature of housing and homelessness service provision in the UK (Reid, 1997). Influences on inter-organisational working included housing governance issues, as well as joint approaches to service provision such as community care and increasing consumer involvement in housing provision. The changing governance of welfare was conceptualised by Stoker (1998) in 'five propositions' which can be related to changing professional relationships:

1. Governance as a complex set of institutions and actors that are drawn from and beyond government.
2. A blurring of boundaries and responsibilities for tackling social and economic issues, notably associated with the rise of third-sector agencies in welfare provision.

3. Changing power dependencies between institutions (although one organization may dominate the governance process, it would not command it)
4. Autonomous self-governing networks of policy actors with varying degrees of regulation and accountability.
5. Government steers rather than commands (Stoker, 1988).

Partnership working emerged as an important aspect of governance associated with the New Labour ideology of the 'third way' between the centralised welfare state and the free market (Powell and Glendinning, 2002). In relation to the governance of service provision for those with multiple and complex needs, Rankin and Regan (2004) identified four key gaps: services failed to recognise the inter-connected needs of individuals; services were fragmented and organised around single needs or issues; planning to meet needs often did not address housing; and area based initiatives were often disconnected from social care policy.

Research across five European countries also found that both organisational change and the multi-dimensional nature of homelessness drove the need for 'joined-up' policies and for inter-agency co-operation to better meet needs (Anderson *et al*, 2005). Addressing complex needs often involved agencies from different sectors including health, social services and housing - but the required services may not be available or complex problems may fall outside the scope of services. Co-ordination between services and sharing of specialist skills may not be evident and people may remain homeless or in precarious housing circumstances for longer than if their problems were properly recognised. While drivers for inter-agency working on homelessness were identified in all five countries in the Anderson *et al* (2005) study, actual inter-agency working tended to be relatively weakly developed and of recent origin.

In a very substantial review of the literature on multiple and complex needs conducted for the Scottish Government, Rosengard *et al* (2007) found that people could still be excluded from services because their needs were assessed as 'too complex or challenging'. Staff attitudes could be insensitive and unhelpful, and inflexible service criteria sometimes prevented continuity of care. Service users and carers could be unaware of entitlements to

assessment and many still reported receiving repeated assessments which was stressful. Some of those with complex needs did not engage with services because of factors including: lack of trust and confidence, cultural insensitivities, services being incompatible with life-styles, poverty impacts, and people not being ready to address problems. Persistent exclusion from services could be associated with homelessness or health crises. The review emphasised the need to involve service users, and to persist with those reluctant to engage with services. Significant shortfalls in funding also needed to be addressed. The Rosengard *et al* (2007) review indicated clearly that service users with complex needs wanted: a personalised, sensitive and comprehensive approach; access to ordinary independent living; and effective co-ordination of their case.

Research on multiple exclusion homelessness (MEH), associated with some combination of substance dependency, mental health problems, domestic violence, having been in care or prison, prostitution, begging, and sleeping rough, identified the continuing potential for complex interplay between many different professional or occupational groups (Cornes, *et al,* 2011). Evidence from the four linked MEH studies found that homelessness commonly happened after contact with non-housing agencies (such as mental health services, drug services, criminal justice services or social services); that people with complex needs remained at serious risk of falling through cracks in service provision; and that workers could feel isolated and out of their depth in trying to support this group (McDonagh, 2011).

Looking at the drivers for interprofessional working the evidence suggests some consistency in the identification of groups with complex needs (e.g. substance use, mental health issues) and increasing acknowledgement of the association of complex needs with housing exclusion and homelessness. Despite substantial developments in inter-agency working to meet complex needs, even the most recent studies continue to note that some vulnerable people still 'fall through the cracks' of service provision, resulting in extended or repeated risk of homelessness and social exclusion.

Approaches to interprofessional working – terms, definitions and models

Interdisciplinary work, multidisciplinary work, and coordination are all terms used with reference to cooperation in public health, housing and social work. Distinguishing between these concepts, multi-disciplinarily work could mean that while each professional makes their own contribution, different professional contributions are not linked. Each profession is independent. Interdisciplinary work may mean that the insights from the various professions are connected together and have an impact on the outcome. Interdisciplinary work is ideally different from multi-disciplinary work in that the results from interaction between professionals are different than if they had not interacted. The concepts of coordination and cooperation also have different meanings. Coordination can be the formalized ability to work together to achieve common goals (Jacobsen, 1993), or where two or more organizations develop decision rules with an intention of joint action in a common environment (Knudsen, 1993). Cooperation is defined as a pattern of sustained interaction and as a voluntary process.

The concept of collaboration can be used for all of these types of work, either in terms of cooperation within an organization or between organizations (Huxham, 2000, p. 339; Danermark and Kullberg, 1999; Sullivan and Skelcher, 2002; Hjortsjo, 2006). Ideally cooperation between health and social care professionals should include the involvement of service users, such as homeless people or others with complex support needs. Cooperation can then be defined as an interaction between professionals from both the same and different organizations and interaction between professionals and users of services with an intention to coordinate and strengthen skills, interests and experiences and to harmonize efforts in specific contexts. Collaboration can be formal and informal and between different work places or organizations and individuals.

In a study commissioned for the Scottish Homelessness Task Force, joint/multi-agency working on homelessness commonly included information sharing, client referral and general liaison between statutory and non-statutory agencies (Kennedy *et al*, 2001). However, this study did not conceptualise interagency

working beyond looking at rationales/approaches to joint working and highlighting examples of good practice. As a 'collaborative discourse' emerged in the UK, terms such as partnership, inter-agency working, integrated delivery, joined up government, and co-ordination were commonly used. Much of the literature has focused on 'partnerships', construed as having more than one agency, with a common interest, undertaking joint implementation to achieve shared goals (Powell and Glendinning, 2002) as opposed to interprofessional working (which would emphase the specialist contribution of different professions to resolving a complex issue).

Interprofessional working also draws on 'networks' which may be loose and dependent on trust or focused on a formal contract (Powell and Exworthy, 2002). Hudson and Hardy (2002) further identified vertical (between national and local government/agencies) and horizontal (across local organisations) dimensions of partnership working. For example, cooperation may occur between both between employees and agencies in the community (vertically); and across the specialist health services and municipality employees (horizontally). While specialist health and community care services can work together based on the user's future care plans, it has been shown that this type of collaboration can be challenging to put into practice (Hansen and Fugletveit, 2010). Clarke and Glendinning (2002) argued that account needed to be taken of actual practice in relation to theoretical models. Lowe (2004) also stressed the importance of networks and inter-organisational working for housing but maintained that the central state still had significant influence and FEANTSA (2004) concluded that the level or degree of development of inter-agency working on homelessness was associated with the overall national approach to tackling homelessness (i.e. strong interagency working was likely to emerge where there was a strong national/legal framework for homelessness).

In terms professional roles, 'working in partnership' has been identified as the first of ten 'essential shared capabilities' for mental health workers (Department of Health, 2004). Reflecting a shift in culture towards choice and person-centeredness, partnership is taken to include working positively with service users, carers, colleagues and wider community networks. The ten essential capabilities guidance is a document for practice which links to

education curricula, personal development planning and joint education and training plans for the mental health workforce, but has resonance for other welfare professions. Multidisciplinary working is understood as engaging with a wide range of professions and services: nursing, psychology, psychiatry, occupational therapy, medicine, social work, local authority housing, voluntary organisations, community groups and other social support services.

Drawing on Rogers and Whetton (2002) and Lloyd *et al*, (2001) the following definitions were suggested by Anderson *et al* (2005) with respect to homelessness and interagency working:

- *Inter-agency working* - involving more than one agency working together in a planned and formal way, rather than simply through informal networking (although the latter may support and develop the former). This can be at strategic or operational level.
- *Multi-agency working* - implying more than one agency working with a client but not necessarily jointly. Multi-agency working may be prompted by joint planning or simply be a form of replication, resulting from a lack of proper interagency co-ordination. The study noted that the terms 'inter-agency' and 'multi-agency' (in its planned sense) were often used interchangeably.
- *Co-operation:* a relatively informal process involving 'deliberate relations between otherwise autonomous organizations for the joint accomplishment of individual goals.
- *Co-ordination:* the process whereby two or more organizations create and/or use existing decision rules that have been established to deal collectively with their shared task environment.
- *Partnership:* a working relationship predicated upon sharing of skills, information, accountability and decision-making, marked by shared goals and objectives and possibly involving agreed protocols, procedures and shared staff in a contractual manner.
- *Merger:* where agencies determine that shared goals, opportunities and threats mean that expansion and/or

diversification is necessary and is best achieved through organizational merger.

Anderson *et al* (2005) identified top down and bottom-up drivers of inter-agency working in different EU countries and concluded that the presumption in policy was that inter-agency working was a necessary development since homelessness, as a complex problem, required multi-dimensional responses. Inter-agency and partnership working were also perceived to be 'a good thing' when the prevailing policy approach recognised that service provision should be needs-led. However, the focus of their review was at the organisational level, with less discussion of the roles of different professional groups (hence offering no explicit definition for interprofessional working).

The Norwegian government has long recommended cooperation among different professional groups as a means to create coherent and effective services to people with complex needs (White Paper No. 69 (1991-92), Norwegian Board of Health Supervision 2000, Official Norwegian Report 2004: 18). The health and social care sector in Norway have met constant and repeated encouragement to cooperate. Cooperation was revitalized through reforms in health care and substance abuse care (White Paper No. 47 (2008-2009)). An essential requirement in all interprofessional work is that the interaction with the individual service user must be at the centre of procedures (Official Norwegian Report 2003:4. Report no. 25 (2005-2006)). However, homeless people are not mentioned as one of the groups where the health service must cooperate to an even greater extent than previously (Official Norwegian Report 2005:3).

In Norway the "Individual plan" is a planning tool, which has the purpose of enabling close cooperation with the users of services. The use of individual plans should contribute to better coordinated services for the user. Individual plans will be used in work with people with who need long-term, coordinated health and/or social services (Health and Social Affairs, 2006, IS-1362, Health and Social Affairs 2007). Research has shown that positive responses to the use of individual plans developed among professional groups. Studies show that many consider an individual plan is a valuable tool for service coordination. At the same time there is a certain scepticism to measure outcomes because work with an individual plan can be time consuming and it

can be challenging to ensure the participation of all relevant actors (Myrvold and Helgesen 2009).

The emergence of "Responsibility groups" is another example of a recommended form of cooperation with and around each person in need of help to ensure access to all relevant services. "Responsibility groups" are not a statutory service, but a recommended action to users that receive services from different agencies. Responsibility groups function as a cooperative arena and a link between service users and staff. Evaluations of treatment to drug addicts show that those who participate in this type of treatment receive additional help, support and follow-up, to a greater extent than others with substance abuse problems. Service users increasingly participate in Responsibility Groups, although there are wide variations in assessments of how Responsibility groups actually work for people with complex needs.

Another example of a collaborative mechanism is the use of the ACT (assertive community treatment) team. This is a model for organizing interdisciplinary outreach work for people with mental health problems. The model was originally developed in the United States and was subsequently recommended for use in Norway. Different professional groups will be represented on the ACT team. The team will work together over time, ensure long-lasting and continuous contact with the user and have a profile based on outreach work in the community). The team should ideally provide integrated treatment. At the same time, it is noted that this type of team cannot help to solve problems that have to do with fragmented assistance from other services (Nesvåg and Lie, 2010). Consequently, the use of this type of team should also be considered in conjunction with other services for the user group. In Norway the development of the local mental health services will have implications for the need for ACT teams because mental health workers will be able to cover many of the tasks described for an ACT team.

In Norway there is no specific sector or profession which has overall responsibility for services and help to homeless people. Staff in different sectors may play different rolls in assisting homeless people. In some municipalities staff in mental health services will have a central role; in others employees with responsibility for services to individuals with substance abuse

problems are more central to homelessness service provision. Non-governmental organisations also play an important role in the overall services available to homeless people in many municipalities. In some places there is an extensive collaboration between NGOs and the municipality for services to this group. Non-government organizations and the local authority can refer users to each other's services and work together to find solutions for the individual. However, it is likely that non-government organisations will have a less significant role in working with homeless people (and so also in interdisciplinary work) in Norway, compared to other countries.

At the operational level in Scotland care management and co-ordination have also emerged as important tools in working with people with complex needs (Rosengard *et al*, 2007; Pleace, 2008). For example single shared assessments involve all relevant services in a joint process of assessing need to improve co-ordination and prevent service users having to repeat the same information. However, Rosengard *et al* (2007) suggested that care management had failed to realise its potential as a response to complex and multiple needs resulting in attempts to further refine practice. At times, people with multiple needs valued the input of various services, provided that these were co-ordinated. The model of a 'service navigator' or link worker who could address issues across service boundaries was promoted, but depended on individuals with appropriate qualities being readily available and/or suitably trained (Rosengard *et al,* 2007). Joint work required appropriate resourcing and training for those involved in new ways of working and the review indicated a high level of need for staff training to meet co-occurring and multiple needs better, including 'peer educators', as a route to empowering service users and 'educating' professionals (Rosengard *et al*, 2007).

The Pleace (2008) review identified substance misuse workers trained to work specifically with homeless people, as well as in the community; and services which catered for both substance misuse and mental health problems. Approaches included case managers who arranged packages of care; key workers who provided low level support and advocacy; and interdisciplinary case conferences. Case management included a combination of professionals covering housing needs; financial needs; education, training and employment needs; physical health; substance misuse; mental

health; anti-social behaviour or offending; personal care needs; social and emotional support; training and support in daily living skills; and advocacy.

In addition to evidence reviews for policy, extensive guidance has been produced for practitioners, for example, on the design of integrated care for drug or alcohol users (Figure 8 Consultancy Services Ltd, 2008) There was limited reference to housing in this document but the relationship between homelessness and alcohol problems was acknowledged. For England, the Department for Communities and Local Government (2008) issued non-statutory guidance for housing and children's services managers on preventing and reducing the incidence of homelessness. Key elements for effective joint working included: joint protocols; a shared prevention ethos; use of joint resources; information sharing; a Common Assessment Framework; and involving service users.

The literature review has not revealed a consensus definition of interprofessional working. Indeed, much of the research and guidance to date focuses more on other dimensions of joint working. For this study, interprofessional working suggests joint working which draws upon the expertise of different specialist professions to resolve complex problems (which can't be fully resolved within one professional service area). A wider definition of joint working could include working across professions (in the same or different organisations) and working across organisations (vertically or horizontally). Both interprofessional and inter-agency working can be informal or formal, and can draw on professional and organisational networks. Partnership working suggests a formalised working arrangement between organisations and has been a significant focus of the research literature. For example, Ball *et al* (2010) used a definition of partnerships where parties agree to co-operate to achieve common goals and implement new organisational processes or structures. Merger between partnership agencies has been conceptualised as the 'ultimate outcome' of joint working, but seems rare in practice and less directly related to the interprofessional exchange of specialist expertise. The main operational approach to interprofessional working in the evidence reviewed has been the co-ordination of service provision through case management involving complex combinations of services, professionals and organisations.

Effectiveness of interprofessional working

Cooperation can be challenging for many reasons. Structural and institutional barriers can be obstacles to cooperation. Participants can have different points of view on what is important from that of service providers (Reitan, 1993). Some scientific perspectives or professional groups may come to dominate a collaboration. For example, professionals who are responsible for housing allocations may have a different interpretation of a person's needs than those who provide medical or social care. Furthermore, not all professionals will have the same interest in interprofessional working and participation may be perceived as more or less voluntary, with varying degrees of autonomy in working among different professions (Glendinning *et al*, 2002).

Working together to offer an effective service that contributes to a better life for homeless people, can be time consuming for both health professionals and service users. Many will experience setbacks and cooperation may be perceived as requiring unreasonable time and resources, without achieving adequate results. Cooperation may also produce, rather than reduce, duplication. Services may overlap and different agencies or groups may have the same expertise and therefore could replace each other. In some cases service providers have different formal roles, while in reality they offer users the same kind of service. One reason for this may be the lack of an explicit policy for coordination. An important prerequisite for a good partnership is that it must be adapted to the local context. Responsibility for services is divided between sectors and institutions at various levels. How actual services for homeless people are organized between local and specialist health services may vary for different health and local government services and depends on many factors, such as accessibility, accommodation, expertise, geographical distance and prior experience of cooperation.

Collaboration and interdisciplinary work in itself is not enough to enable a stable housing situation and good services for homeless people. An important condition that must be present is the recognition that joint effort will simplify the work and produce a better result for the homeless person than the efforts of just one professional. Another assumption is that those who participate in the collaboration must intervene in each other's fields and

recognize each other's expertise. A joint strategic perspective, a collaborative organizational structure and expertise in the skills needed are some necessary prerequisites for interprofessional working. The organizational culture should have norms and values that support and promote cooperation.

As early as 2001, inter-agency working was seen as a strength of homelessness service provision in Scotland through factors such as staff commitment, good communication and working relationships, shared aims and goals, resource availability and commitment at a senior or political level as well as operational level. Difficulties in joint working included organisational and professional boundaries, lack of mutual understanding and trust, and time required to develop sustainable relationships (Kennedy, *et al*, 2001). Hudson and Hardy (2002) proposed six principles for assessing the effectiveness of partnership or inter-agency working: acknowledgement of need for partnership; clarity and realism of purpose; commitment and ownership; development and maintenance of trust; establishment of clear and robust partnership arrangements; and monitoring , review and organisational learning. The importance of leadership in joint working was highlighted by Harris (2003), with respect to overcoming both vertical and horizontal barriers. Interagency work needed to function at operational and strategic levels, and across practitioners from different agencies irrespective of professional cultures and priorities.

Although implementation of co-ordinated homelessness policy is the responsibility of local housing authorities in partnership with other local agencies in the UK, comprehensive evaluation of whether needs were better met as a result has been lacking (Anderson, 2005) or at best contradictory (Sykes, 2004; Lewis; 2003). However, evidence from the Rough Sleeping Initiatives in England and Scotland, which were more rigorously evaluated, did suggest effective interagency working (Randall and Brown, 2002; Yanetta *et al,* 1999; Fitzpatrick *et al,* 2005).

Tensions that impeded effective partnership working included: incompatible agency boundaries and time-scales; remits being inadequate to the complexity of the problems; communication problems arising from contrasting cultures, practice and knowledge; poor briefing on other agencies' roles; and structures

that encouraged competition rather than collaboration (Rosengard *et al,* 2007). Pleace (2008) concluded that evidence on the effectiveness of joint working was thin, with few questions raised about care management as no significantly different approach was employed in Scotland. Service failure was associated with failing to overcome impediments to effective joint working, but effective outcome monitoring was not a simple exercise. Crude measures may not properly represent a service's achievements while detailed measures were costly and complex to record and analyse. Longitudinal monitoring was recommended to assess whether service outcomes were sustained over time and accurately judge whether services were of lasting effectiveness (Pleace, 2008). A User Defined Service Evaluation Toolkit (UDSET) designed to contribute to evaluating interprofessional working defined outcomes as '*the impact or effect of services on people's lives*' (Figure 8 Consultancy Services Ltd, 2008). In recent evaluations of interprofessional working in relation to aspects of homelessness, Cameron *et al* (2009) found that while outcomes achieved were modest, individual service users' lives were significantly improved in a way that would not have been achieved by agencies working in isolation and Lewis *et al* (2009) concluded that while collaboration was successful in increasing funding, this was in the context of a highly impoverished area and overall under-funding.

In a robust international review of health and social care partnerships, Rummery (2009) found that evidence of improved outcomes for service users was equivocal, but that user-defined priorities were taken seriously in the statutory health and social care sectors. A 'theories of change' approach designed to incorporate the views of a range of stakeholders about what works and why (rather than simply measuring success against service objectives) was recommended to help improve the evidence base. Bottom-up, incrementally developed partnerships emerged as more effective than top-down government driven ones, as did liberal approaches compared to state-driven approaches, although there was a lack of evidence on Scandinavian welfare models.

Ball *et al* (2010) adapted a Partnership Assessment Tool developed by Hardy *et al* (2003) to evaluate community health partnerships (CPHs) which were designed to better integrate national health services with local authority care services in Scotland. They sought to bring together outcomes, causality and costs of partnerships

(after Dowling *et al*, 2004) and assess whether services actually improved. The assessment tool developed a series of statements in which respondents indicated the degree of success of six 'partnership principals' within four bands from *working very well* to *working badly in all respects*. Emerging areas of relative strength were inclusiveness, common goals, trust and leadership; while areas of relative weakness included pooling budgets and engagement with public/communities. Outcomes appeared to relate to both the organisation's previous record in partnership working and the need to fit Scottish Government priorities and targets.

In an evaluation of interprofessional working in three settings (housing support for offenders; a rent deposit scheme; and a hostel) Cornes *et al* (2011) tracked cases over six months using case notes, interviews, and observation, supplemented by staff interviews (using vignettes instead of real cases). Each agency developed its own support plan (which was rarely shared with others) and each agency invested in co-ordination. Practice was characterised as multi-professional rather than interprofessional in that agencies and professionals were mostly working in parallel. Cornes, *et al* (2011) identified forms of 'professional protectionism' where alcohol, drugs, and mental health problems were seen as beyond the professional capacity of housing support workers, yet these workers were providing more than 'low intensity housing related support' (a finding supported by Cameron (2010) who argued that housing support workers were filling the vacuum left by the retreat of social workers from 'direct work' with adults). Despite evident scope for more interprofessional training and education, cultural barriers persisted (Cornes *et al,* 2011). The challenge was still to secure the conceptual shift from multi-professional to interprofessional ways of working to integrate 'homeless people' as part of the adult social care population.

Despite longstanding UK programmes and guidance, the multiple exclusion homelessness research programme found little evidence of integrated working across housing, health and social care and it was not clear that homeless people's needs were being properly assessed under NHS and Community Care Act (McDonagh,2011; Fitzpatrick *et al*, 2011). Priorities of staff did not always converge with those of service users and service commissioning sometimes avoided people with the most complex needs. Funding targets also constrained service provision. Interventions needed to respond to

individuals at a pace at which they can interact and the research programme recommended a review of how homeless people with complex needs are incorporated into adult social care. The research also indicated that professionals could learn more from each other through interprofessional education and training, with a focus on outcomes for the whole person rather than services designed around client groups.

In a study of what supported or inhibited interagency working to promote the health of homeless people, Joly *et al* (2011) conducted interviews and focus groups with residents of staff from 32 different services (mainly health services, rather than housing providers). They developed a taxonomy of interagency working with six levels from *collaboration absent* to *collaboration strong* which revealed that how agencies worked together varied according to the extent to which they were accountable to each other (social integration) and the degree to which they were governed by and accountable to rules and roles (social regulation). Four possible types of networks were identified (Hierarchy, Isolate, Individualism and Enclave) reflecting how agencies addressed risk. For example, enclave networks were associated with containment of public risk (tuberculosis, antisocial behaviour and drug use) while isolate networks better addressed service user health priorities. The imperative to work together was not so strong where there was no risk to wider society. The sheer number of services indicated challenges in understanding each other's roles and developing relationships, while service users faced challenges in negotiating services.

Cameron and Lloyd (2011) drew upon theoretical models of Hudson (presence or absence of a range of properties that influence the nature of joint working) and Lowndes and Skelcher (changes in organisational relationships through the life of an initiative) finding that neither provided a sufficient explanation for their evaluation of partnership working across health and housing support. Crawford (2011) has examined joint working between social workers and other professionals, and Koubel and Bungay (2012) have focused on interprofessional working in health and social care. However the research evidence reviewed here suggests that evaluation has focused more on the procedural effectiveness of interprofessional working than on identifying its impact on improvement in outcomes for service users. Those evaluative tools

which have been developed have focused on rating the effectiveness of partnership working from different perspectives, sometimes including service users. No single, ideal theoretical framework for explaining or analysing interprofessional working has emerged and a new study could usefully address this conceptual gap.

Conclusions: Homelessness, interprofessional working and integrating the housing question

A question which emerges from this review is whether the evident common practice of interprofessional working has moved ahead of its conceptualisation and evaluation? The advocacy of joined up working rarely seems to be robustly informed by coherent theories, or by systematic understanding of the changing character of organisations, services and professional roles. At a policy level, inter-agency working is promoted as a 'self-evident good' but problems at strategy and operation levels within organisations are still identified and, importantly, service users with the most complex needs still seem to be most at risk of exclusion from housing and from health and social care services.

There is a much more substantial literature and evidence base on joint working across health and social care than in relation to housing and homelessness. Housing is rarely addressed as a 'professional role' although some studies have looked at the role of housing support worker. There remains scope for updated research on the employment backgrounds, training and qualifications of housing and homelessness workers in both Norway and Scotland.

There also remains scope for research which focuses specifically on 'interprofessional working' as opposed to interagency or partnership working to meet the needs of homeless people. Such a study could focus on issues of governance and professional practice, but in the context of underlying structural and resource issues which impact upon service provision within and across professions. There is considerable scope to refine and further test models for the evaluation of interprofessional working. Overall the evidence base suggests that while interprofessional working has very much become the norm in seeking to meet complex needs, its success in doing so has not been rigorously evaluated. Progress has been made, but problems of vulnerable individuals experiencing

exclusion from housing, health and support services are still reported.

1.3 Methodology in the pre-project

The research method for the pre-project was designed to collect qualitative data from professionals in Norway and Scotland about how the housing question was addressed in interprofessional working with people with complex needs. Tables 1 and 2 below summarise the professional roles of the participants in the two countries.

Nine semi-structured interviews were carried out in Norway, in two municipalities of roughly the same size. All municipalities will have social housing challenges; however, slightly larger municipalities will have more comprehensive experience of resettlement and social housing problems. This was the reason for the choice of municipalities. One of the municipalities was from the east of Norway and the other from the west of Norway.

In Scotland, 6 semi-structured interviews and one group discussion were conducted in a large city municipality. All Scottish municipalities have legal duties to assist households who are homeless or at risk of homelessness, including those with complex needs. Selecting a larger urban authority aided participant recruitment from a larger potential pool of workers across a range of relevant professions. Rather than selecting two municipalities, participants were recruited from within the muncipality and from the National Health Service (from one Community Health Partnership providing health services in the municipality).

In Norway, in order to ensure that we had informants who had experience of the theme of the project and of the field of social housing work, we selected interviewees whom we assumed could play a role or who had knowledge of the interprofessional work in municipalities. Those who took part represented different levels and professions. They were also selected to represent areas of work where help in finding housing and in establishing stable living conditions were central tasks.

The research design acknowledged the existing Scottish framework for meeting the needs of homeless people as characterised by a

relatively high degree of central government regulation of local authority activities (including the legal framework for assisting homeless people into settled housing); a significant social rented sector and distinct housing profession; and a relatively high degree of existing formalised interprofessional working in relation to homelessness. For core 'housing workers' in this system, the *housing question* would be central to their work with homeless people which requires a detailed knowledge of housing law, policy and practice in relation to homelessness. For this study, it was more appropriate to consider how the housing question was included and addressed in interprofessional work among workers who were not core housing professionals (for example, social workers, health care professionals, addictions workers). As the municipality had transferred its previous 'council housing' stock to an independent Registered Social Landlord, it no longer had a social landlord role, but did retain its strategic housing role (including assessing housing needs and responding to homelessness). Strategic housing services were split between two departments in the municipality: Development Services and Regneration; and Social Work (including homelessness and access to housing).

Table 1.1 *Informants in the pre-project – Norway*

Area of work	Number of informantas
Mental health/alcoholism*: Area manager, team leader	4
Nursing and care services: Area manager	2
NAV Manager, former manager**	2
Housing service, Environment worker	1
Total number of informants	9

* Both mental health work and mental health work combined with alcoholism services

** Manager of social services for ten years, responsibility for homelessness etc. at the time of the interviews

Table 1.2 *Informants in the pre-project - Scotland*

National Health Service workers (individual interviews)		Local Authority workers (group discussion)		Total
Community Psychiatric Nurse	1	Care Manager	2	-
Occupation Therapist (Team Leader, Senior, Early Career)	3	Homelessness Case Worker	1	-
Health, Homelessness and Housing Lead	1	Community Case Worker	1	-
Addictions Team Leader (Homelessness) (Nurse)	1	Community Addictions Worker (Senior – social work)	1	-
TOTAL	6		5	11

A common interview guide was used for the interviews in both Norway and Scotland. The interviews consisted of three main elements: determining the housing aspects of the needs of service users for interprofessional assistance; determining the responsibility for, experience with, and participation in, housing aspects of interprofessional work among the professional participants; and assessing the justification for and significance of housing aspects of interprofessional work with people with complex needs (the Norwegian version of the interview guide is attached at the back of the document).

2 Results

Three types of processes are used to help people with complex problems and who also need help with housing. The first involves interpreting the needs and the situation, the second involves taking decisions about giving help for housing and other services, and the third concerns the way help should be offered. In all three phases, the user's situation and needs will be assessed within the wider context of other needs in the municipality and in the political context. These different aspects of the service user's needs and situation were addressed in the interviews and set in the context of the need for interprofessional work and the way such joint working is organised.

The interviews provided a basis for identifying the housing dimension of interprofessional work; housing expertise in interprofessional work; and conditions for cooperation. The data collected indicates both conducive and inhibiting factors for integrating housing issues into interprofessional work and for the efficiency of this work. More specifically, the interviews gave grounds for highlighting three different themes: awareness of housing in interprofessional working, housing expertise in interprofessional work, and the importance of management, structures and professional boundaries. This applied equally in the Norwegian and Scottish contexts, even though processes were more formalised in Scotland due to the nature of its legal and policy frameworks.

2.1 Awareness of housing in interprofessional work

Norway

The Norwegian informants expressed support for the need for cooperation, albeit to different degrees. However, there was little explanation of actual models and time allocated to housing issues in interprofessional cooperation. The degree to which the informants had an intuitive understanding of what social housing work involved also varied. On the whole, the interviews indicated that social housing work had not become part of "mainstream" health and welfare services offered by the municipality.

One inhibiting factor for interprofessional work can be a strong affiliation and obligation to one's own profession and the belief that only one profession can solve the task. No-one laid claim to that expertise in the social housing field. Motivation and interest in subjects are bound up with professional identity. In Norway, the field of social housing has not developed based in a specific profession or professional interests. The social housing profession has grown into a field developed by national administrative and professional authorities and in combination with local practice. As well as being characterised by conflicts of interest and conflict between the professions, the interviews also gave the impression that the field is characterised by a lukewarm approach to interprofessionality relating to social housing conditions and a lack of management and structures to regulate the integration of housing work in interprofessional working.

A factor highlighted in the literature as promoting cooperation, is the development of informal networks based on common interests amongst professionals to work together. The initiative for interprofessional work can come from different quarters. We also know that interprofessional cooperation is stimulated by interests and professional awareness, and is initiated on the basis of worker motivation, and not just on the basis of systems and structures adapted by leadership and management. Thus interprofessional work in relation to housing problems can be a form of cooperation which also leads to learning and development for the parties involved, and thus can become something more than idealistic

work models imposed on the profession by the authorities. However, the Norwegian interviews revealed little about this kind of initiative.

Experience is also a factor that can drive interprofessional work on housing issues. Professionals who have previous work experience of housing issues have acquired knowledge and expertise of this way of working and can therefore be forerunners in the field. The social housing field in Norway can be regarded as a new professional field. This will also be a factor which will contribute to interprofessional work on housing not being primarily initiated by the profession itself. The interviewees were aware of housing work through their own work experience, but only two had been trained in this field.

Different players who are involved in the work and who will offer help will necessarily depend on each other. The theory of interprofessional work therefore indicates that it is necessary for cooperation to be understood and valued by those involved. Some participants stated that they knew what social housing work was and its significance. For others, however, social housing work was unknown and they had no opinions about this work.

Participation by different municipal bodies was not regarded as a given by everyone and hence cooperation did not appear to be a regular part of participants' work. However, the interviewees did not give the impression of a negative attitude towards cooperation. Not everyone felt that it was necessary for housing problems to be tackled with interprofessional input. We know from other theories that a lack of belief in the significance of interprofessional cooperation can be a limiting factor. We cannot ignore the fact that the lack of knowledge and awareness that some expressed may delay the development of good housing and service provision for relevant user groups.

Resources are a factor that must be discussed in relation to interprofessional cooperation. Dependency on resources can act as an engine for inter-departmental cooperation, but can also encourage competition for scarce resources. Including housing issues in interprofessional work was associated both with resource requirements and with efficiency, but first and foremost with the fact that it was time-consuming. In the interviews, resource and

efficiency issues were not directly linked to the value of interprofessional work for the service user with complex needs.

A standard approach in interprofessional work is for it to be regulated by specific agreements or separate models and methods and clearly defined tasks. This model of interprofessional cooperation is the one that is referred to most often but none of the Norwegian informants knew about this type of model of interprofessional cooperation. This model is perceived as the opposite of a network model where the emphasis is on flexibility, development and motivation. The examples of interprofessional cooperation on housing in the Norwegian part of the pre-project can primarily be classified as network cooperation.

The literature indicates that interprofessional cooperation on service provision for people with multiple complex needs can be full of conflict and characterised by over-ambitious and unclear goals and a lack of clarity regarding responsibilities. This was not the picture that the interviewees portrayed of the situation with respect to addressing housing in interprofessional work in Norway.

Scotland

The participants in Scotland worked in a mixture of specialist homelessness teams and community settings. Some participants had many years of experience, and some had experience of a range of roles including both health and social care. Both groups revealed a quite detailed knowledge of the nature of homelessness in the city, the range of health and social care needs of service users, and the procedures in place to resolve their housing problems. This was the case for both health workers and local authority workers and reflected the structures and target client groups of the services from which participants were recruited.

Joint working across health and social care professions was very much the norm for the Scottish participants. This included both formal interprofessional working where staff from different professional backgrounds were clearly working together in a team/collaborative framework; and multi-professional working, where staff from different professional backgrounds drew upon the knowlege, skills and functions of other services to help meet the complex needs of their clients. For example, some participants worked in interprofessional teams providing specialist health

services for homeless people with complex needs, including mental health and substance misuse problems. Some participants who worked in the municipality social services department also worked in interprofessional teams and were engaged in joint working with both health services staff and social housing landlords. Other participants who worked in community settings equally had well-developed sets of inter- and multi-professional working relationships. Municipality workers generally had better developed working relationships with social landlords, which reflected the organisation's legal responsibility for assisting homeless households with housing. Health workers tended to have less direct contact with landlords, although occupational therapists had a clear role in making recommendations about suitable accommodation for their clients. Other health workers provided specialist services for homeless people while they were in temporary accommodation and sometimes for an initial period in a settled tenancy, but had less direct contact with landlords.

Service provision for adults with complex needs appeared to be relatively well integrated into adult social work, within the framework fo Community Care Assessments. Specific mechanisms in place included single shared assessments of needs and case conferences to review 'progress'on the well-being and/or housing situation of service users. In line with the findings of the literature review, while many participants could identify areas where services could be further improved (including overcoming resource constraints), the core structures for interprofessional working to meet complex needs were recognised as largely being in place.

None of the Scottish participants were 'housing professionals' in the sense of either having a professional qualification in housing or working mainly in a social housing landlord role. However some were specialist homelessness case workers, for whom a significant part of their job was interprofessional working with landlords to secure housing for their service users. Tensions are known to exist within the structure of the housing profession: for example between delivering services to housing applicants and tenants, and managing properties and neighbourhoods. Participants reported that some social landlords were more receptive than others to providing accommodation for homeless people with complex needs. A formal procedure for referral from the municipality to a Registered Social Landlord exists under Section 5 of the Housing

(Scotland) Act 2001, but implementation of this was not always smooth. Issues arose in terms of effective sharing of information about the support needs of clients referred and whether support offered was considered sufficient by the landlord. Some landlords and support providers wished to conduct further assessments before accepting referrals. There was also an overall general perception that there was not enough appropriate housing available and that this impacted negatively on the potential effectiveness of health and care interventions. Some participants also commented that those with complex needs, and particularly those with substance addictions, still faced stigma from within the social housing sector to which they looked for rehousing assistance.

Health service and municipality workers generally had a good understanding of each others' professional roles. Most felt they had a good understanding of which different professions could help clients with specific needs and how to contact the appropriate team or make a referral on behalf of a client. Some participants expressed a concern about professional boundaries and were more cautious about joint working with colleagues who may not have a recognised professional qualification and therefore may not have had training/education to the same level in terms of ethical and professional values in working with vulnerable people. This could have implications, for example, for information sharing. The legal, policy and organisational frameworks generally facilitated stronger integration between health and social care – than with social housing landlords.

Health workers in Scotland reported having learned a lot about housing and homelessness from their clients' stories, rather than through formal training or education. While they had varying knowledge of detailed housing law and practice, most knew about basic procedures, such as who to contact, and how to refer a client for a homelessness assessment or to make an application to a social housing register. Most health workers also expressed views about the availablity and quality of housing for their service users and the use of emergency, transitional and settled accommodation in the municipality.

Resource issues emerged as an important factor in Scotland although resource constraints appeared to manifest themselves

more within services than in terms of interprofessional working. Participants did not report that interprofessional working was particularly onerous, time consuming or expensive – rather that overall resources were being cut back. Budget cuts were a feature of all local government services across Scotland at the time of the study. While health service budgets were relatively protected compared to municipalities, they were not entirely immune to austerity measures. Other specialist health services for homeless people were being scaled back due to changes in the nature of demand and service provision – with an increased focus on reintegrating formerly homeless people into community based health services.

Interprofessional working in Scotland may be formally governed by protocols and service level agreements. Other than managers, informants had varying awareness of these procedures. Most reported a sound knowlege of the core legislation which framed their area of work and a more limited knowledge of frameworks for other professions. Across the participants, a substantial number of legal and regulatory frameworks governed work with service users with complex needs: Health and Community Care, Adult Social Work, Children and Families Social Work, Housing and Homelessness, Mental Health, Substance Misuse, Criminal Justice and Immigration. Participants worked within both national legal and regulatory frameworks and local level protocols or service agreements for specific aspects of joint working.

Both vertical and horizontal dimensions of interprofessional working were revealed in the Scottish interviews. Participants particularly emphasised the importance of horizontal networks which individual workers had developed through their experience in their jobs as they built up contacts and working relationships with their counterparts in other professions. Although no housing professionals were interviewed in the pre-pilot, housing professional expertise was a feature of the municipality in terms of its strategic role in planning for housing and meeting its statutory homelessness responsiblities. Formal procedures for working with social landlords and other partner organisations flowed from these strategic duties.

2.2 Housing expertise in interprofessional work

Norway

Securing good services depends on a number of different issues that all relate to each other. However, knowledge, education and training are always central factors and will affect how housing problems are conceptualised, tackled and resolved within interprofessional work. Thus knowledge, expertise and training are important topics in all discussions about interprofessional cooperation. The concepts of *shared expertise*, *complementary expertise* and *cooperation expertise* are used as concepts of the expertise that is part of interprofessional cooperation. Tasks that will require interprofessional cooperation assume that there is a need for expertise from a number of different practitioners. The interviews reveal the opinions of, and expertise in, housing within interprofessional work that the informants have.

The professions that are involved in interprofessional work will put their own mark on its implementation. The professional groups that took part in the study have different professional backgrounds and experience. The interviews also showed that the participants have differing opinions of housing problems and how housing fits within interprofessional work. There were also significant differences in how different participants related to and described the problems, solutions and needs for interprofessional social housing work.

Based on the awareness they had of the field of social housing, the interviews provided a basis for dividing the participants into three groups. The aim was to indicate how a basic theoretical knowledge can contribute in relation to the social housing field and to the assessment of the value of and need for interprofessional work.

Two of the informants had basic training in social housing and in interprofessional work. One referred to theoretical knowledge she had acquired through education and stated how this affected her view of how the tasks should be solved. Hence this informant indicated that she had a principal knowledge that was expressed in a mental picture of the problem complex and also possible solutions, involving housing as part of interprofessional work. This

basic knowledge appeared to affect how she interpreted and identified needs and not least which priority she gave to the needs and the interprofessional work. The interview indicated that she put more emphasis on both housing problems and the need for interprofessional cooperation than the other participants did. Another informant is the manager of an interprofessional team in mental health. The informants emphasised the significance that interprofessional work and cooperation have in meeting users' needs in a number of areas.

Other informants were involved in the work of ensuring a stable living situation for people with alcohol problems and mental illnesses. Three were nurses and had no training in social housing subjects or in interprofessional work. One informant referred primarily to services and provision that are found in municipalities when she was asked about housing issues in interprofessional work. A third approach involves a very limited description of the place of housing within interprofessional work, linked to the municipality's duty to provide housing.

Here we see that three types of expertise were communicated in the interviews. One is a principal basic expertise. The second is an operative expertise which involves knowledge of existing provision and services, and the third type of expertise deals with regulations, guidelines and formal controls of social housing work.

The report "Innovasjon i omsorg" (*"Innovations in care"*) (Official Norwegian Report 2011:11) put great emphasis on the significance of flexible approaches that can create opportunities to find new forms of cooperation and new solutions. As with results from other research on interprofessionality, professions, training and education, we can highlight the significance of basic expertise in developing and changing the service. Training in both social housing conditions and within interprofessional work can result in different attitudes to the work. Here the interviews provide a basis for assuming that the principal basic expertise can be important with regard to identifying housing problems and for implementing interprofessional work. A lack of basic expertise can delay the identification of the need and the implementation of interprofessional work, or conversely, as here, expertise can contribute to giving priority to housing in interprofessional work. This basic expertise can thus influence the operative expertise

which is more directly related to the concrete solutions that can already be found in the workplace, and can contribute to developing and changing them.

The lack of a professional basis for cooperation can affect the development of cooperation and how cooperation is developed. Cooperation can take a more instrumental form, for example simply the reciprocal exchange of information and, to a lesser degree, cooperation that contributes to the development of joint services in the actual situation. Service providers need to maintain and value the various skills and knowledge that they have linked to their discipline. However, it is generally recognised that significant benefits are associated with having pragmatic, flexible and unified ways of working. Our study may indicate that basic knowledge is significant in being able to develop flexible interprofessional working methods.

Scotland

Although the Scottish participants came from a range of different professional backgrounds, the majority worked with homeless/precariously housed people with complex needs on a daily basis. Interviews revealed both a detailed knowledge of the range of support services required by service users and considerable empathy with service user groups (for example those with long term and substantial alcohol and drug use problems; with mental health problems; with physical health problems, sometimes related to substance use; and with a combination needs which could imply a somewhat chaotic lifestyle). Indeed, services had been develped within the city specifically to respond to the complexity of such cases. Even those interviewees who worked in a community setting (as opposed to homelessness services) encountered vulnerable people on a regular basis who may be homeless, recently housed, requiring support to get by in settled accommodation, or in some cases at risk of losing accommodation.

Service provision could be categorised as focusing on meeting housing needs (through emergency, temporary/transitional and settled accommodation); providing housing support (developing independent living skills) to help people sustain settled tenancies; and providing ongoing health and social care support, most frequently in relation to substance misuse and/or mental health

issues. The different aspects of service provision were generally co-ordinated through a case management approach, with a designated Care Manager, co-ordinating the process of assessment and service provision. The use of assertive outreach was also mentioned as a mechanism for interprofessional working. Being a Care Manager was the job title of two of the social services interviewees, but health professionals such as Addiction Workers or Commuity Psychiatric Nurses could also assume this role. While a range of professionals may be involved in delivering a package of support services to a service user, the care management approach should faciliate co-ordination of service provision. Further, a number of participants indicated that they felt they could ask for an interprofessional case review if they thought this was necessary in terms of service provision or in the interests of the client (for example in considering any changes to service provision or accommodation). Informants reported a good understanding of the case management process and of protocols for supporting service users to move from use of specialist homelessness services to taking up community based services on resettlement (for example moving from support from the homelessness addiction team to a community addiction team). Person-centredness was mentioned by a number of participants as a core professional value which should ensure that service co-ordination focused on best meeting service users' needs.

Within the care management approach, almost all informants were aware of whether service users were currently considered homeless by the municipality (for example in temporary accommodation awaiting rehousing); were tenants of social landlords; or were in other housing circumstances. One community based health worker worked with mental health patients in a wide range of housing situations including living with family/friends, and a range of privately rented housing cirucmstances. Sometimes health workers encountered patients who were roofless and they generally knew the procedure to make a referral to the municipality's emergency homelessness service.

In the case management approach, the interprofessional team would include a homelessness or community case worker who would be the person with the lead expertise on housing and homelessness issues. Case management teams would not routinely include a landlord representative although on occasion they might

be invited or request to be present. The case worker would liaise with the municipality or with social landlords/supported housing organisations with regard to the accommodation needs of a client, in cooperation with the Care Manager who would be responsible for overall coordinationand delivery of a care plan. This was the core way of working and the wide range of other services (addictions and mental health support, occupational therapy support, housing support) should be provided in a coordinated package. No housing support workers were interviewed as such services tended to be separately commissioned from third sector providers. This represents another dimension of both inter-ageny and interprofessional working to meet complex needs in the Scottish case.

In terms of whether professional boundaries were flexibile, some management-level participants talked of staff 'going the extra mile' to help meet the needs of a client. Although few significant barriers to interprofessional working were mentioned, one participant did explain how distinct professional codes could both create boundaries and drive joint working - 'I cannot operate outside my field of expertise', so it becomes imperative to call on a service/profession with that expertise, if it is needed for the service user.

One specific issue mentioned was the loss of homelessness expertise within the municipality due to recent staff changes and some informants also mentioned recent procedural changes in relation to partnership working arrangements. Constraints were identifed in relation to sharing information sharing about clients which did result in repeat assessments and opinions varied as to how onerous this was for clients. Keeping up with procedural changes within large, complex organisations was an issue for some participants, as was the clarity of decision making procedures on complex cases/resource issues.

Some participants saw a need for better specific training on homelessness and wider housing issues, though some had received occasional training. Other informants indicated that required information was generally available via policy/professional bulletins. Most participants maintained that they had a good understanding of what different professions did and how each could contribute in a particular situation. Health workers tended to

be client focused and would work with others as necessary/appropriate in the interests of their client/patient. However, some participants felt that their own profession was not accurately understood by others, potentially indicating that shared understanding of each others' roles may not be as effective as participants imagined. Moreover, despite having a basic knowledge of housing and homelessness issues, some health and social care workers acknowledged that there was scope to enhance their expertise on how housing issues were addressed in interprofessional working.

2.3 Management, structures and professional boundaries

Norway

We know that not only the professions' interests but also organisational issues and other controls can be important issues in interprofessional work (Meyers 1993, Farmakapoulou 2002). The literature mentions many different barriers to interprofessional cooperation. Lack of a common language, lack of leadership, as well as structure and adaptations are examples of this. Here the interviews indicate that guidelines and controls for social housing are lacking at the service level. Both municipalities have a social housing action plan. Knowledge of the content of these plans varied between the interviewees.

In spite of the fact that managers for the areas of work in question took part in the interviews, little was stated to indicate the degree to which strategies, guidelines and routines for cooperation had been developed at the service level. No guidelines were given regarding how the work should be done and who should be involved and have main responsibility. A lack of strategy and plans for social housing cooperation can lead to a lack of ownership in cooperative approaches and lack of leadership and management of the work. This in turn can create resistance to interprofessional cooperation, and a view that this is something that will simply generate huge amounts of work.

However, one example was given in the interviews where middle managers had been asked by senior managers to cooperate in order

to provide help for people with housing problems. Before this request, no one had taken responsibility for providing help for this group using an interprofessional approach. Professionals from different municipal bodies had worked together to find solutions.

Interprofessional social housing work requires working across professional boundaries, vertically and horizontally. In many contexts the advantages of having a flexible role in meetings with people with social housing problems are emphasised. Traditionally, however, interprofessional cooperation has been perceived as something that can create conflict and unclear professional boundaries and this threatens the professional groups' autonomy and authority. In professions theory, the emphasis is on the fact that boundaries between the professions can represent barriers to professional cooperation. The emphasis has been on professional boundaries as potential obstacles to interprofessional cooperation, rather than as something that can be expanded and changed and can provide opportunities for learning. Boundaries defined by management may be different to what the professional groups in fact experience as their boundaries for work and cooperation.

It can also be maintained that professional boundaries can in fact be strengthened through contact with the users in interprofessional cooperation. Professional boundaries are then highlighted and strengthened in order to define areas of responsibility. The professional work can thus encourage opposition and boundaries rather than developing more flexible approaches to cooperation.

However, the question has been raised as to whether professional boundaries have now been replaced by new methods that relate to cooperation amongst the professions, and that flexible boundaries are built in as a standard element in professional practice. Interprofessional work creates opportunities for innovation, development and changes in professional identity, and thus can strengthen the professional role. Based on the findings in the pre-study, we can ask whether having fundamental theoretical expertise in social housing work could be a central factor in the development of interprofessional social housing work. This question will be followed up in the main project.

Scotland

In the Scottish case, guidelines and protocols for social housing (and the ways in which other tenures can meet housing needs) are very well established at local and national levels. These underpinned service provision in the case study municipality. Even though lead housing staff were not directly interviewed, a pre-meeting with senior housing/homelessness strategy managers was held as a preliminary to recruiting the discussion group participants, which provided a strategic overview of the service.

Further insight into management, structures and policies of the Scottish municipality was obtained from its Housing Strategy document (available on its web site). Although not a landlord, the municipality identified three key areas of strategic housing activity: regeneration, access to housing and delivery (including maximising resources, improving partnership working and effective monitoring). The overall strategic vision for housing was to achieve 'better homes, better communites and better lives' and this was underpinned by four key principles of equality, sustainability, health and partnership. Impact assessments had identified the damage from poor housing and homelessness, and the importance of housing and the environment to people's mental and physical well-being. Housing supply across tenures was part of the regeneration brief and this included plans for accessible housing and housing for particular needs. In order to deliver on its strategic goals, the municipality sought to promote positive partnerships and co-ordination among statutory and voluntary agencies across a range of housing and housing related areas (including regeneration, housing, support, health and care). The strategy document illustrated the wide range of agencies in the network of engagement across the city. A key challenge was to deliver more effective and efficient services within severe financial constraints.

One health service team leader took part in the interviews and was able to give a strategic perspective from within the health services and in relation to working with the municipality. This included describing joint procedures and protocols and how these had changed over time. For example, the specialist health services for homeless people had been set up up to address exclusion from mainstream services but provision was now being scaled back with a focus on reintegration of service users into community health

services and fewer new clients were registering with the specialist services. A key role in the health service was that of 'Health, Homelessness and Housing Lead' – a post created specifically to provide the 'service navigation role' identified in the literature review. The post acted as a single point of contact for housing services/workers who had queries about health services and case management. These co-ordinating workers initially focused on working with the municipality but were increasingly developing links with Registered Social Landlords and third sector support service providers.

Some frontline staff in both organisations reported feeling remote from the strategic level of management. Most knew where to find relevant guidance or protocols on different aspets of joint working but some found it difficult to keep up to date with internal organisational change, as well as national level policy change (though others proactively did so). Although the interviews suggested some vertical communication issues within organisations, these did not appear to unduly inhibit positive horizontal collaboration within and between organisations and individual professionals. There were differing views about whether staff needed to be managed from within their professional service (rather than in interdisciplinary teams). In part this reflected differences in approach to staff supervision across professional groups, notably whether this included individual support in relation to the pressures of working with challenging client groups (as opposed to supervision simply as line management of tasks). Supportive supervision was much more prevalent in health services, and was also referred to in social work services but was not reported among housing/homelessness/housing support workers.

Rather than revealing possibilities for new methods of co-operation, the Scottish interviews were more indicative of a process of increasingly embedding interprofessional working in everyday working life. There was a near universal recognition it was crucial to fully meeting complex needs. However, this should be interpreted as a 'necessary but not sufficient' requirement, as most participants equally recognised that some service users still 'fell through the cracks'. Housing expertise in interprofessional working combined with a municipal housing strategy does not simplistically imply a sufficient supply of adequate, affordable

housing (with necessary support) to meet all of the evident complex needs of service users. Indeed, the question was raised as to how to rationalise the situation where a small proportion of persons with complex needs realistically did not wish to engage with having those needs met by offical services. Unless individuals are considered a danger to themselves or others, Scottish authorities have no legal power to enforce acceptance of either housing or support, but it was reported that professionals could feel they were 'failing' in such circumstances. It could be difficult to acknowledge whether it was appropriate or acceptable to stop working with some individuals if there appeared to be no further benefit from an intervention or service users were just not receptive to it. Future research on the effectiveness of intervention might try to better take account of these challenging issues as part of client-centred service provision.

3 Results and benefits of the comparative pre-project

Findings from the pre-project are linked to the ongoing discussions about education and health politics in Norway about the further development of welfare education and are linked to the need for innovation in the welfare services. The interviews provide a basis for discussing issues related to state guidance and policies that deal with local social housing work. The interviews provide grounds for highlighting education as a central factor which plays a role in and sets conditions for social housing work.

Today, public documents reflect an increasing interest in the sharing of tasks, flexible professional boundaries and the need for more flexible methods when solving tasks. Both interprofessionality and breaking down professional boundaries are tools in this respect. Breaking down professional boundaries can stimulate cooperative working and interprofessional work in order to achieve effective user-targeted services. This development raises questions about how specific tasks should be solved in practice and also how educational provision as a whole can ensure that professional groups target their interest towards tasks and areas where society has a need for expertise in the future.

Factors that can encourage and factors that can hinder the integration of housing in interprofessional work must be seen in the light of local service provision, expertise and education. The increased emphasis on the need to strengthen cooperation and working together supports the need for further study into how this work can meet the challenges in the service most effectively. For example, how can the field of social housing be promoted in order to receive attention from the municipal services system and from professional groups in the welfare services? How can the field of

social housing be included in welfare education in Norway? Should social housing questions be studied in further education courses or should elements of this subject be included as part of a general welfare component in foundation level education? Or should Norway, as Scotland has already done, have a separate educational course with housing as the main theme?

Theories of interprofessional work emphasise the significance of trust as a central element in good relationships. Similarly, the various cooperating players need to know about each other's expertise in order to understand the benefits of cooperation. Another factor is the significance of a common theoretical starting point for interprofessional work. The preliminary analysis of the interviews in Norway indicates the significance of basic social housing expertise as a factor that will influence interprofessional social housing cooperation.

The parliamentary report "utdanning for velferd" *("Education for welfare")* indicates the need for specific welfare expertise that can provide a common basis for welfare education. The report does not go into detail about what this type of basic welfare expertise should encompass. The interviews here justify highlighting housing as part of this common welfare component. One recommendation from this pre-project is that social housing expertise should be made visible and should be represented in further reports on welfare expertise in welfare education. The report "innovasjon i omsorg" *("Innovations in care"),* (Official Norwegian Report 2011:11, highlights the significance of adaptability for the development of new models of care.

In a comparative context, it could be suggested that there remains a need to better define what social housing work entails in Norway. What assistance is provided to those in precarious housing circumstances who also have complex health and social care needs? In the Scottish case, the legislative and policy context is clear, even if housing and service provision is not wholly adequate to meet needs. Professional housing education in Scotland emerged in relation to both strategic planning and policy for housing, and the direct provision of affordable housing by municipalities and registered social landlords. Increasingly, professional housing education also recognises the centrality of health and social care, as well as 'lower level' housing support to

both the sustainability of social sector tenancies and to the prevention and alleviation of homelessness. Wider structural changes in higher education, combined with the long term contraction of the social rented sector in the UK have resulted in professional housing courses in Universities coming under some pressure in terms of student recruitment and affordability of tuition fees to potential students/their employers. University level Housing Studies programmes are continuing in Scotland, but the question of how housing issues might be incorporated into wider welfare education programmes is pertinent to Scotland/the UK in the current economic and political climate.

More fully integrating housing education with health and social work education in both countries could provide a driver for further innovations in welfare provision, enhancing relationships of trust, and encouraging greater fluidity of professional and service boundaries in the interests of achieving more effective outcomes for service users.

3.1 Further plans

This report has integrated the results of our exploratory fieldwork in Norway and Scotland with the evidence for practice and theoretical developments emerging from the literature review. It is proposed that a subsequent main study would be a comparative study of interprofessional social housing work among health and social welfare professions in Norway; and health, social welfare and housing professions in Scotland. The aim would be to examine the role that expertise and the organisation of training can play in incorporating the housing dimension into interprofessional work. The main project would seek to obtain a wider range of perspectives than we have looked at in this pre-project. For example it would include senior and middle management, as well as frontline staff and would facilitate a more rigorous investigation of how different players contribute to interprofessional work, act and take part in this process.

The main study would directly consider issues raised in this report such as establishing what is needed in order for horizontal cooperative relationships to occur? How can professional debate and development take place in cooperation? And to what extent

can understanding, practice and professional identity be related to the field of social housing? If so-called vertical organisational opposition entails trying to develop inter-departmental cooperation between different organisations, will vertical opposition represent a barrier to integrating housing in interprofessional working? The main study would also seek to assess the effectiveness of interprofessional working, including housing work, in achieving better outcomes for service users. In the Scottish context it would also be important to examine the contribution of third sector/voluntary organisations to housing and interprofessional working.

The integration of housing issues in interprofessional work can be analysed on the basis of the significance of the exchange of resources between the players involved, based on political and financial controls. Such approaches emphasise the significance of sharing work, of regulations, and of political controls. We consider that the main project should put greatest emphasis on the significance that integration of housing knowledge into interprofessional expertise has for service innovation and the organisation of education provision. Awareness of external controls must also be included. Studies of interprofessional work often start with professionals who should be working together but who work within different systems and structures that set the frameworks for their work and hinder cooperation. The pre-project has been limited in the extent to which it reveals whether employees who do not have a management role experience the freedom to implement cooperation across organisational affiliations. Although the Scottish participants included front-line staff, the Norwegian informants mainly represented management-level staff. This problem would be specifically addressed in the subsequent main project.

Interprofessional cooperation can incorporate different degrees of service user involvement. Users can be involved at the start or simply as participants in some selected contexts; they can be involved in complete processes without taking part in decision-making; participate fully as equal partners or, as a fourth possibility, take on the role of the main player with control over the cooperation and the implementation thereof. Findings from both the Norwegian and Scottish elements of the pre-project, and

from the literature review, indicate that service user involvement should be a central element in a main project.

References

Anderson, I. (2005) *Services for homeless people and inter-agency working in the UK*. Report to European Observatory on Homelessness. Brussels: FEANTSA.

Anderson, I., Baptista, I., Wolf, J., Edgar, B., Sapounakis, A., and Schoibl, H. (2005) *Services for homeless people and inter-agency working*. Brussels: FEANTSA.

Anderson, I. and Quilgars, D. (1995) *Foyers for young people: evaluation of a pilot initiative*. Centre for Housing Policy, University of York.

Axelsson, R. and S. Bihari Axelsson (2007) *Folkhälsa i samverkan mellan professioner, organisationeroch samhällssektorer*. Lund, Studentlitteratur.

Baldwin. N and Walker, L. (2005) Assesment. In Adams, R., L. Dominelli (ed.): *Social work futures: crossing boundaries, transforming practice*. New York, Palgrave Macmillan.

Ball, R., Forbes, T., Parris, M. and Forsyth, L. (2010) The evaluation of partnership working in the delivery of health and social care, *Public Policy and Administration*, 25(4), pp387-407.

Cameron, A. et al (2009) Working across boundaries to improve health outcomes: a case study of a housing support and outreach service for homeless people living with HIV, *Health and Social Care in the Community,* 17 (4), pp388-395.

Cameron, A. (2010) The contribution of housing support workers to joined-up services, *Journal of Interprofessional Care*, 24(1), pp100-110.

Cameron, A. And Lloyd, L. (2011) Are some boundaries easier to bridge? (joint working), *Policy and Politics*, 39(3)m pp361-377.

Clarke, J. and Glendinning, C. (2002) *Partnership and the remaking of welfare governance.* Ch 3, pp33-50, Glendinning, C., Powell, M. and Rummery, K. *Partnerships, New Labour and the governance of welfare.* Bristol: The Policy Press.

Cornes, M., Joly, L., Manthorpe, J., O'Halloran, S. and Smyth, R. (2011) Working together to address multiple exclusion homelessness, *Social Policy and Society* 10(4), pp513-522.

Crawford, K. (2011) *Interprofessional collaboration in social work practice.* London: Sage.

Danermark, B. and Kullberg, C. (1999) *Samverkan: välfärdsstatens nya arbetsform*. Lund: Studentlitteratur

Department for Communities and Local Government; Department for Children, Schools and Families. (2008) *Joint working between housing and children's services: preventing homelessness and tackling its effects on children and young people*. London: Communities and Local Government.

Department of Health (2004) *The ten essential shared capabilities: a framework for the whole of the mental health workforce.* London: Department of Health.

Dowling, B., Powell, M. and Glendinning, C. (2004) Conceptualising successful partnerships, *Health and Social Care in the Community*, 12 (4), pp309-317.

Farmakopoulou, N. (2002) What Lies Underneath? An Inter-organizational Analysis of Collaboration between Education and Social Work, *British Journal of Social Work* 32(8), pp. 1051-1066.

FEANTSA (2004) *Cooperation between all relevant bodies to improve the fight against homelessness*. Brussels: FEANTSA.

Figure 8 Consultancy Services Ltd (2008) *Integrated care for drug or alcohol users: principles and practice update 2008*. Edinburgh: Scottish Government.

Fitzpatrick, S., Pleace, N. and Bevan, M. (2005) *Final evaluation of the Rough Sleepers Initiative*. Research Findings No. 200/2005. Edinburgh: Scottish Executive Development Department.

Fitzpatrick, S., Johnsen, S. and White, M. (2011) Multiple Exclusion Homelessness in the UK: key patterns and intersections, *Social Policy and Society*, 10(4), pp501-512.

Glendinning, C., Powell, M. and Rummery, K. (2002) *Partnerships, New Labour and the governance of welfare*. Bristol: The Policy Press.

Hansen, G.V. and Fugletveit, R. (2010) "*... Vi driver og rydder hver uke vi...": evaluering av Oppsøkende rusteam i Moss/Rygge*. Halden: Høgskolen i Østfold

Hardy, B., Hudson, R. and Waddington, E. (2003) *Assessing strategic partnerships- the Partnership Assessment Tool. Strategic Partnership Task Force*. London: Office of the Deputy Prime Minister.

Harris, S. (2003) Inter-agency practice and professional collaboration: the case of drug education and prevention, *Journal of Education Policy* 18(3), pp.303-314.

Hjortsjö, M. (2005) *Med samarbete i sikte. Om samordnade insatser och samlokaliserade familjecentraler*. Lund: Socialhögskolan, Lunds Universitet.

Hudson, B. and Hardy, B. (2002) What is a 'successful' partnership and how can it be measured? CH 4, pp51-65, Glendinning, C., Powell, M. and Rummery, K. *Partnerships, New Labour and the governance of welfare*. Bristol: The Policy Press.

Huxham, C. and Vangen, S. (2000) Leadership in the shaping and implementation of collaboration agendas: How things

happen in a (not quite) joined up world, *The Academy of Management Journal*. Vol 43. No. 6, pp 1159-1175

Jacobsen, D.I. (1993) Hvorfor er samarbeid så vanskelig? Tverretatlig samarbeid i et organisasjonsteoretisk perspektiv. I Repstad, P. (red.) *Dugnadsånd og forsvarsverker. Tverretatlig samarbeid i teori og praksis*. Oslo: TANO

Joly, L., Goodman, C., Froggatt, K. and Drennan, V. (2011) Interagency working to support the health of people who are homeless, *Social Policy and Society*, 10(4), pp523-536.

Kennedy, C., Lynch, E. and Goodlad, R. (2001) *Good Practice in Joint/Multi-Agency Working on Homelessness*. Scottish Executive Central Research Unit, Development Group Research Programme, Research Findings No. 130.

Knudsen , H (1993) Samarbeid på tvers av organisasjonsgrenser. I (red.) Repstad, P. *Dugnadsånd og forsvarsverker. Tverretatlig samarbeid i teori og praksis*. Oslo: TANO

Koubel, G. and Bungay, H. (eds) (2012) *Rights, risks and responsibilities: interprofessional working in health and social care.* Basingstoke: Palgrave Macmillan.

Lewis, B. Boulahanis, J. and Matheny, E (2009) Joined-up governance: mandated collaboration in US homeless services, *International Journal of Public Sector Management*, 22 (5), pp392-399.

Lewis, H. (2003) *Healthy relationships? Health and social services engagement in homelessness strategies and services*. London: Shelter.

Lewis, J. and Surender, R. (2004) *Welfare state change: towards a third way?* Oxford: Oxford University Press

Lloyd, G. *et al* (2001) *Hanging on in there: a study of interagency work to prevent school exclusion* London: National Children's Bureau/ Joseph Rowntree Foundation.

Lowe, S. (2004) *Housing Policy Analysis*. Basingstoke: Palgrave Macmillan.

McDonagh, T. (2011) *Tackling homelessness and exclusion: understanding complex lives*. York: Joseph Rowntree Foundation

Myrvold, T. and Helgesen, M. K. (2009) *Kommunalt psykisk helsearbeid. Organisering, samarbeid og samordning*. NIBR-rapport 2009:4.

Nesvåg, S. and Lie, T. (2010) The Norwegian Substance Treatment Reform: Between New Public Management and Conditions for Good Practice . *Nordisk Alkohol- og narkotikatidsskrift (NAT)*. 27(6), pp 655- 666

Norwegian Board of Health Supervision (2000), *Koordinering av psykososialt arbeid for personer med langvarig og alvorlig psykiske lidelser.* (Coordination of psychosocial care for people with long-term and severe mental illness) (IK-2692). Oslo: Norwegian Board of Health Supervision

Official Norwegian Report 2003: 4 *Forskning på rusmiddelfeltet En oppsummering av kunnskap om effekt av tiltak.* (Research on substance misuse*)* Oslo: Norwegian Ministry of Social Services

Official Norwegian Report 2004: 18 *Helhet og plan i sosial- oghelsetjenestene. Samordning og samhandling i kommunale sosial- og helsetjeneste.* (Comprehensive and Plan in Social- and Health Services). Oslo: Norwegian Ministry of Health and Care Services and Norwegian Ministry of Labour and Social Services

Official Norwegian Report 2005: 3 *Fra stykkevis til helt. En sammenhengende helsetjeneste.*(A coherent health services). Oslo: Norwegian Ministry of Health and Care Services.

Official Norwegian Report 2011:11. *Innovasjon i omsorg.* (*Innovations in care.* Oslo: Norwegian Ministry of Health and Care Services.

Official Norwegian Report 2011:15 *Rom for alle. En sosial boligpolitikk for fremtiden* (*Room for all. A social housing policy for the future).* Oslo: Norwegian Ministry of Local Government and Regional Development

Pleace, N. (2008) *Effective services for substance misuse and homelessness in Scotland: evidence from an international review*. Edinburgh: Scottish Government Social Research.

Powell, M. and Exworthy, M. *Partnerships, quasi-networks and social policy*. Ch 2. pp15-32, Glendinning, C., Powell, M. and Rummery, K. *Partnerships, New Labour and the governance of welfare*. Bristol: The Policy Press.

Powell, M. and Glendinning, C. (2002) *Introduction,* pp1-14, Glendinning, C., Powell, M. and Rummery, K. *Partnerships, New Labour and the governance of welfare*. Bristol: The Policy Press.

Randall, G. and Brown, S. (2002) *Helping rough sleepers off the streets*. A Report to the Homelessness Directorate. London: ODPM.

Rankin, J. and Regan, S. (2004) *Meeting complex needs: the future of social care*. London: Turning Point and Institute for Public Policy Research.

Reid, B. (1997) Interorganisational relationships and housing services, in Malpass, P, *Ownership, Control and Accountability: the New Governance of Housing*. Coventry: Chartered Institute of Housing.

Reitan, T.C. (1993) Hvem eier rusproblemene? I Repstad, P. (red.) *Dugnadsånd og forsvarsverker. Tverretatlig samarbeid i teori og praksis*. Oslo: TANO

Rogers, D. and Whetton, D. (2002) *Interorganisational Co-ordination: Theory, Research and Implementation* (Ames, IA: Iowa State University Press).

Røiseland, A. and Vabo, S.I. (2008) Governance på norsk. Samstyring som empirisk og analytisk fenomen. *Norsk statsvitenskaplig Tidsskrift*. Vol. 24, nr. 2 2008

Rosengard, A., Laing, I., Ridley, J. and Hunter, S. (2007) *Closing the opportunity gap – findings of a literature review on multiple and complex needs*. Edinburgh: Scottish Executive Social Research.

Rummery, K. (2009) Healthy partnerships, healthy citizens? An international review of partnerships in health and social care an patient/user outcomes, *Social Science and Medicine*, 69, pp1797-1804.

Stoker, G. (1998) *Governance as theory: five propositions*, Oxford, Blackwell Publishers

Sullivan, H. and Skelcher, C. (2002) *Working across boundaries – collaboration in public services.* Basingstoke: Palgrave.

Sykes, R. (2004) *Homelessness Strategies: A Survey of Local Authorities*. London: Local Government Association.

White Paper No. 69 (1991-92) *Tiltak for rusmiddelmisbrukere.* (Measures for substance abusers). Oslo: Norwegian Ministry of Health and Care Services

White Paper No. 47 (2008-2009) *Samhandlingsreformen. Rett behandling – på rett sted – til rett tid.* (Coordination Reform. Right treatment - the right place - at the right time).

Oslo: Norwegian Ministry of Health and Care Services White Paper No. 13 (2011-2012) *Utdanning for velferd. Samspill i praksis*. (Education for Welfare: Interaction as Key). Oslo: Norwegian Ministry of Education Research.

Yanetta, A., Third, H. and Anderson, I. (1999) *National monitoring and interim evaluation of the Rough Sleeping Initiative in Scotland.* Edinburgh: Scottish Executive Central Research Unit.

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The main theme of the project are: how cooperation between welfare agencies and professions contribute to a better life for homeless people, and the role of housing in interprofessional work. The project is a comparative study between Norway and Scotland.