



Cameron, A. M., Abrahams, H. A., Morgan, K. J., Williamson, E., & Henry, L. W. (2016). From pillar to post: homeless women's experiences of social care. *Health and Social Care in the Community*, 24(3), 345–352. <https://doi.org/10.1111/hsc.12211>

Peer reviewed version

License (if available):  
CC BY-NC

Link to published version (if available):  
[10.1111/hsc.12211](https://doi.org/10.1111/hsc.12211)

[Link to publication record in Explore Bristol Research](#)  
PDF-document

This is the author accepted manuscript (AAM). The final published version (version of record) is available online via Wiley at <http://onlinelibrary.wiley.com/doi/10.1111/hsc.12211/abstract>. Please refer to any applicable terms of use of the publisher.

## University of Bristol - Explore Bristol Research

### General rights

This document is made available in accordance with publisher policies. Please cite only the published version using the reference above. Full terms of use are available: <http://www.bristol.ac.uk/pure/user-guides/explore-bristol-research/ebr-terms/>

## **ABSTRACT**

This paper reports findings from a longitudinal study of homeless women. Thirty eight women were initially recruited with a retention rate of 58% over three rounds of interviews. Interviews explored specific events in women's lives, their current living arrangements and how their experiences and needs, including for social care, changed over time. Women reported a range of complex issues and difficulties, consistent with experiences of deep social exclusion and received support from both statutory and voluntary agencies. Although women appreciated the support they received, many reported that services were fragmented and rarely personalised to their needs.

Key words: **homelessness; social care; fragmentation; personalisation.**

What is known about this topic:

- The causes of homelessness are multi-faceted and impact differently on men and women.
- Social care services for homeless people are provided by a wide range of agencies from across the statutory and non-statutory sectors.

What this paper adds:

- Many women were supported by multiple key workers, each based in separate agencies. Successive interviews with women revealed that this approach intensified the fragmented and uncoordinated nature of services.
- There were mixed views about the benefits of counselling. Group sessions were reported to be intimidating and unproductive, particularly when men were present.

## **Introduction**

There is growing recognition, both in the UK and internationally, of the complex needs faced by people who are homeless, or at risk of homelessness, as well as an appreciation of the importance of working across organisational boundaries to ensure a co-ordinated response (Minnery & Greenhalgh 2007, Fitzpatrick *et al.* 2011). Within the United Kingdom (UK) housing sector the term 'multiple exclusion homelessness' has gained currency and is generally used to refer to the complex relationship between the factors thought to lead to homelessness as well as those that may be the consequences of homelessness (Corney *et al.* 2014). Despite the problems of finding and maintaining contact with homeless people (particularly women, whose homelessness is often 'hidden') there is a growing body of longitudinal studies on their experiences (see for example Crane *et al.* 2012). This paper adds to this evidence base, reporting data from a longitudinal study of homeless women exploring their experiences of social care services.

## **Women's homelessness**

The causes of homelessness are multi-faceted, triggered by structural trends, such as changes in welfare benefits as well factors such as family disputes, leaving care, drug or alcohol dependency or involvement in the criminal justice system. Routes into homelessness can have a gendered dimension, as do people's experiences of being homeless and accessing and using homeless services (Williamson *et al.* 2010, Bowpitt *et al.* 2011). One of the factors identified as resulting in episodes of homelessness for women is abuse and violence within their sexual and emotional relationships (McNaughton & Saunders 2007, Netto *et al.* 2009).

Once a woman becomes homeless, many existing problems are made more difficult. The insecurity of homeless life, either on the streets or in hostels, can lead to feelings of stress, powerlessness and low self-esteem, particularly if children are taken into care (Tischler *et al.* 2007). This, in turn, puts strain on physical and mental health. It may also lead to, or worsen, reliance on drugs or alcohol as a coping mechanism. Problems which might have been manageable with early intervention are likely to be made worse. As a result, women who are homeless often have complex social care and health needs and are vulnerable to further abuse (Williamson *et al.* 2010).

## **The policy context**

The importance of housing to wellbeing was a theme that underpinned much of New Labour policy. The Supporting People programme was introduced in England in 2003 as a means of facilitating independent living in the community for groups that require low-intensity support and also for those that are socially excluded [unable to participate in normal relationships and activities available to the majority ] (Levitas *et al.* 2007). The programme became the main source of funding for housing support services in England as part of the government's broader strategy to maximise social inclusion whilst at the same time reshaping services around the needs of individuals who use them (Foord & Simic 2001). While critics of New Labour's homelessness policy have noted its paternalistic and interventionist approach, the Supporting People programme is credited with saving more than £3.4b of public money by supporting individuals to live independently thus avoiding the costs associated with institutionalisation and as such contributing to a 'vastly improved' landscape of provision for homeless people (Whiteford 2013:27).

Despite the Coalition government's stated commitment to continue this focus, signalled by the establishment of its cross department Ministerial Working Group (DCLG 2012), the policy context for homeless people has become more precarious. Not only have local authorities been required to make significant savings resulting in cuts to services, including homelessness and social care services, but in 2012 the ring fencing was removed from Supporting People services which ended the protection of these funds for housing support (Crane *et al.* 2014). Additionally changes to welfare benefits provision, such as the cap on the total amount of welfare benefits that can be claimed by people of working age, may have a significant impact, particularly on those at risk of homelessness (Shelter 2014). The effect of these changes are thought to have a greater impact on women, with the Fawcett Society warning that they will result in more women living in poverty with 'women's basic rights to safety and justice under threat' (2012:41). At the same time commentators have noted that broader policy discourses have shifted towards an emphasis on 'resilience' as opposed to one that emphasises vulnerabilities (Harrison 2013), marking a move away from the original ethos of Supporting People.

## **Social work and social care for homeless people**

The landscape of social work and social care has changed radically in recent decades (Gray & Birrell 2013). The establishment of the mixed economy of care along with the introduction of care management has seen social workers in the statutory sector move away from a therapeutic role into one of assessment (Cameron 2010). More recently the separation of adult social work from children and families services has been perceived as a further diminution of the adult social work role (Gray & Birrell 2013). Consequently many people with complex needs, including those who are homeless, receive support from agencies outside of the statutory sector, many of whom will not include social workers in the workforce (Manthorpe *et al.* 2013). Indeed the role of social work in supporting homeless people is limited. As Teater (2014) explains:

Within statutory settings, social workers are most likely to work with individuals or families who have accessed statutory services for reasons other than housing. Rarely will social workers work with individuals on the sole basis that they are homeless.

While the precise nature of what constitutes 'social care' is debated there is consensus that it encompasses a 'wide range of services designed to support people to maintain their independence, enable them to play a fuller part in society, protect them in vulnerable situations and manage complex relationships' (DH 2006:18). For homeless people, such care might include emotional and practical support to establish or sustain contact with friends and family, help to maintain a tenancy, as well as specialist support for those with drug and alcohol addiction or experiencing mental health problems. This support is usually provided by workers in statutory services, such as mental health or drug and alcohol projects, housing associations or voluntary organisations. An important element is the recognition of the need for workers to work across organisational boundaries to ensure that homeless people are supported to access a wide range of services (Cameron 2009, McDonagh 2011, Cornes *et al.* 2014).

A more recent development has seen the introduction of the personalisation agenda within social care. Personalisation emphasises the need for services to be re-designed, ensuring that they are 'fair, accessible and responsive to the individual needs of those who use

services and their carers' (DH 2007:2). Local authorities have been required to put person centred planning at the centre of the assessment process, with personal budgets available for individuals that are eligible for publicly funded adult social care (DH 2007). While this agenda is still in its infancy within homelessness services (Joly *et al.* 2011) there have been pilot schemes introducing personal budgets for rough sleepers (Blackender & Prestidge 2014).

### **The TARA project**

TARA was a two year longitudinal study, funded by National Institute for Health Research, School for Social Care Research. The study was based in a large English city and followed a group of homeless women (without secure housing) and women at risk of homelessness (from tenancy breakdown) to identify how their experiences and needs changed over this time. The aim was to gain a fuller understanding of their needs, including their social care needs, as a means to understand how best to support women to access, and maintain engagement with, support services. In doing so it was hoped to contribute to the evidence base for social care practice.

### **Methodology**

Over a four month period in 2011 members of the team visited shelters and hostels to explain the project and ask women to take part. Although the study had planned to recruit 40 women, the final sample was 38. Women were recruited via hostels (nine), the night shelter and specialist services that supported homeless women and those at risk of homelessness (two).

The first interview focused on women's views of their living arrangements, past and present. We also asked about factors thought to have an impact on women's homelessness, for example experiences of domestic violence, time spent in 'care' as a child and involvement with the criminal justice system. At the end of the interview women were given a cash payment of £20 and asked if they were willing to take part in further interviews, and if so, to provide us with contact details. Thereafter, women received a payment after each interview. Women were also asked if they would give consent for us to contact any of the services that they were currently in contact with, in order that we could

trace them if necessary. It was made clear that the information would be kept confidential, and that whether they gave consent or not would make no difference to the services they were receiving. Between interviews we kept in contact with women by text message or email.

At the second stage, six months later, 28 women were re-interviewed. Once again the interviews covered their current living arrangements. In addition we asked them about their experiences of services (including social care) as well as exploring their relationships with family and friends. At the final stage, six months later, 22 women were interviewed. The interviews covered similar areas as well as asking women to reflect on their experiences of taking part in the study. Of the 16 women we were unable to interview at the final stage, only one was untraceable. One woman was in a closed detox unit and another in prison, the remaining 13 either did not wish to take part or told us they were too busy.

All interviews were digitally recorded and transcribed in full. Transcripts were analysed thematically using a priori codes derived from the existing research literature and supplemented with additional codes as the analysis proceeded (Flick 2009). Occasionally codes overlapped (Gilbert 2008), reflecting the interconnectedness of events and feelings reported by participants. Coded transcripts were cross checked by members of the team to ensure consistency. Data was managed using computer-assisted data analysis software (NVivo9).

## **Ethics**

Ethical review for the project was provided by [name of institution] Research Ethics Committee. Having established women's willingness to take part, informed consent was gained prior to each interview. To ensure anonymity and maintain confidentiality, pseudonyms have been used. A longitudinal study of this kind raises many ethical issues, not least the sensitivity of discussing homelessness, discussion of these are published elsewhere [author's name].

## **Results**

The women participating in the study ranged in age from 19 to 59. The majority described their ethnicity as White British (27) with four women describing themselves as White European; two as Black African; and five as mixed race.

The 38 women who took part in the first round of interviews were staying in different kinds of accommodation: a women-only night shelter (12), women-only hostels (seven), mixed hostels (four), supported housing (six), social housing (six), refuge (one), sofa surfing (one) and living with family (one). At the first interview women were asked about specific events in their lives and the challenges they had, or currently, were facing. Of the 38 women: 14 revealed they had been abused as a child; 13 had been neglected as a child and 13 had experienced sexual abuse; seven women revealed they had been in care, one in kinship care; 33 women told us they had mental health problems; 25 revealed problematic alcohol consumption and 21 problematic drug use; 16 women had experienced domestic violence in the past and six were currently, or had recently, experienced domestic violence. 16 women reported involvement with the criminal justice system and seven women had, or were, involved in the sex trade. All of the women reported multiple events and/ or problems, consistent with experiences of deep social exclusion (Fitzpatrick et al. 2011, McDonagh 2011).

At the final interview the housing status of six of the 22 women interviewed had improved: two had moved from hostels into supported housing and one from a refuge into social housing; of three women who were originally recruited from the night shelter, one had moved into supported housing and two into hostel accommodation. Of the rest: 11 women remained in hostel accommodation; one had been evicted and was living with family and four continued to live in social housing with on-going support.

### **Supporting women**

All of the women were receiving support from a range of services, including: housing support charities; health services; education and training services as well as voluntary sector organisations and churches. With respect to what might be regarded as social care, women received support via a number of different routes: through named key workers based in, or linked to, their accommodation; at specialist services, such as mental health or drug and



alcohol services, as well as by accessing support from local voluntary groups, for example, an organisation working with street sex workers.

Many of the women had multiple key workers. Lavender, for example described how she was *'getting all the support I need'* from workers at a community based drug treatment service for Black Asian and Minority Ethnic adults as well as from a generic drugs project and a housing association. Similarly Heather received support from workers at both a statutory drug and alcohol service and an organisation supporting street sex workers. Having different sources of support gave Heather the opportunity to discuss concerns that she didn't feel able to share with her hostel based key worker. However, many women did not find it easy to engage with multiple services at the same time, Lilac commented *'.. I think it's easier just to have one person to talk to.'*

In common with Cornes *et al's* study (2014) most women were appreciative of the support from their key workers, whether these were based in hostels or specialist services. When discussing what made an effective key worker Daisy reported that she appreciated the consistent and non-judgemental support she received from workers based in a voluntary organisation, she said:

*Cos I just gave up, you know. But they've never given up on me, even though I've made mistakes and I've still fucked up and I've had my relapses and I've had whatever – their door's always open to me.*

For Lilac having a worker of a similar age who had been through comparable experiences and could therefore empathise with her problems was crucial, she said *'they will share their experiences with us ..... and we can all relate to one another.'* Other women simply appreciated the practical and emotional support provided by workers.

Some women valued having a key worker who took a holistic, person centred approach. Jasmin explained how her worker from a local drugs project had supported her back into education. Her worker had:

*..filled out forms to get funding, and like she knew who to get in contact with ... which I wouldn't have a clue ... and she come to college with me to try and like enrol me.'*

She went on to say that *'.... since I've been working with her, I cut down on drink and drugs.'*

However it wasn't just key workers from specialist community services that took this approach. Carnation reported how staff in the refuge in which she was staying had liaised with a range of services on her behalf, including drug workers and social workers. Additionally a refuge worker had accompanied her to the local housing department. Other women described how their key workers had taken them to medical appointments as well as supporting them with practical tasks, such as budgeting their money or going shopping. In these instances it was clear that women appreciated this holistic support to engage with services which they might otherwise have struggled to access.

Not all of the women had a good rapport with their key workers. Sometimes this was because the initial contact with a worker had been difficult. During the second and third round of interviews several women told us that their relationships had deteriorated, sometimes as a result of workers enforcing policies about the use of alcohol and/or drugs.

Receiving support was not a one-way relationship and several women reported they had struggled to accept support but were now willing '*...to do the work*' (Lavender). As Daisy said:

*I have to show that I'm wanting the help and looking for the help and putting the work in to get it.*

Although 'resentful' of this, Daisy described masking those feelings in order not to jeopardise her support.

### **Fragmented services**

Despite appreciating this support, women found attendance at services both physically and emotionally draining. They also commented on the lack of co-ordination between services. The diffuse location of services meant women had to trek back and forth across the city, particularly when they were initially assessed. As Daisy described in her first interview:

*... it's just when they pass you from pillar to post, from post to pillar ... and that's what they're doing with me ... the other day I had to go all the way to [name of area] to do an assessment, and then they wanted me to go to [another area] yesterday. That all costs money, buses and that ... or I have to walk it. And by the time I've done all that, I'm knackered ...*

For other women the un-coordinated nature of their support meant that they missed appointments. Flora described having had to attend various group sessions, tenant meetings as well as child contact appointments in recent weeks with the result that she had missed several medical appointments.

In contrast to Cornes *et al's* study (2014) some women talked explicitly about the fragmented nature of the services they received. Jacinta, for example, described in her second interview how she had recently received contradictory advice about which services she could attend, pointing out:

*...if I'm going to one organisation I'd like the information and the advice I'm given to be consistent, so I don't come out even more confused than I already am.*

Other women told us that services didn't communicate with each other, for example Pansy reported:

*... they occasionally fail to pass messages on, and that's cos they're all over the place...*

Anise relied on her key worker to act as a 'go-between' with other services ensuring a co-ordinated approach. However she said *'it's not happening, it hasn't for about a month.'*

### **Counselling and group work**

Most of the women were attending one to one counselling and/or group sessions. These were usually a condition of the support they received, either from their housing agency or specialist support agency, as Flora remarked *'you have to go out to the groups and stuff and the meetings.'*

There were mixed views about the benefits of counselling. Willow found that counselling had:

*helped me with my anger like obviously ... overdosing, self harming, things from my childhood.*

However, many women found these sessions harrowing and unhelpful, particularly because they didn't resolve their immediate difficulties.

Group sessions were universally thought to be intimidating and difficult to attend. Lilac, for example, had found group sessions unproductive and as a consequence her key worker had

arranged for her to attend one to one sessions instead. Heather also found group sessions difficult but had found a strategy to cope with them. She told us:

*someone said to me the other day "in like a group situation you can sit back, take a back seat and just listen." And I said "Oh that's so true, you don't actually have to talk you know". Yeah, so it's not as daunting as I thought you know.*

Jacinta described the culture at some mixed sessions:

*... you have a guy or a woman who's in recovery who does a share and then people share back .... and it's war stories.*

She went on to say these sessions were distressing and sometimes made her feel like a fraud.

### **Statutory social work services**

Women were reluctant to talk about their experiences of statutory social work services. However over the course of the research several women revealed that they had been involved with social work services, either in their own childhood or as a parent involved with the children protection system. In her final interview Daisy revealed having had a social worker when she was growing up '*... due to my mum dying at a young age, cos my mum died two days before my fifth birthday*' and subsequently as an adult when she had voluntarily given her children up for adoption. Discussing these encounters was difficult and women rarely revealed much detail. However Petula told us of a more positive outcome, although she had been in contact with social work services after the birth of her son, this involvement had recently ended:

*a year now he's been off child protection, social services, like the whole lot. Yeah and they're just happy with him, with his progress, they're just happy.*

Despite the complex nature of their needs none of the women reported being in contact with social workers from adult services. In part this might reflect antipathy towards social work services per se, particularly if a child had been removed from their care, which meant they wouldn't readily consider accessing the service. But it may also reflect the nature of their needs. As Manthorpe *et al.* (2013) have described '*multiple risks may not equate to major risks*'. In other words, some women with multiple needs might not receive support because their needs did not meet the eligibility criteria.

## **Women only services**

Given the history of abuse and sexual violence many of these women had experienced, it was not surprising that having access to women only services, including hostels, was frequently reported. Women experienced mixed hostels as hostile environments (Bowpitt *et al.* 2011) and often felt unsafe:

*..., cos the men there think they can just grab you when they're drunk and do what they like, you know, but they can't really can they? (Ginger).*

In contrast, being in a women only environment provided a measure of peace. For Pansy attending a women's morning at a specialist drugs project offered some respite and was an important part of her care:

*because it's just somewhere you can go and have a cup of tea and paint your nails and there's people there ... if you need some support they can help you sort of thing .*

Lavender described similar sessions as '*.... a safe place for women*'.

## **Changes to services**

During the course of the research the local authority re-commissioned some of its supported housing contracts; cuts were made to the budgets of services and the women only night shelter closed. These developments were known to many of the women. For Pansy, changes in staffing levels at one of the services she attended meant that by the time of her second interview she no longer had the same key worker. She said:

*.... they had a whole massive mix up in [name of service] a load of people had to be let go and they had a budget cut ..... so she isn't a support worker any more, she's got a different role in [name of service] which is a shame.*

Additionally she noted that staff were having to support more women with the result that they appeared more stressed and had less time for individual women. Having spent months building a trusting and positive relationship with key workers, many women had to forge new relationships. Some found this process frustrating, for example Fern told us that:

*.. I've had three key workers, and each key worker seems to be leaving every two or three weeks.*

## Discussion

One of the aims of the project was to gain a fuller understanding of homeless women's needs, including for social care, as a means to understand how best to support them. The analysis of the data suggests two areas for discussion: the fragmentation of services and personalisation.

The findings illustrate the patchwork nature of social care available to homeless women. Echoing Cornes *et al's* (2011) previous work, this support was fragmented, a situation made worse by recent changes in funding. Women told us that agencies did not routinely communicate with each other, offered conflicting advice and generally did not work in a co-ordinated fashion. Despite these apparent failings in the organisation of services, women were generally appreciative of the support they received from workers located within individual services, particularly specialist services. In keeping with the UK and international evidence, women valued workers who were non-judgemental, empathetic, knowledgeable and practical (Neale 2002), they also appreciated continuity of support (Ploeg *et al.* 2008) Ironically, most women described having several key workers, each based in separate agencies and frequently operating in isolation. Some women found it difficult to work with multiple workers and implied that it amplified the fragmented nature of services. In contrast, other women valued this approach and appreciated the opportunity to access different sources of support while maintaining some control over the information they gave services. However, this approach reinforces the sense in which homeless women are 'viewed through a succession of separate and uncoordinated professional lenses' (Fitzpatrick *et al.* 2011:501) and would seem the antithesis of the co-ordinated response advocated by policy makers (DCLG 2012).

There were, however, examples of workers adopting a more person centred approach, providing not just practical and emotional support but also working across organisational boundaries to co-ordinate services (Cameron 2010). Not only did this support include signposting women to relevant agencies but it also involved a more interventionist role, including taking women to medical appointments and negotiating with agencies so that services were tailored to women's individual needs. Rather than feeling like they were being fitted into existing services, this approach ensured that women experienced services

that were co-ordinated and 'personalised' to their own needs. In that sense, workers responded to the needs of individual women rather than seeing them as types of people, 'the addict, the mentally ill, the runaway' with particular risk factors (Jones *et al.* 2012:113).

Despite the complexities of their lives and the challenges they were facing none of the women reported being supported by social workers from adult services. This is not a surprising finding, it merely illustrates the realities of the way in which social work and social care are provided (Manthorpe *et al.* 2013). However, it does serve as a reminder that the social care workforce, particularly those working in the homeless sector, is now dealing with tasks that in the past would have been the preserve of social workers who had undergone extensive training (Cornes *et al.* 2011). While many housing associations and support agencies routinely provide training for support workers in methods that are core to social work practice, such as the person-centred approach, this practice is not universal. However, if the potential offered by the 'personalisation' agenda is to be realised, for example through the use of personal budgets, then attention needs to focus on ensuring that the workforce has the skills and knowledge to support this development.

### **Limitations**

This small scale longitudinal study of homeless women aimed to explore how their needs for, and experiences of services, changed in order to understand how best to support them. Despite repeated visits to hostels and support services we recruited 38 women, instead of the 40 we had hoped. Additionally 16 women dropped out of the study. Some women only revealed detail about their needs as they grew to trust the researchers. Consequently, although we are able to offer an account of the social care support they received, as well as their experiences of this, we are unable to provide much detail about how their needs changed over time.

### **Conclusions**

The TARA study revealed the fragmented nature of support for homeless women, a context made worse by recent budget cuts that left services employing fewer workers to support growing numbers. This situation is mirrored elsewhere in the UK (Fitzpatrick *et al.* 2011, Joly *et al.* 2011, Cornes *et al.* 2014). Although all of the women in the study valued the support

they received it was clear from their accounts that support was rarely 'person-centred' or co-ordinated around their individual needs. In order to make personalisation a reality for homeless women this study suggests that commissioners of social care and housing support services work with service providers to develop a range of services so that women can choose to attend specialist services, including women only services if that is their preference, rather than feeling like they are being fitted into existing services that don't meet their needs.

### **Acknowledgments**

This research was funded by the National Institute for Health Research (NIHR), School for Social Care Research. The views expressed are those of the authors and not necessarily those of the NIHR School for Social Care Research, or the Department of Health, NIHR or NHS.

### **References**

Blackender L. & Prestidge J. (2014) Pan London personalised budgets for rough sleepers. *Journal of Integrated Care* **22** (1), 23-26.

Bowpitt G. Dwyer P. Sundin E. & Weinstein, M. (2011) Comparing Men's and Women's Experiences of Multiple Exclusion Homelessness. *Social Policy & Society* **10** (4), 537-546.

Cameron A. Lloyd L. Turner W. & Macdonald G. (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), 388-395.

Cameron A. (2010) The contribution of housing support workers to joined-up service. *Journal of Interprofessional Care* **24** (1), 100-110.

Cornes M. Manthorpe J. Huxley P. & Evans S. (2007) Developing wider workforce regulation in England: Lessons from education, social work and social care. *Journal of Interprofessional Care* **21** (3), 241-250.

Cornes M. Joly L. Manthorpe J. O'Halloran S. & Smyth R. (2011) Working Together to Address Multiple Exclusion Homelessness. *Social Policy & Society* **10** (4), 513-522.

Cornes M. Manthorpe J. Joly L. & O'Halloran S. (2014) Reconciling recovery, personalisation and Housing First: integrating practice and outcome in the field of multiple exclusion homelessness. *Health and Social Care in Community* **22** (2), 134-143.



Crane M. Warnes A.M. & Coward S. (2012) Preparing Homeless People for Independent Living and its Influence on Resettlement Outcomes. *European Journal of Homelessness* 6 (2), 17-45.

Crane M. Warnes A.M. Barnes J. & Coward S. (2014) The resettlement of homeless young people: their experiences and housing outcomes. *Social Policy and Society* 13 (2), 161-176.

DCLG (2012) *Making every contact count. A joint approach to preventing homelessness*. DCLG, London.

DH (2006) *Our health, our care, our say: A new direction for community services*. Cm 6737. The Stationery Office, London.

DH (2007) *Putting people first: a shared vision and commitment to the transformation of adult social care*. The Stationery Office, London.

Fawcett Society (2012) *The Impact of Austerity on Women*. Available at: <http://www.fawcettsociety.org.uk> (accessed on 8/2/2014).

Fitzpatrick S. Johnsen S. & White M. (2011) Multiple Exclusion Homelessness in the UK: Key Patterns and Intersections. *Social Policy & Society* 10 (4), 501-512.

Flick, U. (2009) *An Introduction to Qualitative Research* (4<sup>th</sup> Edition). Sage, London.

Foord M. & Simic P. (2001) A sustainable approach to planning housing and social care: if not now, when? *Health and Social Care in the Community* 9 (3), 168-176.

Gray A.M. & Birrell D. (2013) *Transforming adult social care*. The Policy Press, Bristol.

Gilbert N. (2008) *Researching Social Life* (3<sup>rd</sup> Edition). Sage, London.

Harrison E. (2013) Bouncing Back? Recession, resilience and everyday Lives. *Critical Social Policy* 33 (1), 97-113.

Hough J. & Rice B.(2010) *Providing personalised support to rough sleepers*. The Joseph Rowntree Foundation, York.

Joly L. Goodman C. Froggatt K. & Drennan V. (2011) Interagency Working to Support the Health of People Who Are Homeless. *Social Policy & Society*. 10 (4), 523-536.

Jones M.E. Shier M.L. & Graham J.R. (2012) Intimate Relationships as Routes into and out of Homelessness: Insights from a Canadian City. *Journal of Social Policy* 41 (1), 101-117.

Levitas R. Pantazis C. Fahmy E. Gordon D. Lloyd E. & Patsios D. (2007) *The Multi-dimensional analysis of social exclusion*, University of Bristol, Bristol.

Manthorpe J. Cornes M. O'Halloran S. & Joly L. (2013) Multiple Exclusion Homelessness: The Preventive Role of Social Work. *British Journal of Social Work* Available at: doi:10.1093/bjsw/bct136 (accessed on 10/2/2014).

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

McNaughton C. C. & Sanders T. (2007) Housing and Transitional Phases Out of 'Disordered' Lives: The Case of Leaving Homelessness and Street Sex Work. *Housing Studies* **22** (6), 885-900.

Minnery J. & Greenhalgh E. (2007) Approaches to Homelessness Policy in Europe, the United States, and Australia. *Journal of Social Issues* **63** (3), 641-655.

Neale J. (2002) Good practice towards homeless drug users: research evidence from Scotland. *Health and Social Care in the Community* **10** (3), 196-205.

Netto G. Pawson H. & Sharp C. (2009) Preventing homelessness due to domestic violence: providing a safe space or closing the door to new possibilities? *Social Policy and Administration* **43** (7), 719 – 735.

Ploeg J. Hayward L. Woodward C. & Johnston R. (2008) A case study of a Canadian homelessness intervention programme for elderly people. *Health and Social Care in the Community* **16** (6), 593-605.

Shelter (2014) Housing benefit changes and welfare reform. Available at: <http://england.shelter.org.uk> (accessed on 1/7/2014).

Teater B. (2014) *Contemporary Social Work Practice. A Handbook for Students*. McGraw Hill, London.

Tischle, V. Rademeyer A. & Vostanis P. (2007) Mothers experiencing homelessness: mental health, support and social care need. *Health and Social Care in the Community* **15** (3), 246-253.

Williamson E. Henry L. Abrahams H. & Cameron A. (2010) *Evaluation of The Women's Night Service Bristol*. University of Bristol, Bristol.

Whiteford M. (2013) New Labour, Street Homelessness and Social Exclusion: A Defaulted Promissory Note? *Housing Studies* **28** (1), 10-32.