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Opening the 'too difficult box': strengthening Adult Safeguarding responses to homelessness and self-neglect

A research study led by the NIHR Policy Research Unit in Health & Social Care Workforce at King's College London working with the Care Policy and Evaluation Centre at the London School of Economics. The study is funded by the NIHR School for Social Care Research and has approval from the Social Care Research Ethics Committee: 20/IEC08/0040

For information about the research study and publications see: www.kcl.ac.uk/research/homelessness-and-self-neglect

Safeguarding responses to homelessness and self-neglect Communities of Practice (CoP) Report

Key messages emerging from conversations in research study sites

Background to this report

As part of the study, in 2021 the research team held 12 Community of Practice (CoP) sessions in our research study sites, which included three Safeguarding Adults Board (SAB) areas encompassing six local authorities. Participants included practitioners from across local statutory and independent sector organisations including Police, Probation, Prisons, Housing, Rough Sleeper Street Outreach, NHS Trust and local authority Safeguarding, Adult Social Care, Mental Health, providers of Homelessness Accommodation, Health Care and Substance Misuse support, plus Expert by Experience (EBE) input from the research team. The focus of the sessions was for participants to discuss their experiences of responding to homelessness and self-neglect – both what works and what are the barriers – and to share and develop ideas for improvements. The messages are summarised here.

Perceptions of Adult Safeguarding

Understandings of adult safeguarding vary, with perspectives ranging from *'strikes the fear of God into services'* to *'facilitates positive lawful multi-agency practice in a timely way'*. Whilst some participants have examples of it working well for this group, safeguarding is often perceived as inaccessible for people experiencing Multiple Exclusion Homelessness (MEH) and for the practitioners working with them.

Safeguarding referrals can be used as a way of coping with individual or organisational uncertainty – an administrative process of *'covering one's back'* – rather than a process securing multi-agency support. Referrals may not always result in a response, or common responses are: *'They've not given consent'* or *'It's not really our remit'*. Attempts to safeguard someone can go round in circles as service responses may be: *'It's not us, speak to the Police'*; *'speak to Mental Health Services'*. For people who are homeless, safeguarding has sometimes felt like no-one's business because no one agency is seen as responsible.

Practitioners may not continue to put in referrals: *'That's an hour spent on a form going nowhere which could be better spent giving someone care. But in court you're asked 'Why didn't you put a safeguarding in?' and it isn't acceptable to say 'There's no point, I've put 100 in, they never get picked up.'*

Do we recognise self-neglect or care needs within Multiple Exclusion Homelessness?

Reviewing homelessness cases, we often find a lack of Care Act and Mental Capacity Act assessments, despite significant mental and physical health and substance misuse needs. Whilst some practitioners *'go the extra mile'* when trying to support individuals, others fail to recognise the care and support needs, or the duty to reduce future needs, so responses can be *'if they just came off their drink or drugs, they wouldn't have those needs'*. The statutory guidance is clear but is not always followed and could be strengthened, possibly by case law. We need wider understanding that trauma affects the makeup of your brain, and that addiction may be a result of self-medication for untreated trauma and mental health problems. Substance use and addiction can compromise personal wishes, choices and strengths. How do we find out more about an individual and use that information to make 'best interests' decisions if required? There is great frustration amongst homelessness specialists that all services are not working in a trauma-informed way.

The importance of legal literacy

We know that SARs repeatedly highlight that legal literacy is needed: the understanding and application of the legal rules laid out in primary legislation, statutory guidance and significant court judgments. One concern is that when we work with someone, we may assess them based on what resources we know are, or are not, available locally, rather than based on their individual needs. But if assessments, or refusals to carry out assessments, are not needs-led, it does not absolve practitioners of our duties under the Care Act 2014. Good practice is *'let's make decisions about eligibility with good legal literacy, then argue about resources'*. In some cases, practitioners are looking for advice and guidance, because we are unsure what to do, and we know there is an imminent risk of death. That can be a due to problem with the law, or a problem with local resources and provision, or both.

Building trust and relationships with individuals

Building trust and a relationship with an individual requires persistence over time, even in the face of repeated rejection and challenging behaviours. Examples given by Experts by Experience (EBEs) show that it was the tenacious efforts of a single worker which made the difference to them. It was this consistency which broke down barriers of service mistrust and led to engagement, so that an assessment of needs was carried out and support was accepted. An important contribution to any assessment is the individual being able to contribute their thoughts and feelings to the case evidence. We know relationship building takes time, so we need to 'free up' practitioners with high caseloads and accommodate this approach within protection and risk management plans, so that time with the individual is prioritised. It takes a trauma-informed Assertive Outreach approach, coming to find the person where they are, not expecting them to come to you, and having familiar trusted workers not different strangers all the time. It is not necessarily that somebody does not want support, it may be about what form it takes. How can we be supported to be flexible within our own practice when conventional approaches are not effective?

Importance of community-based, accessible services

Local community services which people trust, can drop in to when they want and feel comfortable with, help people to have agency in moving forward with their lives, and to access support that does not rely on phones or the internet. Phones can be difficult to maintain for people on the streets but are repeatedly used by services as a form of contact. There is concern that many community-based organisations that are closest to people who reject statutory services have reduced or closed. Community services do a lot of relationship and trust building to help

One man had his Universal Credit and Housing Benefit stopped because he failed to attend an appointment, but he doesn't read or write or have internet access, and they said they'd notified him via his online journal.

people to get to the point where they will be comfortable sharing information or meeting other professionals, and are likely to pick up problems in-between contact with other services. If we call a professionals' meeting, we want the individual to attend but it can be overwhelming for them, so there needs to be somebody to say *'I'll sit with you'* and have a coffee and chat about how they are feeling; that is vital work in supporting them to achieve tangible changes.

Keeping cases open across services

'Didn't engage, case closed' is heard when services fail to understand how to work with complex individuals who – unsurprisingly – may not engage consistently. Staff regularly waste time repeating referrals to those services, re-telling someone's story. *'We're still expecting people to fit into our processes when we should fit in with them. If they've fallen off the radar we should innovate to get them back into treatment quicker, rather than punishing them by saying 'start again'.* This repetition wastes resources and can reduce someone's willingness to engage because they are facing rejection - again - and do not want to repeat their story yet again.

Experts by Experience (EBE) experiences

I was in a 'wet' hostel, then I was hospitalised but I couldn't get back into the hostel because my needs were too high, so I was put on the streets. Some safeguarding should have been in place. I could hardly walk and I was sleeping on the streets. At one point I physically was really bad; if I was on the floor I couldn't get up and the security from the building I was outside was coming out every morning to physically pick me up off the floor and help me put my sleeping bag away.

Lots of homeless people self-medicate because they don't have a doctor, so they use street drugs to feel better, then once addicted that's the main thing they care about. When I was on the streets, I had drug workers come out to me a couple of times a week because I would never go pick up my prescription, and they would buy me coffee or lunch. It did help me because they got to know me as a person, but then I've had other workers say *'You're not engaging, we're not going to work with you,'* so having someone that comes out to work with you on the street makes a hell of a difference. I had the same two workers from the minute they got me on the script (prescription) until the minute I was off everything; they stayed with me all the way through.

Multi-disciplinary outreach teams with social work embedded in day-to-day working

Day-to-day good practice with homelessness and self-neglect is easier to achieve with multi-disciplinary teams working across substance misuse, mental and physical health, housing and social work, by workers with passion, training and experience in this area. This is complex work and non-specialist practitioners often say they don't know what to do or may not want to work with this group, who can be seen as making unwise decisions and 'undeserving' of support. Relationship building is dependent upon not just practitioner skills but willingness to engage in the face of rejection and hostility. Having 'peer' workers – Experts by Experience – in outreach services also strengthens engagement. Even specialist homelessness practitioners will want advice and reflective spaces to explore how best to support individuals, including access to legal guidance. A social worker or other practitioners with legal know-how who is able to offer safeguarding and care and support expertise is something described as often missing in homelessness teams. Such practitioners need to have interest and expertise in working with this group and be able to

Currently social workers who come out to see people have to go back for sign off from panel (a group of managers), who often say someone needs to engage in an assessment, not understanding that they are self-neglecting and might not engage.

EBE experiences

One of the biggest gripes that I had is constantly having to repeat yourself, tell your story over and over. You disengage and they close the books because you haven't turned up, so then they do the whole process again, and how much does that cost? I'm back and you want me to jump through this hoop again. There's doesn't appear to be a grown-up approach that says '*actually this person is in chaos and therefore we need to adapt our services to be more responsive, more holistic*'.

work in a peripatetic way. Without decision making and budget spending authority practitioners are unlikely to be able to address some of the existing barriers to safeguarding and support for this group.

A focus on mental capacity, service refusal and legal considerations

Localities need confidence and expertise in the application of the Mental Capacity Act 2005 and a grasp of the significance of executive functioning as well as an understanding of what's going on for someone if there is high risk of harm and service refusal. Adults must be presumed to have capacity and may make apparently unwise decisions and choose to disengage, but that does not excuse practitioners failing to assess someone's capacity in relation to the risks they are living with and may die from. If someone is not engaging, the assessment can be done in a modified way by a multi-disciplinary team, which will help share the responsibility. We know that capacity to make a decision changes, so assessing someone's capacity to look after themselves when *not* inebriated may not be sufficient to understanding the risks. Assessment by observation can be a strong tool. Rough sleepers can be a very complex group and it can be difficult to understand the implications for people affected by addiction, trauma, mental health problems and poor previous experiences of services, and talk simply about 'choice'. If it's not possible to carry out assessments on the street, the Court of Protection can authorise a deprivation of someone's liberty in the community while we assess capacity and best interests, but it depends on a suitable placement and care plan for the Court to approve. People are rightly concerned about encroaching upon someone's personal freedoms but it may be possible to intervene without someone being too unsettled and to manage agencies' concerns about risk and support. Where we have a multi-disciplinary team going out and working with an individual over time and that doesn't work then we need to consider legal frameworks for removing someone from high levels of risks on the street and so need access to expert legal guidance. Agencies need to agree what good would look like, consider the application of appropriate legal structures and agree the trigger points, recognising that there will be no quick fixes.

Resolving disputes across a system

How do organisations agree on their evaluation of the likelihood and impact of risk to an individual, when there is not always a common language across a system? Needs and risks assessments require frontline data but finding a statutory 'home' for data to ensure it is acted upon by services is not always straightforward for practitioners: '*I don't know what to do with it. It gets overwhelming and frustrating*'. Do we recognise that different opinions on practice approaches and ethical viewpoints exist and address these? What are the multi-agency processes for mediation without it being experienced as personal conflict? We may bypass this and go through 'escalation' by raising safeguarding alerts because raising concerns about perceived poor practice carries reputational risk. One service may lobby another saying '*I think he's going to die on the streets*' but others' professional judgement is often not trusted. At times, concerns about practice standards are not distinguished from individual safeguarding concerns, for example, is hospital discharge to the streets a safeguarding issue? Concerns may be dealt with case-by-case without addressing systemic problems.

Commissioning accommodation that is fit for purpose

After our safeguarding, or our care and support assessments, what services can we then implement?

We can put safeguarding measures in place, a support plan and funding package, but there isn't suitable accommodation.

Valued services, such as supported accommodation, may be unavailable, leaving people in unsuitable general needs temporary accommodation which is expensive but doesn't meet their needs: most cannot cope unsupported, so there are often additional costs of repairs and police and ambulance call-outs and people tend to relapse, are rendered street homeless, and the cycle continues. How do we strengthen the local function to supply supported accommodation, to support people to stabilise and move on into semi-independent or general-needs accommodation? Where do we put people who've got alcohol, mental health and physical health problems? Many people attempting to address their addiction problems say they would rather be on the streets than in accommodation with people using drugs and alcohol.

If you've been in that life for a while, you present as someone a lot older with declining health, but for people under 65 there may be few or no options, and hostels or hotels may be unsuitable. Commissioning is problematic because we often haven't created our own services so rely on the independent sector to produce something that we can buy. We increasingly spot purchase placements which are more expensive, and there are Directors' meetings discussing people whose needs are high but, due to the lack of appropriate accommodation and support, remain on the street. SARs have highlighted this lack of provision. Local care home-type facilities are needed that are not intended primarily for older adults, and central or regional Government may need to step in if levels of need don't conform to local authority commissioning areas.

We're working with a young man with mental health issues, an ex-drug user, he's now in nursing care at £2,000 a week because of the reluctance of domiciliary care to support him in the community, because of his history.

Commissioning care and support that is fit for purpose

Commissioning services may be reluctant to commission home care because of the high risks and complexity, low numbers, and the costs, but we lack accommodation options and need to expand specialist support for people in the community. There are skilled people who want to do this work so can employ them within specialised domiciliary / homecare services or as Personal Assistants for multiple and complex needs, not ask somebody who hasn't got expertise or doesn't want to work with this group. Care relationships often break down when care workers haven't been exposed to those types of behaviour and trained.

People need ongoing wraparound support to help to get them stabilised. They may not have the skills to cook, budget, manage a tenancy or to engage with authority figures because they've had poor experiences. Addressing these things takes time but without this support we struggle to move people on because they haven't improved. Direct payments via a third party are an important option to explore; what is the best way to ensure services are flexible enough to provide appropriate support? It might be one particularly good day delivering six hours because that person is receptive but you might not be able to engage them for the next few days. Commissioning a 'Navigator' type support worker working in an Assertive Outreach model can offer this flexible support.

Sometimes services will draw up a rota, trying to fill the gaps in wraparound support by going in every day until they settle, local Police officers, Street Outreach, Drug and Alcohol Teams, Adult Social Care, going out in the evenings and weekends, outside of their working hours, just to keep someone in a property, because the alternative is back on the street where they will die.

EBE experiences

You've got to find the right accommodation; you can't put someone in a wet house if they're recovering and you can't put someone in a dry house if they're actively using (drugs). You've got to understand if you put someone in a place where everyone's using all the time, but this person is trying to be clean, sometimes that can be too much of a temptation.

You should have an allocated Key Worker because they would notice straight away '*this shouldn't be happening*', but often you're not supported, you get dumped in hostels or accommodation and just left.

I did have three different carers (care workers) at one point, and for somebody who is complex, who doesn't want to work with people, having that many strangers coming into their room can be a very daunting experience.

Successful network of support beyond the ‘roof over the head’

Co-dependency and cuckooing are problems affecting vulnerable people with addiction problems. Peer group members, some of whom are equally vulnerable and exploitative, are often each other’s only social network, leading to ‘drug enabling’ which undermines recovery attempts and causes tenancy failures. Tenancy agreements can be easily breached, so there is no longer a duty to accommodate. Strong relationships with Police Community Support Officers are important: if we move somebody into a property, they will keep it on their radar, do welfare checks, look out for anti-social behaviour and cuckooing. If individuals don’t interact with anyone outside that community, expecting them to step out of it is asking them to leave everyone they know, but we don’t always attempt to replace that support network when we offer a roof over their head.

‘Rejecting’ services or are our services not fit for purpose?

‘Non engagement’ with services could be seen as a reflection of our services and us as professionals – we should say ‘*found offers of engagement unappetising*’. The flexibility of our offer is important and any professional should be

When someone is picked up on the street in a mental health crisis there’s an admission, and then the offer of a B&B far away. When you advocate and explain their issues, their local support networks, and that they will not manage to sustain this, the local authority may say that they have fulfilled their responsibility and put down the phone. People are pushed into further mental health and homelessness risks because offers are unsuitable.

able to act as the direct route into other forms of support if more help is needed. Someone may be offered a service or an appointment but that means getting from A to B by themselves and this cohort often don’t have the ability to do that. Without somebody advocating and working alongside, such as a Navigator, they may fall out of the system again and have their services, prescriptions or benefits stopped. For this cohort it is more effective if services offer outreach and are available collectively – such as within community hubs.

Under Covid, the policy of ‘Everyone In’ escalated and tested the multi-disciplinary wraparound approach, a team around the individual, and was able to achieve great things.

Stopping the cycle with (earlier) intervention or costs of failing

More comprehensive assessments and support at the first contact with services when professionals spot someone at risk can reduce complex needs developing and people cycling in and out of hospital. Localities can use their discretionary powers under the Care Act 2014 to provide accommodation to enable an assessment of safeguarding and support needs. How does a locality shift the spend into preventative and ongoing support, to stop the cycle back to the streets and though reactive ‘blue light’ and other stretched crisis services? Invest in more intensive support with tenancies, physical and mental health and addiction. Social care will carry more of the budget and some emergency services would save, so how can this be reflected in the distribution of public sector funding across a locality? Does it help to justify costs if the person is under a safeguarding protection plan? Would we withhold funding to safeguard other cohorts? Strategically – at central government and all levels – we need to be clearer about the wider financial and broader public costs of *not* addressing complex cases, including bringing people through the criminal justice system, public concerns and anti-social behaviour. However, we note that whilst it’s useful to undertake comparative financial analysis to understand how to invest effectively, practitioners emphasise the importance of their duty of care, rather than to save costs.

Ultimately, the cheapest person with complex needs may be a dead one, but we should be delivering quality care, not trying to save money.

EBE ideas

There should be a centralised funding pot to enable joined up approaches to complex needs, so the only thing services need to agree at the time is, is this suitable for us to dip into that? You can then move fast and remove a lot of the red tape, before the situation for that person becomes more risky and harder to address.

Some professionals describe a lack of understanding of how to work with people with such complex needs, but you won’t find a better resource than people with lived experience so draw them in. Try to understand that moving on from chaos is very hard, so you’re able to engage more or less at different times, but sometimes you’re able to be quite lucid about what worked, what didn’t, and professionals can draw on that resource.

Effective multi-agency approaches to keeping someone safe

Multi-agency approaches outside of adult safeguarding can lack coordination and only if a case is escalated, a 'lead' is appointed. Section 42 carries more legal weight: it makes lines of accountability clear, brings partners together to construct a jointly held protection or risk assessment plan, and provides impetus for its delivery; the Care Act reminds all partners of the duty to cooperate and share information and resolves any fragmentation of services; without that you are relying on goodwill and availability. It doesn't have to be a social worker leading; has 'Causing enquiries to be made' progressed enough? Who does an individual want to have regular contact with? The social worker may have the coordination but not the visiting role, unless they have built a relationship of trust. However, voluntary sector and other agencies may not feel trained or resourced to coordinate multi-agency working, and without a section 42 agencies may decline to cooperate.

If a safeguarding concern to Adult Social Care does not meet the criteria, is it consistently picked up by an alternative risk management forum to ensure nobody falls through the cracks? We need a clear pathway with a lead agency for people who are homeless and very vulnerable. Staff can be confused about the various multi agency forums, processes and meetings, and which take precedence or run concurrently, so clarification is important. Risk management meetings may be infrequent but things can change or deteriorate rapidly so what is effective is joined up working and information sharing in real time. Agencies need to enable access to each other's information systems or use a shared system. This group may warrant a similar approach to multi-agency public protection arrangements

I put in a safeguarding referral – there is a form to fill for Adult Social Care – then we document it on our organisation's database, and the Council will repeat that process on their database, whilst Drug Services have got another database, so we're triple noting, and all that is time away from giving care to someone.

(MAPP) level 3, where senior practitioners from all agencies meet regularly, are accountable and able to make decisions about service and resource allocation to avoid delays to multi-agency working; meetings are chaired and supported and actions are followed through. Without all these important elements, professionals' meetings may not be effective, which leaves professionals frustrated and people without the support they need. We may say 'individual is not engaging' rather than 'we're struggling to do assessments' or 'we lack the right provision', so an oversight process can help to reflect when things are not working well.

Workforce anxiety, burnout, support and turnover

Where does the anxiety that practitioners feel when working with homelessness and self-neglect get located within the system? Some may legally 'hold' the risk, but others may experience it daily. At times practitioner anxiety is high and

Thinking about some very vulnerable people that we're now housing, our team put hours into supporting them but they are still at risk of dying because of a host of unmet needs, and no matter the amount of safeguarding alerts we put in, or requests for care needs assessments, there doesn't seem to be support. What more does a person need to be going through to get help?

there isn't an appropriate local service response which may increase staff burnout. Reflective practice and supervision are vital, as burnout leads to workers leaving. Retention is a national problem, leading providers to recruit agency staff, consuming greater resources. Staff exit has a destructive effect on relationship and trust building with people, a central element of effective working to safeguard people experiencing homelessness and self-neglect.

Strengthening the long-term picture through oversight, legal underpinnings, status and funding

How do we strengthen strategies, structures and oversight going forwards? Locally, have we secured the interest of elected members and identified a lead for homelessness on SABs? Is the oversight process for safeguarding MEH incorporated into the SAB's quality function, with a subgroup reporting to the Board and feeding into a shared process of learning and improvement? Some advocate for Outreach and Substance Misuse Services to be integrated with social care teams; legally informed advocacy via specialist MEH Care Act Advocates could also strengthen approaches. Professionalising the homelessness workforce more would recognise the importance of this group experiencing very high levels of risk and of the workforce who support them; training, career progression, and recognition of practitioner expertise by other professionals are important. Much of the current innovative and successful practice with homelessness and self-neglect is funded by short-term initiatives so there is no long-term security for the people receiving support, the organisations providing it, or the staff they employ. This work, safeguarding some of the people most at risk in our communities, must shift from being a time limited 'add-on' to being strategically planned and resourced.

For Safeguarding Adults Boards and other local and national stakeholders:

Reflecting on these messages, which are most important for strengthening safeguarding responses to self-neglect and homelessness? How are you addressing them? Please let us know: jess.harris@kcl.ac.uk