Adult Safeguarding and Multiple Exclusion Homelessness

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January 2020

Definition: Multiple Exclusion Homelessness

People who have been 'homeless' (including experience of temporary, unsuitable accommodation as well as sleeping rough) and have also experienced one or more of the following additional domains of deep social exclusion:

- *'Institutional care' (prison, local authority care, psychiatric hospitals or wards);*
- *'substance misuse' (drug problems, alcohol problems, abuse of solvents, glue or gas); or*
- *Participation in 'street culture activities' (begging, street drinking, 'survival' shoplifting or sex work)*

Rough sleepers, face significant increased risk of serious abuse, exploitation and neglect. Those risks are increased for people with MEH backgrounds, because they are likely to be street homeless for longer and this usually leads to an escalation in health and care needs and a reduction to their life expectancy.

Myth Busting

- There **is** a definition of care and support needs.
- In the context of people's experiences of multiple exclusion homelessness, the notion of lifestyle choice is erroneous.
- The problem is not the problem; it is the solution that is the problem. Tackling symptoms is less effective than addressing causes.
- Making Safeguarding Personal is not just about respecting the wishes and feelings that an individual expresses.

Some more definitions

- Care and support needs arise from or are related to physical or mental impairment or illness. This can include conditions as a result of physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury (Care and Support (Eligibility Criteria) Regulations 2014.
- There is a duty to meet eligible needs (which are defined) and a power to meet other needs (section 19). Human Rights Act 1998 assessments crucial here.
- Unable to protect themselves – applying what is known about a person's life experiences, history and current circumstances, take the ordinary meaning of the words.
- Care Act 2014 statutory guidance (Chapter 15) on interface with housing and care and support. Consider housing and the provision of suitable accommodation when considering the provision of care and support. Part of the wellbeing principle.
- Section 23 (Care Act 2014) clarifies the boundary with the Housing Act 1996.

Some issues to consider – messages from the national workshops

- There is a spectrum of what is meant by ‘safeguarding’: ranging from a broad concept of safeguarding (general safety) to Safeguarding Adults duties (as defined by the Care Act) – these can often get confused
- There are multiple missed opportunities for raising safeguarding concerns about people who are rough sleeping or homeless because we only see the person as a rough sleeper/homeless
- Multiple exclusion homelessness = no fixed accommodation + childhood trauma + marginalisation + physical and mental illness + substance issue + institutional care + custody. Can this also mean exclusion from services?

Some issues to consider – messages from the national workshops (2)

- Safeguarding adults is ‘everybody’s business’, including people working directly with rough sleepers and homeless people, so listen to their concerns, support them to reduce potential harm or abuse (prevention), and include them in any multi-agency discussion (risk assessment , protection planning)
- What is the person’s story? Ask ‘why’ and ‘how’ as well as ‘what’? This should help to understand any safeguarding concerns
- Who is raising the concern and why? – understand what statutory adult social care, adult safeguarding, mental health, physical health, housing services etc…. can and can’t do….to help identify what is the most appropriate pathway for support for someone

Some issues to consider – messages from the national workshops (3)

- ‘service refuser’ - look beyond presentation and consider trauma informed approaches, use professional curiosity
- ‘has mental capacity’ – consider long term impact of illness, drug and alcohol misuse
- Working collaboratively with partners to achieve the appropriate outcomes for the person can be challenging but is essential and starts with the first conversation
- Rough sleepers - average mortality 44 (men) 42 (women) , so consider palliative care?
- This is complex and complicated work – be flexible and person centred

Available reviews

- In addition to the 14 reviews included in the Kings College analysis (2019) …
- Torbay SAB (2011) ‘Ms Y’
- North Yorkshire SAB (2012) ‘Robert’
- Lambeth SAB (2012) ‘Mr A’
- Walsall SAB (Learning Review summarised in Annual Report 2016/17)
- Doncaster SAB (2018) ‘Adult G’
- Bexley SAB (2019) ‘AB’
- Wiltshire SAB (2018) ‘Adult D’
- Milton Keynes SAB (2019) ‘Adult B’
- Tower Hamlets SAB (2019) ‘Ms C’

Forthcoming reviews

- Thematic review – a Northern SAB (street homeless deaths)
- Thematic review – a North West SAB (seven street homeless deaths involving self-neglect, substance misuse, homelessness, imprisonment, mental and physical ill-health)
- Thematic review – a North West SAB (four cases involving self-neglect, substance misuse and housing/homelessness issues)
- Thematic review – a London SAB (two cases involving self-neglect, substance misuse and homelessness issues)
- A SAR – a South West SAB (a homeless person now in nursing care following a Court of Protection ruling)

Milton Keynes – Adult B (2019)

- Adverse childhood experiences; substance misuse as response to trauma
- Unable to sustain hostel place due to substance misuse
- Unplanned hospital discharges
- Adult Social care assessments of his needs arising from autism and homelessness delayed and incomplete at time of death
- No lead agency or practitioner championing his unmet underlying needs
- Lifestyle and health concerns mount with no signs of professional scrutiny – no professional curiosity
- No mental capacity assessment or full safeguarding assessment
- No use of advocacy or escalation of concerns
- Lack of inter-agency response including multi-agency meetings
- Lack of management guidance, direction and supervision

Isle of Wight – Howard (2018)

- Homeless single adult without local family support
- Longstanding alcohol misuse and physical ill-health
- Hospital and prison discharges to no fixed abode
- Police and ambulance crews concerned about risks of financial and physical abuse, and his self-neglect
- Refused housing as not regarded as in priority need
- No wet hostel available
- Referrals to adult safeguarding do not prompt multi-agency meetings or investigation; no completed Care Act 2014 care and support assessment
- No lead agency or key worker; no risk assessment or mitigation plan

Learning from Reviews (1)

- The need to improve
  - Safeguarding and legal literacy
  - Integrated whole system working
- The need to clarify
  - Pathways into safeguarding
  - The role of different multi-agency panels
- The need to assess
  - The likelihood and significance of risks
  - Executive functioning after prolonged substance misuse
  - The impact of trauma and adverse experiences

Learning from Reviews (2)

- The need for creativity
  - Thinking collectively about ways forward
  - Avoidance of case dumping
- The importance of wrap-around support
  - Not just for service users but also for staff; the work is challenging
- The importance of candour and challenge
  - The importance of escalation of concerns
  - Ensuring all voices are listened to

Drawing on all available evidence – what needs to happen

Across the 4 domains:

- Working with the person
- Team around the person
- Organisations around the team
- Governance and strategic leadership

The Evidence-Base: Working with the Person (Domain 1)

- Person-centred practice – be proactive, explore the person's history: ask why?; apply curiosity and challenge; address our unconscious bias
- 'Hard to reach' – try different approaches; use outreach specialists and advocates; involve family and friends; maintain contact; avoid case closure
- Mental capacity assessment - review and focus on decisional and executive capacity, consider how substance misuse, adverse childhood experience, brain injury and trauma affect decision making
- Address safeguarding issues through detailed risk assessments – likelihood and significance; balancing autonomy and duty of care – risk mitigation planning and review
- Detailed health, care and support assessments, plans and reviews
- Thorough mental health assessments and reviews
- Focus on planning at points of transition (e.g. hospital - mental health ore acute, or prison) and discharge from institutions

Make every contact count / Make every adult matter

The Evidence-Base: Team around the Person (Domain 2)

- Multiple exclusion homelessness is a safeguarding issue
- Working together and multi-agency meetings – to counteract silo working, threshold bouncing, ‘hand offs’, inflexible agency responses.
- Shared assessments & plans, liaison & challenge, follow-through, lead worker/agency/to provide leadership, shared responsibilities
- Information sharing and shared language and understanding
- Recording – clarity & thoroughness of work done, agreed plans, outcomes achieved, discussions held
- Legal literacy – know and consider available legislation (e.g. NRPF);
- Safeguarding literacy – awareness of guidance & procedures, of risks and vulnerabilities, of safeguarding systems; adequate exploration of choices
- Advocacy and outreach – consider use with people who seem ‘hard to engage’
- Understand pathways into provision – housing, mental health etc
- Use of procedures – DNAs, safeguarding alerts, risk assessments
- Standards of good practice – thoroughness of assessments, challenge professional optimism, lack of assertiveness & curiosity

The Evidence-Base: Organisations around the Team (Domain 3)

- Support and supervision– cases are complex, high risk, stressful & demanding, so support systems essential; review scope and adequacy of policies and procedures
- Ensure access to specialists (legal, safeguarding, mental health, housing)
- Culture – encourage challenge & escalation of concerns; balance personalisation with duty of care; promote a culture that ‘makes every contact count/ makes every adult matter’
- Learn from Safeguarding Adult Reviews, e.g. where there are gaps in provision, where commissioning can promote change
- Consider partnership management oversight of complex cases; partnership strategic meetings to consider safeguarding and multiple exclusion homelessness; use and review risk panels; audit cases to learn from them
- Workforce development – practitioners must have appropriate knowledge, literacy, experience & resilience. Provide training on mental capacity, legal and safeguarding literacy, trauma-informed practice, unconscious bias
- Guidance for staff regarding people with mental capacity who refuse services and are at risk
- Commissioning – consider integrated pathways for multiple exclusion homeless/ adults with complex needs/ whole system approach

The Evidence-Base: Governance/Strategic Leadership (Domain 4)

- SAB strategic plan focus on multiple exclusion homelessness
- SAB engagement with Community Safety Partnership, Health and Wellbeing Board, and Safeguarding Arrangements for Children on multiple exclusion homelessness - what works locally (e.g. two tier) and politically
- Learn from SARs and reviews completed locally and elsewhere for service improvement, and practice development, use audits to identify areas for improvement
- Monitoring & action planning – robust action plans and audits of impact needed
- Procedures & guidance – develop protocols on multiple exclusion homelessness, self-neglect, risk & capacity assessments, follow up of service refusal, cases where adults have capacity but at risk of harm,
- Consider protocols for multi-agency, inter-authority working and working across District Council and County Councils

Some issues for SAB partners to consider

- Multiple exclusion homelessness as a safeguarding issue in your strategic plan
- How does local governance work? (Safeguarding Adults Board, Homelessness Reduction Board, Community Safety Partnership, Health and Well-being Board)
- How do you learn lessons from different types of reviews and audit? and then can you evidence improvement from that learning?
- Multi-agency meetings offer a framework to reach safer uncertainty where wellbeing outcomes cannot be guaranteed – where do these take place?
- Is there clarity regarding pathways into provision (housing, health, social care, support etc) and sufficient safeguarding and legal literacy in all agencies
- Are you addressing barriers to best practice, e.g. through policies and procedures to support practice – including across multiple boundaries (District/County; inter Local Authority areas)