Strengthening adult safeguarding responses to homelessness & self-neglect
Emerging messages from an English study

Jess Harris, HSCWRU, King’s College London
Inaugural International Adult Safeguarding Conference
Trinity College Dublin - 27.10.23
Background, context, aim, definitions, methods
Title: *Opening the ‘too difficult box’: Strengthening Adult Safeguarding responses to homelessness and self-neglect*

Funder: National Institute for Health and Care Research (NIHR) School for Social Care Research (SSCR).

Research Team: Jess Harris, Stephen Martineau, Jill Manthorpe (King’s College London), Michelle Cornes (University of Salford), Michela Tinelli (London School of Economics and Political Science), Bruno Ornelas (Expert Practitioner), Stan Burridge (Lived Experience Lead).
Mean age at death: 45.9 years men; 41.6 years women (Office for National Statistics, 2021, Deaths of homeless people in England and Wales).

Care Act 2014 Guidance included ‘self-neglect’ for first time as a category of ‘abuse and neglect’ under adult safeguarding responsibilities in England.

Cross-government Rough Sleeping Strategy (2018) made explicit link between adult safeguarding and homelessness: to carry out and learn from Safeguarding Adult Reviews (SARs) into homeless deaths (follow up Strategy (2022) states ‘Rough sleeping and multiple disadvantage is a safeguarding issue’, p94).

In absence of prior research, learning from SARs* which featured deaths of people experiencing homelessness indicated lack, or failure, of adult safeguarding:

- More than half of SARs featured self-neglect
- Failure to see or name self-neglect
- Missed opportunities for safeguarding to intervene
- Normalising high levels of risk
- Chronic alcohol/drug use seen as ‘lifestyle choice’

*Martineau, Cornes, Manthorpe, Ornelas et al. (2019)
Aim

Explore how self-neglect is experienced by people who are homeless, particularly at the intersection with other forms of deep social exclusion which feature within multiple exclusion homelessness (MEH) and how this might be addressed through strengthening safeguarding responses... including those outside formal adult safeguarding... and in day to day multi-disciplinary practice.
Definitions: what is Multiple Exclusion Homelessness?

MEH captures overlap between homelessness and other forms of severe disadvantage and deep social exclusion: experience of ‘institutional care’, substance misuse, and participation in ‘street culture’ activities: ‘a distinctive and exceptionally vulnerable subgroup within the broader homeless population.’*

A range of factors and risks contribute to people both becoming and remaining homeless, particularly ‘street homeless’ including adverse childhood experiences, trauma, mental illness, acquired brain injury, autistic spectrum conditions and learning difficulties.

Past negative experiences of statutory services and of stigma and discrimination contribute to service mistrust and deter people from seeking or accepting help.

Definitions: what is self-neglect?

‘This covers a wide range of behaviour **neglecting to care for one’s personal hygiene, health or surroundings** and includes behaviour such as hoarding. It should be noted that **self-neglect may not prompt a section 42 enquiry.** An assessment should be made on a case by case basis. A decision on whether a response is required under safeguarding will **depend on the adult’s ability to protect themselves by controlling their own behaviour.** There may come a point when they are no longer able to do this, without external support.’

**Statutory guidance to the Care Act 2014 (14.17)**
Methods: three main strands

1. Primary data collection (qualitative)
   - Interviews with 82 professionals (social workers, SAB members, homelessness services, safeguarding leads in local authorities and NHS, police, probation, housing).
   - Interviews / focus groups (with peer researcher) with 30 people experiencing or with lived experience of MEH: webinar 25.4.23
   - Observation (online) of risk management forums.

2. Communities of Practice in three study sites
   (3 Safeguarding Adults Boards = 6 English Local Authorities)
   - Report 2022: doi.org/10.18742/pub01-075

3. Economic analysis and modelling
   - Reviewing SARs to compare the costs of the ‘un-met needs’ with possible ‘met needs’ scenarios developed with experts, exploring potential cost savings: webinar 12.12.22
emerging

Study findings
1 - Messages about safeguarding responses to multiple exclusion homelessness, including those outside formal adult safeguarding, and day to day multi-disciplinary approaches.
Putting in referrals - ‘alerts’ - to adult safeguarding can be experienced as ‘going through the motions’ or ‘covering our back’; very few accepted or enquiries undertaken; there may be slow or no response; practitioners may stop making safeguarding referrals, preferring to prioritise client time over form filling.

Practitioner uncertainties, attitudes and barriers that emerged:

- Can be unclear if homelessness ‘fits’ Safeguarding:
  
  ‘We make referrals for safeguarding, we quote the Care Act and we quote all the risks and the vulnerabilities. Nine times out of ten it comes back ‘Not going to a Section 42’ … They have left that risk and not done anything because that person is ‘difficult’ … usually safeguarding doesn’t go anywhere.’ V17B Social Worker

  ‘We had a response that came through stating that ‘We don’t accept safeguarding referrals for individuals who are rough sleeping.’ LS5 Rough Sleeping Coordinator

- Homelessness doesn’t ‘fit’ Safeguarding as housing is ‘primary need’ and needs are sequential:
  
  ‘He is a danger to himself - it is self-neglect … he has been in and out of hospital I think it was ten times … he’s been referred to Housing … his primary need.’ V18A Social Worker
Safeguarding falls within the responsibility of Adult Social Care within local authorities: but homelessness is not always seen as part of the wider social care ‘umbrella’.

Adult Social care and safeguarding teams may not fully understand or appropriately address the complexity of MEH, including why people may reject support, so may not explore mental capacity or identify care and support needs:

‘If you make a referral ... a social work assistant, so not a qualified worker, calls the person ... that immediately sees off most of my clients because either they don’t answer the phone or ... they’re going to be like ‘No, I’m fine...’ and then it’s ‘Ok, close that.’ ... That’s been so frustrating! ... this person needs a full assessment by a qualified social worker.’ LF2 Mental Health Outreach Social Worker

‘We get a homeless person or substance misuse person coming through the system ... social workers say ‘lifestyle choice’ or ... ‘can’t really assess his needs because he’s living on the streets, he’s told us to cart off so it’s a ‘non engagement’ ... I probably keep cases open that I shouldn’t.’ SSW5 Social Worker

‘They’re very geared up that people are allowed to make unwise decisions ... ‘case closed’ because ‘they have capacity’ and they have a roof over their head ... they’ll be kicked out again because there’s no change; they’re back on the street.’ V4A Social Work Manager
Services may try and hand off responsibilities (to protect limited resources) so safeguarding referrals are used to address stalemates:

‘Adult Social Care, Housing Needs, they’ve known for months that he’s going to be evicted … nothing’s happened because it’s just been a lot of people pointing at each other saying ‘Oh, it’s your responsibility’... so [X] said ‘this is ridiculous, this is a safeguarding concern’.‘ LF2 Mental Health Social Worker

Safeguarding referrals can be triggered by practitioner concerns about inaccessible or stretched services, or gaps in day-to-day statutory or commissioned provision; this generates frustration from safeguarding staff about what they can offer, and contributes to cycle of emergency service contact, repeat safeguarding referrals, and homelessness:

‘They’re just turfing him back out onto the streets and he’s coming back [into A&E] ... I don’t think we’ve got a service for somebody like that.’ V18A Social Work Assistant

‘There’s a high likelihood that they would fall under the Care Act ... I don’t think it’s necessarily just that Adult Social Care are just, ‘Oh they’re homeless, they aren’t our problem’ ... They don’t necessarily fit well into the statutory framework ... I don’t think it’s just apathy on behalf of the workers but also a knowledge that there isn’t actually much we can offer.’ LSW2 Homelessness Social Worker

**Concern:** How are we mapping any service gaps if we anticipate the lack of a service response, and so fail to carry out assessments that would identify un-met needs?
Examples of good practice

- There is good safeguarding and social care practice; although often localised, may be led by individuals rather than being systematic:

  ‘I’ve got a bit of a passion for people who are homeless ... other areas, it doesn’t hit their radar because they don’t see it as their issue.’ NSW1 Social Worker

  ‘The only way I can do it is to allow my staff the flexibility to keep chipping away at cases ... I have to tell a few porkies with senior management.’ SW2 Team Manager

- Some signs of broadening the social work ‘umbrella’:

  ‘I can see now we are starting to work with those people that historically I would not have been able to get through Adult Social Care’s doors.’ NSW3 Principal Social Worker

- Good practice: specialist homelessness social worker role working in outreach:

  Supporting Safeguarding referrals and inquiries; carrying out Care Act 2014 assessments in homelessness settings; bring legal literacy; offer earlier advice and intervention; reduce crisis escalations and inappropriate / repeat referrals for assessments. However, a rare, often short-term role.

  See Social Work and Homelessness webinar 26.10.22

  See Evidencing the social work role within responses to MEH project developing further evidence about role: Homelessness Social Worker Role webinar 20.7.23

  See Addressing MEH in social work education project promoting good practice in social work education: Social Work Education and Homelessness webinar 20.9.23
2 - Messages about safeguarding responses to multiple exclusion homelessness, including those outside formal adult safeguarding, and day to day multi-disciplinary approaches.
Most MEH risk managed outside Safeguarding

We found multiple, sometimes overlapping, alternative risk management forums / processes to address multiple and complex needs including MEH; some described as used ‘because safeguarding is not suitable’ or because someone ‘has capacity’ or is ‘not consenting’; can be (confusion if) for short term crisis management or ongoing case management; few powerful ‘creative solutions’ models.

Concerns:

- Is there a transparent, agreed risk management pathway for MEH?
  ‘We’ve now got two processes that could or should pick them up ... potentially ... these people might fall - even more - through a hole?’ NS3 SAB Independent Chair

- Is there the equivalent leadership, infrastructure, statutory ownership, local governance and national oversight that safeguarding brings?
  ‘They have the [Risk] system and although it’s a very laudable sentiment there is no central oversight ... nobody co-ordinating or checking that if a plan has been made that actually actions have happened.’ NO2 Probation Manager
Positive practice: alternative risk management

Forums / processes which combine multi-agency risk management expertise in working with MEH with the statutory ‘ownership’ that Adult Safeguarding brings:

‘In terms of making sure that we are not exclusionary in our approach to rough sleepers ... it’s really important that services try and do what the legislation purports ... [so] Adult Social Care team are every fortnight operating a meeting that’s got Mental Health, Housing ... Voluntary Sector ... Substance Misuse ... Police ... are proactive about saying `Ok, who have we got on our streets at the moment? All of these people are at risk of very serious health outcomes, what can we do to make a difference?’ And that just needs to be enshrined in legislation ... [and] auditable. LF4

‘They start to become a problem ... putting a high demand on other services ... then it would come to Adult Social Care as safeguarding ... they might seek to just pass it back to the Homelessness Outreach ... My job is just saying `I think we should have a meeting about them’ ... somebody that you’re concerned about who doesn’t ‘fit’ safeguarding ... there’s nothing actually different ... just doesn’t use the word ‘safeguarding’.’ V6A Senior Social Worker (ex-Safeguarding Lead)
Whether inside or outside of Safeguarding...

- **Is multi-disciplinary process experienced as a ‘hand-off’ or a sharing of risk?**

  ‘The need for multi-disciplinary input ... the fear comes from a hand-off culture which says ‘Once this is a section 42 inquiry we don’t have to do anything more with it, we hand it over to the local authority and it’s their problem’ ... staff get very defensive ... [we need] commitment that any sharing around cases or people’s lives would not be a hand-off.’ LS3 Safeguarding Adults Board Chair

- **Do practitioners leading cases experience more scrutiny than support?**

  ‘You can refer yourself to get support via the [risk panel], I’ve done it twice, I’ll never do it again ... Everyone looks from their little laptops – because we’ve all got different systems that don’t talk to each other – and says `X’s been through our services’ ... There’s no actual support!.’ V3B Hospital Social Worker

- **Cases may require legal intervention under the MCA; are all options considered?**

  ‘We referred [X] into the [risk] panel ... Safeguarding Adults Manager said ‘we need to go for a Court of Protection’ ... That was the sort of response that I wanted, the co-ordination of that all coming together in a statutory framework ... The response is just so inconsistent ... to support people that are really, really vulnerable and at risk of dying on the streets ... We’ve built up cultures of wanting to say that this person is ‘choosing’ to live like this, it’s not our responsibility.’ LF5 Homelessness Services Manager
Day to day: challenge to good practice

**Challenge**: People are less likely to receive support of non-homelessness services due to inflexible service models and discrimination/stigma:

‘Drug and alcohol service ... are not good with cases like this because they would not engage with someone in the community ... [and] mental health team don’t want to know as much if someone’s a drug user.’ V11B Social Worker

‘They might just see her ... ‘This is just an absolute waste of money, she’s a drug addict’ ... people may have their own biases ... who ‘deserves’ to be helped and who doesn’t.’ V19B Manager, High Risk Team

**Successful practice**: multi-disciplinary teams including social work, mental health, housing, and drug and alcohol expertise; shared ‘trauma informed’ approach; reduces repeat referrals to adult safeguarding:

‘Creating the [specialist] team ... it requires some specialist knowledge and specialist trainings, dealing with people who have multiple issues going on simultaneously and may have found themselves in this chaotic lifestyle actually through no fault of their own ... To make sure we didn’t miss people who fell through the net.’ NS5 Assistant Director Social Work

‘There’s been a case of somebody who died ... after that ... they formed this team ... to support the person, whether it’s housing, whether it’s personal care, whether it’s support with drug and alcohol rehabilitation, people cannot just be left in the streets.’ V9B Social Worker
‘Lived experience’ perspectives on safeguarding
‘Lived experience’ participants

Captured the voices of 30 people experiencing, or with lived experience of, multiple exclusion homelessness:

- **Face to face interviews in three study sites**: in homelessness day centres, specialist accommodation, small community organisation working with marginalised populations; participants experiencing many facets of MEH, including mental ill health, drug and/or alcohol use, street sleeping/ hostel accommodation.

- **Online group chats (focus groups)**: facilitated by Expert by Experience lead; some joined once, others contributed repeatedly; participants in more settled situation, still experiencing facets of MEH, able to reflect on experiences of themselves, others, and discuss wider issues.
‘Lived experience’ (1/2): awareness and views

- Participants often had low or no awareness or ‘safeguarding’ for adults; understandably the term was strongly associated with child protection:
  ‘I just stopped eating, just neglecting myself ... I don’t know what Safeguarding is? ... Just to stop me feeling, like, mad, to stop me feeling suicidal...?’ NSU07

- When safeguarding was described, there were mixed views about having been referred:
  ‘It means that you’re not able to safeguard yourself and you need people to help you ... the way that makes me feel is like I'm useless.’ NSU01
  ‘I wouldn’t be here ... I was determined [to kill myself] ... they’ve put themselves out for me so it’s like I don’t want to let them down.’ NSU04

- Some reflected that they were unlikely to be aware of or remember any one conversation with a practitioner, if it happened when experiencing extreme distress, a mental health crisis, or drug or alcohol use:
  ‘They’ve got to do it’s their job ... I can’t remember because obviously everything going on, but I probably weren’t interested at the time.’ NSU03

- Referrals to Adult Safeguarding had not led to any action or intervention for almost everyone we spoke to [information shared by staff, with client permission]
‘Lived experience’ (2/2): looking beyond ‘choice’

Individuals described rejecting offers of support when experiencing MEH; long-standing distrust of services, addiction, ‘bravado’, shame and despair were factors:

‘People in authority, I put my trust in them, I spoke with them and they stabbed me in the back by taking my boy away, and I’ve been sexually, mentally and physically abused ... I promised my little boy when he was a baby that I’d [look after him] and they took that opportunity away.’ NSU01

‘We were there, say in doorways, and they’d just come ... [but] I think you’ve got this bravado built up ... I needed help then, but through the alcohol, that was just blocking it, and it was just ‘Well, I can do this on my own,’ when really you can’t, you know.’ NSU04

‘I’m a young vulnerable female on the streets that’s addicted to substances, that’s street working, clearly putting herself in danger every day, playing Russian Roulette with a needle, I mean I can’t see why there was no safeguarding.’ SSU02

Is it helpful that safeguarding and adult social care refer to ‘choices’ and ‘unwise decisions’ as reasons not to engage with tenacity or proceed with safeguarding?

Individuals said they may reject support but with hindsight may be grateful, and even perplexed where no safeguarding intervention took place.
Summary, reflections, national policy direction in England
Summary of findings

- **Interviews with practitioners** found that adult safeguarding is often inaccessible for people experiencing MEH; no lack of good practice by individual practitioners and localised teams working to support and reduce levels of risk for vulnerable individuals, *but* there are widespread attitudes, service gaps and structural barriers across systems that contribute to failures to respond to MEH.

- **Interviews with people with lived experience of MEH** found people may not agree to ‘safeguarding’ or support when self-neglecting and at risk, but with hindsight were grateful for support and often perplexed where no safeguarding took place.

- **Economic analysis** of SARs featuring the deaths of people experiencing MEH found that a shift from the emergency care but lack of integrated support that people had received to timely multidisciplinary care and support, would have resulted in a **significant cost-saving in two of three cases** and probably have saved all three lives.
(14.9) Safeguarding is not a substitute for:
• providers’ responsibilities to provide safe and high quality care and support.

(14.12) In order to achieve these aims, it is necessary to:
• clarify how responses to safeguarding concerns deriving from the poor quality and inadequacy of service provision ... should be responded to.

Concern:
Safeguarding referrals that attempt to address risks from self-neglect that require local authority-led multi-disciplinary risk management can get lost in an overload of referrals that are simply highlighting everyday gaps in ‘safe and high quality care and support’.
Findings indicate need to re-visit the six principles in Care Act 2014: stronger evidence of two – **Empowerment** and **Proportionality** (professionals describe not safeguarding where individuals seen as making ‘unwise decisions’, or walking away when someone ‘chooses’ to reject services); **less evidence of Prevention and Protection of people through local Partnership and Accountability mechanisms.**

- **Empowerment** - People supported and encouraged to make own decisions and informed consent.
- **Proportionality** - Least intrusive response appropriate to the risk presented.
- **Prevention** - It is better to take action before harm occurs.
- **Protection** - Support and representation for those in greatest need.
- **Partnership** - Local solutions through services working with their communities.
- **Accountability** - Accountability and transparency in safeguarding practice.
How else do we address reluctance to safeguard?

Why is there a reluctance to accept Adult Safeguarding referrals where there is homelessness and self-neglect?

- The ambiguity in the Care Act 2014 Guidance re ‘self-neglect’?
  ‘... self-neglect may not prompt a section 42 enquiry. An assessment should be made on a case by case basis...’

- Lack of clarity over ‘thresholds’ for safeguarding duties?
  Only need reasonable cause to suspect care and support needs; needs can be triggered by substance use or mental ill health; no requirement for ‘ordinary residence’; refusal to engage or to consent, capacity or lack of capacity, and immigration status are not barriers to safeguarding, yet all were cited as such.

- Because Safeguarding ‘cannot offer anything new’?
  Except timely, statutory-led multi-disciplinary information sharing, risk assessment and action planning across all local services (where this is not in place systematically within day-to-day service responses).
Going forward…

- Positively, homelessness, self-neglect and safeguarding are increasingly featuring within national policies / guidance (to follow).

Question for us:

- In England, how do we accelerate the shift from reactive responses to risks and re-occurring and worsening needs (seen in safeguarding alerts) to timely, appropriate multi-disciplinary support for people experiencing MEH - to help improve lives and minimise harm and deaths; this can also save money for emergency and hospital services, so how can localities shift / pool spending and so reduce calls for safeguarding?
Thanks

Study website (all publications so far and more to follow): www.kcl.ac.uk/research/homelessness-and-self-neglect

HSCWRU homelessness webinar series (free and open to all): www.kcl.ac.uk/events/series/homelessness-series

Disclaimer: This presentation draws on independent research funded by the National Institute for Health and Care Research (NIHR) School for Social Care Research. Views expressed are those of the authors and not necessarily those of the NIHR or Department of Health and Social Care.

Thanks: To all research participants and Lived Experience and Advisory Group members for their generous time and insights.
National policy direction in England: positive (but tentative)

National Institute for Health and Care Excellence (NICE) Guideline ‘Integrated health and social care for people experiencing homelessness’ (2022)

- ‘Local authorities should consider having a lead for people experiencing homelessness on the Safeguarding Adults Board (SAB) ... SABs should ensure that specific reference is made to people experiencing homeless in their annual reports and strategic plan ... [and] check that local safeguarding arrangements offer the necessary protection.’ (p29-30)

- ‘Designate a person to lead on safeguarding the welfare of people experiencing homelessness, including engagement and face-to-face practical safeguarding support ... Where a social worker is embedded in the homelessness multi-disciplinary team ... consider appointing them to lead on safeguarding enquiries ...’ (p29)

Cross-government Rough Sleeping Strategy ‘Ending Rough Sleeping For Good’ (2022)

- ‘Rough sleeping and multiple disadvantage is a safeguarding issue ... DLUHC and DHSC are strongly recommending that every SAB has a named member advocating for people ... [and] clear accountability for people sleeping rough.’ (p94)

- ‘We will ensure new local Integrated Care Systems (ICSs) take account of the health and social care needs of people sleeping rough.’ (p14)

Association of Directors of Adult Social Services (ADASS) and Local Government Association (LGA) guidance note for Directors of adult social services: ‘Care and support and homelessness: Top tips’ (2022)

- ‘Early intervention and outreach work can help avoid a need for more serious interventions. Be as proactive as possible – use safeguarding preventative measures.’ (p9)

- ‘Consider jointly commissioning dedicated resource, in the form of specialist multidisciplinary teams, homelessness nurses or social workers, to ... meet the specific needs of this cohort. There is evidence that a more specialist response can deliver improved outcomes.’ (p13)