Homelessness - strengthening the linkages between housing and health System reflections for discussion

Introduction:

1. The Hampshire Homelessness workstream formed in March 2020 to co-ordinate a system wide Covid19 response for people experiencing homelessness[1]. The Workstream has continued to meet finding value in shared learning and expertise, alongside peer/critical friend challenge in the way we work together to improve our collective response to homelessness prevention.

2. Bringing and keeping an 'everyone in'[2] focus has highlighted opportunities and learning for us all – as a system - to improve the way we support and engage with people living at the edge of mainstream services because the way our system is currently designed keeps them there.

3. Our intention with this paper is to highlight the key issues and supporting evidence, at appropriate levels, where a number of service changes and joint ownership of service design and delivery could significantly alter the level of engagement, experience and outcome for people who need help and support ensuring they keep safe and well as we work as a system to end their homelessness and address their health and wellbeing needs.

4. Our narrative is illustrated by case studies drawn from across our geographical footprint. They reflect examples of people experiencing multiple disadvantage within our system as reported by our local authority partners.

5. These studies are intended to act as a basis for reflection and further conversations regarding improvement in our operational model of service delivery and design.

Purpose:

6. This paper is presented as a reflective piece, written with the intention of:

    a) Generating debate and discussion about how we are working together regarding people who experience homelessness and who may be difficult to engage within agreed thresholds
    b) Recognising that there are instances, over time, when traditional models of service delivery have not been effective for some of our most marginalised residents and for people who do not engage with support
    c) Identifying opportunities for action/service improvement
    d) Ensuring commissioned/statutory services and protocols are connected both operationally and strategically as intended

Outcome:

7. By coming together we believe we can:

    a) Change how we work together as a system in a way which enables people currently experiencing homelessness to go on to lead flourishing lives

[1] The workstream comprises housing representation from all 14 local authority partners (boroughs, districts and unitaries), NHS, Public Health, Social Care, specialist housing providers and colleagues representing Hampshire & Isle of Wight Integrated Care System.

[2] 23 March 2020 'Everyone in' – Government instruction to bring everyone experiencing homelessness inside

b) Ensure systems and processes are more flexible, that they are working effectively for all our residents in a joined-up way, and escalation levels are known and quick and easy to engage with for professionals across front line services.

Context and summary

8. Health and addiction related issues, including physical health, mental health, drug and alcohol misuse, are intrinsically linked.

9. They are factors that often precipitate homelessness and rough sleeping, and are nearly always a feature of people who sleep rough.

10. Further, often, and for a range of complex reasons, these underlying health related factors cannot be addressed by offers of accommodation alone.

11. In this context, we believe that safe, secure and stable housing is a fundamental social determinant of wider health and wellbeing[3]. We recognise that:

    a) Homelessness is multi-factorial, with complexities further evident when people experiencing homelessness sleep rough[4] despite numerous offers to come in.

    b) Safe, secure and stable housing when provided in isolation, is not always the solution to provide for a better and more sustained quality of life

    c) We need to work as a whole system and garner a sense of 'collective ownership' of homelessness to reduce health inequalities, poor life outcomes and costs to all local parties.

    d) More must be done to support local outreach efforts to bring people inside who may be acutely unwell, even where they may have an active addiction and/or may be refusing to engage with services.

    e) The wider system e.g. criminal justice, MOD and health, needs to take a more active role in preventing local people leaving institutions direct to the street in the first place. Real life case studies are used as illustrative examples to further highlight opportunities for learning and change – further details at Appendix A.

> **People are complex:** everyone's life is different, everyone's strengths and needs are different.
>
> **The issues we care about are complex:** issues – like homelessness – are tangled and interdependent on wider health inequalities.
>
> **The systems that respond to these issues are complex:** in that the range of people and organisations involved in creating 'outcomes' are **beyond the management control of any individual person or organisation – and yet there is an individual person at the heart of each and every decision we make.**
>
> - *Adapted from Mayday Trust*

[3] Exploring-the-New-World-Report_Digital-report.pdf (maydaytrust.org.uk)

[4] Rough sleeping is the most visible form of homelessness. It is dangerous and seriously detrimental to a person's physical and mental health. The difference between rough sleeping and homelessness is that it is **possible to be homeless, but not be rough sleeping**. For example, someone can be homeless if they are staying in temporary accommodation, but they are not rough sleeping outside in doorways, bus shelters etc as they have a proper roof over their head at night. Entrenched rough sleepers are more likely to develop additional physical and mental health needs and substance misuse issues – making it harder for them to engage with services as currently designed in order to leave the street and rebuild their lives.

Case 1. Local Authority Housing Team example

Single female. Learning difficulties. Diagnosed with Early Onset Parkinson's Disease. Prescribed Quetiapine[5]

28/11/18	Referral to Adult services
18/01/19	Referral chased, update requested
10/06/19	Referral chased, update requested
24/06/19	MH incident in Gosport. Police resolve – no further action
13/08/19	MH incident in Fareham. Police resolve – no further action
06/11/19	Partnership Action Group meeting. CMHT state "behavioural issues not mental health"
14/01/20	Minor MH episodes in home. Neighbours disturbed, consider calling Police
05/02/20	Ongoing MH incidents in public, deemed "attention seeking". Police involvement
02/06/20	CMHT state due to behavioural issues/public disturbances/anti-social activities they were discharging from their services
25/06/20	Police arrest and detain in HMP for breach of probation
09/07/20	Referral to CMHT to arrange support upon release
03/08/20	Referral chased, update requested
03/08/20	Request for update made to HMP
21/08/20	HMP chased, update requested
22/08/20	HMP informed us that lady had been released 7 days ago on the 14/08/20.
15/12/20	MH incident at home, attempted suicide, (overdose); Checked by Ambulance crew, (non-life threating); Ambulance submitted referral to CMHT; Referral not undertaken as CMHT colleagues reiterate lady has "behavioural issues not mental health"

12. Covid19 has exposed significant health inequalities in our work, particularly for people experiencing homelessness, rough sleeping and those experiencing multiple disadvantage.

13. The call to bring 'everyone in' in March 2020 proved that we can make greater strides to end homelessness when we work collaboratively as a system around the person. Simultaneously, it highlighted demand from people who had otherwise been living in shared accommodation arrangements such as sofa surfing, and the characteristic vulnerabilities within this 'hidden' group.

14. There continues to be a number of individuals falling out of support and emergency accommodation, and there are others who cannot be sensibly moved on from emergency accommodation due to their presenting issues. Some are struggling to engage, and have been for some time, in the way our system is currently designed to come in off the streets and/or maintain their temporary or emergency placements and convince landlords that they will be able to sustain more settled accommodation solutions. Others have been evicted from successive B&Bs with a very real possibility that they will end up living on the streets.

[5] An antipsychotic medicine

Case 2. Local Authority Housing team example
Male. Sleeping rough. Date of Birth unknown. Thought to have a military service background. Neat. Well presented. Shaven. Belongings organised, neatly packed.

1. Gentleman sleeping rough under a bridge
2. Over 15 street link referrals received from the public. Gentleman repeatedly seen talking to himself or an imaginary person, often shouting at the wall
3. Agitated when approach by female outreach worker – refused to engage/give his name
4. Thought to be connected to parents in local area, but council tax and property ownership checks have shown the address doesn't exist. Gentleman has never been registered for Council tax in the local area
5. Only housing history confirmed is 4 nights spent in LA night shelter in 2010. Recent history:
    - Early December 2020 the LA approached CMHT asking team to attend. Team declined suggesting LA approach Police or refer him to the MH Acute team
    - Police speak to gentleman, but did not make any onward referrals or safeguarding concerns
    - At meeting with CMHT with another client, MH colleagues again referred LA to refer to MH Acute team or contact Police
    - Further calls to the Police and contact with a LA officer Police advised they would keep an eye on him.
    - Gentleman moves from under the bridge to the Graveyard.
    - LA and specialist housing outreach worker visited Graveyard a couple of times.
    - 21 January 2021 – Police confirm gentleman's name; No Date of Birth
    - Outreach work completes an urgent assessment for CMHT now name known, but remains no outcome from this referral (April 2021)
    - Severe Weather Protocols implemented in early/mid Feb (low temperatures) LA and specialist housing outreach try again to engage, but gentleman packs his things and walks away.
    - LA partners approaches specialist health advisor at MHCLG for advice. MHCLG write to all LA partners advising them to contact the Police to essentially section people who were still choosing to stay out in the extreme weather
    - LA contact Police via 101 quoting Government letter requesting attendance to carry out a Section 136[6]. 101 declined to take any details. Copy of Government letter forwarded to Police colleagues but no reply.
    - April 2021 - Gentleman has not been seen for about 3 weeks. LA believes persistent outreach has forced him to move on. It has notified surrounding authorities with a description as confident that this gentleman remains homeless, still in need of support and high risk of not receiving a Covid19 vaccine.

[6] Section 136 is part of the Mental Health Act. Police can use this section if they think you have a mental illness, and you need 'care or control'. The Police use S136 to take you to a place of safety where a Mental Health Act Assessment is undertaken.

15. However, when we do work differently together, we achieve some amazing outcomes:

Collaboration between Southern Health Foundation Trust and New Forest District Council has seen mental health outreach services supporting people to sustain their temporary placement.

A number of people experiencing homelessness had previously 'cycled around' the system following MH crisis – being admitted to services and then discharged homeless, only to tip back into crisis again. The 'Everyone In' response to the Covid19 pandemic has seen specialist MH teams provide directed outreach services into temporary accommodation setting to stabilise tenancies, and keep people safe and well in the community.

During Wave One of the Covid19 pandemic Mental Health Commissioners commissioned specialist Mental Health outreach across the Hampshire footprint to support Local Authority housing partners engage with people experiencing homelessness who were not self-isolating, where mental health was deteriorating, and where individuals were an increased suicide risk.

Pioneering collaborations
- keeping people safe and well at home

We've also brokered pioneering collaborations between **Solent NHS Trust:VIVID and Southern Health NHS Trust:Winchester City Council** to develop housing led Wellbeing Services which keep people safe at home.

Our community mental health hospital colleagues provide monthly cross sector mentoring and support to three Wellbeing Workers employed by housing partners who support people living in the community with mental ill health.

VIVID's Wellbeing Service launched in December 2018 and was a finalist in the national Housing Heroes Awards 2019.
With a caseload of around 30 residents at any one time, the Wellbeing Service has already helped turn lives around and in just one case alone saved the NHS £17,000 a year through reduced GP appointments and repeat calls to 111 and 999 services.

Enabling people to 'step out' of the system

Reframing our map of the world presents game changing opportunities.

As members of a system, we have pioneered the development of a **'Step out' housing model** which enables people to be discharged from rehab and/or acute mental health services into their own permanent home.

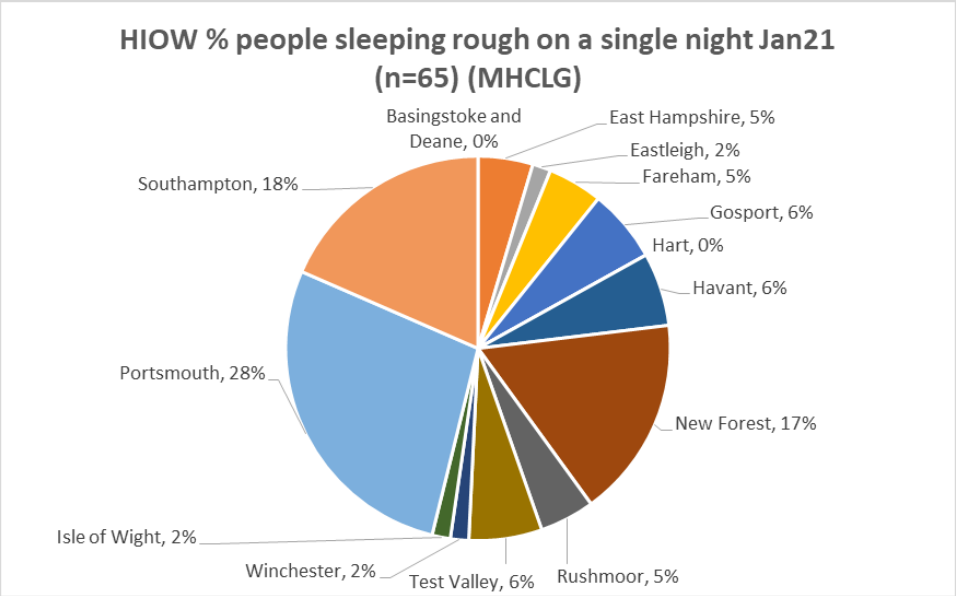
Working with **partners Abri, Southern Health and the Society of St James**, we've brokered a growing pipeline, initially of five permanent homes, pepper potted around a local a community café enabling patients to 'Step Out' of MH acute and rehab facilities – improving inpatient flow and reducing the need for out of area placements and subsequent demand on the local housing register. Our sixth home is now under offer, with discussions underway to explore how we can 'scale up' this offer across local authority partners. Staff report:

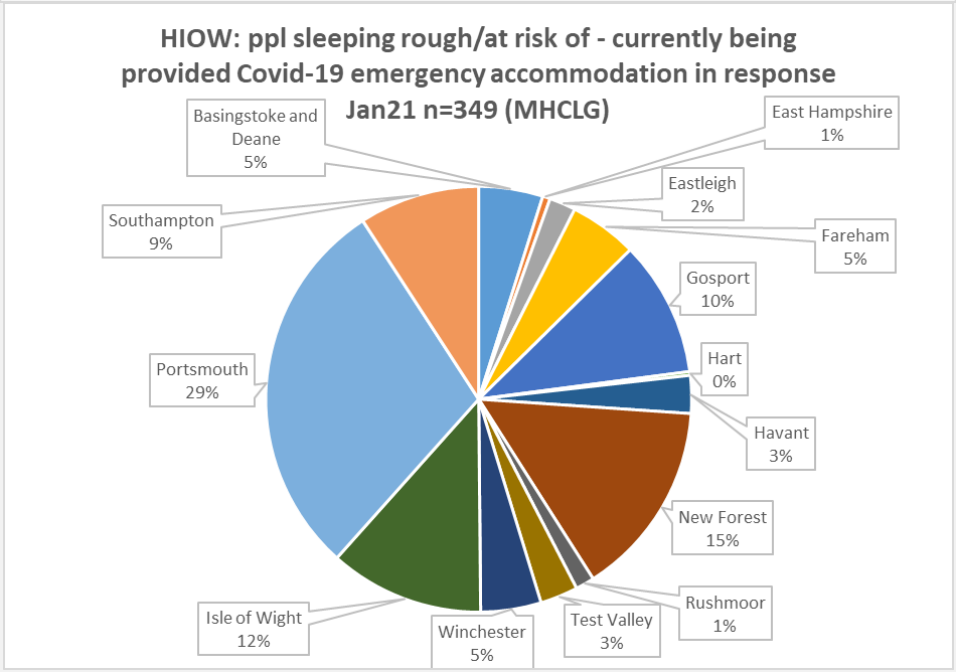
- People leave with feelings of joy and happiness
- Increased staff morale seeing people step out of the system into true independence
- Patients were able to be discharged an average of three months earlier than expected, and remain successful in moving forwards with their lives
- No one has been readmitted - no further use of 111, 999, Ambulance or MH hospital emergency presentations

16. The current state of homelessness across Hampshire and the Isle of Wight:

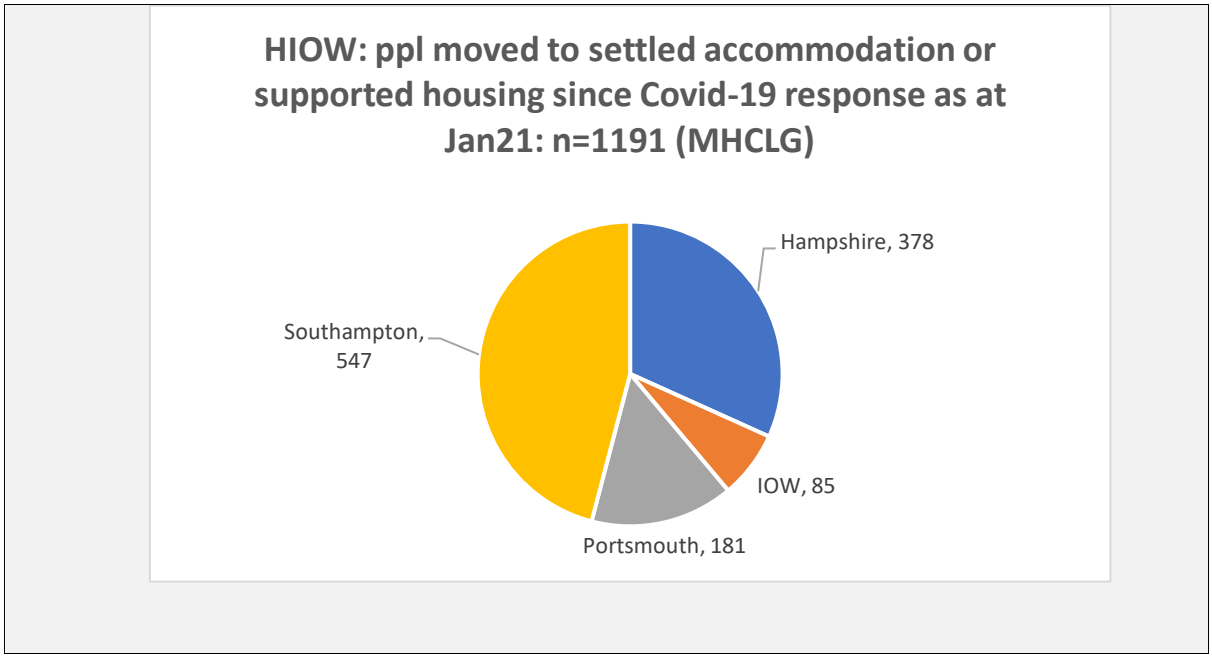
Hampshire and Isle of Wight (HIOW) – local authorities homelessness data:

a) Indication of the number of households experiencing homelessness:
(ie sleeping rough and in local authority funded temporary and/or supported housing)
- May 2020 = 1685 (collated from HIOW Homelessness Workstream partners)
- Jan 2021 = 1626 (as below)
  - Sleeping rough – 65 (MHCLG)
  - In Covid19 emergency accommodation – 349 (MHCLG)
  - Pre-existing homelessness accommodation – 1212 (Workstream data capture May 2020)





b) People supported to move into settled or supported housing since Covid19 response = 1191 (MHCLG)



17. In April 2021 a survey was undertaken across the 11 Hampshire districts. Data has been submitted by 10 out of 11 Hampshire authorities, largely reflecting H-CLIC data[7] reported to government, and representing statutory housing authority activities under the Housing Act 1996 Part 7 (as amended). The survey also asked for information associated with safeguarding and homelessness where it was available and recorded.

Local Authorities are required to assess homelessness under three main categories:		
Prevention Duty	**Relief Duty**	**Main Duty**
Relates to those households presenting who were threatened with homelessness	The relief duty relates to those households presenting who were homeless at the time they approached the authority	The main duty relates to households for whom homelessness was neither prevented nor relieved, and who were in priority need[8] and not homeless intentionally

18. The **headlines below represent the caseload of three complete financial years (2018/19, 2019/20 and 2020/21).** Since the introduction of the Homelessness Reduction Act 2017 in April 2018, the Hampshire districts have:

[7] H-CLIC is a statistical system for local authorities to collect homelessness data and report back to the Ministry of Housing, Communities and Local Government (MHCLG). The MHCLG has said the aim is to provide more detailed, case-level statistics on homelessness – for example, data on the ages and genders of household members and their employment and benefit status.

[8] In March 2021 the High Court ruled councils can provide emergency housing during the pandemic to homeless people who would not normally be eligible for support. *Judicial Review – Brighton & Hove vs Ncube* Covid-19: All homeless can be housed in pandemic, court rules - BBC News

Owed a homelessness duty to approximately 15,462 households*, of which:

- *8,407 (54%) households owed a prevention duty*
- *5,694 (37%) households owed a relief duty*
- *1,361 (9%) households owed the main duty*

- **Official counts and estimates for rough sleeping in the autumn of each year total 365 individuals across the 3 years.** Expressed as a percentage of all homelessness duty cases above, this figure represents 2%.

- **The districts reported being approached by 10,822 single homeless people over the period.** Of all single homeless people approaching local housing authorities, the number of rough sleepers represents 3.4%.

- **Of all single homeless approaches, 61% were men and 35% were women**.

- Of all the 15,462 households, **various support needs were established through case assessments and recording**. NOTE: Of those support needs identified at an initial assessment, the following may be most relevant to single people with complex needs and are provided below as a percentage of all assessed support needs associated within the overall caseload figures:

    - *26% had a mental health problem*
    - *14% had a physical health issue or disability*
    - *10% had a support need associated with domestic abuse*
    - *8% had a history of repeat homelessness*
    - *8% had a history of offending*
    - *7% had a drug dependency need*
    - *6% had a history of rough sleeping*
    - *5% had a history of alcohol dependency*

**Households can move between duties (e.g. from prevention to relief and into main duty) so this will not necessarily accurately reflect a 'total caseload' figure, however it is a good indication of the total number.*

19. Safeguarding referrals relating to homelessness

    a) The survey demonstrated that district recording of safeguarding referrals relating to people who were experiencing homelessness or who were at risk of homelessness can be significantly improved.

    b) The following figures have to be understood in that context, and are therefore indicative.

Across Hampshire Districts:

- **352 safeguarding referrals were made relating to homelessness and housing** - which expressed as a percentage of all duty cases, represents 2.3% of cases.

- **107 of 298 referrals were associated with rough sleeping or a history of rough sleeping** – which expressed as a percentage of all duty cases, represents an indicative 0.7%.
- Of 352 safeguarding referrals made, the **data returned suggests** that low numbers of referrals have a known or reportable outcome. Using the data returned, **just 3% of the total recorded referrals had a known or reportable outcome.** Of these, although we recognise the data may be unreliable:

    - 0.8% of referrals were ultimately supported through safeguarding (where the outcome was known)
    - 0.5% were refused (where the outcome was known)
    - 0.8% were escalated (where the outcome was known)
    - 0.8% were supported through alternative pathways of support (e.g. Multi-Agency Risk Management, Community MARAC or other)

20. The overall data demonstrates that local housing authority caseloads are, collectively, very large. It also demonstrates that mental health is a primary support need featured. Yet the number of single people with complex needs was relatively low. Considering those with complex needs who were found to be rough sleeping, and who triggered a safeguarding referral, the level is comparatively very low indeed.

21. The data demonstrates that local housing authorities flag safeguarding concerns associated with people experiencing homelessness in a proportionally very low number of cases across the county when compared with the high numbers of people they see. It also suggests that feedback isn't being received and cases are not being escalated appropriately.

22. Anecdotally, discussion suggests that current escalation processes put further work on the referrers and this often requires them to redouble the efforts they have already made to engage a multi-agency response.

23. We must reflect on whether this is a wider system cultural or process challenge - or indeed both - in that cases are initially raised to cover personal/organisational risk, but not escalated because it is considered unrealistic, with no guarantee that further time spent will elicit a positive system response.

Case 3. Local Authority housing team example
Single male. Care leaver with known history of childhood abuse. Diagnosis: Emotionally Unstable Personality Disorder, depression, anxiety, self-harm and suicidal ideation.

Placed in temporary accommodation. In the last 46 week period (to April 2021):

- 93 case notes have been entered, (around 2 per week), on average emergencies noted once in every 6 weeks
- At least 6 referrals to CMHT from multiple sources including: Fire, Police, Ambulance, Local Authority, Housing Association and QA Hospital
- Over 65 calls to the 999/111 emergency numbers requesting help/reporting desire to self-harm or suicide.
- At least 17 suicide attempts, the majority being determined as "attention seeking" and not admitted to hospital, however 3 more serious occasions resulted in admission for treatment/observation.
- 3 "Safeguarding" referrals to HCC services

As yet, CMHT will not accept any of the recent referrals based on their previous report that he has "behavioural not mental health problems".

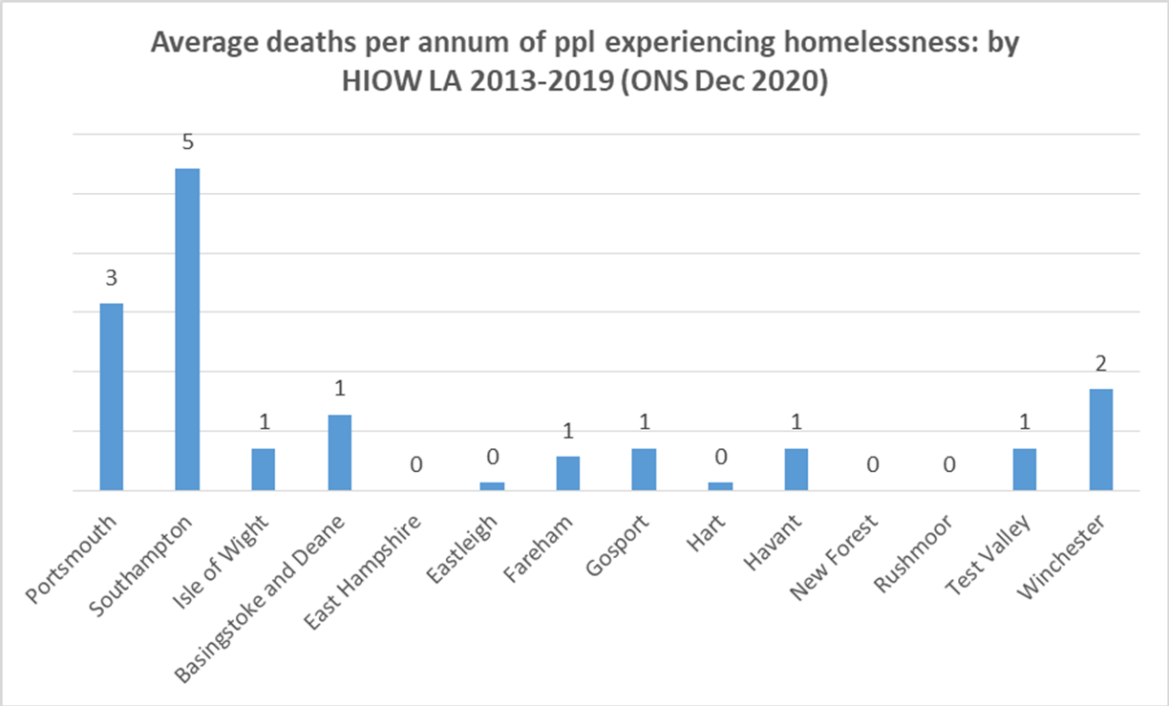
Issues:

24. We believe that a home provides the cornerstone and stability required to lead healthy, purposeful and fulfilling life - but is only one piece of a broader societal jigsaw of health and support needs which together enable people experiencing multiple disadvantage to lead their best lives.

25. It is also true that health problems, including mental health and addiction, reflect underlying causes of homelessness.

26. Despite our best intentions, we recognise we have a number of people, who for one reason or another are falling between gaps in services. These individuals are at increased risk of very poor outcomes and potentially dying from completely treatable causes unless we change the way we work together. There is an opportunity to make small service changes that may result in improved access and outcomes for clients.

a) Deaths of people experiencing homelessness 2013-19 (Data from ONS)
   - Based on people sleeping rough or using emergency shelters / direct access hostels, at or around the time of death
   - 115 registered to have died whilst experiencing homelessness in 7 year period
   - 15 people pa = average of 1 person per HIOW local authority per year



27. The Bureau of Investigative Journalism – Museum of Homelessness: Dying Homeless Project[9] finds a significant and increasing number of people are still dying when they come in off the streets - a stark reminder that housing is only part of the solution, and that partners across the system must work together around homelessness prevention to properly consider both the suitability of accommodation and wrap around support provided.

Adult Safeguarding

28. There are common themes from safeguarding adult reviews (SARs) that have looked at the experiences and voices of people who are homeless. The story of Howard[10] clearly shows how people can 'slip through the net' even though many services are involved. In Howard's case, for example, adult safeguarding enquiries did not result in further investigation or multi-agency meetings. He was refused housing as he was not considered as in priority need, and yet there was a Care Act 2014 care and support assessment.

[9] Museum-of-Homelessness-report-of-findings-on-homeless-deaths-in-2020-FINAL-2.pdf (museumofhomelessness.org)

[10] SAR Howard 2018

29. A key challenge is that when health services advise housing teams that an individual's vulnerability is not a result of a health condition but behavioural, then housing teams do not necessarily have a Duty to accommodate an individual as they may not fulfil the test of priority need (Part 7 Housing Act 1996 (as amended)) – which means people fall through both 'health' and 'housing' gaps in the system.

30. To aid learning and systemic change, all case studies included in this paper are being referred for a Safeguarding Adults Review.

31. Other SARs highlight the importance of seeing multiple exclusion homelessness as a safeguarding issue. A number of case studies discussed at the Homelessness Workstream show that there is not always an understanding across agencies of when safeguarding concerns should be reported. Legal literacy is vital for practitioners, especially the Mental Capacity Act, the Care Act and inherent jurisdiction.

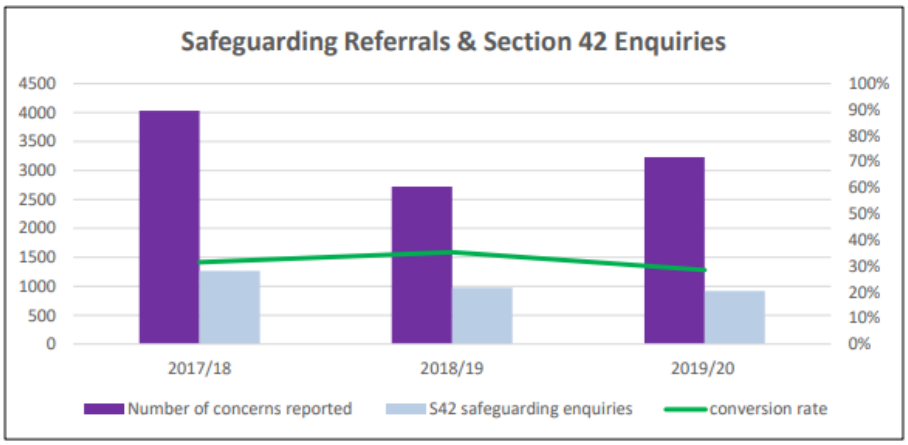
Best Practice from SARs

- Understanding the connection between homelessness and safeguarding risk- safeguarding is the thread running through everything, including commissioning, and multi-disciplinary working
- Aligns with the six safeguarding principles
- Use of multiagency meetings and safeguarding enquiries
- Understanding the MARM framework
- Information sharing and consent is understood
- Strategies to reduce homelessness make links to/refer to adult safeguarding
- Promote trauma informed approach
- Audits of decision-making process in adult safeguarding (section 42)
- Looking after staff and supervision –remembering vicarious trauma
- Understanding the impact of childhood adversity

32. Data from the Hampshire Safeguarding Adults Board Annual Report 2019/20 finds that overall there were 3231 safeguarding concerns raised which represented an increase of 510 (19%) on the previous year. We know this data does not specifically reference homelessness, but it does demonstrate a huge increase in demand on safeguarding services. In the light of the fact that people experiencing homelessness do not necessarily have a voice in the existing system, there is a clear and apparent risk that they may be lost amongst general referrals.

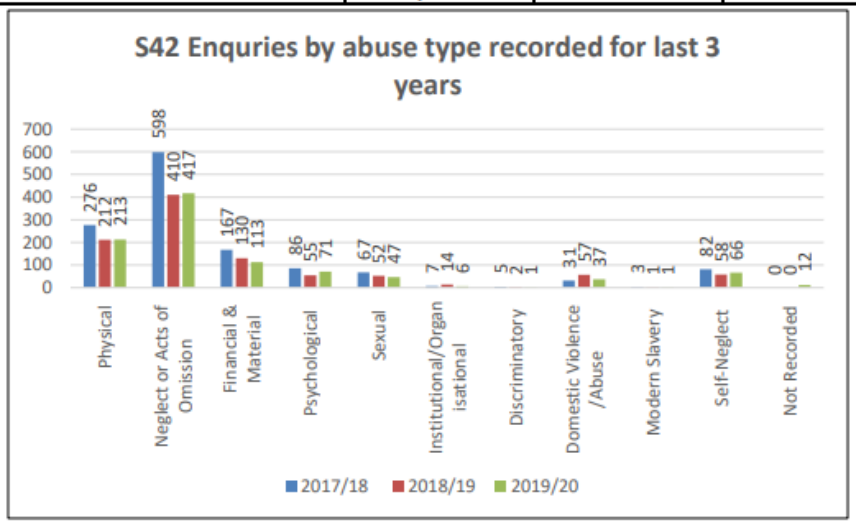
33. Of the 3231 concerns reported, 919 resulted in a Section 42[11] safeguarding enquiry. This represents a conversion rate of 28% of concerns progressing to an enquiry. This figure had decreased by 35% compared to 2018/19. Further work to understand this drop in conversion rates may be appropriate in terms of known safeguarding risks associated with being homeless.

[11] Section 42 of the Care Act 2014 requires that each local authority must make enquiries (or cause others to do so**)** if it believes an adult is experiencing, or is at risk of, abuse or neglect**.** When an allegation about abuse or neglect has been made, an enquiry is undertaken to find out what, if anything, has happened.

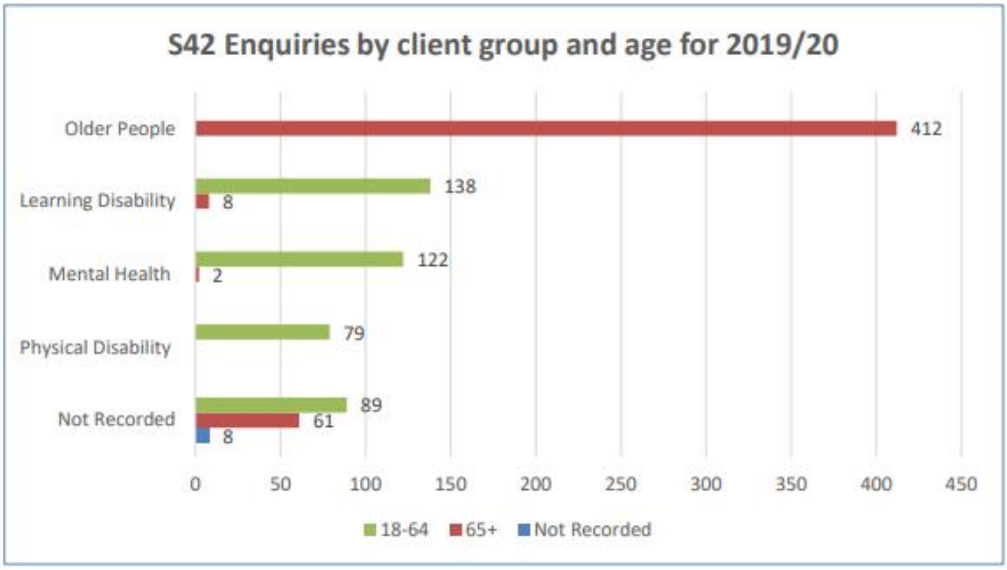


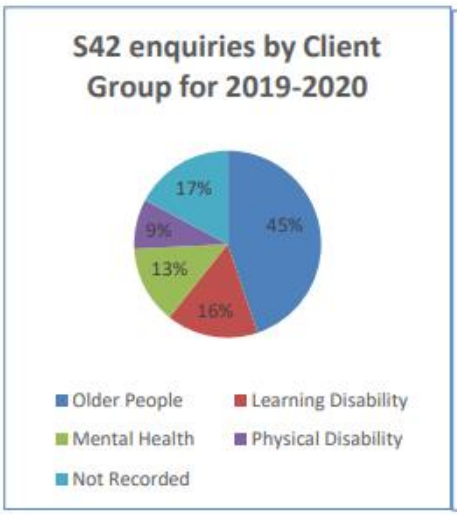
34. Of the Section 42 enquiries, there were 417 cases of neglect and acts of omission and 213 physical abuse enquiries. Together, these two categories represent 64% of all concluded safeguarding enquiries and therefore, account for the majority of the concerns reported. Neglect and acts of omission along with physical abuse have been the most common forms of abuse over the past four years. *The total figure of 984 is larger than the 919 recorded concerns, owing to the cases in which there are more than one type of abuse.

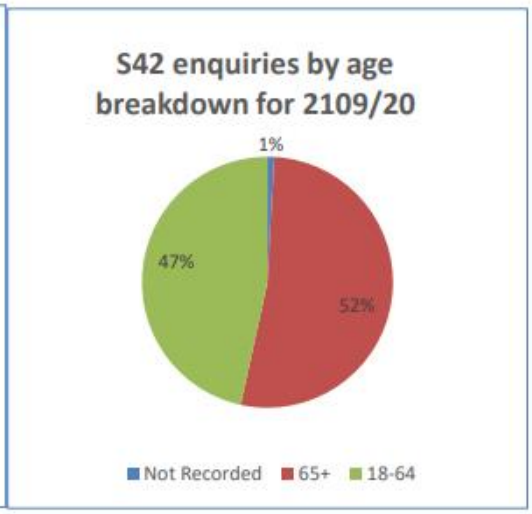
Types of abuse reported	2017/18	2018/19	2019/20
Physical	276	212	213
Neglect or Acts of Omission	598	410	417
Financial & Material	167	130	113
Psychological	86	55	71
Sexual	67	52	47
Organisational	7	14	6
Discriminatory	5	2	1
Domestic Violence /Abuse	31	57	37
Modern Slavery	3	1	1
Self-Neglect	82	58	66
Not Recorded	0	0	12
Total	**1,322**	**991**	**984**



35. Continuing the pattern of previous years, the majority of adults having a Section 42 enquiry are older adults, that is, adults over 65 years old. This group accounts for a total of 52% of all enquiries.

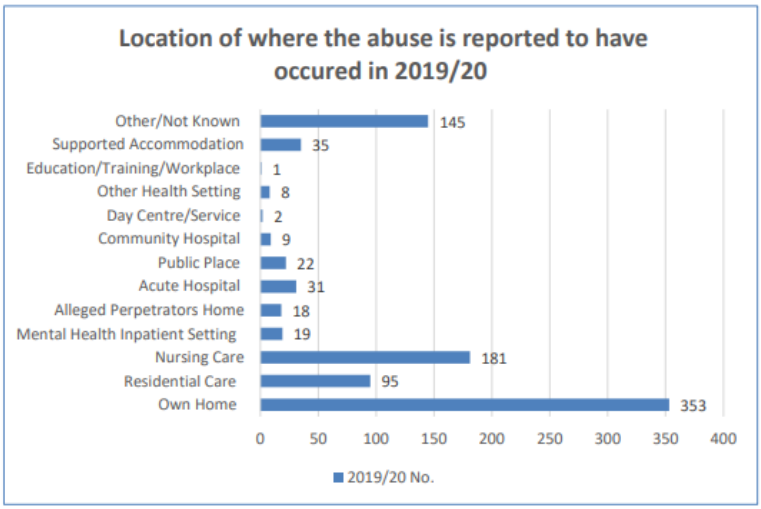






36. Under half of adults, that is 38%, for which Section 42 enquiries were completed, lived in their own home. The next most prevalent area of where adults lived when experiencing risk, lived in nursing and residential care homes, which accounted for 30% combined.

37. It is difficult to form a conclusive view, but this may indicate a large proportion of people currently counted in the Section 42 safeguarding enquiries are either in their own home or already in the system in different ways – criminal justice, health, supported housing etc. This means that it is difficult to ascertain from the data what percentage of the 16% 'other' are either experiencing homelessness or on the cusp of services ie sofa surfing, and are lost to us.



	2019/20	
	No.	%
Own Home	353	38%
Residential Care	95	10%
Nursing Care	181	20%
Mental Health Inpatient Setting	19	2%
Alleged Perpetrators Home	18	2%
Acute Hospital	31	3%
Public Place	22	2%
Community Hospital	9	1%
Day Centre/Service	2	0%
Other Health Setting	8	1%
Education/Training/Workplace	1	0%
Supported Accommodation	35	4%
Other/Not Known	145	16%
Total	**919**	**100%**

Non-Engagement

38. The evidence collated in this paper suggests that, for those people who do not necessarily engage in support when it is offered, the system at large could operate with greater tenacity and persistence in offering its support to those people.

39. This is often achieved over time, and through winning trust by continuously seeking to engage. We can see that, in terms of people experiencing homelessness and marginalised by the system, the proportion of cases that we can readily identify from data that might require a completely different approach from a network of services - not least in a collaborative and assertive approach to outreach for rough sleepers that includes health and housing working side by side – is actually small.

"No matter how passionate organisations and individuals are about changing what they perceive as people's harmful behaviour, without a wider understanding of who the person is, they will almost never succeed. Yet every day, workers are trying to help 'fix' their issues, their drug use and their mental health problems. The impact of this is that we end up compounding people's belief that their situation is hopeless. If the person has become institutionalised, they will have built up an entire history of repeated failures within the system, so they will have limited evidence that they can have a different life which creates a huge psychological barrier for change"

Pat McArdle, The Mayday Trust[12]

40. Yet those cases demonstrably impact across the system, with multiple touch points representing multiple crises. The way the system currently responds does not seem to address the issues in a way that might confidently prevent further arrests, admissions to A&E, evictions, nights out on the street, or acute psychiatric admissions. Only by working together, outside traditional models of delivery, can we hope to address these instances and prevent otherwise preventable harm.

41. We must find a way to work differently together to support local outreach efforts to bring people inside who may be acutely unwell and actively support them, even where they may have an active addiction. This is at a strategic and operational level.

"We must break the cycle of homelessness or unstable housing by transforming our approach particularly for people who have a dual diagnosis where they are experiencing mental ill health but self-medicating using drugs and/or alcohol and just stuck between services in limbo … Mental health colleagues can't assess due to active addiction … Inclusion services say addiction is driven by mental health problems … and local authority partners are left trying to support individuals from tipping further into crisis.

"It becomes a 'chicken and egg' situation and people get stuck. How do we get our heads around this to solve it? What practical help can each of us bring to the table? What is the support needed to make it safe for the person to step into services, whilst safeguarding those people in the service already? Knowing how some individuals have been marginalised by the system, how can key agencies with fundamentally important skillsets remain engaged when their help is refused on the first and second attempts?"

Local Authority Senior Housing Lead

42. We must work as a system to ensure the right level of support at the right time is in place for the length of time needed to enable people to successfully transition from the street, or out of Covid19 B&B accommodation, and into more settled housing and that as a system, we are not desensitised or hardened to risks in particular cases, or when standard approaches to an individual means that important information or different ways of seeing a situation are overlooked.[13]

[12] What'S WRONG WITH THE SYSTEM? (maydaytrust.org.uk)

[13] Michael Preston-Shoot, LGA ADASS: Adult safeguarding and homelessness: a briefing on positive practice (local.gov.uk)

43. We must dispel the myth that homelessness is a lifestyle choice, because it isn't. Neither is homelessness necessarily symptomatic of a 'housing related problem'. We must ensure the system that can recognise, understand and respond to trauma.

44. All residents, regardless of their presenting levels of need, are deserving of our help – they may not tick the right box, or indeed they may tick too many boxes, but we must still respond effectively and particularly in that handful of cases where the local housing authority actively reaches out to ask the system to operate outside its 'normal' practice.

45. Safeguarding adults is improved through learning to work together and is achieved like a jigsaw fitting together all the elements – joint commissioning, legal literacy, joint working, good information sharing, transition between services such as discharge from hospital, reflective discussion for practitioners, and understanding safeguarding processes.[14]

46. We must, collectively, challenge legacy stereotypes, unconscious bias and pre-judgements about people reflecting on how at times, we can be complicit in discharging people from services without care of their next step, or if they do not engage in the way the system is currently designed.

47. We recognise that mental ill health is often prevalent within this cohort, and yet system mental health resources are already stretched.

48. As well as the human cost of disadvantage, we calculate that homelessness alone costs the HIOW system additional £38m per annum, based on current figures (ref: Crisis Report[15])

Opportunities and strategic links

49. County-wide discussion during the Covid19 crisis, raises opportunities for us to ensure that system protocols and processes are working as intended.

50. We previously recognised there was a service gap in clinicians reaching out to hostels, and have worked hard to secure funding for an outreach type model where we link clinicians to our larger hostels as we have done in care homes. We will monitor the impact of this extension in the way Primary Care Networks work as part of the mobilisation.

51. Another area that has been regularly highlighted relates to mental health services where some operational adjustments may have a significant impact. We recognise that service redesign opportunities exist within the Community Mental Health Framework for Adults and Older Adults – transforming the way people can access mental health services at a neighbourhood level.

52. There is appetite at a system level to undertake a whole system wide review of service transition and discharge points – using transition points as opportunities - 'Changing Futures' - to ensure that people experiencing multiple disadvantage can be supported to flourish and lead their best life.

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[14] *'Homelessness and adult safeguarding: adopting a human rights-based approach'* - Safeguarding for people experiencing homelessness 2020 NHSE

[15] costsofhomelessness_finalweb.pdf (crisis.org.uk)

53. It is not currently clear that pre-existing strategies and plans in motion will achieve this, and so we must think afresh about how direct action in the way we collectively deliver services on the ground can be achieved quickly and sustainably through effective line management and commissioning opportunities, recognising the challenges highlighted in this paper.

54. We recognise the more we get right for people experiencing homelessness, the more we get right for the wider community and the better we will become at protecting our resources and targeting them in the right way to get the best impact. Sometimes, this may require us all to look beyond our statutory duties and towards how we might sensibly adapt our discretion and our powers to facilitate new ways of working that are effective.

55. We need to use our learning to reflect on our preparedness for broader known pressures bubbling underneath the system as we anticipate the impact of the end of the eviction moratorium, the £20 per week uplift in Universal Credit, end of furlough, end of probation service capital funding for prison leavers and increasing need to house asylum seekers/refugees across the southeast.

56. Locally there are a number of strategic links/points of influence[16] for this work:

- Learning from Homelessness Trailblazers across Hart and Rushmoor, and Southampton – generating recommendation regarding collaborative working, shared activity, co-location etc
- The delivery of MHCLG funded Rough Sleeping Initiative projects across the county
- Serving Hampshire – Strategic Plan for 2017 – 2021
- Towards a Healthier Hampshire: A strategy for improving the Public's Health 2016-2021
- HIOW Integrated Care System – roadmap – Housing Programme
- Hampshire Health and Wellbeing Board – exploration of a Health begins at Home Memorandum of Understanding
- Existing MEAM and MECC practice across some of our local authority partners
- Mental Health Transformation - Community Mental Health Framework for Adults and Older Adults
- Changing Futures whole system review of service/institution transition and discharge points to prevent people experiencing multiple disadvantage from falling between gaps in services
- Learning from MARMs; SARs; SIRIs, and Thematic Reviews
- District level Preventing Homelessness & Rough Sleeping Strategies

57. And nationally:
- GOV.UK Covid19 Response – Spring 2021 (Roadmap)
- Kings Fund – The NHS role in Tackling Poverty
- NHS White Paper – innovation and integration
- GOV.UK Rough Sleeping Strategy[17] (2018) committing to end rough sleeping by the end of the current Parliament in 2024 – 3 years earlier than the previous commitment.
- Groundswell's reports "Monitoring the Impact of Covid-19 on People Experiencing Homelessness" and "The Lived Experience of Homelessness"

[16] There may well be others ie local authority Housing and/or Homelessness Prevention Strategies, Local Plans etc

[17] Rough Sleeping Strategy August 2018 (publishing.service.gov.uk)

Reflections – for discussion:

58. We believe we must work as a whole system and garner a sense of 'collective ownership' of homelessness to prevent it happening in the first place, respond to it effectively when it cannot be prevented, end rough sleeping, reduce health inequalities, poor life outcomes and costs to all local parties.

59. It may be appropriate for all system partners to reflect collectively how they might work together differently to avoid the very real personal cost and tragedy that home loss brings, and so:

    a) Do we recognise this problem? How do the themes highlighted in this paper resonate with each of our activities at an operational and strategic level?

    b) At a time when all aspects of the system are strained, how can we make this everyone's business? How can each of us lever change in the way we work so that our collective efforts achieve the cultural change necessary to reach beyond organisational boundaries?

    c) How can we all support local outreach efforts to bring a handful of people inside who may be acutely unwell and at high risk of harm, even where they may not be easy to diagnose, and may have an active addiction and may self-medicate with drugs/alcohol (currently a barrier to access Mental Health services).

    d) Rather than wait for formal service reviews/redesign what can we begin to do today to change the life chances of people tomorrow - by simply changing the way the work together as one team from this point forwards?

    e) If we're asking mental health services to operate outreach support, how can we strengthen mental health capacity given that it's not just a question of investment, but of recruitment too? Are there different models/offers/hybrid services we can deliver collaboratively?

    f) How can we work together to ensure the right level of support is in place for the length of time needed to help people successfully transition in from the street, or out of Covid19 B&B accommodation into more settled housing. What is the art of the possible?

    g) Where we have concerns for individual wellbeing what mechanisms are already in place; Are they working as intended? Are there any gaps? Can they be streamlined and made more accessible to front line professionals working across the system so that they are easy to use – and so that they are being used?

    h) How can we use existing serious case review recommendations as a basis for an audit/reflection – have actions been completed? What has changed because of findings?

    i) Is there a case for us to undertake further analysis into safeguarding data to better understand the demographic profile of those identified as experiencing 'self-neglect' to understand of those case, how many experience homelessness? Is the system able to

recognise sleeping rough as a form of self-neglect when offers of accommodation and support have been refused?

j) How can we make changes in the way we work together to get our offer right for this group: 'minding the gap' as people transition between services, or are discharged/ released from prison, hospital, military service and custody? What mechanisms are already in place? Are they working as intended? Are there any gaps?

k) Is there a case for exploring greater reciprocal working between local authority partners for people experiencing significant multiple disadvantage, including an established baseline service offer that reflects the 'Everyone In' ethos beyond the current pandemic?

l) How can we prepare for pressures bubbling underneath the system as we anticipate the end of: eviction moratorium, furlough, £20pw Universal Credit Covid-19 uplift; probation service capital funding for prison leavers and increasing need to house asylum seekers/refuges across the southeast? Not to mention increasing pressures on mental health services and social care?

m) Should the HSAB consider this paper in its fullest form?

Next steps

60. The answer to these problems is within our gift, collectively, but we have to firstly be able to accept collectively, that there are problems, and secondly, that we must change together across a complex network of services.

61. The changes we each make today, tomorrow and the next day may well be small, but have the potential to create immediate impactful and positive change.

62. Each of us will see this problem through a variety of different lenses. No one individual will fully understand all the nuances of what change will mean for individuals, for teams or partner organisations, but if each of us shares the will to tackle these challenges head on as one team, we will create momentum to enable marginalised individuals to lead their best lives.

63. Thank you for taking time to reflect. We are pleased to discuss how we might move our discussions forward into practical action, both strategically and operationally.

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15 July 2021

Appendix A

Further Hampshire & Isle of Wight case studies

The case studies included in this paper reflect the lived experience of people who have lost their home and are revolving within our system as reported through the lens of our local authority partners.

The insight they provide is not intended to finger point any one single issue/point of failure but to demonstrate that we are collectively responsible for the challenges illustrated here. Partner organisations across the system are invited to reflect on the way it works with other agencies to enable people to step forward from their toughest times towards a purposeful, fulfilling life.

To aid learning and systemic change, all case studies included in this paper are being referred for a Safeguarding Adults Review.

Case A

Single female. Currently sleeping rough. Diagnosis: Emotionally Unstable Personality Disorder, alcoholism. Previously in place in homeless hostels, before that Council accommodation. Has since lost all accommodation.

Multi agency meeting in 2019 stated:

- History of self-harm
- Known to have overdosed before & suicide attempts by ligature
- Deemed "Vulnerable" & at risk of death if homeless
- Deemed not suitable for independent housing
- Evidence that "Hostel accommodation" with low level support fails
- Multiple mental health assessments, not detained, as assessed to have capacity
- Known to CMHT for 18 years, but colleagues state poses more risk to herself in hospital than in the community

For the next 18mths, this lady was helped numerous times into accommodation by local authority partners, interspersed with stays in hospital (voluntary and under section). Local authority made many referrals raised to CMHT colleagues, but always the service always declined to support her as she was "a drinker", 'has capacity' 'it's behaviour' and "refuses to engage".

In April 2020 this lady was placed into temporary accommodation so that she was able to access other services.

Despite protests by local authority teams, in May 2020 CMHT colleagues discharged their duty as she had refused to engage and continued to drink.

May 2020 lady sadly attempts suicide following discharge from hospital (jump from height). Almost dies – sustaining a broken neck, back and other life changing injuries.

Lady now placed in a long-term high support residential setting.

Case B

Client (gender not disclosed). Aged approx. 26 years old. History mental ill health. Previous substance misuse.

Concerns raised by professionals working with the client when they were in (hospital) and the risk this client posed due to their behaviour when they were unwell. Supported accommodation providers had not accepted the client for accommodation due to possible risks the client posed.

There had been concerns raised about the client's poor engagement with community support, as well as concerns raised that the client may return to illicit drug use and that if this happened this would have impact on the client's mental wellbeing when living independently. The client's previous housing broke down due to this.

When unwell the client had been verbally aggressive, threatening, and hostile and it had been reported that they had carried knives and behaved in a sexually disinhibited manner.

The client had set fires in the past and been physically and verbally aggressive to others.

This client was discharged by the hospital mental health team into a Travel lodge. No Duty to Refer form was received. There was no move on plan in place nor any partnership working.

The accommodation was secured for the client for 2 nights by the mental health team at the hospital and the client was advised to present to Local Authority partners on the Friday as homeless.

Case C

"The client was holding a blade to his throat in the emergency access hostel. He was drawing blood and threatening to go further. Hostel staff were unable to secure an emergency response from Adult Mental Health Team – the feedback was that it appeared to be attention seeking behaviours.

"Ambulance would not access the hostel because there was a blade involved. The Police would not respond because they deemed it to be in a private setting and therefor a civil dispute.

"I think this may have been a combination of many factors and maybe not a straightforward example to use. However very important when we're looking at the wider processes and responses that complement any safeguarding practices."

Case D

"In November 2020 we referred a female rough sleeper through to Community Mental Health Team colleagues following an incident which involved a council officer and specialist outreach worker where they felt at risk of violence due to the applicant's mental health.

"The incident was reported to the Police whose response was "*it's [individual] again*'. It took us about 3-4 weeks of consistent pressure with Community Mental Health Team, Adult Mental Health Team and Safeguarding colleagues before we could get a Mental Health Assessment. It was then determined that the lady did not have a significant or enduring mental health issue, her problem was:

"Following CMHT team meeting on the 3rd December 2020 it was deemed that there is no immediate need for mental health services as housing and social circumstances are at the forefront of her needs.

Management will review the proposition to discharge [individual]''

"No further action was taken with the applicant."

Case E

"This individual had a social housing tenancy which he left following a Closure Order.

"This individual was being targeted by drug users/dealers who were causing Anti-Social Behaviour around his home. The individual left his home and set up a camp by (a leisure centre). He really enjoyed being left alone and would beg outside Lidl.

"We believe this individual uses substances. The individual is open to CMHT because he receives a depot injection. We had no other reason to question his capacity to decide not to accept accommodation until the weather turned cold in February 2021.

"A council colleague tried to contact CMHT colleagues, but they didn't return her call. She rang the 101 service, but they declined to take any details.

Case F

Male. 23 years old - currently living in Stage 1 Mental Health supported housing
Diagnosis: Schizophrenia and Mild learning disabilities

This gentleman presented as homeless on 26th September 2019 due to parental eviction. His parents were unhappy that he lost his voluntary job at a charity shop. (The Police having helped him secure Bed and Breakfast accommodation for one night with B&B owners kindly giving him a lift to our offices the next morning.)

This gentleman is supported by a Social Worker, Adult Mental Health, the Substance Misuse Social Care Team and a named individual within the Community Mental Health Team.

"I was in close contact with social worker and her team but they were unable to offer him any accommodation. I had concerns in securing emergency accommodation for him, as I didn't feel this was appropriate. I had concerns regarding his mental health and he presented quite childlike so was concerned for his understanding and capacity. Previously he lived in accommodation secured by health care/mental health colleagues but had always lost this due to his behaviour.

Alternative accommodation was secured for this gentleman at another local hotel where he behaved and was there until he was secured accommodation in Stage 1 Mental Health. His tenancy started on 30th October 2019. In January 2020 complaints started from neighbours to the Social Landlord regarding his behaviour.

Social Landlord has been left with no option but to issue at 28-day notice. His parents do not want him to return home.

His Social Worker suggests that this gentleman needs self-contained accommodation and his behavioural issues are linked to him not being able to share accommodation with others.

This gentleman will need high level support to sustain a tenancy. He has limited life skills and unsure how much he will understand regarding sustaining a tenancy in general. His current situation is not solely a housing issue although I feel that the expectation is that emergency accommodation / long term housing will be secured for him. It is concerning as he has been unable to sustain high level supported accommodation.

Case G

Female. 27 years of age. Prescribed seizure medication.

File note from Housing Officer after phone call from the above lady:

"I took a call from this lady advising she wanted to go to a hostel as she could not return to her parents address at [redacted]. I attempted to establish why she felt unable to return to her parent's property and she advised she felt it wasn't safe for her to be at her parents' address.

"I asked her why she felt it was unsafe to go back to her parents. She advised she just didn't want to be there. I asked her if her parents had asked her to leave and she advised they hadn't and re-iterated she just didn't want to be there and wanted to be somewhere on her own.

"I tried to establish why she didn't want to return and she advised again she felt it was unsafe. She advised she was worried she would hurt her parents as she has done before – losing her temper and getting angry - and didn't want to go back to the property.

"We discussed if I made contact with her Mum & Dad to gain an understanding of her housing situation, but she declined me speaking to her parents she did not want them to know where she was.

"I advised that for me to be able to assist her and check I was not sending her back to somewhere unsafe, she would need to tell me more about why she did not want to return to her parents address.

"The lady then advised me while she was on the phone to me, she was self-harming with a piece of glass and was sitting outside day [named] pharmacy on [Redacted] Road in [local area] waiting for it to open so she could buy paracetamol to take.

"She advised she had been admitted to hospital the night before 15/07/2020 and had been discharged on the 16/07/2020. I asked her why she had been admitted to hospital and she advised she was slashing her wrists and had taken pills.

"I tried again to establish why she didn't want to return to her parents address but she advised she just didn't want to be there.

"I asked her if she was working with any support. She advised she had an appointment with CMHT on the 17/07/2020.

"I asked her if she was on any medication and she advised she took seizure medication but did not know what it was or how much she took.

"My colleague [Housing Officer 2] called the pharmacy to determine if she was outside. The pharmacy advised they could not see a girl but there was a boy. [Housing Officer 2] advised the pharmacy that the lady was planning to buy tablets to take an overdose.

"I called CMHT to determine if they were aware of this lady, but was advised all staff were in a meeting and I was unable to interrupt them. [Staff member] from CMHT advised they were aware of this lady, and that she had an appointment booked for her by her GP for the 17/07/2020. I asked [CMHT Staff Member] to advise what they do in these situations. [CMHT Staff Member] advised they worked on an appointment service and if I felt this lady needed to see someone I should call the emergency services.

"[CMHT Staff Member] advised this lady had previously advised she was out on the streets, but on investigation she was at home with her parents. [CMHT Staff Member] advised she would pass on my update to her team and someone would call me if they require any other information.

"Housing Officers made the decision to go out and see if we could locate this lady. On arrival the pharmacy staff advised she had purchased paracetamol and was taking them while drinking cider. They had started to make a call to 999 to call an ambulance. They were also concerned as she had glass in her pocket and was cutting herself with it.

"My colleague [Housing Officer 2] tried to speak to the lady asking her how many tablets she had taken. She advised she had taken 60 paracetamols. [Housing Officer 2] asked if she had been drinking as well and she confirmed she had been drinking cider. At this point the ambulance arrived and we left this lady with the ambulance who took her to hospital to be checked.

"As a Housing Officer, given details above, we went out as we were very concerned and I felt that we needed to do a welfare check as it appeared no mental health service was available to do this.

"Since then on a daily basis we have received calls from this lady advising she is homeless and that she wants to harm herself. She has also called our out of hours service (Friday) and spoken to them for advice.

"This lady has since had admissions to A&E on a daily basis since last Thursday. On Monday the Housing team received a call from her and she advised that she had been raped and the Police were investigating. Her story around the sexual assault allegations do change.

"This lady had an appointment on 17/07/20 with CMHT and they have assessed her as having no mental health issues and feel that it is a Learning Disability and referred her to the Learning Disabilities team.

"The Housing team has since had permission from this lady to speak to her parents. Parents confirmed that they are so worried about her choosing not to go home - she is not homeless and they are happy for her to return.

"I took a call from the [redacted] Hospital yesterday advising that had she was going to be discharged and required emergency accommodation. I was speaking to a sexual abuse advocate, she had been called in due to the rape allegations. I gave them some background information as the worker was unaware of the daily admissions to A&E.

"I explained that she was a young girl that needed help but that this was not a housing issue as she could return to her family home and we have no reason to believe that this accommodation is not safe or unreasonable for her to remain in. I have passed the hospital the contact details of the LD team and CMHT and advised that they need to be supporting her.

Ends