Manchester Safeguarding Partnership

Homelessness Thematic Review

This report was commissioned and prepared on behalf of the Manchester Safeguarding Partnership

Independent Reviewer: Prof. Michael Preston-Shoot

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1. Introduction

1.1. The Safeguarding Adults Review Sub Group, which considers all Safeguarding Adult Review (SAR) referrals for the Manchester Safeguarding Adults Board (MSAB) received seven referrals between June and October 2018 where an individual who was homeless had died. In five of these cases the referrer considered self-neglect to be the type of abuse or neglect that the individual had experienced. In two of the cases the referrer did not state the type of abuse or neglect experienced by the person who had died.

1.2. The SAR referral form used by MSAB records the circumstances known to the referrer and a chronology that combines contacts with the person by different agencies known to have been involved in the case. The referral form records the discussion amongst sub group members and the conclusion regarding whether the case met the criteria for a SAR.

1.3. The sub group recommendation to MSAB's Independent Chair was that the referrals were borderline or did not meet the mandatory criteria for a SAR[1]. However, the recommendation was that, in the public interest and to gain learning from the cases, MSAB should exercise its discretionary power to commission, in this instance, a thematic learning review. In part, this recommendation was influenced by the similarity between the referrals and an emerging national picture in that most people who have been homeless have been through the system on a number of occasions. Sub group members identified a number of repeating themes which would likely become key lines of enquiry:

- Drugs and Alcohol Misuse;
- Mental Health;
- Accommodation;
- Family Breakdown;
- Domestic Violence and Abuse;
- Abuse in childhood;
- Past criminal record/time in prison/contact with Probation.

1.4. An eighth case, GN, again referring to self-neglect, was considered by the SAR Sub Group but not formally added to the sample owing to the similarity of issues raised – domestic violence, custodial sentences, violence, alcohol abuse, drug misuse, rough sleeping, frequent hospital attendance and lack of engagement.

1.5. The sub group's recommendations were accepted by the MSAB Independent Chair. The thematic review was commenced in February 2019.

[1] See section 2 for an outline of the legal rules pertaining to the commissioning of SARs.

2. Safeguarding Adults Reviews

2.1. MSAB has a mandatory statutory duty[2] to arrange a SAR where:

- An adult with care and support needs has died and the SAB knows or suspects that the death resulted from abuse or neglect, or an adult is still alive and the SAB knows or suspects that they have experienced serious abuse or neglect, and
- There is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult.

2.2. MSAB has discretion to commission reviews in circumstances where there is learning to be derived from how agencies worked together but where it is inconclusive as to whether an individual's death was the result of abuse or neglect. Abuse and neglect includes self neglect.

2.3. It is important to emphasise the distinction between the mandatory and the discretionary criteria because this is not always appreciated. Under current law (Care Act 2014), for the mandatory criteria to be met, a SAB must have reasonable reason to believe that the adult whose case has been referred has/had care and support needs, has/had experienced abuse or neglect, including self-neglect, and there is/was reasonable cause for concern about how agencies have worked together in that case.

2.4. In response to rising concerns and increased visibility of homelessness as an issue across the country, but particularly in big cities, the Government has released its Rough Sleeping Strategy: https://www.gov.uk/government/publications/the-rough-sleeping-strategy

2.5. The Strategy says…

"We agree with the Advisory Panel, who were clear that Safeguarding Adult Reviews are powerful tools, which unfortunately are rarely used in the case of people who sleep rough. We will work with Safeguarding Adult Boards to ensure that Safeguarding Adult Reviews are conducted when a person who sleeps rough dies or is seriously harmed as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. Lessons learned from these reviews will inform improvements in local systems and services".

2.6. The reason for emphasising the distinction between mandatory and discretionary reviews in section 2.3 above is that the Government Strategy appears to fail to recognise that, for the mandatory criteria to be met, the adult must appear to have/have had care and support needs as defined by the Care Act 2014[3].

2.7. MSAB's SAR sub-group, considering that a causal link had not been clearly established between self-neglect and the deaths of homeless people that had been referred, recommended that a discretionary thematic learning review be commissioned. This

[2] Sections 44(1)-(3), Care Act 2014

[3] The Care and Support (Eligibility Criteria) Regulations 2014

was finally agreed by the Independent Chair of MSAB in December 2018. I was confirmed as the reviewer and overview report writer in February 2019.

2.8. Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons in the future[4]. The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work, singly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.

2.9. The question of whether there should be a specific pathway for reviews of street homeless deaths or whether the discretionary provisions in section 44 Care Act 2014 should be used is considered further in section 9.

[4] Section 44(5), Care Act 2014

3. Review Process

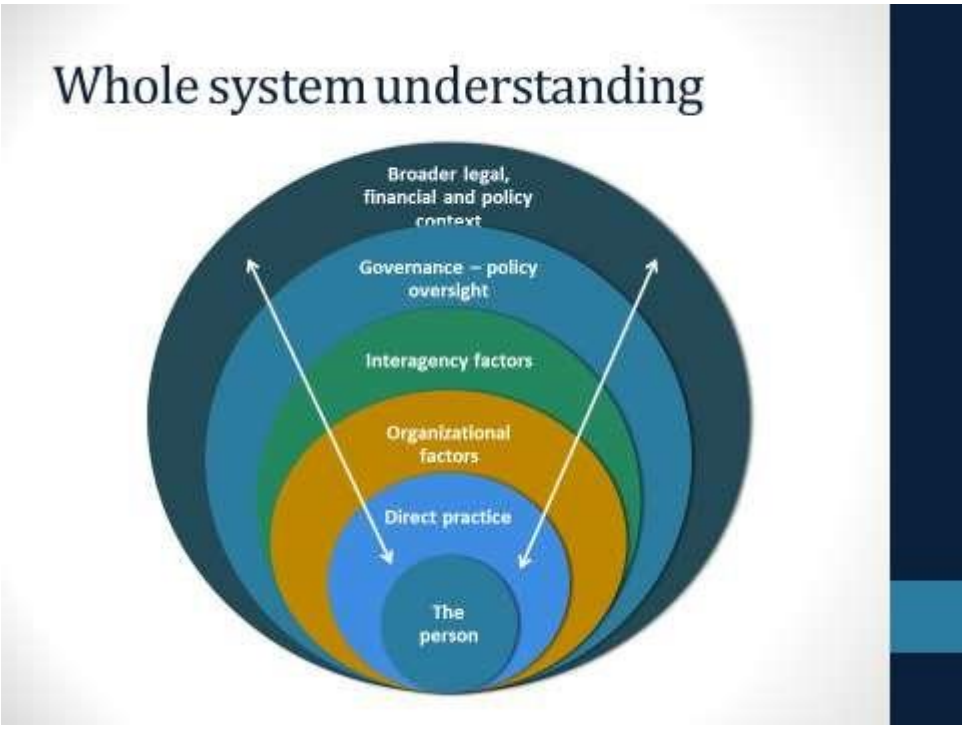
3.1. Focus

3.1.1. MSAB agreed a specification for the thematic learning review on homelessness. Its purpose was to identify trends and shape/change the strategy for supporting people who experience homelessness. The basis for the review would be to examine policy and practice surrounding the seven SAR referrals where the death of a person experiencing homelessness was a factor.

3.1.2. The review would also look at the range of existing provision, including statutory services, outreach work and third sector organisations in order to gain a better overview of whether and where the system had failed these individuals, and identify what actions agencies can take to seek to address those gaps.

3.1.3. The seven individual cases are summarised below. However, rather than a traditional review that would concentrate on a detailed chronology of a single case, this thematic review would look across all seven cases for learning from recurring themes that would indicate systemic issues to be addressed.

3.1.4. The review has adopted a whole system focus. What enables and what obstructs best practice may reside in one or more of several domains, as captured in the diagram. Moreover, the different domains may be aligned or misaligned, meaning that part of the focus must fall on whether what might enable best practice in one domain is undermined by the components of another domain.



3.2. Methodology

3.2.1. As part of the SAR sub group's deliberation on the seven referrals that were specifically included in the sample for this thematic learning review, and indeed also for the eighth case, combined chronologies were compiled from information supplied by partner agencies. Some information was available in two cases from when the individuals were still in law children. Otherwise chronologies reached back towards 2000 and enabled a longitudinal perspective on recurring themes.

3.2.2. A review team was established to support the independent reviewer. Membership comprised:

- Social housing associations
- Third sector organisations
- Prison Service
- National Probation Service
- Community Rehabilitation Company
- Local authority children's social care
- Local authority adult social care
- Local authority community safety
- Local authority youth justice
- Local authority housing and homeless services
- Change Grow Live
- Substance misuse services
- Greater Manchester Mental Health
- Manchester Foundation Trust
- North West Ambulance Service
- Clinical Commissioning Group
- Health and Care Commissioning
- Greater Manchester Police
- Urban Village Medical Practice
- MSAB

3.2.3. At its first meeting it reviewed the themes that appeared to be emerging from the combined chronologies, identified further information that was necessary from partner agencies and discussed family involvement. It endorsed use of the evidence base now available for working with people who self-neglect[5].

[5] Braye, S., Orr, D. and Preston-Shoot, M. (2014) *Self-Neglect Policy and Practice: Building an Evidence Base for Adult Social Care*. London: Social Care Institute for Excellence. Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234.

3.2.4. A learning event with practitioners and managers involved in the cases, or in the strategic development, commissioning and/or delivery of services for people who are homeless, explored key themes that had been extracted from the combined chronologies. The learning event offered an opportunity for those involved in working with people who are homeless and with adult safeguarding more generally to comment on what they believed was working effectively in Manchester and on where they felt that improvements were required.

3.2.5. A questionnaire[6] was also circulated by Survey Monkey to practitioners and managers involved in the field. Once again, the purpose was to enable them to comment on both positive and concerning features of policy and practice with respect to responding to the needs of people experiencing homelessness. The focus was on the enablers within policy, procedures and practice that facilitate effective work with people who are homeless, and also on the barriers that render effective work difficult. Respondents were asked where possible to give examples drawn from specific cases and to indicate the frequency with which such features arose.

3.2.6. A second meeting of the review team evaluated the outcomes of the learning event and identified further information that was required about provision available for people who are homeless in Manchester.

3.2.7. A third meeting of the review team commented on the first draft of the report, considered an action plan to implement the recommendations and discussed methods of dissemination of the findings of this thematic review.

3.3. Family Involvement

3.3.1. Through a process of reviewing the records held by partner agencies, family relatives were identified for six of the seven cases formally included in the sample for the thematic learning review. Where more than one relative was identified, a letter inviting involvement in the review was sent to the person who was the next of kin together with a leaflet that explained the purpose of the review.

3.3.2. Despite several agencies being involved with all those whose cases were included in the sample, information about next of kin and other family relatives did not appear to have been routinely collected or shared. As will be seen, the evidence-base for working with people who self-neglect indicates that it is helpful to build up a picture of the person's history and, where possible, to involve family members in assessments and care planning.

3.3.3. Only one person responded to the invitation to be involved, a former partner. Unfortunately, it did not prove possible to make contact on the telephone number that was given.

[6] 143 responses were received.

4. Seven Cases

4.1. All the cases in the sample are male. The implications of the composition of the sample are discussed later in this review report. In all cases the person was homeless at the time of death. In two cases the person died in hospital.

4.2. Case One – David[6]: a pen picture

- Died aged 44, owing to drug misuse, liver disease, lower limb cellulitis and pneumonia, with official cause of death being respiratory failure, pneumococcal pneumonia and alcohol & Hepatitis induced liver failure
- History of offending as a young person and adult
- Breaches of probation
- Frequent A&E attender
- Drug misuse
- History of squalid living conditions and abandoning tenancies
- Domestic abuse incidents
- Periodically he attended for medical and drug misuse assessments
- Seen by UVMP, Community drugs workers, Homeless workers
- History of anxiety and depression

4.3. Case two – Stephen: a pen picture

- Died of drowning associated with multiple drug use (Heroin, Cocaine, Diazepam), aged 40
- History of offending , including violence, drug misuse and domestic abuse
- Schedule 1 offender; MAPPA involvement
- Domestic abuse incidents discussed at MARAC
- Drug misuse
- Prison sentences
- Seen by Urban Village, City Vagrancy Team and Manchester City Council (MCC) Rough Sleepers team
- Not offered accommodation when seen by Housing Solutions
- Wound infections treated at Manchester Royal Infirmary (MRI)

4.4. Case three – Luke: a pen picture

- Died aged 37 in hospital with cause of death being hypoxic brain injury, pneumonia, intestinal mucosal infarction, coupled with near drowning and combined toxicity from recreational use of heroin, cocaine and synthetic cannabinoids and chronic Hepatitis C infection

[6] All the names used in this report are pseudonyms.

- Twenty year history of offending – theft, public order, violence and drugs, sometimes resulting in custodial sentences

- Records note adverse childhood experiences
- History of perpetrating domestic abuse incidents
- Pattern of attendance at A&E, sometimes leaving before seen
- History of alcohol and drug misuse, depression, panic attacks, flashbacks and nightmares (PTSD), self-harm, leg ulcers and hepatitis
- Accesses Booth Centre, Urban Village, Riverside, MCC Outreach Team, sometimes disengaging/not attending
- Periods in emergency accommodation but asked to leave because of bullying, intimidation and theft from other residents, or leaves as he feels unsafe

4.5. Case four – Lester: a pen picture

- Died aged 28, drug overdose
- Records note adverse childhood experiences
- History of domestic and sexual violence incidents, both victim and perpetrator
- History of offending
- History of self-harm and inpatient treatment both as informal patient and under section due to psychosis
- Diagnosis of borderline personal disorder; assessed as emotionally unstable
- Found temporary accommodation but becomes intentionally homeless as he does not follow the rules/conditions of tenancy

4.6. Case five – Larry: a pen picture

- Died aged 31, heroin toxicity
- Records note adverse childhood experiences and impact on his mental health
- Drug misuse from an early age
- Diagnosis of emotional dysregulation; pattern of overdoses, self-harm and depression, sometimes prompting emergency admissions
- History of perpetrating domestic violence towards his family
- Prison sentences
- Some engagement with a complex lifestyles service but also pattern of disengaging from counselling and drug/alcohol services, MRI and urban Village, Shelter, Barnabus Day Centre
- Unable to sustain his own accommodation or maintain hostel place
- Custodial sentence for breach of community order
- Referred to adult safeguarding in 2017 by his GP.

4.7. Case six – Darren: a pen picture

- Died aged 38, cause of death not yet established

- Extensive offending history from age 12 – burglary, theft, criminal damage, assault, public order, including custodial sentences for offences or breach of orders
- Possible adverse childhood experiences
- History of perpetrating domestic violence incidents

- Mental health, including diagnosis of schizophrenia
- Known to Riverside Housing, Booth Centre, CGL, GMMH – often unable to sustain engagement and hostel places or temporary accommodation
- Pattern of A&E attendance

4.8. Case seven – Jacob: a pen picture

- Died aged 60 – homeless at time of death from bronchopneumonia and alcohol toxicity
- No recourse to public funds
- Heavy drinker
- Lost employment due to an accident – unable to work
- Immigration Removal Centre involved twice
- Described as "very disabled"
- Intermittent contact with agencies, one unsuccessful hostel accommodation
- Victim of crime
- Required an interpreter to access services

4.9. In addition to the pen picture details above, drawn from the combined chronologies, initial reading of the information provided by partner agencies enabled cross-case comparison, themes that were subsequently explored in the learning event and which are outlined in detail below. Broadly summarised, the themes arising from cross-case comparison are:

4.9.1. In five of the cases the person had been provided at times with, or had themselves been able to access hotel, hostel or temporary accommodation. In two cases these arrangements had collapsed because of difficulties involving other residents.

4.9.2. Six cases involved domestic abuse (Jacob is the exception here).

4.9.3. Six cases involved drug misuse.

4.9.4. Six of the seven cases involved known mental health concerns (Jacob is the exception here).

4.9.5. Four of the individuals had served prison sentences.

4.9.6. Four of the cases involved alcohol misuse (Luke, Larry, Darren and Jacob).

4.9.7. The chronologies for three of the cases specifically referenced adverse childhood experiences (Luke, Lester and Larry). The case of Darren may also have contained a history of trauma.

4.9.8. Adult safeguarding concerns are mentioned in only three cases (Luke, Larry and Darren).

4.9.9. There are references in the combined chronologies to mental capacity assessments in only two cases (Larry and Darren).

4.9.10. Judging from what is recorded in the chronologies, there do not appear to have been any multi-agency risk management meetings or complex case discussions in any of the seven cases. Repeating patterns and breakdowns in plans do not appear to have prompted a review of the approaches being taken in the cases. It is not clear how a strategy meeting in Darren's case influenced subsequent attempts to engage and work with him.

4.9.11. In none of the seven cases was there a referral for an assessment of care and support needs[7]. Five cases were not known to either Manchester Adult Social Care or the Manchester Adult Multi-Agency Safeguarding Hub (MASH). The case of Luke was known to the Adult MASH. The recommendation following initial assessment was that, as partnership working was already happening between the different agencies supporting him, and as the police were aware of him being missing and at risk, this approach should continue and future strategy meetings arranged to share information and coordinate efforts. Darren was known to the substance misuse team.

4.10. As noted in the introduction, an eighth case was not formally added to the sample following referral for consideration as a SAR. However, it is being included for illustrative and comparative purposes.

4.10.1. Graham died of a cardiac arrest aged 43. He had an extensive criminal history, dating from when he was aged 14, which included manslaughter, assaults, drug convictions, public order and breaches of anti-social behaviour orders. He had served a significant number of prison terms, some of which included detoxification, some drug and housing assessments. He did not always cooperate with requirements of release on licence, resulting in breach proceedings, and his engagement with drugs recovery teams was intermittent.

4.10.2. When not in prison, for much of the last seventeen years of his life he was homeless and was sometimes discharged to no fixed abode. There are records of him having lived for a short time in approved premises in 2016. A picture emerges of alcohol and drug abuse, domestic violence, abusive behaviour towards professionals and rejection of offers of support.

4.10.3. The combined chronology contains reference to a mental health assessment that did not diagnose mental illness. He did not follow through on occasional contact

[7] Section 9, Care Act 2014

with homelessness services, even when on one occasion he was provided with temporary accommodation for one night and when supported to attend appointments, and appears to have been assessed as intentionally homeless and not in priority need. He is noted as struggling with self-care, possibly as a result of physical ill-health, but he was not referred to Adult Social Care.

4.10.4. His frequent custodial sentences appear to have cut across attempts by CGL to engage him in treatment. On one occasion, when he disengaged from services seeking to help him with his alcohol and drug misuse, a multi-agency meeting was held with the purpose of trying to reengage him and identifying a key worker.

4.10.5. He was a frequent flyer, reporting pain, falls, head injuries and possible overdoses but he did not always engage with treatment. He could become hostile when asked questions and found it difficult to commit to appointments with the result that periods of intensive engagement with him by health care providers fell away. There is no reference in the chronology to mental capacity. No detail is given either that would enable identification of adverse childhood experiences.

4.11. These cases exemplify multiple exclusion homelessness. This comprises extreme marginalisation that includes childhood trauma, physical and mental ill-health, substance misuse and experiences of institutional care[8]. Adverse experiences in childhood can include abuse and neglect, domestic violence, poverty and parental mental illness or substance misuse[9]. Cases in the sample demonstrate that, for many, street sleeping is a long-term experience and associated with tri-morbidity (impairments arising from a combination of mental ill-health, physical ill-health and drug and/or alcohol misuse) and premature mortality[10].

4.12. Women were not represented in the cases referred to the Manchester Safeguarding Adults Board for inclusion in this thematic review. In one analysis of SARs[11] only one case involved a woman, who was in a permanent tenancy at the time of her death but who had experienced homelessness alongside physical and mental ill-health. Another review[12] of a woman with experience of homelessness, domestic violence and substance misuse expresses concern regarding decisions by Adult Social Care not to assess for care and support needs, and not to invoke safeguarding procedures to facilitate multi-agency risk and safety planning. It criticises too the absence of psychological support or rehabilitation to address her mental health needs because she was not drug free. It concludes with recommendations that focus on information-sharing, use of multi-

[8] Mason, K., Cornes, M., Dobson, R., Meakin, A., Ornelas, B. and Whiteford, M. (2017/18) 'Multiple exclusion homelessness and adult social care in England: exploring the challenges through a researcher-practitioner partnership.' *Research, Policy and Planning*, 33 (1), 3-14.

[9] Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping)*. London: Public Health England.

[10] See note 9.

[11] Martineau, S., Cornes, M., Manthorpe, J., Ornelas, B. and Fuller, J. (2019) *Safeguarding, Homelessness and Rough Sleeping: An Analysis of Safeguarding Adult Reviews*. London: Kings College London.

[12] Bexley Safeguarding Adults Board (2019) *AB: Safeguarding Adult Review*.

agency meetings and high risk panels, support for victims of domestic violence, safety plans for high risk cases and provision of supported accommodation for people who want to recover from substance misuse. Similar themes will be explored in this thematic review.

4.13. Research[13] has found that the causes of homelessness are multi-faceted and impact differently on men and women. Routes into homelessness can have a gendered dimension, founded in abuse and violence in close relationships. Support is often fragmented, available across separate agencies, with budget cuts intensifying this picture. The research has found positive appreciation of keyworker and women only provision but frustration at having to engage with multiple services at the same time and with provision that was not personalised to their needs. Adverse childhood experiences have resulted in women who are homeless experiencing a complex range of social and health needs and their situation exposes them to risk of further abuse. These are themes that will run through much of the analysis that follows.

[13] Cameron, A., Abrahams, H., Morgan, K., Williamson, E. and Henry, L. (2016) 'From pillar to post: homeless women's experiences of social care.' *Health and Social Care in the Community*, 24 93), 345-352.

5. The Evidence-Base for Best Practice

5.1. Reference was made earlier (section 3.2.3) to research and findings from SARs[14] that enable a model of good practice to be constructed in relation to adults who self-neglect. The model comprises four domains. In line with Making Safeguarding Personal, the first domain focuses on practice with the individual. The second domain then focuses on how practitioners worked together. The third domain considers best practice in terms of how practitioners were supported by their employing organisations. The final domain summarises the contribution that Safeguarding Adults Boards can make to the development of effective practice with adults who self-neglect. The domains are summarised here.

5.2. For the purposes of this thematic review, evidence has been integrated into these domains regarding best practice drawn from research and SARs on multiple exclusion homelessness and substance misuse.

5.3. It is recommended that direct practice with the adult is characterised by the following:

5.3.1. A person-centred approach that comprises proactive rather than reactive engagement, and a detailed exploration of the person's wishes, feelings, views, experiences, needs and desired outcomes; work to build motivation with a focus on a person's fluctuating and conflicting hopes, fears and beliefs, and the barriers to change[15];

5.3.2. A combination of concerned and authoritative curiosity appears helpful, characterised by gentle persistence, skilled questioning, conveyed empathy and relationship-building skills; early and sustained intervention includes supporting people to engage with services, assertive outreach and maximising the opportunities that encounter brings[16];

5.3.3. When faced with service refusal, there should be a full exploration of what may appear a lifestyle choice, with detailed discussion of what might lie behind a person's refusal to engage; loss and trauma often lie behind refusals to engage; failing to explore "choices" prevents deeper analysis;[18]

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[14] Braye, S., Orr, D. and Preston-Shoot, M. (2014) *Self-Neglect Policy and Practice: Building an Evidence Base for Adult Social Care*. London: Social Care Institute for Excellence. Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234.

[15] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern. NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

[16] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. London: Alcohol Change UK. Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping).* London: PHE. Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern. [18] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. London: Alcohol Change UK.

5.3.4. It is helpful to build up a picture of the person's history, and to address this "backstory"[17];

5.3.5. Recognition and work to address issues of loss and trauma in a person's life experience;

5.3.6. Recognition and work to address repetitive patterns;

5.3.7. Contact should be maintained rather than the case closed so that trust can be built up;

5.3.8. Comprehensive risk assessments are advised, especially in situations of service refusal and/or non-engagement, using recognised indicators to focus work on prevention and mitigation[20];

5.3.9. Where possible involvement of family and friends in assessments and care planning[21];

5.3.10. Exploration of family dynamics, where appropriate, including the cared-for and care-giver relationship;

5.3.11. Thorough mental capacity assessments, which include consideration of executive capacity; assumptions should not be made about [people's capacity to be in control of their own care and support[22];

5.3.12. Thorough mental health assessments;

5.3.13. Careful preparation at the point of transition, for example hospital discharge, prison discharge, end of probation orders and placement commissioning;

5.3.14. Use of advocacy where this might assist a person to engage with assessments, service provision and treatment;

5.3.15. Thorough assessments, care plans and regular reviews, comprehensive enquiries into a person's rehabilitation, resettlement and support needs[23]; taking into account should be the negative effect of social isolation and housing status on wellbeing[24];

5.3.16. Where multiple agencies are involved, appointment of a lead agency and key worker to act as the continuity and coordinator of contact.

5.4. It is recommended that the work of the team around the adult should comprise:

5.4.1. Inter-agency communication and collaboration, working together[25], coordinated by a lead agency and key worker in the community[26], with named people to whom

Services: Improving the Experience of Care and Support for People Using Adult Social Care Services. London: National Institute for Health and Clinical Excellence.

[20] Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25. Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[21] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[17] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. London: Alcohol Change UK. NICE (2018) *People's Experience in Adult Social Care*

[22] NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence. [23] Ministry of Justice (2018) *Guidance: The Homelessness Reduction Act 2017 Duty to Refer*. London: MoJ.

[24] NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

[25] Parry, I. (2014) 'Adult serious case reviews: lessons for housing providers.' *Journal of Social Welfare and Family Law*, 36 (2), 168-189. Ministry of Justice (2018) *Guidance: The Homelessness Reduction Act 2017 Duty to Refer*. London: MoJ.

[26] Whiteford, M. and Simpson, G. (2015) 'Who is left standing when the tide retreats? Negotiating hospital discharge and pathways of care for homeless people.' *Housing, Care and Support*, 18 (3/4), 125-135. NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

referrals can be made[18]; the emphasis is on integrated, whole system working, linking services to meet people's complex needs[19];

5.4.2. A comprehensive approach to information-sharing, so that all agencies involved possess the full rather than a partial picture;

5.4.3. Detailed referrals where one agency is requesting the assistance of another in order to meet a person's needs;

5.4.4. Multi-agency meetings that pool information and assessments of risk, mental health and mental capacity, agree a risk management plan, consider legal options and subsequent implement planning and review outcomes[20];

5.4.5. Use of policies and procedures for working with adults who self-neglect and/or demonstrate complex needs associated with multiple exclusion homelessness, with specific pathways for coordinating services to address such risks and needs as suitable accommodation on discharge from prison or hospital[21];

5.4.6. Use of the duty to enquire (section 42, Care Act 2014) where this would assist in coordinating the multi-agency effort, sometimes referred to as safeguarding literacy;

5.4.7. Evaluation of the relevance of diverse legal options to assist with case management, sometimes referred to as legal literacy;

5.4.8. Clear, up-to-date [22] and thorough recording of assessments, reviews and decisionmaking; recording should include details of unmet needs[32].

5.5. It is recommended that the organisations around the team provide:

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[18] Parry, I (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25.

[19] Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping).* London: PHE. Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern. The MEAM Approach (2019) *Making Every Adult Matter*. London: Homeless Link and Mind.

[20] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[21] Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping).* London: PHE.

[22] Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25. [32] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

5.5.1. Supervision that promotes reflection and critical analysis of the approach being taken to the case;

5.5.2. Support for staff working with people who are hard to engage, resistant and sometimes hostile;

5.5.3. Access to specialist legal, mental capacity, mental health and safeguarding advice;

5.5.4. Case oversight, including comprehensive commissioning and contract monitoring of service providers;

5.5.5. Agree strategically and operationally how different social issues will be connected in policy, procedures, protocols and practice, through the operation of MAPPA, MARAC, MASH and other complex case or multi-agency panel arrangements, namely anti-social behaviour, domestic violence, offending (community safety) and vulnerability[23]; strategic agreements and leadership are necessary for the cultural and service changes required[34]; when there are robust policy, procedures and protocols in place, they will only be effective if implemented in front line multi-agency practice.

5.5.6. Agree indicators of risk that are formulated into a risk assessment template that will guide assessments and planning;

5.5.7. Attention to workforce development[24] and workplace issues, such as staffing levels, organisational cultures and thresholds.

5.6. SABs are recommended to consider:

5.6.1. The development, dissemination and auditing of the impact of policies and procedures regarding self-neglect;

5.6.2. Review of the interface between housing/homelessness and adult social care, mental health, and adult safeguarding, and including housing in multi-agency policies and procedures[25];

5.6.3. Establishment of a system to review the deaths of homeless people and/or as a result of alcohol/drug misuse;

5.6.4. Working with Community Safety Partnerships, Health and Wellbeing Boards and partnership arrangements for safeguarding children and young people, to coordinate governance, namely oversight of the development and review of policies, procedures and practice;

5.6.5. Workshops on practice and the management of practice with adults who selfneglect.

5.7. This model enables exploration of what facilitates good practice and what acts as barriers to good practice. The thematic analysis that follows draws on information contained within the chronologies, responses to the circulated questionnaire, group discussions during the learning event, and feedback from review group members. Where relevant, it also draws on available research. It follows the whole system framework for analysis

[23] Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25. [34] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[24] Whiteford, M. and Simpson, G. (2015) 'Who is left standing when the tide retreats? Negotiating hospital discharge and pathways of care for homeless people.' *Housing, Care and Support*, 18 (3/4), 125-135. The MEAM Approach (2019) *Making Every Adult Matter*. London: Homeless Link and Mind.

[25] Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25.

presented above, beginning with the components of direct work with individuals and moving outwards to the legal, policy and financial context within which adult safeguarding and work with people who are homeless are situated.

6. Thematic Analysis – Direct Work with Individuals

6.1. A person-centred approach should comprise proactive rather than reactive engagement, and a detailed exploration of the person's wishes, feelings, views, experiences, needs and desired outcomes.

6.1.1. In the chronology for David there is evidence of single agency assessments and reviews, for example by Urban Village. However, recorded evidence in all agency records is lacking of his wishes, feelings, experiences and desired outcomes beyond one reference from the National Probation Service that he wanted to be on the streets and was using drugs to cope. In the chronology for Larry there is evidence that a complex lifestyles team in another local authority within the Greater Manchester area had some success in engaging with him. In the chronology for Jacob some history had clearly been taken but it is unclear whether there was a detailed exploration of his wishes and desired outcomes.

6.1.2. In the learning event a view was expressed that assessments and services are not always "client" focused or person-centred but rather process-led. The importance of attempting a deeper understanding of why people were street sleeping, of their life trajectory (see the emphasis on history below), was appreciated. However, concern was expressed that services were not always working flexibly to engage the person where they were, not always recognising that individuals had varying levels of ability to be in particular places at set times because of street living.

6.1.3. Both feedback from the learning event and comments in the survey emphasised the need for organisational flexibility in order to permit individual practitioners to maintain continuity with individuals at risk. Rather than time limited, reactive work, workplaces needed to endorse more open-ended, relationship-based work, involving motivational work and building trust, and assessment that demonstrates understanding of how the lived experience of the person influences their choices.

6.2. A combination of concerned and authoritative curiosity appears helpful[26], characterised by gentle persistence, skilled questioning, conveyed empathy and relationship-building skills.

6.2.1. Larry's case is potentially illustrative here. He had a local connection with another local authority area in Greater Manchester and did at times live there. It is not clear from the chronology whether there was any attempt to talk through where he might feel most settled, for example when he was unwilling to return there. He had engaged with a complex lifestyle service in that other local authority area, and that service appears to have had most success in establishing a relationship

[26] On admission to hospital, for example, asking "have you somewhere safe to stay?"

with him but low mood, exacerbated by chronic drug misuse and periods of homelessness, meant that he could not sustain this contact.

6.2.2. In the learning event a sense emerged of Manchester being a magnet, drawing people into the city centre. A clearer pathway for communication between different local authorities would be helpful.

6.2.3. A view was also expressed that more resources were needed to enable practitioners to build relationships with homeless people and to walk with people to services or to take services to them. This corresponds with Equality Act 2010 duties to make reasonable adjustments for people with complex needs whose lives are frequently chaotic. There are initiatives elsewhere[27] of street-based Adult Social Care and mental health/multi-agency assessments delivering positive outcomes.

6.3. When faced with service refusal, there should be a full exploration of what may appear a lifestyle choice, with detailed discussion of what might lie behind a person's refusal to engage; loss and trauma often lie behind refusals to engage. Contact should be maintained rather than the case closed, in an effort to build up trust and continuity.

6.3.1. In several cases (Stephen, Luke, Larry, Darren, Jacob) agencies closed down contact when the person did not engage. In three cases (Darren, Stephen and Luke) there are references to assertive outreach but either the person could not be located or their engagement was poor. In David's case his refusal of assistance with accommodation and drug treatment whilst under the supervision of the National Probation Service seems, ultimately, to have been accepted.

6.3.2. At the learning event there was recognition that services can become desensitised by repeating patterns of service refusal and disengagement. Pressure on workloads and the increasing complexity of cases were also felt to be barriers to engagement. It was also acknowledged that unconscious bias towards homeless people and the influence of assumptions or stereotypes can impact on assessment.

6.3.3. In the survey there was some recognition that barriers preventing people seeking help had to be explored. This recognition included the observation that the way services were structured, and the approach they adopted, could make matters worse. This recognition ranged from observations that services were "relatively inaccessible" to barriers created by approaches to assessment, for example of homelessness, and the challenges of waiting for a service response, for instance at the Town Hall. Put another way, "the system is not set up for people with active addictions, complex mental health needs and anxiety about authority." Or again, council services can aggravate problems; making contact is difficult." Reluctance to engage might also arise from the challenge of having to navigate different services[39] and to meet with different staff, or from the absence of dignified and confidential places where assessments could be conducted and support offered.

[27] For example, Leicester City Council, the social worker role attached to the street life operational group. [39] One example given of services difficult to navigate was those responsible for cases of individuals with no recourse to public funds.

Situations were also mentioned of cases being closed where people were regarded as making unwise decisions. As the cases in the sample amply demonstrate, a system that relies on people keeping appointments will very often not meet the needs of people whose substance misuse, transient life and mental health complexities drive their behaviour.

6.3.4. Research and SAR evidence[28] indicates that professionals often prioritise and emphasise a person's autonomy rather than respectfully challenging why an individual is refusing care and support.

6.4. It is helpful to build up a picture of the person's history. It is helpful to recognise and work to address issues of loss and trauma in the person's life experience.

6.4.1. The chronologies of six of the seven cases provide some details either of adverse childhood experiences or involvement with youth justice services. In one case (David) homelessness may have begun whilst he was still a young person. In one case (Darren) the chronology explicitly states that the person was unwilling to look at his past, which suggests that it was recognised as helpful to attempt to work with the effects of the person's past. The remaining chronologies do not convey a sense of attempts to explore the impact of the person's history.

6.4.2. Luke was known to various practitioners to have been physically and sexually abused as a child. He is recorded as experiencing flashbacks and depression as a result. Lester alleged that he had been physically and sexually abused as a child also. Mental health records for Larry refer to his very dysfunctional family, including abuse by his mother and neighbours. He is described as having emotional dysregulation and poor impulse control. Anger management had been a key challenge for him. These are common manifestations of trauma.

6.4.3. Attendees at the learning event expressed the view that, by the time of their involvement, they are often trying to work with people who feel let down by the system. They have little if any trust in the system. If earlier intervention was a theme, it was accompanied at the learning event again by the spectre of resources, this time the decommissioning of services, such as youth provision and mental health outreach. There was something approaching a perfect storm – increasing numbers of people with complex needs and chaotic lives but more gaps to fall through. Nonetheless, importance was attached to understanding people's life journeys and the impact on them of lived experiences.

6.4.4. Manchester City Council has invested in a pilot project focusing on adverse childhood experiences (ACEs) and trauma-informed practice. The purpose is to evaluate the differences made by engaging and understanding the root causes of behaviour rather than "treating" presenting behaviours. This approach was not

[28] Mason, K., Cornes, M., Dobson, R., Meakin, A., Ornelas, B. and Whiteford, M. (2017/18) 'Multiple exclusion homelessness and adult social care in England: exploring the challenges through a researcher-practitioner partnership.' *Research, Policy and Planning*, 33 (1), 3-14. Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234.

available to any of the men in the review sample. Research[29] has highlighted the impact on the life course of children and young people of domestic violence, abuse and neglect, parental separation, mental illness and/or substance misuse and/or criminal incarceration of a household member. They are four times more likely to be high risk drinkers, fourteen times more likely to become victims of violence, fifteen times more likely to commit violence against others, sixteen times more likely to misuse substances and twenty times more likely to be incarcerated.

6.4.5. It requires time to uncover what might lie behind a person's homelessness and street sleeping. It should not be assumed to be a lifestyle choice. However, as recognised at the learning event, meeting complex needs as they come to be understood can be challenging, even when individuals are provided with somewhere to stay.

6.5. It is helpful to recognise and work to address repeating patterns.

6.5.1. Repeating patterns are especially striking in Larry's case – domestic violence involving family members and partners, overdoses, abusive behaviour on hospital wards, referrals for counselling followed by case closure when he did not engage. The contribution to the chronology from Greater Manchester Mental Health indicates at one point that the stressors in his life were discussed and a plan formulated but he did not engage, probably because of his "chronic maladaptive coping."

6.5.2. At the learning event some participants acknowledged that nobody seemed to be picking up repeating referrals. This was one instance where a key worker system could be useful. It was acknowledged that frontline staff do not consistently look back at what has happened previously, perhaps because of shortage of time. Looking back at case history holistically would inform assessment and treatment/intervention going forward.

6.6. Comprehensive multi-agency risk assessments are advised, especially in situations of service refusal and/or non-engagement.

6.6.1. Both Lester and Larry appear to have been victims of sexual assault as adults, in one instance by a landlord. Records for LU indicate suicidal ideation and an absence of protective factors, implying awareness of risk. Jacob is also recorded as having twice been a victim of crime. In the chronology for Jacob there is also one reference to him having been thrown out of a hostel. Concerns are also recorded about his (disability) "condition." No risk assessment or onward referrals are apparent. Similarly, in the case of Luke, temporary accommodation and losses of housing do not appear to have triggered a review of risks. Darren had an extensive criminal history dating back to when he was a young person but there is no

[29] Felitti, V., Anda, R., Nordenberg, D., Williamson, D., Spitz, A., Edwards, V., Koss, M and Marks, J. (1998) 'Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the Adverse Childhood Experiences (ACE) study.' *American Journal of Preventive Medicine*, 14 (4), 245-258. Rockpool (2019) https://rockpool.life/about-adverse- childhood-experiences/ accessed 29th September.

reference to a risk assessment. In Stephen's case, however, risk assessment is implicit with respect to the risks he posed to children.

6.6.2. At the learning event it was acknowledged that greater use could be made of multi-agency meetings in the community to assess risk. It was also suggested that the approach to conducting and then sharing risk assessments could be strengthened, recognising the increasing complexity of people's needs when they are homeless that included poly-substance use and mental health, and the reemergence of public health outbreaks of Hepatitis A, TB and Sepsis. To this end
there seemed to be some uncertainty about what risk assessment tools might be available and helpful. Greater flexibility in the location of risk assessments might also be required, going to where the person is rather than expecting individuals to attend appointments at fixed times and places.

6.6.3. It was also recognised, however, that care needed to be taken when presenting risk assessments. For example, determining that an individual was high risk might discourage some agencies, for example housing providers, from offering a service.

6.7. Where possible and appropriate, it may be helpful to involve family and friends in assessments and care planning.

6.7.1. In only one case (David) is any contact recorded with the person's next of kin. No information about family and friends is given in three cases, whilst in three others information about family and/or former partners is recorded but there is no evidence of any contact with them.

6.7.2. Part of any risk assessment should be the availability of circles of support.

6.8. Mental capacity assessments should be thorough and include consideration of executive capacity.

6.8.1. Especially where there are repetitive patterns, it is essential to assess executive capacity as part of mental capacity assessment. Guidance has commented that it can be difficult to assess capacity in people with executive dysfunction. It recommends that assessment should include real world observation of a person's functioning and decision-making ability[30], with subsequent discussion to assess whether someone can use and weigh information, and understand concern about risks to their wellbeing.

6.8.2. There is no reference to mental capacity in five of the chronologies. In the Larry case there are references to him "appearing to have capacity" and "having capacity", for example to participate in decision-making alongside other references to emotional dysregulation and not following through on agreed referrals or plans. It is not clear whether observations about mental capacity were the outcome of a formal assessment. There does not appear to have been an assessment of whether he had executive capacity.

[30] NICE (2018) *Decision Making and Mental Capacity*. London: National Institute for Health and Clinical Excellence.

6.8.3. In the Darren chronology there is a similar reference to him "appearing to have capacity to make decisions."

6.8.4. Mental capacity assessment featured strongly at the learning event. Some participants acknowledged that there was anxiety and a lack of confidence in assessing mental capacity in some sectors, for example GPs, with the result that some assessments were referred to mental health services. This lack of confidence arose partly from a lack of understanding about the Mental Capacity Act 2005, partly from the challenge of assessment of fluctuating capacity, and partly from uncertainty about the interface between substance misuse, addiction and mental capacity. Although organisations do provide training on mental capacity assessment, complex situations, such as non-engagement with services, are experienced as particularly challenging.

6.8.5. Other participants at the learning event expressed some frustration at what was described as a "brick wall" – "they have capacity." Examples were given of assessments not being completed when individuals were refusing support on the grounds that they had a right to make unwise decisions. This, of course, is a misreading of the Mental Capacity Act 2005, which actually states that a person is not to be treated as unable to make a decision merely because it is unwise[31]. That requires an assessment.

6.8.6. One area within which the impact of ACEs and trauma must be understood is assessment of mental capacity. The Mental Capacity Act 2005 requires that there be impairment of mind and brain when assessing whether or not a person has decisional capacity. Disorder of mind or brain may include symptoms arising from alcohol or drug misuse[32]. There is evidence[33] that prolonged exposure to trauma affects brain development, especially on its executive, emotional and survival centres. There is also evidence[34] that substance misuse, for example of alcohol, results in cerebral degeneration and cognitive impairment, and that nutritional deficiencies related to chronic alcohol misuse can precipitate cognitive impairment. Thus, whilst language and visual/spatial awareness may be preserved, there may be impairment of executive functioning, the ability to plan, organise and implement decisions. If this is observed, can the individual understand and use and weigh when such observations are shared with them?

[31] The Mental Capacity Act 2005 code of practice states that one of the reasons why people may question a person's capacity to make a specific decision is: "The person's behaviour or circumstances cause doubt as to whether they have capacity to make a decision." Department for Constitutional Affairs (2007) *Mental Capacity Act 2005: Code of Practice*. London: The Stationery Office, section 4.35.

[32] Department for Constitutional Affairs (2007) *Mental Capacity Act 2005: Code of Practice*. London: The Stationery Office.

[33] Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M. and Cloitre, M. (2005) 'Complex trauma in children and adolescents.' *Psychiatric Annals*, 35 (5), 390-398.

[34] Restifo, S. (2013) 'A review of the concepts, terminologies and dilemmas in the assessment of decisional capacity: a focus on alcoholism.' *Australasian Psychiatry*, 21 (6), 537-540. Hazelton, L., Sterns, G. and Chisholm, T. (2003) 'Decision-making capacity and alcohol abuse: clinical and ethical considerations in personal care choices.' *General Hospital Psychiatry*, 25, 130-135.

Assessment of executive function is, therefore, especially important[35]. Feedback at the learning event and discussion amongst the review team highlighted the need for further workforce development on assessment of executive capacity in cases of self-neglect (including substance misuse).

6.8.7. The Mental Capacity Act 2005 should not be interpreted as stating that individuals have a right to make unwise decisions. Rather, the Act is clear that a person is not to be treated as unable to make a decision merely because that decision is unwise. When working with individuals who misuse substances, this requires professionals to understand the addictive nature of alcohol and/or drug use and the impact on a person's ability to make decisions[36]. Amendment to the Code of Practice that accompanies the Mental Capacity Act 2005 has been recommended to strengthen guidance on assessment of cases involving complex needs, fluctuating capacity and alcohol misuse[37].

6.9. Mental health assessments should also be thorough.

6.9.1. Stephen appears at one point to have been a voluntary mental health patient but it is not clear from the chronology what assessment was undertaken or diagnosis determined. Mental health assessments of Luke found no evidence of mental illness but maladaptive coping mechanisms. No evidence of psychosis was found with Larry but rather issues relating to grief and trauma. The chronology refers to (mild) depression and a history of overdosing and suicidal ideation, with one entry from Greater Manchester Mental Health referring to him experiencing mild depression when the threshold operating for intervention was severe and enduring mental illness. Lester was assessed as having a borderline personality disorder and the chronology refers to use of the Mental Health Act 1983. There is no indication that this diagnosis, and the episodes of self-harm and suicidal ideation, were taken into a risk management, or care and support plan. Darren was given a diagnosis of possible schizophrenia and he appears to have been under the Care Programme Approach and on anti-psychotic medication.

6.9.2. Participants at the learning event raised several issues. In relation to assessments under the Mental Health Act 1983, some referrals were felt to be inappropriate as the primary problem was said to be misuse of drugs and alcohol and detention under the 1983 Act cannot be used for that issue alone. It was also stated that day centres were reluctant to allow their premises to be used for assessments under the Act.

6.9.3. In relation to mental health assessments and treatment more generally, access issues were reported, with views expressed that more resource here was

[35] Hazelton, L., Sterns, G. and Chisholm, T. (2003) 'Decision-making capacity and alcohol abuse: clinical and ethical considerations in personal care choices.' *General Hospital Psychiatry*, 25, 130-135.

[36] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. London: Alcohol Change UK.

[37] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. London: Alcohol Change UK.

necessary to meet demand, for example for outreach. There was also the challenge of recognising and responding to personality disorder and trauma.

6.10. Careful preparation is required at points of transition, for example hospital discharge, prison discharge, end of probation orders and placement commissioning.

6.10.1. Four cases (Stephen, Luke, Larry and Darren) reference custodial sentences but the chronologies do not provide details of any discharge planning. Stephen was homeless immediately after one prison discharge, for example, as were Larry and Darren.

6.10.2. Several of the individuals (Luke and Larry for example) were frequent flyers at Accident and Emergency Departments, sometimes leaving without waiting to be assessed or treated. The same individuals did not always keep medical/health care appointments. The chronologies do not provide details of any planning in terms of a community response.

6.10.3. Finally, it appears that several individuals when young were known to children's services but again the chronologies are silent about what transition planning may have been attempted. For example, David appears to have been homeless at the age of fifteen. Darren's criminal record began around the time he was twelve.

6.10.4. Some participants at the learning event expressed the view that short- term custodial sentences cut across attempts to engage individuals, or to keep them engaged, in treatment and could contribute to insecure housing. In their view more support was needed before release and closer liaison between mental health and drug and alcohol treatment in prison and subsequent follow-through in the community.

6.10.5. Section 76 (Care Act 2014) requires the local authority in which a prison is situated to assess an individual when they appear to have care and support needs. Eligible needs must be met whilst in prison and plans prepared to meet eligible needs on release. It does not appear that any of the individuals in this review's sample were so assessed. The subjects of this review who had been in prison frequently had little health information shared between the prison and their General Practitioner or with the relevant local authority on discharge; this needs to be reviewed along with effective discharge from prison into the community. It is known that difficulties have been experienced in formulating and implementing care plans when the individual is ordinarily resident in a different local authority area[38]. Research[39] has also found considerable variation in how social care and support is assessed and delivered in prisons. It suggests training for staff to ensure that prison entry checks detect needs, such as those arising from mental health

[38] Mason, K., Cornes, M., Dobson, R., Meakin, A., Ornelas, B. and Whiteford, M. (2017/18) 'Multiple exclusion homelessness and adult social care in England: exploring the challenges through a researcher-practitioner partnership.' *Research, Policy and Planning*, 33 (1), 3-14.

[39] Tucker, S., Hargreaves, C., Roberts, A., Anderson, I., Shaw, J. and Challis, D. (2018) 'Social care in prison: emerging practice arrangements consequent upon the introduction of the 2014 Care Act.' *British Journal of Social Work*, 48 (6), 1627-1644.

problems and substance misuse. Staff may also benefit from training on assessment of prisoners' care and support needs.

6.10.6. NICE has issued guidance about the transition between inpatient mental health or general hospital settings and community settings. For people with serious mental health issues who have recently been homeless or are at risk of homelessness, the guidance[40] recommends intensive structural support to assist with finding and retention of accommodation. This support should begin prior to discharge and continue for as long as necessary. Housing and mental health services should work together to jointly problem solve. Similar guidance for people in inpatient general hospital settings[41] recommends on admission that a person's housing status is established and that, prior to discharge, if a person is likely to be homeless, liaison occurs with the local authority's Housing Options
service to ensure that advice and help is offered. Homelessness and safeguarding issues should be addressed by agencies working together to ensure a safe and timely discharge. Those at risk of readmission should be referred to community practitioners prior to discharge for health and social care support.

6.10.7. At the learning event examples were given both where hospital discharge had been delayed in order to secure an effective transfer of care and where the demand on beds had resulted in the discharge of people in social crisis.

6.11. Advocates should be used where this would assist a person to engage with assessments, service provision and treatment.

6.11.1. Jacob's English is recorded as having been very poor but an advocate was not appointed to help him engage with services. The chronologies are silent on the use of advocacy.

6.11.2. Panel members have commented that little use has been made of "language line" or services for specific ethnic groups. This may relate to a lack of awareness, noted elsewhere in this report, of what services actually exist.

6.12. Thorough assessments, care plans and regular reviews characterise best practice.

6.12.1. There were no assessments in any of the seven cases for care and support (section 9, Care Act 2014) The Adult MASH recommendation for Luke was that he had assessment needs and would benefit from multi-agency follow up. Particularly interesting here is the case of Jacob. He was known by his GP, day centre staff and secondary healthcare services to be disabled and the chronology gives some detail of assessments in response to his disability by his GP and a hospital. However, these contacts do not appear to have prompted referral to Adult Social Care for a care and support assessment. Additionally, the chronology states that hospital notes record that his health was deteriorating rapidly in March 2015. However,

[40] NICE (2016) *Transition between Inpatient Mental Health Settings and Community or Care Home Settings*. London: National Institute for Health and Clinical Excellence.

[41] NICE (2015) *Transition between Inpatient Hospital Settings and Community or Care Home Settings for Adults with Social Care Needs*. London: National Institute for Health and Clinical Excellence.

there appears to have been something approaching a three-month delay before the Consultant wrote requesting that he be provided with temporary accommodation. It appears that he remained homeless, which not all agencies were aware of. Jacob required an interpreter; however, this service was not always accessed by professionals and therefore his needs and wellbeing were not thoroughly assessed.

6.12.2. It was often the case that individuals (for example, Lester, Larry and Darren) did not attend planned sessions, adhere to agreed plans or follow advice but these repeating patterns did not seem to prompt a reassessment of the approach being taken by staff and services. For example, Lester was housed in temporary accommodation for three months by Housing Solutions. A decision was eventually reached that he was intentionally homeless and given 28 days to leave. He would have been evicted anyway because of ongoing use of drugs. Placed in a hotel to prevent homelessness he did not attend appointments to claim housing benefit and continued to misuse drugs in breach of accommodation rules. He died shortly afterwards but the chronology does not indicate that this sequence of events would have prompted a review of the approach to the case. This might have been one case where a high risk panel, or other multi-agency meeting approach, would have been useful.

6.12.3. This case exemplifies two concerns expressed at the learning event. One is the expectation that individuals with chaotic lifestyles will comply with organisational processes and attend appointments at specified times. The second is that decisions regarding people being intentionally homeless were being made without health and mental health input. The importance of such informationsharing to ensure that housing decisions regarding priority need, vulnerability and intentionality of homelessness are properly made has also been highlighted in other SARs[42].

6.12.4. Larry on one occasion had lived in his own flat but had "smashed it up." Referrals for or periods in short-term accommodation or hostels did not work out, sometimes because of reported pressure from other residents to use drugs. There is evidence that he could not maintain habitable accommodation. Not only does this information suggest the appropriateness of a referral for assessment for care and support, it also highlights the importance of ensuring wrap around, longerterm support when accommodation is provided. There is also a debate required whether 'wet' accommodation is required for some people whose only alternative is to sleep on the streets.

6.12.5. Discussion of Larry's case in the panel elicited the observation that "everything is recovery and change focused." There are, however, some people who "cannot change." Consideration should be given to whether there are gaps in provision for these individuals with complex needs.

[42] Isle of Wight Safeguarding Adults Board (2018) *Howard: A Safeguarding Adult Review*.

6.12.6. Darren appears to have been under the Care Programme Approach but it is not clear from the chronology what the plan was to address his mental health needs in the community.

6.12.7. In Stephen's case there was one assessment by Housing Solutions that resulted in a decision not to accommodate him. Many years later Housing Solutions offered a full assessment the day after his initial presentation, having decided not to offer temporary accommodation immediately. An opportunity may have been lost at this point because he did not return for the full assessment. On the same day, however, that he missed this appointment he did attend medical and health care appointments.

6.12.8. Sometimes assessments and planning were interrupted by the individual being sentenced to custody, for example for breaches of community orders. Section 8.5.3 below returns to this issue with reference to a multi-agency approach to divert individuals from custody.

6.12.9. Some concerns were expressed at the learning event about the pressures on Adult Social Care in the community from increasing caseloads and complexity of cases referred, and the lack of feedback or updates on referrals that had been made. There was a view expressed that greater use could be made of joint visits. Not all referrals made by telephone appear to have been followed-up in writing to ensure a written record.

6.12.10. The concern about caseload pressures surfaced also in responses to the survey. Here there were comments about high thresholds when all that is required for a care and support assessment is the appearance of need (section 9 Care Act 2014) and there are three clear criteria against which referrals of adult safeguarding concerns should be judged (section 42(1)). Comment was also made about "extremely high thresholds" for funding for specialist placements.

6.12.11. Not all participants felt confident about when to refer and how to frame referrals to Adult Social Care for a section 9 (Care Act 2014) assessment or a section 42 (Care Act 2014) enquiry. Since there are procedures in place for safeguarding adults in the City of Manchester, questions arise about willingness to refer, supervision and support for referrers to raise safeguarding concerns.

6.12.12. Not all participants felt confident either in working with people with acquired brain injury.

6.12.13. Assessment toolkits can be useful in helping practitioners to focus assessment. Some use appears to be made of one toolkit[43] but other feedback from the learning event suggested an absence of resources that could support frontline staff. Such toolkits might enable practitioners to appreciate the potential contribution of Adult Social Care and the Care Act 2014 to meeting people's needs, promoting their wellbeing and safeguarding their welfare.

[43] Voices of Independence, Change and Empowerment in Stoke-on-Trent (no date) *The Care Act Multiple Needs Toolkit*.

6.13. Where multiple agencies are involved, appointment of a lead agency and key worker is helpful to act as the continuity and coordinator of contact.

6.13.1. The only mention of a key worker is in the case chronology for Darren and it is unclear how formalised this arrangement was or for how long it lasted.

6.13.2. Participants at the learning event acknowledged situations where it was unclear, for example, who managed frequent flyers at A&E departments and that, generally, greater use could be made of key workers and nominating lead agencies. This component of best practice is picked up again in the next section of the report.

7. Thematic Analysis – Team around the Person

7.1. Inter-agency communication and collaboration should be evident, coordinated by a lead agency and key worker, which may be termed working together.

7.1.1. Only in the Darren case does there appear to have been any kind of key worker arrangement. For some time a social worker seems to have been an informal point of contact for services if Darren wished to engage. However, the chronology does not give any detail of how this arrangement worked. Darren was known to a social housing association, GMP, Greater Manchester Mental Health, Booth Centre, CGL and the National Probation Service. It is unclear from the chronology which agency, if any, and which practitioner pulled these separate involvements with Darren together. For example, he was found temporary accommodation at one point following liaison with a "rough sleeper" team but within two months he was homeless again and this does not appear to have prompted a multi-agency reappraisal of their approach to the case. The chronology does record liaison between some of the services involved but no whole system meeting took place.

7.1.2. The chronology for Luke records various referrals between different agencies but no overall coordination in the community with respect to his drug and alcohol use, depression and physical health concerns. There was considerable single agency involvement but it is unclear how, if at all, these disparate inputs in the community were coordinated, for example when outreach teams could not find him. There is one exception, namely a period of four months where the combined chronology mentions joint work between an outreach engagement worker, a social housing association and drug and alcohol workers in an effort to engage him in treatment whilst he was accommodated in a flat provided for people who had been homeless with "life issues."

7.1.3. In Jacob's case working together is not evident. It appears that agencies worked in silos, with no obvious liaison between the GP, MFT, the day centre and/or GMP. Despite a Consultant writing to request temporary accommodation because of the impact on his health and disability of being homeless, he remained without accommodation. No referrals were made to Adult Social Care or adult safeguarding despite concerns about his disability and self-neglect. The question

to ask is “why? Services should reflect together whether this is due to lack of agency operational guidance/protocols for working with people who are homeless and/or lack of responsiveness in the past to referrals and/or concerns about the impact of referrals on overstretched provision and/or some other reasons.

7.1.4. In Lester’s case, the implications of having been assessed as intentionally homeless did not trigger a case review despite his recorded “emotional instability.” Once again, there was considerable single agency involvement, often responding to events. However, the failure of a period of temporary accommodation does not appear to have prompted a case review. Larry had his own tenancy or was housed in temporary accommodation for some of the time. The chronology, however, does not record any liaison between different agencies when these arrangements collapsed. Greater Manchester Mental Health had extensive involvement in this case but it is not clear how this was tied into inputs from other agencies. Indeed, at one point, the chronology contains an observation that it might have been appropriate to pull agencies together to agree a strategy.

7.1.5. The risks that Stephen was regarded as presenting to children was the focus of liaison between GMP and Children’s Social Care. Adult Social Care had no known involvement with Stephen and there was limited involvement of mental health providers and housing/homeless teams. He was homeless immediately on release from prison. In summary, despite being seen by different agencies at various times, it is unclear from the chronology what, if any, coordination there was. In David’s case, there were no referrals to Adult Social Care or adult safeguarding and no onward referral by the National Probation Service, for example to housing/homeless support agencies. It is not clear what, if any, liaison there had been between Children’s Social Care and other services earlier in his life, for example relating to his offending. The combined chronology does not indicate that staff in different services liaised, for example healthcare practitioners within the Prison Service with community-based staff.

7.1.6. The apparent absence of coordination and of multi-agency meetings in the community with respect to their housing, health and care and support needs stands in marked contrast to that pertaining to risks to children. In the Stephen and Luke cases there was evident liaison between agencies with respect to the risks they posed to children and current or former partners. There is evidence of case conferences and MARAC involvement.

7.1.7. Positive examples of agencies working together were given at the learning event, alongside a sense being conveyed, from some participants at least, that collaboration had improved in the last year, including a greater use of multiagency meetings. For example mention was made of the Wythenshawe Integrated Neighbourhood System where services/agencies, including registered providers, meet routinely to discuss all cases of abuse and neglect. There was also positive endorsement of co-location or “in-reach” initiatives, such as housing practitioners working in secondary healthcare settings.

7.1.8. Nonetheless, concerns about multi-agency working in the community were also expressed at the learning event. For example, some attendees felt that there would be little that MARAC could offer for individuals who were perpetrators, even when acknowledging that sometimes they had been victims also, as is the situation in the sample of cases in this review. There was no evidence in the chronologies that programmes for domestic violence perpetrators were considered for any of the individuals in the sample and it was suggested during review group meetings that some agencies did not share information about perpetrators at MARAC.

7.1.9. In cases involving mental health, concern was expressed about inconsistent links with Care Coordinators working through the Care Programme Approach. More positively, it was noted that the Mental Health Trust now has a homelessness lead.

7.1.10. Examples were cited where mainstream services had passed cases onto homelessness services where this was inappropriate because lack of housing was not the central issue. Other examples included services that should have been included in a coordinated approach to a case not being part of the team around the person, and multi-agency meetings being called too late and concluding without an agreed risk assessment and management or action plan. A clear priority for those attending the learning event was the need for greater coordination, including appointment of lead agencies and key workers in the community, so that those involved were clear where responsibility lay for case management.

7.1.11. Some of those attending felt that guidelines for working with people who are homeless would be useful about when to refer cases on and when to initiate early communication with other services. An example here is co-occurring mental illhealth and substance misuse and the perceived need to focus on arrangements for those with multiple, complex needs. Others suggested the need for guidance on the process to be followed for convening a multi-agency professionals' meeting.

7.1.12. At the learning event hostel staff indicated that they sometimes felt left with high numbers of complex individuals to support with little help from other services. This highlights a question about whether services are being commissioned to support hostel staff when they are assisting individuals who are homeless.

7.1.13. Overall, whilst a sense was conveyed of a multi-agency system beginning to work better together, there was still a view expressed that working together was inconsistent, with a lack of communication and trust between sectors, and the need for more effective coordination and integrated working in the community with respect to complex cases.

7.1.14. A similar mixed picture emerged from responses to the survey. On the one hand there was evident commitment to working together, positive experiences of key workers and multi-disciplinary teams, and examples of good partnership working (for example the Adult MASH). There were positive evaluations of co-location, for

example to seek to prevent hospital discharge to no fixed abode. On the other hand there was a perception that much work was disjointed and would benefit from greater coordination, for example between staff working in the substance misuse, probation and/or homelessness sectors, or between health and homelessness services ahead of discharge. There were references to services being happy to "leave it to others." One respondent observed that "getting people round a table was often difficult due to time pressures." Another's experience had been of a "distinct unwillingness of agencies to engage and assist", a "no wrong door" approach had not been evident.

7.1.15. The challenges involved in working together have also surfaced in research, for example the lack of coordination between Housing, Adult Social Care and Mental Health services in the community, and referral bouncing[44].

7.2. A comprehensive approach to information-sharing is required, so that all agencies involved possess the full rather than a partial picture.

7.2.1. In two cases (Lester and Larry), the individuals concerned moved between different local authorities within the Greater Manchester area. In one of these cases, the individual might not have been regarded as "ordinarily resident" in Manchester. It is unclear from the chronologies what information was shared between the respective local authorities. The GP responsible for Lester when he returned to Manchester does appear to have received some information.

7.2.2. Whilst the chronologies do record some information-sharing, for instance between secondary health care settings and GPs, Jacob's case illustrates ongoing barriers. In that case, no other agency was able to access day centre records.

7.2.3. At the learning event this emerged as a strong theme, with considerable uncertainty being expressed about when it was lawful to share information. Uncertainty was expressed about how much information should be given to support applications for housing, or when seeking to facilitate joint working, for example between health and criminal justice agencies.

7.2.4. Within the survey the importance of sharing information was recognised when respondents were reflecting on how they would respond when someone with capacity refuses care and support but is at risk of significant harm. However, information-sharing appeared to be a barrier in working together. It should be noted that there was a high risk protocol in place at the time to respond to individuals with capacity who were challenging for services to engage with.

7.2.5. Alongside uncertainty about the law relating to information-sharing, now encapsulated in the Data Protection Act 2018, concern was also expressed at the lack of access to information held by different agencies, such as mental health

[44] Mason, K., Cornes, M., Dobson, R., Meakin, A., Ornelas, B. and Whiteford, M. (2017/18) 'Multiple exclusion homelessness and adult social care in England: exploring the challenges through a researcher-practitioner partnership.' *Research, Policy and Planning*, 33 (1), 3-14.

services' access to GM Think. However, GM Think attracted positive comments in the survey, highlighting the positive benefits of an integrated data system.

7.2.6. Poor information-sharing can place the individual, other service users and practitioners at risk. Information-sharing could still represent a "massive barrier" – understanding what other services are involved and/or exchanging information at key transition points, such as prison/hospital discharge or handover from Children's Social Care to Adult Social Care.

7.3. Multi-agency meetings pool information and assessments of risk, mental health and mental capacity, agree a risk management plan, and consider legal options.

7.3.1. In David's case there was a repeating pattern in where and how he presented but no multi-agency complex case discussion in response. He was breached by the National Probation Service for non-compliance with a community order that included supervision, specified activity and drug rehabilitation but his continued refusal of assistance with accommodation or drug treatment did not prompt liaison with other services.

7.3.2. Repeating patterns are also evident in the cases of Lester and Larry but there were no multi-agency meetings to agree risk management plans or, in Larry's case, to respond when he did not follow through on plans that had been put in place. In the combined chronology for Larry there is a passing mention that it may have been appropriate to pull agencies together to share information and agree a strategy. With Lester, despite evidence of suicidal ideation and self-harm, known to the National Probation Service and GMP at different times, and episodic hospital admissions, sometimes under section (Mental Health Act 1983), there does not appear to have been a coordinated approach to meeting his mental health, housing and care and support needs.

7.3.3. With Darren, similarly, the breakdown of a plan, on this occasion when he became homeless again following a period in temporary accommodation, did not trigger multi-agency meetings. One strategy meeting is recorded following concerns raised by an accommodation project but the chronology does not detail the outcome. Greater Manchester Mental Health record one multi-disciplinary team meeting when he did not engage but the plan only appears to have been to update records.

7.3.4. Similarly, with Luke, he twice lost accommodation, once due to risks for his safety and once due to bullying, intimidation and theft from other residents. However, on neither occasion did this prompt a risk management meeting. A safeguarding concern from a social housing support worker elicited a single rather than a multiagency response. As previously noted in this review, Luke was known to services and a multi-agency approach had been recommended to assist with assessment of needs and management of risk.

7.3.5. Finally, the case chronology for Stephen mentions MARAC referrals and repeating patterns of domestic abuse, offending, drug misuse and non-attendance at appointments. In what might be described as a complex case, whilst there is

evidence of liaison between agencies, there does not appear to have been any multi-agency meetings.

7.3.6. Feedback from the learning event regarding current use of, and concerns regarding multi-agency meetings has been referred to in section 7.1 above. The chronologies give little indication of the use of multi-agency and/or multidisciplinary team meetings in the community. Whilst some progress was evident for some of those attending the learning event, practice was patchy, with others concluding that multi-agency meetings needed to be more effective, with the "right people" around the table and with clearly agreed actions that were followed through. Greater use of key workers would, some people argued, prompt the calling of multi-agency meetings.

7.3.7. Perhaps more encouragingly, when asked how they would respond when someone with capacity refuses care and support but is at risk of significant harm, there were frequent mentions of discussing the case with colleagues and/or arranging a meeting of professionals to share responsibility, identify risks and agree options. It might be timely, therefore, to collect data on whether multiagency meetings are being used more frequently than the cases in the sample would suggest.

7.3.8. Beyond the use of multi-agency meetings to coordinate a risk management and mitigation plan, positive evaluations are emerging of next level multi-agency panels[45] when initial attempts at an integrated approach have failed. Once again shared problem-solving is central, alongside a policy of no "hand-offs" and a focus on stalled cases. A system rather than service approach is taken, seeking flexible, bespoke responses to individual need.

7.4. Policies and procedures for working with adults at risk are referred to and used.

7.4.1. In Larry's case chronology an entry from Greater Manchester Mental Health refers to him experiencing mild depression when the threshold operating for intervention was severe and enduring mental illness.

7.4.2. Feedback from the learning event was positive about the work of the Manchester Homeless Partnership and Homelessness Action Groups. However, feedback also cast doubt on the strategic commitment from some partner agencies and the lack of alignment between different policies and procedures and how these are meant to contribute to the City's homeless strategy.

7.4.3. The combined chronologies give little indication of knowledge and active use of procedures. Manchester Safeguarding Adults Board launched its self-neglect strategy in Autumn 2019[46]. This strategy draws attention to the risk of becoming homeless and to the impact on a person's mental capacity, specifically executive functioning, of substance misuse. It draws on the evidence-base that has been

[45] Creative Solutions Forum, Plymouth City Council; Multi-Agency Resolution Group, City of Stoke-on-Trent.

[46] Manchester Safeguarding Adults Board (2019) *Self-Neglect and Hoarding Strategy and Toolkit*.

used in this review. It would be advisable for the Manchester SAB to audit the impact of this strategy.

7.4.4. Conversely, there is no specific reference to either homelessness or substance misuse in Manchester Safeguarding Adults Board's multi-agency policy and procedures[47]. It concentrates on the types of abuse. The focus therein on safeguarding enquiries, SARs, information-sharing and MARAC and MAPPA meetings could be updated to take account of the findings of this thematic review.

7.4.5. The cross-cutting nature of homelessness is recognised in central government guidance[48], with an expectation that housing authorities will work together with organisations specialising in primary care, substance misuse and mental health. This guidance emphasises that acts or omissions, which might result in a decision that a person is intentionally homeless, should not be considered deliberate where they are the result of limited capacity, mental illness or an assessed substance misuse problem. This is correctly represented in Manchester City Council's own procedures[49]. These procedures correctly observe that priority need arises from vulnerability by virtue of disability, including physical and mental health issues that have a substantial and long-term adverse effect on normal daily activities. The procedures state that addiction is excluded from the definition of disability. However, it could add that a physical and/or mental impairment caused by or the result of addiction would fall within the definition of disability (Equality Act 2010 (Disability) Regulations 2010).

7.4.6. Policy on floating support[50] focuses on protecting homeless people from significant harm, providing a safe environment to live in and developing individuals' autonomy and independence. There is, however, no reference to selfneglect or to the Care Act 2014. It also appears to suggest that confidentiality is absolute when, under the Data Protection Act 2018, there will be occasions when it is necessary to share information without consent to safeguard an adult at risk.

7.4.7. There was at the time of the cases within the sample a high risk panel[51] for the discussion of adults with capacity at risk of serious harm through self-neglect, risk taking behaviour and/or refusal of services. The panel is available for cases where service involvement and safeguarding meetings have failed to mitigate serious risks, including those arising from substance misuse and homelessness. It aims to provide a multi-agency response through a risk action plan. The criteria for consideration are similar to those within section 42 (1) Care Act 2014, which means that the individuals concerned must be recognised as appearing to need care and support. The panel was not used for any of the cases in the sample.

[47] Manchester Safeguarding Adults Board (2015) *Multi-Agency Policy and Procedures*.

[48] Ministry of Housing, Communities and Local Government (2018) *Homelessness Code of Guidance for Local Authorities*. London: The Stationery Office.

[49] Manchester City Council Housing Solutions Service (no date) *Intentional Homeless Procedures*.

[50] Homelessness Floating Support (2018) *Safeguarding Adults Policy*.

[51] Manchester Safeguarding Adults Board (2018) *Adult Social Care High Risk Protocol*.

7.4.8. From January 2019 a task and target approach has been adopted that focuses on cases of people with complex needs who sleep on the streets. It focuses on cases where there appear to be "no options", bringing key agencies together to formulate and regularly review action plans. Feedback from the learning event contained positive expressions of support for this approach, as an example of multi-agency working, although concern was occasionally expressed that not all agencies with potential contributions to make were represented, such as Adult Social Care.

7.4.9. Also newly available is a policy designed to reduce homelessness after hospital discharge [52]. It stresses the importance of discharge planning beginning at preadmission or within twenty-four hours of admission, initially by establishing whether or not an individual has suitable accommodation to return to. It emphasises the importance of timely referrals to facilitate the formulation of plans and of thorough written records. It references the provision available from day centres for homeless people, the hospital homeless in-reach service (MPath) and specialist GP services for homeless people. It itemises procedures to follow when individuals self-discharge.

7.4.10. GM Homes Partnership has been delivering the "Social Impact Bond entrenched rough sleepers' service" since January 2018. It was originally aimed to achieve positive outcomes for 200 entrenched rough sleepers from an identified cohort of 300 referrals over a 3 year period. Currently almost 400 individuals are being supported and 303 have moved away from sleeping rough and into their own accommodation. Properties are available through a partnership with Greater Manchester Housing Providers and individuals are offered long term, settled and sustainable tenancies. SIB operates via an intensive, person centred outreach provision, providing support to enable access to a home, health, wellbeing and employment services. The aim is to work intensively with individuals via a strength based approach to enable to them to move away from rough sleeping towards independent living.

7.4.11. At the learning event there was some criticism of "did not attend" procedures for focusing on children and young people to the exclusion of adults at risk. Safeguarding procedures for the Police[53] focus much more extensively on children and young people, and on parents who abuse drugs and/or alcohol, with consequent risks for their children. There is no reference to the Care Act 2014 or Adult Social Care and very little on safeguarding adults.

7.4.12. A considerable number of operational policies and procedures were made available for this thematic review. Some were in existence at the time of the cases within the sample. Some have been developed more recently. Several observations arise from reading this material. Firstly, many of these policies are single agency and there is little cross-referencing. Secondly, it is unclear how

[52] Manchester University NHS Foundation Trust (2019) *Homelessness Reduction Policy*.

[53] Greater Manchester Police (2016) *Safeguarding Children and Adults. A-Z Procedure and Guidance*. [66] Manchester Homelessness Strategy 2018-2023. *Ending Homelessness Together*. Manchester Homeless Partnership.

individual procedures are explicitly intended to take forward that agency's contribution to the City's homelessness strategy. Thirdly, there does not appear to be a whole system operational set of procedures for practice with respect to people experiencing multiple exclusion homelessness, designed to bring together diverse support right from the beginning. The City's homelessness strategy[66] stresses the importance of joint working, provision of advice and support, continuity of treatment and support, planned discharge, and accessing wider support services. The question is how this integrated support will be achieved in operational practice? Who will bring the diverse support that people need together? One result of this is the development of multi-agency initiatives, such as the high risk panel, section 42 enquiries and the task and target approach, where it might not be clear to practitioners which procedure should be used when. Another result is that the potential contribution of Adult Social Care and Adult Safeguarding is not always highlighted. Fourthly, no evidence of auditing the outcomes of policies and procedures has been seen[54].

7.5. The duty to enquire (section 42, Care Act 2014) is used where this would assist in coordinating the multi-agency effort, sometimes referred to as safeguarding literacy.

7.5.1. No notifications or referrals of adult safeguarding concern are recorded in the chronologies for David, Stephen, Lester and Jacob. In David's case there are two references to him holding a tenancy but living in squalid conditions. There are repeated references to his poor health. These do not appear to have been seen as safeguarding concerns[55].

7.5.2. In Darren's case, NWAS raised one safeguarding concern but the outcome is not given in the chronology. In Larry's case, one safeguarding concern was raised when he was admitted to MRI by ambulance. The outcome appears to have been a referral to an Engagement Homeless Team but he could not be located. This referral does not appear on Adult Social Care or Adult MASH records in Manchester. In Luke's case, only one safeguarding adult concern was raised, by a social housing support worker concerned about financial and material abuse when he had been accommodated. As a result of cuckooing he had left his accommodation. The case was allocated to an Adult MASH social worker for information gathering and risk analysis. The decision was that he should remain in contact with services and that there should be a follow-up multi-agency response. Whilst this approach may have been compliant with MCC safeguarding adult policies and procedures in operation at the time, it did not address his "loss" of accommodation or his inconsistent engagement with services. Other possible causes for concern, such as being conveyed to hospital with hypothermia or being on the street with serious health issues, did not prompt referral of safeguarding concerns. Rather, his behaviour appears to have been seen through an anti-social lens.

[54] In fact the reviewer understands that the Manchester Safeguarding Adults Partnership has completed audits on self-neglect and domestic abuse. The next audit for completion focuses on mental capacity.

[55] This raises the question of what might be seen as a safeguarding concern when Manchester Safeguarding Adults Partnership completes an annual audit to seek assurance that agencies have effective safeguarding arrangements.

7.5.3. At the learning event some uncertainty about or lack of knowledge of safeguarding pathways was expressed, including the criteria within the three subsections of section 42 (1) that need to be met for an enquiry to be mandated. This suggests both a lack of legal literacy as well as safeguarding literacy. It was also suggested that homelessness may still not be seen as a safeguarding issue[56].

7.5.4. A mixed picture emerged from responses to the survey. When asked how they would respond when someone with capacity refuses care and support but is at risk of significant harm, there was frequent mention of using safeguarding policies and procedures, including those advising use of high risk panels, and of making referrals either to Adult Social Care or Adult Safeguarding, or seeking advice from safeguarding specialists. However, there were comments too that some services did not understand pathways into, or processes of adult safeguarding, and that responses from adult safeguarding staff in the community were not always timely. This should be of concern when the Safeguarding Partnership undertakes an annual audit of partner agencies to seek assurance that staff understand safeguarding policy and procedure.

7.5.5. At one panel meeting it was suggested that agencies might be deterred from sending in concerns because previous referrals had been "knocked back." There was also a view that thresholds for adult safeguarding were set too high.

7.5.6. Given the apparent disparity between the absence of safeguarding in the seven cases and the responses in the survey, it would seem appropriate to audit referrals into and the responses of adult safeguarding to cases of multiple exclusion homelessness. One focus in such an audit should be whether there is an understanding that people who are experiencing homelessness may have care and support needs and be at risk of abuse and/or neglect (including self-neglect).

7.6. Work should include evaluation of the relevance of diverse legal options to assist with case management, sometimes referred to as legal literacy.

7.6.1. Jacob had no recourse to public funds. There is no evidence in the chronology of an assessment using the Human Rights Act 1998, and specifically Article 3 of the European Convention, the right to live free of inhuman and degrading treatment, or of consideration of whether anything could be provided through the Localism Act 2011.

7.6.2. Some uncertainty was expressed at the learning event about what the law would permit in terms of supporting people with no recourse to public funds. Whilst not all practitioners will require detailed legal knowledge in this field of practice, some basic awareness would be useful when supporting and/or advocating for people in that situation. Important here will be awareness of powers in the Localism Act 2011, especially where Article 3 of the European Convention of Human Rights (Human Rights Act 1998) might be triggered because intense mental suffering and/or physical harm might result without the provision of support.

[56] This is despite the availability of safeguarding training and policies and procedures that contain information on safeguarding adults at risk of abuse.

7.6.3. Otherwise the chronologies provide little evidence in the community of an active consideration of the legal rules when working with complex cases. There is no sense that the advice of legal practitioners is being sought as part of developing a risk management plan or meeting people's complex needs.

7.6.4. The survey asked respondents how they would respond when someone with capacity refuses care and support but is at risk of significant harm. A few responses considered the involvement of advocates, assessment under the Mental Health Act 1983, reviews of mental capacity, and consideration of inherent jurisdiction. However, other responses give rise to cause for concern about legal literacy. Thus, "if they have capacity I do not feel I could go further" or "if someone has capacity we have no powers to force them to do anything; they are adults and are fully and wholly responsible for their own decisions and actions." There were statements to the effect that "a person with capacity is allowed to make an unwise decision", that "this is a lifestyle choice" and we must "respect the right to make unwise decisions." These statements are a misreading of the Mental Capacity Act 2005. A range of legal options should be considered in this scenario, including referral to the High Court and its inherent jurisdiction.

7.6.5. Under the Care Act 2014, care and support needs arise from or are related to physical or mental impairment or illness. Thus, such needs may arise from physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury. Reviewing what is known about the individuals whose cases prompted this thematic review, it is hard to understand why it did not appear to those who knew them that they appeared to have care and support needs, which would have rendered them eligible for a section 9 assessment.

7.6.6. Following an assessment, eligible needs that would trigger a duty to provide care and support include being appropriately clothed, being able to maintain a habitable home environment and being able to use facilities and services in the community. Feedback at the learning event suggested the need to raise awareness across agencies about the recognition of care and support needs. The review team, when discussing the minimal involvement of Adult Social Care and Adult Safeguarding in the seven cases, explored three hypotheses – the impact of gatekeeping, the assumption that other agencies would have sent referrals, and the influence of attitudes regarding people who self-neglect.

7.6.7. The survey also drew comments that rights of, and duties towards people experiencing homelessness were not being adhered to, for example in decision making about whether someone was intentionally homeless when they decline offers of temporary accommodation, or whether there was evidence of priority need (Housing Act 1996). It was suggested, for instance, that relapse back into substance misuse was assumed to be evidence of intentional homelessness, also that thresholds for priority need were set too high. Along similar lines, there were suggestions that understanding of the Homelessness Reduction Act 2017 required improvement. Information-sharing was also experienced by some respondents as problematic, suggesting that the circumstances outlined in the Data Protection Act 2018 on when it is lawful to share information has not been understood.

7.6.8. Research [57] has also spotlighted the challenge of different workforce sectors understanding the powers and duties available to different statutory agencies. Thus, Adult Social Care staff have the challenge of exploring the fit between vulnerability as defined by the Housing Act 1996 and subsequent case law with the duty in the Care Act 2014 to assess anyone who appears to have care and support needs. Staff working directly with homeless people similarly have to know about how the Care Act 2014 conceptualises wellbeing and eligible needs, and to map people's stories and needs accordingly to secure access to Adult Social Care. The development of such legal literacy has a direct relevance for the quality of referrals, which is the immediate focus below.

7.7. The evidence-base (section 5) highlights the importance of detailed referrals.

7.7.1. In section 6.12 this theme was picked up with feedback at the learning event regarding understanding amongst different agencies and professionals on how to frame referrals as well as the capacity of departments, especially Adult Social Care, to absorb them. Research[58] has also highlighted this issue, for example social workers experiencing difficulty in interpreting referrals from homelessness organisations. Staff working with homeless people might stress their vulnerability. However, the duty to meet eligible needs in Care Act 2014 terms arises from the presence of physical and/or mental impairment or illness, which can include conditions that are the result of substance misuse or brain injury. Similarly, the criteria that should prompt an adult safeguarding enquiry are clearly specified in section 42 (1) Care Act 2014.

7.8. Recording of assessments, reviews and decision-making is clear and thorough.

7.8.1. The chronology for David mentions one referral by Greater Manchester Police to Adult Social Care. However, available records within Adult Social Care do not record him as known to that service. In the same case the chronology records the lack of detailed notes on the case held by the National Probation Service. In Jacob's case a Consultant wrote to request temporary accommodation for him but there is no record of the outcome of this request and Jacob remained homeless. Limited record keeping is also noted by Greater Manchester Mental Health with respect to drug treatment planning for Stephen.

7.8.2. It remains unclear whether Larry was known to Adult Social Care in another of the local authorities in the Greater Manchester area, and how (quickly) records were shared of assessments and interventions with respect to people experiencing homelessness who moved between local authority areas (Lester and Larry).

[57] Mason, K., Cornes, M., Dobson, R., Meakin, A., Ornelas, B. and Whiteford, M. (2017/18) 'Multiple exclusion homelessness and adult social care in England: exploring the challenges through a researcher-practitioner partnership.' *Research, Policy and Planning*, 33 (1), 3-14.

[58] Mason, K., Cornes, M., Dobson, R., Meakin, A., Ornelas, B. and Whiteford, M. (2017/18) 'Multiple exclusion homelessness and adult social care in England: exploring the challenges through a researcher-practitioner partnership.' *Research, Policy and Planning*, 33 (1), 3-14.

Neither the National Probation Service nor CRC appear to hold records of at least one occasion when Larry was in prison for burglary.

7.8.3. At the learning event there was some optimism that the information system GM Think would facilitate information-sharing and the use of recorded information to highlight repeating patterns of risk and need. GMThink is a shared data system used by services working with individuals who are homeless or rough sleeping across Manchester. It is a tool to support individuals with the goals they want to achieve, resonating with the person-centred component of the evidence-base, and records outcomes. It also incorporates safety plans, again resonating with the focus on risk management in the evidence-base. It has been designed with the aim of supporting individuals and recording all known contacts at multiple services across the city. This enables shared support between services and accurate management of hard to engage or transient individuals who may be sleeping rough in the city. The system can be used to identify the last recorded contact / sighting of an individual who is engaging with services in the city.

8. Organisations around the Team

8.1. Supervision promotes reflection and critical analysis of the approach being taken to the case. Support is embedded for staff working with people who are hard to engage, resistant and sometimes hostile.

8.1.1. At the learning event the importance of peer-led support was emphasised. For example, some teams hold reflective practice sessions and have formed action learning sets to support relationship-based work.

8.1.2. One positive feature of the service landscape that was emphasised during the learning event was the commitment and level of skill amongst the workforce. Similar views about the commitment of staff were expressed through the survey. However, concern was also expressed at the lack of support and training for staff.

8.1.3. Nonetheless there are emotional costs to working in this field. The value of supervision was recognised, for example in situations of significant risk of harm. However, when asked about the impact of working with people experiencing homelessness in the survey, there were multiple comments about stress, emotional frustrations about “the system” and perceived helplessness because “what we can offer is so limiting.” This helplessness may, of course, mirror that felt by people who are homeless. Thus, the work was “tiring and depressing” and “extremely stressful and emotionally draining.” It could have “significant negative impact on my wellbeing.”

8.1.4. Survey feedback would therefore indicate the need to review single agency and multi-agency support available for those working in this field.

8.2. Access is readily available to specialist legal, mental capacity, mental health and safeguarding advice.

8.2.1. At the learning event some of those present were surprised to hear about the range of services available for people who are homeless and with complex needs. A similar perspective was expressed through the survey, namely that it is "difficult to find out what services are available and who to contact", with some organisations lacking "understanding of how pathways work". This suggests the need for a focus on awareness-raising and for establishing multi-agency practice forums to discuss and share information about responses to homelessness.

8.3. There is case oversight, including comprehensive commissioning and contract monitoring of service providers.

8.3.1. The implication of the commentary in this section and in section 8.6 on resources is the need for regular dialogue between commissioners and providers with respect to the changing demographic of homeless people, especially as there is evidence of the movement into the City of Manchester of people who are homeless. This dialogue needs to inform commissioning regarding where there are perceived gaps in, or insufficiency of provision. However, caution is needed here as the evidence[59] indicates that services are often commissioned to address specific issues when a system-wide integrated approach is needed, linked or even co-located services for people with complex needs.

8.3.2. One specific example of a resource that would be welcomed was an increase in welfare benefit staff to support the work of mental health and homelessness teams in tackling poverty and supporting debt relief in an effort to avoid homelessness. Another was the commissioning of psychologically-informed accommodation, environments that could support people who had been sleeping on the streets but who had been found accommodation. Other specific examples offered during the learning event or through the survey included developing the range of 24-hour provision, services "out of hours" and at weekends, dual diagnosis services and services for people with autistic spectrum disorders and acquired brain injury.

8.3.3. Other gaps and/or insufficiency of provision to emerge through the survey included limited (supported) (temporary) accommodation options, including emergency housing, insufficient gender specific services, lack of access to mental health support and/or substance misuse services, restricted options for ex-offenders, especially those with multiple and high support needs, and what was described as "a serious lack of assertive outreach." Also mentioned were lack of advocacy and access to legal advice, and an absence of emergency accommodation for young people.

8.3.4. What some of the cases in the sample also demonstrate is the importance not just of finding accommodation for homeless people with complex needs but also of

[59] Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping)*. London: Public Health England.

sustaining them in tenancies once they have been provided, sometimes referred to as “wrap-around services”. The shortage of services to meet people’s support needs once they had been accommodated was also flagged through the survey, with views expressed also that temporary accommodation was sometimes experienced as unsafe by those who had been accommodated there, for example for people with mental health needs, where standards were poor. Otherwise, as cases in the sample demonstrate, a cycle of in and out of homelessness can develop. What is provided by way of a community of support has to compete effectively with the sense of belonging that individuals may feel that the street community offers.

8.3.5. Observations offered to this thematic review indicate that a summit involving commissioners, providers and those who are experiencing or who have experienced homelessness would be beneficial to review where there are gaps in provision and then to design services together. It is strongly recommended that commissioners should engage with people who have experienced multiple exclusion homelessness and with practitioners working in this field when reviewing service development.

8.4. Partners agree strategically and operationally how different social issues (including homelessness) will be connected in policy, procedures, protocols and practice, through the operation of MAPPA, MARAC, MASH and other complex case or multi-agency panel arrangements, namely anti-social behaviour, domestic violence, offending (community safety) and vulnerability.

8.4.1. At the learning event practitioners and managers identified the challenge of finding creative solutions with respect to individuals who present with violent or aggressive behaviour. For example, some individuals approach A&E departments not because of a clinical issue so much as a need for a bed. How partners respond is the question that arises here?

8.4.2. At the learning event examples were given where individual agencies were developing their own policies and procedures with respect to homeless people. When an integrated, whole system approach is best practice, a governance issue arises here. Partners need to ensure that individually developed procedures enable rather than cut across the Manchester and Greater Manchester strategies for reducing homelessness.

8.4.3. One example of the importance of having a city-wide approach emerges from the sample of cases. Several individuals had been breached by Probation for noncompliance with court orders. Short custodial sentences cut across support and treatment plans in these cases. The strategic and operational question to be answered is when a criminal justice approach should be taken and when a public health approach should be prioritised. To that end a multi-agency pilot has begun on diversion from custody. It is designed to ensure that individuals engaging with the Social Impact Bond programme are not breached, recalled and sentenced to custody when that would have a detrimental impact on on-going support and service engagement.

8.4.4. A prominent theme at the learning event was that the strategic objectives in Manchester were clear but that further organisational and cultural shifts were needed to achieve full implementation. Instances were cited of different services pursuing different priorities rather than working together in partnership, of rushed hospital discharges resulting in revolving door patients and of the shortage of accommodation to move people into.

8.5. Partners agree indicators of risk that are formulated into a risk assessment template that will guide assessments and planning.

8.6. Attention is given to workforce and workplace issues, such as training, staffing levels, organisational cultures and thresholds.

8.6.1. At the learning event homelessness, self-neglect, trauma-informed practice, safeguarding and the different components included within the evidence-base for working with individuals were seen as issues that all staff needed to know about rather than training just being available to specific teams.

8.6.2. From the survey, 48% of respondents stated that their knowledge and understanding of homelessness was adequate, 36% good and 9% excellent (n=141). 35% (n=141) observed that their understanding of adult safeguarding pathways was average, 49% good and 10% excellent.

8.6.3. If this paints a positive picture of general knowledge, responses on specific topics were less encouraging. Only 31% of respondents stated that their understanding of the legal framework around homelessness was adequate and 18% good. Meanwhile, 42% observed that it was poor (n=142). When commenting in free text boxes in the survey on the availability of services and resources in Manchester, training also featured. Views were expressed that staff in statutory and third sector services were insufficiently trained to manage the complexities with which they were confronted, and that there was little support and training on relevant legal rules and policies. One respondent concluded that more knowledge about mental health and how it affects behaviour would be beneficial. Regular training updates were suggested.

8.6.4. Lack of training has also emerged from research studies. Limited training and experience of working with people who are homeless has been suggested to impact on the involvement of Adult Social Care staff with this service user group[60]. A lack of training on the impact on mental capacity of substance misuse has also been highlighted[61]. Panel members concluded also that working with people who are homeless should be the focus of single agency and multi-agency planning for learning and development.

[60] Cornes, M., Mathie, H., Whiteford, M., Manthorpe, J. and Clark, M. (2016) 'The Care Act 2014, personalisation and the new eligibility regulations: implications for homeless people.' *Research, Policy and Planning*, 31 (3), 211-223.

[61] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. London: Alcohol Change UK.

8.6.5. However, workforce development will be less effective without a concomitant focus on workplace development[62]. One aspect of workplace development, highlighted in section 6, was a perceived need for further culture change within organisations influenced by case management, target and time driven approaches to referrals, to permit continuity in relationship-based work that is indicated as best practice within the evidence-base.

8.6.6. The need for cultural change also emerged from responses in the survey. Responses on the availability of services and resources in Manchester included comments that there was "no understanding of the tolerance you need to jump through hoops" and that "more empathy" and "person-centred" support was needed from statutory services. Commenting on how agencies worked together, there were references to "inertia" and "buck passing", a lack of understanding of "each other's duties". Indeed, without strong advocacy, a sense emerged through the survey that people experiencing homelessness might be denied their rights.

8.6.7. Earlier observations about commissioning connect with comments here about attitudes and cultural change in perspectives offered through the survey about the focus of efforts to assist people who are homeless. Thus, "people see GPs for social and housing needs rather than medical problems" and "recovery from mental health issues is impeded by not having basic needs met." It is not just that resources are stretched but also whether the balance between prevention and crisis response was appropriately struck. One contribution to the survey is particularly forceful here: "people who use substances require trauma-informed work, long-term trusting relationships and stability to be open to support. What is on offer are hostels but tents are preferred because of the standard of housing available and the way they are treated. There is not enough specialist accommodation for people who are actively using. We need to reduce barriers and start treatment people with substance misuse problems as people with health and wellbeing needs. It is not a life style choice; there are vulnerabilities beneath that many professionals are ignorant of and don't want to help."

8.6.8. The lack of parity of voices also emerged, with comments such as "we do not feel heard or respected for the major contribution we are making." Barriers to working effectively together and with people experiencing homelessness included "people themselves are blamed" and "expectations are unrealistic" of people with longstanding problems involving substance misuse who often "do not have the resilience to work through our expectations." Direct work with individuals could be undermined when "personal opinions intrude when drugs and alcohol are involved", namely the "perception that it is the individual's fault." A challenge when working as a team around individuals was "getting other agencies not to judge." The need for "more understanding and compassion" was one respondent's conclusion.

8.6.9. At the learning event there was recognition that there had been some increase in available resources in the last year, that homelessness was higher on the agenda,

[62] Braye, S., Orr, D. and Preston-Shoot, M. (2013) *A Scoping Study of Workforce Development for Self-Neglect Work*. Leeds: Skills for Care.

that “a bed every night” had worked well for individuals with low and medium needs, and that statutory and third sector agencies were developing services to meet the needs of people living on the streets. Amongst the positives noted were the network of statutory and third sector agencies, the employment of people with lived experience working with people experiencing homelessness, and outreach and specialist health services. Nonetheless, concerns remained.

8.6.10. Workloads were frequently mentioned at the learning event. They were seen, for example, as being too high to facilitate relationship continuity with people sleeping on the streets. Concerns about staff shortage were also expressed and linked to burn-out.

8.6.11. Stretched resources, in the view of those attending the learning event, meant that service development was struggling to keep pace with changes in the homeless and street sleeping population. One example given was the lack of service provision for the increasing numbers of women and of young people, many with complex needs, living on the street. It was felt that more could be done by way of late evening, early morning, weekend and twenty-four hour provision. Another example was where short-term funding meant the loss of services that had developed specialist expertise. A third example given was the observation that funding panels would not resource recommended plans because of doubts about whether someone sleeping on the streets would engage. A fourth was the closure of some outreach services and day centre provision, and the lack of supported accommodation for people with complex needs who prove hard to engage.

8.6.12. A similar picture emerged through the survey. Some positives were noted, including GP services and an improving range of resources. More prominent, however, were concerns about services being “overwhelmed” or “overstretched”, with growing caseloads resulting in a lack of time to “deal with deep, entrenched patterns of behaviour and underlying issues like adverse childhood experiences.” There was frequent mention too of loss of services, such as for advice and hands-on support, outreach, and floating support, and supported housing, and concern that the focus was on crisis management rather than prevention. For some respondents, therefore, the picture presented was one of scarcity of resources to break the cycle of multiple exclusion homelessness, including “long-term patient casework.”

8.6.13. There was also reference in survey responses to low pay and poor working conditions, resulting in staff turnover, and a lack of consistency for people who experience homelessness and skilled, qualified and experienced practitioners “who can make a real difference.” Staff turnover has been referenced in the research[63] as undermining the support needs of people affected by homelessness and disrupting the provision of continuity within inter-professional practice.

[63] Mason, K., Cornes, M., Dobson, R., Meakin, A., Ornelas, B. and Whiteford, M. (2017/18) ‘Multiple exclusion homelessness and adult social care in England: exploring the challenges through a researcher-practitioner partnership.’ *Research, Policy and Planning*, 33 (1), 3-14.

9. SAB Governance

9.1. The development, dissemination and auditing of the impact of policies and procedures regarding self-neglect and multiple exclusion homelessness.

9.1.1. During the time that this thematic review was being conducted, MSAB launched its self-neglect and hoarding strategy and toolkit. It also reported a 17% increase in referrals into the Adult MASH of cases involving self-neglect in 2019/2020, following a 35% increase in the preceding year. It would seem timely to audit the impact of the strategy and the outcomes of the referrals into the Adult MASH.

9.2. Review of the interface between housing/homelessness and adult safeguarding.

9.2.1. As has been observed in this thematic review already, few connections have been made in multi-agency and single agency policies and procedures between multiple exclusion homelessness and adult safeguarding. Moreover, not least because of what is known about the seven individuals whose deaths prompted this review, it is difficult to conceive of situations where those experiencing multiple exclusion homelessness do not have care and support needs, and who may well also be experiencing abuse and neglect (including self-neglect). Adult safeguarding responsibilities are therefore also engaged.

9.2.2. A model of positive practice is available, drawn from research, SARs and accounts of practice[64]. It would seem appropriate for MSAB to take the lead in developing a multi-agency strategy that captures the interface between multiple exclusion homelessness and adult safeguarding, and promotes a model of best practice.

9.3. Establishment of a system to review the deaths of homeless people and/or as a result of alcohol/drug misuse.

9.3.1. There is no nationally recognised system for reviewing the deaths of homeless people. For cases where the mandatory criteria in section 44 Care Act 2014 are not met, it is possible for Safeguarding Adult Boards to use the discretionary criteria in section 44. Another option is to develop a bespoke review system. One example here has been developed by the London Borough of Haringey. The aims of this Homelessness Fatality Review system are to learn lessons to prevent the premature deaths of people experiencing homelessness and to improve multiagency partnership practice. It examines chronologies and other available information, convenes practitioners and managers involved in a learning event and results in a report and monitored action plan.

9.4. Working with Community Safety Partnerships, Health and Wellbeing Boards and partnership arrangements for safeguarding children and young people, to coordinate oversight of the development and review of policies, procedures and practice.

[64] Preston-Shoot, M. (2020) Adult Safeguarding and Multiple Exclusion Homelessness: A Briefing on Positive Practice. London: LGA/ADASS.

9.4.1. One link made here, highlighting the necessity of linkages between community safety and adult safeguarding at the learning event was with seasonal begging and organised crime.

9.4.2. What this link highlights is the question of where governance sits with respect to policy and practice on multiple exclusion homelessness. Put another way, what are the accountability lines between the Homelessness Partnership Board and the Safeguarding Adults Board, Health and Wellbeing Board, and Community Safety Partnership? Is it the case that each Board will use its statutory responsibilities, for example, to seek reassurance about the effectiveness of policies and procedures and, if so, how will their activities derived from their different mandated responsibilities inform each other? Alternatively, will one Board take lead responsibility for governance oversight?

9.4.3. The review team was informed that an Inter-Board protocol was under development. Such a protocol should consider the governance question in section 9.4.2 but also the question of future reviews of homeless deaths (section 9.3.1). It should seek to address one concluding comment from the survey, namely that good work with people experiencing multiple exclusion homelessness is not coordinated across the various groups, committees and boards to which reports are submitted.

9.5. Workshops on practice and the management of practice.

9.5.1. Lack of knowledge emerged as a barrier to best practice at the learning event, for example with respect to the law relating to information-sharing, and working with adults who self-neglect and/or experience homelessness. Learning is available from a variety of sources including SARs that feature homelessness as a central issue.

9.5.2. Those attending the learning event felt that more could be done to disseminate the objectives of local and regional policy with respect to counteracting homelessness across different sectors, such as primary and secondary healthcare, mental health and social care.

10. The Wider Legal, Policy and Financial Context

10.1. Practitioners and managers who attended the learning event, and those who responded to the survey, identified several areas where national policy rendered work with people experiencing homelessness more complicated and challenging. The welfare benefits system was clearly in view here, with the roll-out of Universal Credit having a negative impact on work with people with complex needs and increasing people's vulnerability to homelessness. The bedroom tax impacted on parents temporarily unable to live with their children, again increasing the risk of homelessness. A whole system approach is required if issues that are associated with street homelessness are to be tackled effectively. That includes begging and sex work to provide an income source, the need for

a "care of" address to access welfare benefits, and the alignment of housing benefit with city rents. The lack of alignment here makes prevention of ongoing homelessness more difficult; people cannot be moved on and so remain trapped in homelessness; landlords reluctant to take on tenants claiming benefits. One survey respondent suggested that it should be made unlawful for landlords to decline tenants simply because they were on benefits.

10.2. Prominent here too both at the learning event and from survey responses was the issue of the lack of affordable housing in the face of increasing numbers of people living without safe accommodation. The constraints placed on local authorities by successive governments have left a shortage of different types of affordable housing, including supported accommodation, which means that it is difficult for the reality of practice to match the aspirations of policy with respect to housing homeless people.

10.3. Continuing the focus on housing and on the need for whole system alignment, the Homelessness Reduction Act 2017, specifically the duty to refer, had had an impact on referral practice. However, as participants at the learning event and respondents to the survey emphasised, there had been little if any change in the provision available to meet people's accommodation needs. The 2017 Act did not bring with it resources to meet the duties owed to individuals. Nor has the law relating to priority need, intentional homelessness and local connection (Housing Act 1996) been amended. The duty in the 2017 Act to take reasonable steps to prevent and relieve homelessness does not confer new accommodation duties, for which the reference points remain priority need and intentional homelessness within the Housing Act 1996.

10.4. The Homelessness Reduction Act 2017 is silent with respect to two of the main contributing factors towards homelessness, namely the lack of supply of affordable housing and affordability of available accommodation. Welfare reforms have had a negative impact by creating landlord mistrust of Universal Credit and by failing to assist people into the private sector due to the rise in rents not being matched by the level of assistance available. It is not unusual to remark that the achievement of one government policy, namely here the prevention of homelessness, is undermined by another, namely here welfare benefit changes[65].

10.5. Government policy with respect to asylum seekers, captured in the phrase "no recourse to public funds" also presented challenges to those working with people who are homeless with care and support needs, as the case Jacob highlights. At the learning event practitioners identified the impact of this policy, including hospital admission, and the difficulty of finding a long-term means of helping these individuals.

10.6. The impact of financial austerity on all public sector organisations must be acknowledged. As Manchester[66] and Greater Manchester[67] policies with respect to people who experience homelessness recognise, budget reductions have severely

[65] Butler, I. and Drakeford, M. (2005) *Scandal, Social Policy and Social Welfare* (2nd ed). Bristol: Policy Press.
[66] Manchester Homelessness Strategy 2018-2023. *Ending Homelessness Together*. Manchester Homeless Partnership.
[67] Greater Manchester Homelessness Action Network (2018) *A Draft Strategy to End Rough Sleeping, and Lay the Foundations of a 10-year Homelessness Reduction Strategy in Greater Manchester, by 2020.*

curtailed what is possible. For those attending the learning event, this inevitably meant that people would fall through safety nets designed to prevent or make homelessness as brief as possible. Whilst local and regional policies were welcomed, those attending the learning event felt that a lack of resources potentially undermined policy aspirations with respect to the types of accommodation and intensive support required. In that sense there was felt to be a disconnection between the policy and what is actually achievable.

10.7. Research[68] has also shone the spotlight on the financial context, noting the impact of financial austerity on the capacity of all agencies (not just Adult Social Care) to absorb the workload arising from recognition of the care and support needs, and safeguarding concerns of people sleeping on the streets.

10.8. Research[69] has also highlighted that resource scarcity can lead to unlawful gatekeeping and the exclusion of people who are homeless from care and support.

10.9. Section 23 Care Act 2014 seeks to clarify the boundary between care and support and housing legislation. The statutory guidance[70] that accompanies the Act, particularly Chapter 15, provides further detail. The lack of suitable accommodation puts health and wellbeing at risk. Suitable accommodation is one way of meeting a person's care and support needs. However, where a local authority is required to meet a person's accommodation needs under the Housing Act 1996, it must do so. Where housing is part of the solution to meet a person's care and support needs, or prevent them, then the care and support plan may include this, even though the housing element is provided under housing legislation. Any care and support required to supplement housing is covered by the Care Act 2014.

10.10. However, people who are homeless experience difficulties accessing personalised support through Adult Social Care[71]. The cases within this thematic review would appear to support this conclusion. There is also evidence[85] that social workers may see homelessness purely as a housing problem to be dealt with under housing legislation and not as an issue involving social care. Social workers and social care staff may also be uncertain how wellbeing and the criteria regarding eligible needs are to be applied, for example to promote social inclusion of people experiencing homelessness[86]. Case law[87] has also established that local authorities must consider if care and support needs are accommodation related and must involve an advocate in assessment and care planning. It is difficult to conceive of situations in which homelessness does not have a significant impact on an individual's wellbeing. All of which would suggest a required focus on how

[68] Mason, K., Cornes, M., Dobson, R., Meakin, A., Ornelas, B. and Whiteford, M. (2017/18) 'Multiple exclusion homelessness and adult social care in England: exploring the challenges through a researcher-practitioner partnership.' *Research, Policy and Planning*, 33 (1), 3-14. Cornes, M., Mathie, H., Whiteford, M., Manthorpe, J. and Clark, M. (2016) 'The Care Act 2014, personalisation and the new eligibility regulations: implications for homeless people.' *Research, Policy and Planning*, 31 (3), 211-223.

[69] See, for example, Whiteford, M. and Simpson, G. (2015) 'Who is left standing when the tide retreats? Negotiating hospital discharge and pathways of care for homeless people.' *Housing, Care and Support*, 18 (3/4), 125-135.

[70] Department of Health and Social Care (2018) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office.

[71] Cornes, M., Joly, L., Manthorpe, J., O'Halloran, S. and Smythe, R. (2011) 'Working together to address Multiple Exclusion Homelessness.' *Social Policy and Society*, 10 (4), 513-522. Cameron, A., Abrahams, H.,

the provisions in the Care Act 2014 relating to care and support are being implemented with respect to people who are homeless.

10.11. Article 5 (e) of the European Convention of Human Rights allows the lawful detention of people of unsound mind, which can include those with substance addictions. Several jurisdictions outside the United Kingdom have legislated for protective detention of people with chronic alcohol problems or substance misuse issues who are at risk to themselves and/or other people. The purpose of this civil commitment is to reduce harm[88]. In Holland, detention is a judicial decision based on psychiatric advice regarding an individual's ability to care for themselves, immediate danger to themselves and the failure of repeated voluntary treatment. The person is provided with independent legal advice. In New Zealand legislation provides for court-ordered detention to ensure that the person undergoes assessment, detox and treatment. In Sweden legislation provides for civil containment to prevent a destructive way of life, overcome addiction and motivate the person to seek further treatment. There are similar provisions in some jurisdictions within Australia and the United States of America, enabling court orders to address a person's addictions and the likelihood of serious harm. Sometimes there is a requirement, alongside the risk of serious harm, that there is no less restrictive alternative and the person is likely to benefit from treatment.

10.12. The Mental Health Act 1983 and Mental Health Act 2007 explicitly exclude dependence on alcohol and/or drugs as disorders or disabilities of mind for the purposes of that legislation. The Acts cannot be used simply because an individual has an addiction. Clarification is offered by the Code of practice[89], namely that:

> "2.10 This means that there are no grounds under the Act for detaining a person in hospital (or using other compulsory measures) on the basis of alcohol or drug dependence alone. Drugs for these purposes may be taken to include solvents and similar substances with a psychoactive effect.
> Alcohol or drug dependence may be accompanied by, or associated with, a mental disorder which does fall within the Act's definition. If the relevant criteria are met, it is therefore possible, for example, to detain people who are suffering from mental disorder, even though they are also dependent on alcohol or drugs. This is true

Morgan, K., Williamson, E. and Henry, L. (2016) 'From pillar to post: homeless women's experiences of social care.' *Health and Social Care in the Community*, 24 93), 345-352.

[85] Whiteford, M. and Simpson, G. (2015) 'Who is left standing when the tide retreats? Negotiating hospital discharge and pathways of care for homeless people.' *Housing, Care and Support*, 18 (3/4), 125-135. Maeseele, T., Roose, R., Bouverne-De Bie, M. and Roets, G. (2014) 'From vagrancy to homelessness: the value of a welfare approach to homelessness.' *British Journal of Social Work*, 44 (7), 1717-1734.

[86] Mason, K., Cornes, M., Dobson, R., Meakin, A., Ornelas, B. and Whiteford, M. (2017/18) 'Multiple exclusion homelessness and adult social care in England: exploring the challenges through a researcher-practitioner partnership.' *Research, Policy and Planning*, 33 (1), 3-14.

[87] R (SG) v Haringey LBC [2015] EWHC 2579 (Admin).

[88] Ward, M. (2019) 'The case for legal powers to detain chronic problem drinkers who are at risk to themselves or other people.' Unpublished paper.

[89] Department of Health (2015) *Mental Health Act 1983: Code of Practice*. London: The Stationery office.

2.11 even if the mental disorder in question results from the person's alcohol or drug dependence.

2.12 The Act does not exclude other disorders or disabilities of the mind related to the use of alcohol or drugs. These disorders – e.g. withdrawal state with delirium or associated psychotic disorder, acute intoxication, organic mental disorders associated with prolonged abuse of drugs or alcohol – remain mental disorders for the purposes of the Act.

2.13 Medical treatment for mental disorder under the Act (including treatment with consent) can include measures to address alcohol or drug dependence if that is an appropriate part of treating the mental disorder which is the primary focus of the treatment."

10.13. A question for debate is whether there is a gap in the law with respect to addressing the experiences contained within the human stories of the people in the sample for this thematic review, and for people like Carol[72] and Howard[73] whose cases are the subject of SARs. Where a person has lost capacity due to substance misuse and addiction, with their self-determination compromised due to behavioural compulsion, the question for debate is whether for this group of people the use of such legislative powers would promote their wellbeing and future autonomy.

10.14. Feedback from panel members to the independent reviewer suggests that there is a need for greater understanding of how addiction affects someone's capacity to take decisions, particularly how it affects their executive capacity and control over their actions, and the application of this understanding to Mental Capacity Act 2005 assessments. Without such understanding the risk is that practitioners will conclude that the person has capacity if they can clearly state what they want when not under the influence of substances, even if this is still clearly influenced by their addiction. It is suggested that this should become an area of national debate about how the Mental Capacity Act 2005 is configured in relation to executive capacity and the impact of addictive behaviour.

11. Conclusion

11.1. Respondents to the survey offered case examples where practice had proved effective. They commented too on the positive practice of agencies such as Shelter, Barnabus, Coffee4Craig, GPs, Urban Village, Booth Centre, and the Rough Sleepers Team. Initiatives such as the Social Impact Bond and MPath were endorsed, as well as the focus on trauma-informed, no wrong door approaches.

11.2. Panel members have observed that multi-disciplinary teams are working proactively, with dedication to help people experiencing homelessness. There has been positive endorsement of multi-agency Task and Target meetings, of closer cooperation between housing and health practitioners to facilitate planned discharges and to discourage selfdischarge, and of integrated neighbourhood management teams, with outreach staff

[72] Teeswide Safeguarding Adults Board (2017) *Carol: A Safeguarding Adult Review.*

[73] Isle of Wight Safeguarding Adults Board (2018) *Howard: A Safeguarding Adult Review*.

as members. The independent reviewer has been told of a rapid rehousing pathway, with a focus on mental health, substance misuse and young people, and also of increasing resources for outreach and work that is proactive rather than crisis focused. This resonates with observations in the survey and at the learning event that there is some "brilliant work".

11.3. However, panel members and respondents to the survey are clear that further systemic changes are also required. It remains the case that mental health providers are discharging patients due to lack of engagement. This links, in part, to the decommissioning of the assertive outreach team, which means for instance that some patients with a severe and enduring mental health diagnosis who are homeless are not receiving their medication. The expectation that they attend clinic at appointed times will be unrealistic for many. Those attending the learning event also commented on the need for more than the standard NHS response.

11.4. Closely connected is hospital discharge. Whilst there have been policy and practice developments here, as this review report notes, there are still people being discharged to no fixed abode. The pressures on resources, on individual agencies, undermine the policy commitment of a bed for everyone. There remains insufficient accommodation, especially for "moving on" and for supporting people longer-term. Other commissioning gaps that have been reported by panel members include the need for accommodation in psychologically-informed environments for people still using substances, employing staff with the knowledge, training and skills to understand and respond appropriately to behaviours that have their origins in trauma.

11.5. Another reported commissioning gap is the absence of a dual diagnosis patient-facing service. It has been suggested to the independent reviewer that it is unrealistic to expect people with a co-morbidity of mental health and substance misuse to detox in order to be referred for mental health treatment. They are often self-treating their mental health condition, especially if it is trauma-related, with substances and therefore need holistic care for any chance of rehabilitation.

11.6. On the theme of trauma and the impact of adverse experiences, the need for a trauma pathway has been suggested to enable GPs and primary care staff more widely to engage with other services. This pathway would need to the extra needs of people who are homeless, including for mental health treatment.

11.7. Concern has been expressed also that Adult Social Care is closing cases due to non-engagement when proactive outreach is indicated. Concerns remain that it is difficult to secure care and support assessments, and that the interface between the Care Act 2014 and duties and powers in housing legislation remains unclear operationally. Concern has been expressed too about the use of exclusion orders by NHS Trusts with individuals whose behaviour is aggressive. Commissioners and managers should be assured that this approach is not being used with people whose behaviour is a symptom of mental health difficulty.

11.8. Linked to Adult Social Care is the understanding of case and risk management and the need to consider Adult Safeguarding. Further assurance is required in regard to pathways into Adult Safeguarding based on feedback that procedures may not be being followed in

relation to convening the multi-agency system to respond to the needs and risks in a case. It would seem appropriate to review procedures for complex case and high risk panels, and to provide for an escalation procedure when concerns remain about how agencies are responding to risks.

11.9. Concerns remain also about the absence of case coordination and key workers, and delays and/or frequent changes of care coordinators, which can frustrate attempts to engage and delay responses to mental health and care and support needs.

11.10. At the final panel meeting there was broad consensus that Manchester's homeless strategy and associated action plans had pulled partners in but there remained a disconnect, with not everyone seeing homelessness as (partly) their responsibility, as part of their core business. There was support for a summit conversation between commissioners and providers, in part to look at the jigsaw of services and to determine what redesign or refinement of the picture on the jigsaw of services was necessary.

11.11. Panel members and the independent reviewer hope that this report lands in such a way as to make a difference in Manchester's multi-agency partnerships. The hope is that it prompts dialogue between partners about the component parts of the jigsaw of services, which leads to developmental work across the whole system, overseen by renewed clarity on governance.

12. Recommendations

12.1. Arising from the analysis undertaken within this review, the SAR review panel and independent reviewer recommend that the Manchester Safeguarding Adults Board:

12.1.1. A further review of multi-agency procedures for working with people who self-neglect to ensure that they include clear pathways for convening multi-agency panel meetings and for escalation of concerns, and arrangements for agreeing on lead agency and key worker to coordinate practice; SAB partners should nominate a strategic manager in each agency to lead on this aspect of system development;

12.1.2. conduct an audit to assess the impact and effectiveness of the multi-agency procedures for working with people who experience or are threatened with homelessness, with contributory factors including self-neglect;

12.1.3. produce, disseminate and subsequently audit the impact of a procedure and pathway for people experiencing multiple exclusion homelessness;

12.1.4. ensure that SAB partners review and revise their own policies and procedures so that adult safeguarding is referred to since individuals who experience multiple

exclusion homelessness may well have care and support needs and experience, or be likely to experience, abuse and/or neglect (including self-neglect);

12.1.5. produce and disseminate procedures for responding to frequent flyers and to patients/service users who do not engage or attend appointments in situations where risks are significant;

12.1.6. produce guidance and tools for assessing risk in respect of adults who self-neglect and/or experience multiple exclusion homelessness;

12.1.7. commission multi-agency training on self-neglect, legal literacy (including information-sharing), unconscious bias, mental health and mental capacity assessments, trauma-informed practice, and risk assessment;

12.1.8. convene a commissioning summit to review gaps and shortages of provision, the focus to include mental health provision, substance misuse provision, the links between the two, and health, homelessness and social care outreach;

12.1.9. audit referrals for section 42 enquiries involving self-neglect and/or homelessness, and the practice standards and outcomes of completed investigations;

12.1.10. conduct a multi-agency audit to establish the extent to which the Adult MASH receive referrals of people who self-neglect and/or are homeless, and the decision-making response;

12.1.11. conduct single agency audits on cases of self-neglect and multiple exclusion homelessness to explore case management and decision-making where referrals have not been made to Adult MASH.

12.1.12. review health and social care provision available in local prisons and liaison with community providers, involving the National Probation Service also;

12.1.13. review the need for a multi-agency information-sharing protocol with respect to adults at risk of significant harm, to include guidance on when information-sharing is lawful (Data Protection Act 2018; Care Act 2014);

12.1.14. map service developments and current single and multi-agency provision with respect to adults who self-neglect and/or have complex needs/or misuse substances and/or are homeless or threatened with homelessness and, at a summit, consider what refinements and further developments are advisable in light of learning from this SAR;

12.1.15. engage with the Health and Wellbeing Board, Manchester Community Safety Partnership, and the Homelessness Partnership Board to consider future arrangements for leadership and governance of multi-agency partnership work with people experiencing multiple exclusion homelessness;

12.1.16. engage with the Health and Wellbeing Board, Manchester Community Safety Partnership, and the Homelessness Partnership Board to consider the process to be adopted for future reviews of cases involving the deaths of people experiencing multiple exclusion homelessness;

12.1.17. with partner agencies review how staff are supervised and supported to work with adults with complex needs who self-neglect and/or experience multiple exclusion homelessness in line with the evidence-base used in this thematic review, making any adjustments necessary to remove barriers to best practice;

12.1.18. promote through the network of SAB independent chairs a "whole system" conversation, including with central government departments, about the learning from this thematic review and other SARs that have considered cases of people experiencing multiple exclusion homelessness.

12.1.19. audit progress on learning from this SAR after one year from publication, using the evidence-base in section 5 then and subsequently to identify and tackle where barriers and obstacles to effective practice and policy or management for practice remain.

Glossary

A&E – Accident and Emergency
ACE's – Adverse Childhood Experiences
Barnabus – Christian Homeless Charity
Booth Centre – Day Centre for the Homeless
CGL – Change. Grow, Live
Coffee4Craig – Manchester Homeless Charity
GMMH – Greater Manchester Mental Health
GMP – Greater Manchester Police
GM Think – Multi-Agency Database for Information Sharing
GP – General Practitioner
MAPPA – Multi Agency Public Protection Arrangements
MARAC – Multi Agency Risk Assessment Conference
MASH – Multi Agency Safeguarding Hub
MCC – Manchester City Council
MFT – Manchester Foundation Trust
MRI – Manchester Royal Infirmary
MSAB – Manchester Safeguarding Adult Board
NHS – National Health Service
NICE – National Institute for Clinical Excellence
NWAS – North West Ambulance Service
SAB – Safeguarding Adults Board
SAR – Safeguarding Adult Review
Shelter – Homeless Charity
SIB – Social Impact Bond
UVMP/Urban Village – GP Surgery with Specialist Homeless Services

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