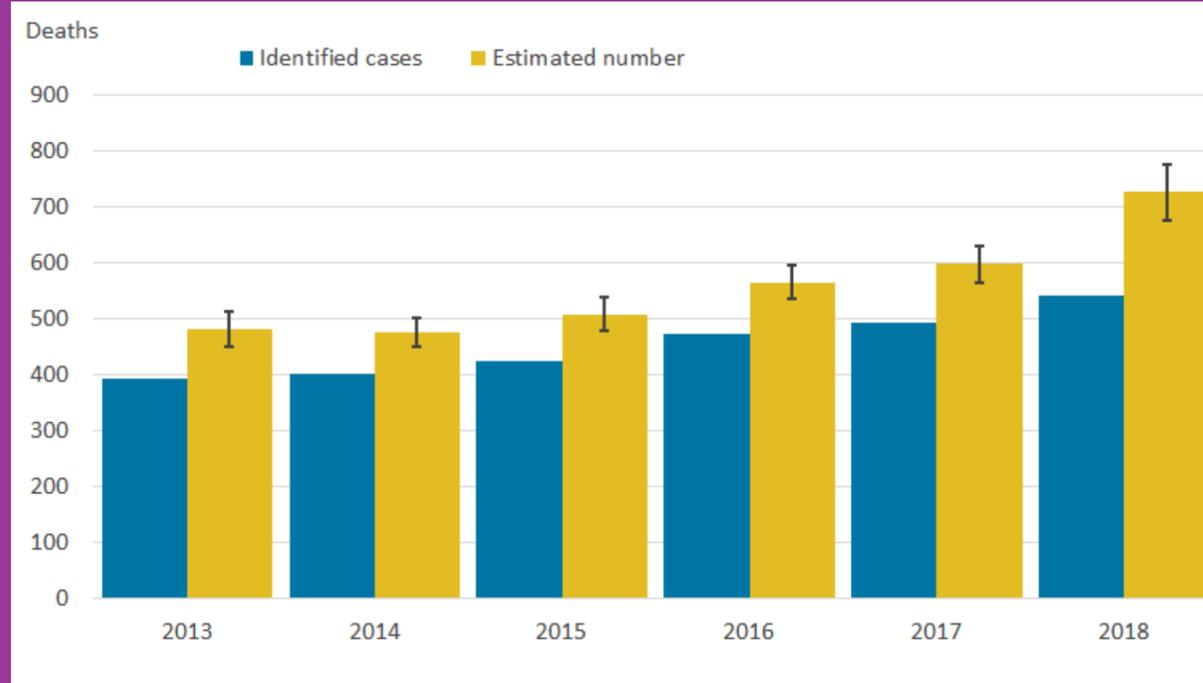


**Life on the streets: how
can we stop homeless
people from dying young?**

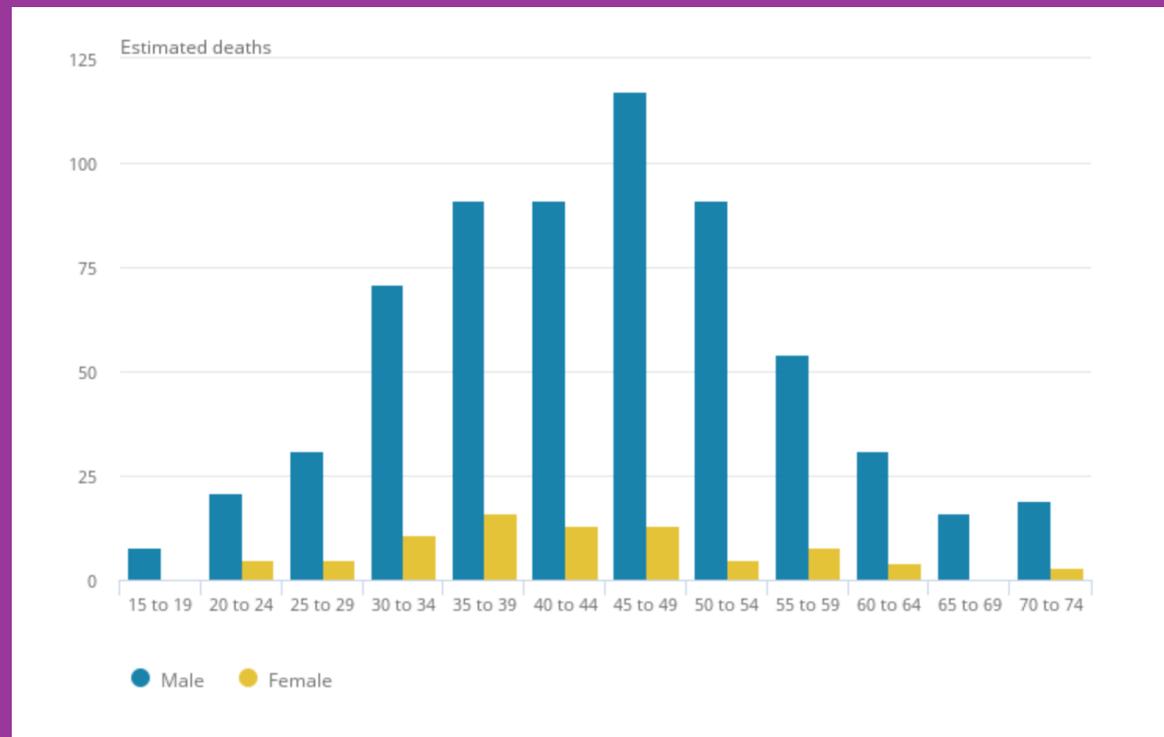


726 deaths of homeless people in England and Wales registered in 2018, highest year-to-year increase (22%) since time series began.



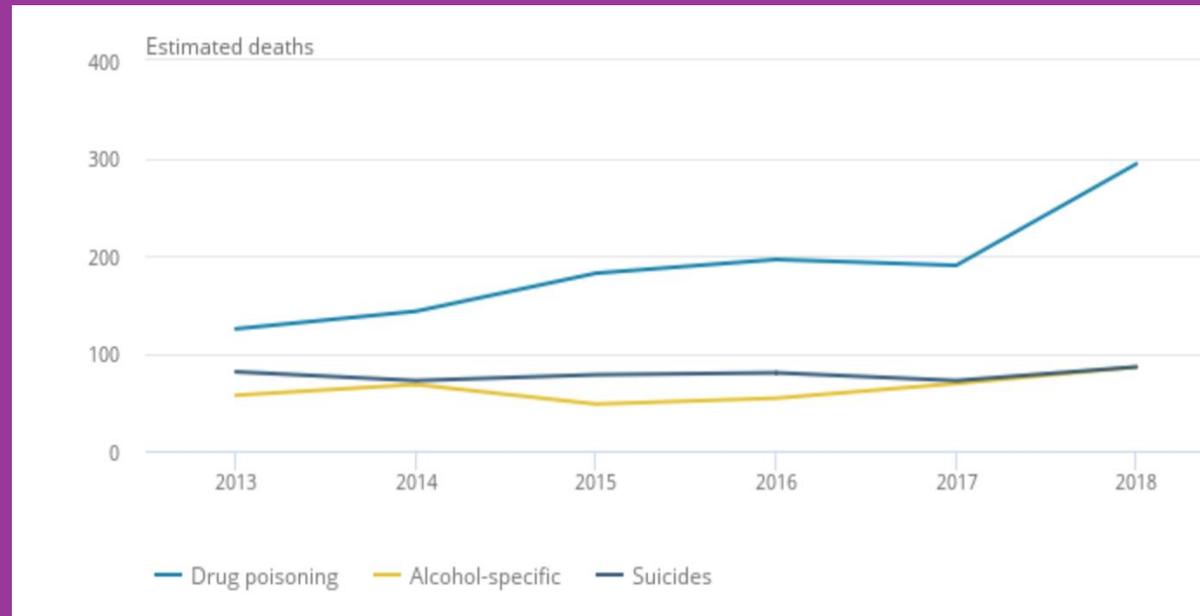
Source ONS
(2019)

Most of the deaths in 2018 were among men (641 estimated deaths; 88% of the total)



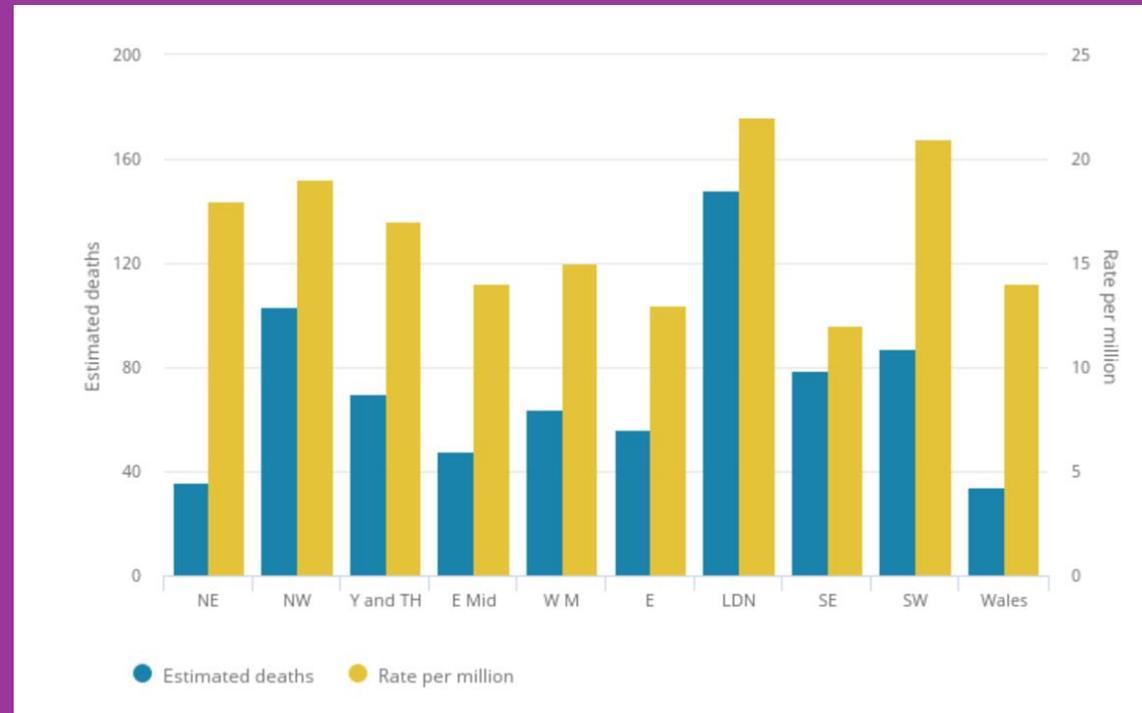
Source ONS
(2019)

Two in five deaths of homeless people were related to drug poisoning in 2018 (294 estimated deaths) and the number of deaths from this cause has increased by 55% since 2017



Source ONS
(2019)

London and the North West had the highest numbers of deaths in 2018, with 148 (20% of the total number) and 103 (14% of the total number) respectively

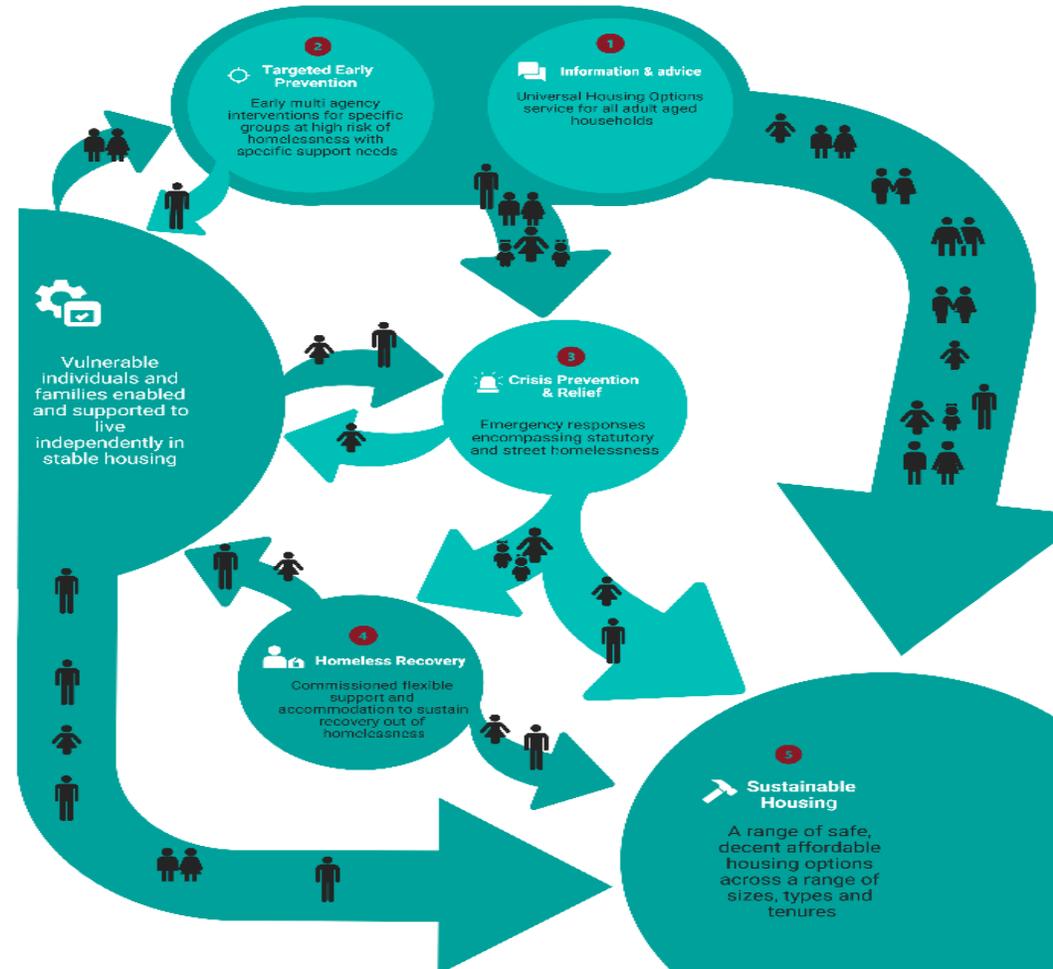


Source ONS
(2019)

<https://www.youtube.com/watch?v=iUmfYC81JjI>

A Positive Pathway Approach

- Long-term delivery of systems change to preventing and tackling homelessness
- Not just a bricks and mortar issue
- Wider focus than rough sleeping
- Homelessness Prevention Pathway (Universal, targeted, Crisis, Recovery, Housing Supply).



How?

- The social care and health responses to homelessness prevention must focus beyond a Duty to refer (Homelessness Reduction Act 2017) into a strong commitment to collaborate
- Leadership in facilitating a dialogue and join up between different agencies, directorate, government departments alongside, directors of social care and the LGA
- May not be able to change systems overnight but we can build excellence into our approaches:

How?

- **Universal** - role of GPs, PCNs, educational establishments, IAG
- **Targeted** - clear pathways and preparation for people leaving institutional settings (young people, prisons, hospital, social care). Investment in community assets, community social work approaches such as three conversations
- **Crisis** - multi agency, timely responses, to multiple presenting needs substance misuse, physical and mental health. Using strength based techniques to support delivery and the provision of emergency accommodations
- **Recovery, Resilience, healing** – to stop people falling back into homelessness
- **Sustainable** housing which is appropriate and affordable

A few examples of specific contributions

- Development of a Homelessness & Health agenda overseen by the Health and Wellbeing Board
- Dedicated social work resources as part of response to vulnerable young people and adults who are/ or at risk of street homelessness
- Preparation for adulthood work includes young people who have chaotic lives yet may fall below thresholds for statutory social care responses
- Leadership in developing responses to safeguarding issues within the non regulated exempt housing sector
- Commissioning of prevention activity including MHCLG funded RSI and Housing First projects (including navigators, peer support, street outreach, street psychologists, dual diagnosis responses)
- NHSE: STP Population Health Management approaches to homelessness

Homelessness and Safeguarding: learning from Safeguarding Adults Reviews (SAR)

- Homeless men and women die young

- at an average age of 44 for men and 42 for women (compared to 79.5 for men and 83.1 for women in the general population)

- Safeguarding Adults Reviews (Care Act 2015, section 44)

- ‘A Safeguarding Adults Board (SAB) must arrange for review of a case involving adult in its area with needs for care and support if there is reasonable cause for concern about how SAB, its members or other persons with relevant functions worked together to safeguard adult, and either:

- the adult has died, and the SAB knows or suspects that the death resulted from abuse or neglect or the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.’

- The aims of a Safeguarding Adults Review are:

- ‘identifying the lessons to be learnt from the adult’s case, and applying those lessons to future cases.’

Available reviews involving Homelessness

In addition to the 14 reviews included in the Kings College analysis (2019) ...

- Torbay SAB (2011) 'Ms Y'
- North Yorkshire SAB (2012) 'Robert'
- Walsall SAB (Learning Review summarised in Annual Report 2016/17)
- Doncaster SAB (2018) 'Adult G'
- Bexley SAB (2019) 'AB'
- Wiltshire SAB (2018) 'Adult D'
- Milton Keynes SAB (2019) 'Adult B'
- London Borough of Tower Hamlets (2019) Ms C

Forthcoming thematic reviews: Leeds (10 deaths), Manchester (7 deaths), and more thematic and single person reviews

Learning from Reviews (1)

Kings College Review of SARs

- Key themes (not generally covered in other SARs): Co-operation, co-ordination and leadership
- some SARs reported: problems with moving between LAs ; housing/homelessness staff excluded from safeguarding processes; people being assessed; failure to recognise care and support needs; some lack of reference to housing rights; mental capacity not considered (this is common in other SARs)
- Suitable accommodation not usually available, especially for people with mental health problems and/or alcohol misuse and some hospital discharge – to shelter or B&B – and not ‘rebuilding lives’
- Safeguarding issues: missed opportunities to make referrals and follow up, self neglect missed as possible safeguarding, Making Safeguarding Personal, difficulties with engagement
- What is needed? professional curiosity; not ‘normalising’ risk; more linkage of homelessness and safeguarding; resources to support practitioners
- NB health care challenges – deaths from cancer and COPD

Manthorpe et al 2019 NIHR, Kings College London

Learning from Reviews (2) LGA Workshops - Michael Preston Shoot

- The need to improve
 - Safeguarding and legal literacy
 - Integrated whole system working
 - Recognition and assessment of care and support needs
 - The need to clarify
 - Pathways into safeguarding
 - The role of different multi-agency panels
 - The need to assess
 - The likelihood and significance of risks
 - Executive functioning after prolonged substance misuse
 - The impact of trauma and adverse experiences
 - The need for creativity
 - Thinking collectively about ways forward
 - Avoidance of case dumping
 - Inter-agency mechanisms for responding to stuck and stalled cases
 - The importance of wrap-around support
 - Not just for service users but also for staff; the work is challenging
 - The importance of time, relationships and being “held”
 - The importance of candour and challenge
 - The importance of escalation of concerns
 - Ensuring all voices are listened to and included in multi-agency meetings
-

Useful Links & Resources

LGA Making Safeguarding Personal resources:

<https://www.local.gov.uk/topics/social-care-health-and-integration/adult-social-care/making-safeguarding-personal>

LGA Safeguarding Adults resources:

<https://www.local.gov.uk/topics/social-care-health-and-integration/adult-social-care/safeguarding-resources>

Manthorpe, J. et al (2019) [https://kclpure.kcl.ac.uk/portal/en/publications/safeguarding-homelessness-and-rough-sleeping\(8500d110-7a16-47c2-bba7-dd5b33b42d7e\).html](https://kclpure.kcl.ac.uk/portal/en/publications/safeguarding-homelessness-and-rough-sleeping(8500d110-7a16-47c2-bba7-dd5b33b42d7e).html)

Homelessness and Safeguarding briefing based on 4 workshops in 2019: to be published 2020

adi.cooper@local.gov.uk Care and Health Improvement Programme – safeguarding adults lead

Questions for Discussion

- What are you doing locally to address the reasons why homeless people are dying so young?
 - What helps?
 - What hinders?
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