Action Plan Closure report	
Action plan title	Thematic Review of Homeless Deaths Action Plan
Plan start date	June 2022
Plan closure date	June 2024
Report author	Chair, PSAB Quality Assurance Subgroup

Background and context

This was a thematic review following the deaths within three months of four men who were homeless. All were white British men in their early 40s or early 50s. Their deaths happened within the context of the first Covid-19 lockdown and three were accommodated in hotels or other accommodation as part of the national “Everyone In” programme.

Mr G had moved to Portsmouth fleeing drug related threats. He had recently been released from prison and had attended hospital for suspected overdoses and other injuries. Mr G was found dead in public toilets approximately 2 miles away from the hotel in which he was living.

Mr H had served several terms of imprisonment, had successfully completed an opiate recovery programme and moved into supported housing. Mr H was concerned about living with other people who might be using drugs or alcohol and wanted to reengage with Community Day Rehabilitation. Four days after last being seen, Mr H was found dead in his room from a suspected drug overdose.

Mr I had moved into a hotel where support staff became increasingly concerned about his physical health. Mr I was not eating, had lost weight loss, was short of breath and was self-neglecting. The ambulance service was contacted three times but only on the third occasion was Mr I was taken to hospital where he died the next day.

Mr J had lived with his sister in Portsmouth but left because he struggled with “lockdown” restrictions and was drinking heavily. Mr J was found collapsed a month

later outside a library, which had closed as part of the “lockdown”, and was taken to hospital. Mr J refused investigations but asked for support with alcohol dependency and was discharged. Mr J was found dead outside the library a month and a half later.

Summary of Findings from the SAR

The following learning and development opportunities were identified during the review. These include areas for development by single agencies.

1. There are several areas for development in the provision of health services for homeless people. For example, Queen Alexandra Hospital does not routinely record whether patients are homeless, which can lead to difficulties in identification and in prioritising interventions for them. This is also significant since, whilst the South Central Ambulance Service works across 16 Safeguarding Adults Board areas, the Portsmouth area has the most ambulance call outs for homeless people.

2. There is also a need to strengthen community mental health support for homeless people. For example, the community mental health team that works with homeless people and visits street homeless people lost its GP member from April 2021 onwards. Developments are already underway, however, and a new peer crisis team is being piloted to facilitate timely crisis support. A new complex needs team is also now in place, which could have supported clients like the four homeless people in this thematic review.

3. Supported accommodation for homeless people is not commissioned to provide high levels of support, so there is a need for a cohesive approach between housing, homeless services, social services and health services to meet the wide range of needs presented by homeless people.

4. Support services for homeless people were described by practitioners as hard to navigate. Some homeless people become used to not getting what they want and therefore do not contact services, are easily put off or have low expectations of the help that can be provided.

5. This is compounded by the low status of services for homeless people and there are misapprehensions and misunderstandings about roles, responsibilities, and powers between voluntary and statutory organisations. It can also be difficult to identify what services are available. Services for homeless people are fragmented with multiple providers. Practitioners identified a need for a directory of services and the need to increase the familiarity of staff with the services available. This perception is being responded to by the enabling Society of St James workers, for example, to be trusted assessors who can make assessments under the Care Act.

6. The impact of long-term alcohol and drug use on mental capacity, either because of the coercive and controlling influence of addiction, or through cognitive impairment needs to be recognised in assessments of mental capacity. Services such as CABIS (Sunderland and Gateshead Community

Acquired Brain Injury Service) operate a flexible model of engagement for people who find it hard to comply with the demands of other therapeutic services and may provide ideas that could be developed in Portsmouth. Similarly, the Plymouth Creative Solutions Group provides a model for senior managers to lead on coordinating and managing interventions with people who are hard to engage.

7. Links with the criminal justice system could also be improved. Prisons have a statutory obligation to refer homeless people to housing services before their release but providers such as the Society of St James do not always have good information about clients when they leave prison to enable them to manage risks. Some people are released from prison with little notice. Some prisons have employed housing specialists but there is a need for improved coordination with the Probation Service, for example.

8. Housing for people who are abstaining from using drugs and alcohol is only available through the criminal justice system, as part of a condition of release from prison. Due to the need to reduce evictions for relapsing into drug and alcohol use, support providers do not otherwise require abstinence. As shown by Mr H's case, this risks exposing people who have completed recovery programmes and want to remain drug and alcohol free to other people who are still using them.

9. The Centre for Homelessness Impact "What Works Evidence Notes 01 Drugs and Alcohol" (2021), highlights a range of service models including MAPS (Managed Alcohol Programmes) to stabilise drinking patterns and reduce the use of liquids containing alcohol which are not meant for consumption and Supervised Consumption Facilities to reduce the risk of, monitor and control the use of alcohol and other drugs. Housing led interventions such as therapeutic communities and approaches such as Intentional Peer Support and Intensive Care Management offer alternative ways of meeting the needs of people who use drugs and alcohol may provide options for further research and development in Portsmouth.

10. The four homeless people interviewed and the seven who completed the questionnaire but did not agree to be interviewed, also identified the need for more support from GPs for example, to be listened to and respected, easier access to housing and other services and more personal care and face to face support.

11. Homeless people are often estranged from their families, but as in the case of both Mr I and J, family members had tried to support them. A "Think Family" approach might help to support engagement, risk assessment and family support. This approach builds the resilience and capabilities of families to support themselves (Wong et al, 2016) and recognises that individuals rarely if ever exist in isolation and that whole-family approaches are often necessary to meet individual and family wide needs. The core principles of the "Think Family" approach are that practitioners:

- Consider and respond to the needs of the whole family, including the poverty, drug and alcohol use, domestic abuse and mental health difficulties of everyone in the home (including frequent visitors) in all assessments and interventions.

- Work jointly with family members as well as with different agencies to meet needs.

- Share information appropriately according to the level of risk.

- Escalate concerns if they are not otherwise being responded to.

12. Family members could also be offered Carer's Assessments under the Care Act. These could assist family members to have their own needs for support met to better enable them to support their homeless relatives.

Recommendations from the SAR

1. Health services should routinely record the homelessness to assist in identifying and prioritising interventions to improve the health of homeless people.

2. Commissioners of services for homeless people should review the levels of support available in accommodation-based services and ensure that these services can meet the wide needs of homeless people.

3. Commissioners (local authority, NHS and public health), and homelessness service providers (both statutory and commissioned) in Portsmouth should identify joint working opportunities to adapt their services to make them easier for homeless people to engage with, based on the principles identified by Alcohol Change UK. (https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/documents/Safeguarding-guide-final-August-2021.pdf**)** and in the Blue Light Manual (https://alcoholchange.org.uk/help-and-support/get-help-now/for-practitioners/blue-light-training/the-blue-light-project) These include creating a directory of services, training specialist and non-alcohol specialist staff in the Blue Light approach (Take every opportunity; Not everyone will change; Change is not the only option; use a whole system and holistic approach; record unmet need and learning lessons); developing a multi-agency operational group to ensure a joint identification and ownership of the highest impact clients, developing assertive outreach approaches by designing and evaluating services, improving the response of local alcohol services through staff training and pathway development

4. The Portsmouth Safeguarding Adults Board should continue to monitor the number of deaths of homeless people in Portsmouth. The Board should bring the need for longer term funding for rough sleeping and homelessness services and the need for long term rather than short term service provision to

the safeguarding adults board chairs' network to raise the profile of homelessness services with central government and the need to recruit, retain and professionally develop skilled staff.

5. The PSAB should seek assurance that workforce development plans address the need for staff to understand the Mental Capacity Act, and the assessment of mental capacity particularly for adults who are dependent on drugs or alcohol.

6. Homelessness service providers (both statutory and commissioned) in Portsmouth, the Probation Service and Hampshire Police should agree a process for sharing information about risk and accommodation needs before release from prison. This should form part of prison release planning and should also include sharing information on potential domestic abuse risk.

7. The PSAB should raise the need to agree a process for sharing information about risk and accommodation needs before release from prison with the Prison Service at national level.

8. PSAB should seek assurance across all services that the Duty to Refer under the Homelessness Reduction Act 2017 (https://www.gov.uk/government/publications/homelessness-duty-to-refer/a-guide-to-the-duty-to-refer) is understood and that workforce development plans (including egal literacy, think family, trauma informed approaches) are in place to equip staff to identify, support and refer on homeless people.

9. The PSAB should lead the development of a multi-agency forum to explore what can be done to improve access to, and expand, service options (wet/ dry accommodation etc) and how to use resources most effectively.

10. Homelessness service providers in Portsmouth which support homeless people who are substance dependent but want to recover and commissioners should review the opportunities for supporting people who have successfully completed recovery programmes to remain abstinent and to have move on plans in place before treatment begins so that there is a seamless follow on between recovery and abstinence.

11. The PSAB should seek assurance that services have put plans in place to identify and reduce barriers to accessing services for people experiencing multiple disadvantages.

12. Services that work with homeless people should implement "Think Family" approaches to maximise the support options available for homeless people and to offer Carer's Assessments to family members to assess their support needs better enable them to support their homeless relatives.

Key actions taken:

1. Scoping of the current practice in health partners recording homelessness status to establish what is practical.

2. Evaluation of the effectiveness of the homeless social worker and pathway into adult social care.

3. Established regular meetings between adult social care and housing at Deputy Director level.

4. Provided a co-located multi-disciplinary health inclusion service for homelessness in Portsmouth. This has ensured that primary care, mental health and substance misuse staff are based together within a homeless setting but also providing street outreach and in-reach into hostels.

5. PSAB monitor the deaths of people deemed to be sleeping rough.

6. Raised the need for longer term funding for rough sleeping and homelessness services and the need for long term rather than short term service provision to the safeguarding adults board chairs' network.

7. MCA Self Audit completed by board member organisations.

8. PSAB provided training on the Mental Capacity Act, including re-commissioning Alcohol UK training and linked with HSAB to promote self-neglect resources.

9. Establishment of a Probation Navigator, which has a focus on individuals released from prison or on probation who are rough sleeping or at risk of rough sleeping. The post is co-located between HNAS and the probation service.

10. Raised the need to agree a process for sharing information about risk and accommodation needs before release from prison, with the regional and national SAB networks. Developed a research project proposal with the University of Southampton for which funding is currently being sought.

11. Developed a communications campaign on the duty to refer and the importance of early intervention and prevention. This included hybrid training sessions.

12. Developed and launched 4LSAB Homelessness guidance.

13. Reviewed the substance misuse supported housing pathway and created clean and dry provision.

14. Board partners have explored how they can address issues of signposting to other services, without following up. However to date we have not made a pledge.

15. Follow up work on how homeless people experience pathways has been carried out.

16. We have updated the Family Approach protocol and resources.

17. Presented the SAR report to the Health and Wellbeing board.

Outcomes

1. Funding has been agreed to support additional social work resource to work within housing and substance misuse services. This will support access to statutory services/assessments of Care Act eligible needs and enable a flexible person-centred approach.
2. Some Clean and Dry accommodation is now available to support people who wish to remain abstinent.
3. Training on the duty to refer has been delivered and there is a commitment to deliver this on an annual basis. Staff are more aware of the duty to refer requirements.
4. There are now clear channels of communication between adult social care and housing at a senior level and adult social care staff are engaged is supporting the work of the Homeless Partnership Board.
5. The multi-disciplinary health inclusion service for homelessness people in Portsmouth has improved access to health and care services for people who are homeless/rough sleeping.
6. The development of a probation navigator post has improved the communication between housing and probation colleagues which has improving the planning for and support of people being released from prison with housing needs.

Next steps:

1. Develop further training to support staff working with people experiencing substance misuse and homelessness/rough sleeping on the application of the Mental Capacity Act and Care Act. This will be dependent on funding being identified through the PSAB.

The chair of the SAR subgroup is recommending the closure of this action plan and the endorsement of the follow up action. The above action will be monitored through the training group and reported into the PSAB on an annual basis.