OutcomeHome
CONSULTING, EVALUATION & TRAINING

Homelessness & Safeguarding

Peer Mentoring Service
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Defining Homelessness

- As defined by the Housing Act (1996), homeless individuals can be described as people who are not residing in any type of housing, lodging or accommodation, and/or are living in unsuitable conditions, such as cars, tents, unsuitable buildings or on the street

- This definition lacks recognition of the complexity and multi-morbidity behind homelessness

Common routes into homelessness

- Homelessness is determined by a **combination of factors** which disconnect people from society and place them at multiple disadvantages.

- Individual factors can involve, but are not limited to; **adverse childhood experiences**, **trauma**, **family and relationship breakdowns**, **poor mental and/or physical health** and **addiction** problems

- The environmental factors include, but are not limited to; **unstable and unsuitable housing**, **poverty and cost of living crisis**, **employment insecurity**, and **immigration status**

Context of Homelessness Support

- What happens when someone presents as homeless?

Agencies and organisations involved;

- Housing teams at local council
- GP, pharmacy, secondary mental health care, addiction services
- Social services
- Police and probation service
- Drop in /day centres
- Food banks
- Support workers at accomodation
- Peer mentors

Background on OCH & Peers

Outcome Home - a social enterprise delivering psychological and peer mentoring interventions serving those experiencing homelessness across Southampton, Basingstoke and Portsmouth.

Evidence based practice generated at the University of Southampton research centre for homelessness

Co-produced with those with lived experience of homelessness

Peer mentoring started in 2018 in Basingstoke, now also in Southampton with 9 peers total

Impact of homelessness

- High Rates of:
  - Addiction
  - Mental illness
  - Communicable disease

Those who experience social exclusion often suffer additional problems to those experienced by clinical populations, evidencing the most complex, multi-morbid conditions requiring significant resource to engage in health interventions.

Mean Age of Death		
	Men	Women
General Population	76	81
Homeless Population	45	43

Main safeguarding risks we see

- Drug/alcohol use
- Fluctuating capacity
- Mental ill health
- Cuckooing
- Domestic violence
- Financial abuse

Health and social care assessments - needs around basic skills to keep themselves well, links to fluctuating capacity

How risk is managed

- Inter-agency collaboration is vital;

Council, OCH, Housing provider, health, social workers

Peers may act as main contact to enable other agencies to support (but must not be assumed to be able to do more than their role)

Multidisciplinary meetings (or MARM) to collaborate on a plan moving forwards, involving the individual where possible

Submitting multiple safeguarding requests from each agency involved with their unique perspectives

How risk is managed

- Person centred – individual needs to be considered and what their normal looks like

- What are the clients goals?
- Allowing people to make ‘bad decisions’
- Risk around abrupting stopping harmful behaviours e.g. heavy drinking, using
- Harm reduction strategies

Case Study - VT -When safeguarding went well

- **Risks:** eating disorder, alcohol use, physical health declining (loss control of bowels and unable to walk up stairs)
- **Actions:** safeguarding referral submitted, pre-MARM with GP, collaboration with social worker and Red Cross
    - Peers helped with establishing daily routine, health and social care needs met by Red Cross
- **Outcome:** VT improved and initial crisis was over, but still following up with eating disorder and psychological services, continued encouragement to engage with GP and other regular services to avoid future crisis

Case study JD - When safeguarding went less well

- **Risk:** Diagnosed with paranoid schizophrenia, Went from 24 hrs supported housing into general needs housing.
  - Did not engage with social services
  - Social services engage 3rd party care company, did not engage (JD feared being evicted)
- **Actions:** Referral to OCH from drop-in centre because he was unkempt and thin, Found his property was being used as crack den, multiple safeguarding referrals, No clear actions
  - Visit to flat, rubbish everywhere,
  - Police raid and safeguarding put in. MARM held.
  - Flat used to deal crack, JD forced to buy and pay for crack
  - Police said he was doing crack by choice - withdraw support
- **Current Outcomes:** Dependent on substances, Trying to get flat clear, funding issues
  - Wants to go back to supported living
  - 5 safeguarding referrals in total

Take away messages

- In homelessness we can tolerate a higher level of risk depending on an individual's ‘normal’
- The individual needs to be ready for change themselves rather than have this imposed upon them
- People have the right to make ‘bad decisions’ without us questioning their capacity
- Homelessness entails multimorbid social and individual issues which should be considered in safeguarding
- **Positive safeguarding outcomes more likely when:**
  - Collaboration between services (+ client engagement)
  - Clear lead agency/person

Thank you!

Questions?

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