Homelessness and Adult Social Care

Homeless Link submission to the Casey Commission, December 2025

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Question 1: Can you give up to three examples of things that work well or new ideas you have seen in adult social care?

1.1 Where they exist, long-term care pathways for people experiencing homelessness are very effective

Long term care pathways have shown to be hugely effective in delivering sustainable support out of homelessness. These involve the provision of specialist support and accommodation delivered on an unconditional and non-time limited basis, akin to models of supported/sheltered housing for older people or those with a learning disability. These are registered with CQC and differ from the general homelessness offer, where short-term support and time-limited accommodation are the norm.

Specialist facilities work well for people experiencing homelessness who may be too young for older-persons facilities and whose needs differ from the general population meaning they can be perceived as too complex or disruptive to accommodate. One facility run by St Mungo's in London delivers personal care alongside permanent residence in a multi-bed facility for people with complex care needs and a history of homelessness (see also their Life Changing Care report). Another example includes sheltered housing delivered by St Martins in Norwich, where scalable care packages are delivered within residential flats for people experiencing multiple exclusion homelessness aged 50+. This was made possible through a block contract with the local authority. The service has been recognised as outstanding by CQC recognising its psychologically informed environment and evidence-based care and support.

However, these facilities are the exception not the rule, and access to such care is very restricted as homelessness – even in the case of people with advanced care and support needs – is generally managed independently of the social care system.

1.2 Truly integrated health and social care support for people experiencing homelessness reduces homelessness and improves health

There are a number of examples of high-quality, multidisciplinary support including social care teams for people experiencing homelessness. The principles of good practice in this area are laid out in detail in NG214: wraparound, holistic and person-centred support enabled through training, peer involvement and embedding of trauma-informed principles. In such spaces, social workers will generally be integrated into a wider team of healthcare staff, housing workers and other specialists to deliver targeted support to people experiencing homelessness, in recognition of the distinct needs of this population.

Examples include in Milton Keynes, where the rough sleeping pathway has been moved to sit within the ASC Mental Health and Complex Needs team rather than under housing. Another example is in Oxfordshire, where discharge from mental health settings into homelessness was recognised as a significant issue. To target this, a discharge team was established in the mental health unit with an embedded social worker. Through this team, support is available in hospital and through to community, providing transitional, wrap-around support to prevent homelessness at a time of known intensified risk. Again, it must be repeated that such teams are the exception rather than the rule, and despite evidence of

their effectiveness, MDT teams are not available at scale for people experiencing homelessness due to lack of strategic buy in nationally, lack of cross-departmental collaboration on homelessness, and insufficient funding.

1.3 High-fidelity Housing First stabilises care needs for people with severe and multiple disadvantage

The clearest overlap in the work of homelessness services and social care is showcased in Housing First teams up and down the country. Housing First is an internationally-recognised philosophy of support for those who have experienced long-term homelessness or who have particularly high levels of care and support need. Its delivery echoes social work values and it holds an obvious role in the National Care Service ecosystem.

Under Housing First, people are given access to permanent accommodation and unconditional wraparound support. Workers hold a lower caseload to allow for more intensive contact. More details on what this means in practice can be found in the Housing First in England Principles (2017).

Research by Homeless Link (2024) shows significant positive improvements to health and social care needs, antisocial behaviour and quality of life, among other outcomes, that improve the longer someone remains in Housing First support.

But despite overwhelming evidence of its effectiveness, Housing First is in jeopardy. Despite successful pilots in three regions of England, the model does not receive any ringfenced funding. It is not prioritised in the National Plan to End Homelessness, meaning its delivery is at the discretion of local areas. Housing First services deliver value for money over time, but can involve higher upfront costs; in the face of funding challenges and rising homelessness, many areas have scaled back and prioritised funding cheaper, higher-occupancy but less effective services.

Question 2: Can you give up to three examples of things that don't work well in adult social care?

2.1 There is a missing step in care and support for people experiencing homelessness

Data consistently shows people experiencing homelessness have the worst health outcomes of any group in our society. Premature death is common, with mortality risk twelve times higher for women and eight times higher for men as contrasted with the poorest housed population. Data from Homeless Link's Unhealthy State of Homelessness report (2025) illustrates these risks: 81% of respondents report physical ill-health, 77% report a mental health condition, and 49% self-medicate with drugs or alcohol. Long-term illness is twice that of the general population, and people with a learning disability, autism or brain injury are significantly overrepresented.

Clearly, there is a breakdown in health and care services that perpetuates this cliff-edge in health inequalities, which is universal across conditions. Support for people with multiple disadvantage is frequently sidelined to the homelessness sector, which has had to step in as a shadow social care system. Without fundamental reform to the sector's governance and oversight, this is neither sustainable nor sufficient. Homelessness services are largely funded through Housing Benefit, with no guaranteed funding for anything beyond basic housing support. Despite providers' best efforts, the system is too often inadequate to

meet complex care and support needs. Evidence for this sits across the ever-growing suite of Safeguarding Adult Reviews commissioned after a person dies while homeless, or within the findings of the Dying Homeless Project – shortfalls in 'security, care and dignity' have led to thousands of preventable deaths.

2.2 People experiencing homelessness are inappropriately gatekept out of social care at a systemic level.

Our members cite inappropriate gatekeeping within safeguarding and care services as one of the primary issues they face when trying to support adults with suspected care and support needs. There is often felt to be a lack of understanding of homelessness and multiple disadvantage in social care teams, leading to a systemic breakdown in the referral and assessment pathway at a national scale. More often than not, referrals for high-risk individuals will be refused even in the face of severe and enduring needs. Members report that the threshold for social care seems 'to be impossible to meet'.

For those living with multiple disadvantage, this can leave people stuck in a limbo of insufficient support and worsening health and care needs. One member told us they see a lot of gatekeeping "*particularly around substance use and mental health issues. Care services will say it's not a care need, it's an unmanaged substance misuse issue, or their mental health is being affected by their housing status".* Homelessness is used as a reason to decline care without ensuring that appropriate support is available elsewhere. In effect, this means people with significant needs become stuck in homelessness services, unable to live independently but equally unable to access long-term care that meets their needs. The insufficiency in care and long-term condition management is almost certainly a central factor in the severity of health inequalities for people experiencing homelessness.

2.3 A shadow social care sector.

Faced with people with acute needs who are unable to access social care support, homelessness services have increasingly stepped in to fill gaps in care provision. This has created a shadow social care sector, delivering support to some of the most vulnerable adults in the community without oversight, input or resource from adult social care.

Members face a dilemma: housing people with complex care and support needs is preferable when their alternative is sleeping rough, but doing so often means other agencies withdraw, meaning long-term needs continue to go unmet. One member articulated: "*We end up housing people even if there's a safeguarding risk issue, as there is no alternative provision. Maybe we as a sector are letting others off the hook because we continue to try to house people, but it's difficult to do otherwise*". Homelessness services are usually conditional and time-limited. Without long-term housing and care, people frequently move in and out of services in perpetuum, all while their care needs deteriorate.

This has led to creeping responsibilities across the sector. High-needs residents are often housed well beyond 'official' time limits. Lower-needs services report increasingly complex caseloads beyond what they are designed to support. Most staff are neither trained nor registered to deliver any form of care and support beyond light-touch case management. Some services report pushing back on inappropriate referrals and facing harsh criticism as a result, with one service reporting threats to their contract after challenging their local authority.

Question 3: Can you give up to three examples of things that waste time, money, or effort in adult social care?

3.1 There is huge untapped potential for integration between social care and homelessness support.

The skill, expertise, and willingness of the homelessness workforce in supporting those with significant unmet needs is a largely untapped resource in the health and social care workforce. Many frontline workers are already acting as de facto social workers, building strong trusting relationships and supporting people to navigate appointments, maintain their health and managing basic tasks such as medication management, self-care reminders, and instrumental activities of daily living.

Oversight, input and resource from adult social care could transform the effectiveness of the homelessness system. Currently, services are delivered almost entirely outside of ASC. Staff training and qualifications are discretionary to employers, meaning workers delivering complex support with minimal (or sometimes no) training. Care coordination is often delivered in isolation from the wider system, and when case management meetings do take place workers have reported their views being dismissed by those within the statutory system or being excluded from meetings entirely.

In the instances where good collaboration with social care exists, the problems in the system means real change often remains inaccessible. One member told us of the introduction of specialist adult social workers in their area, a change which they were initially very welcoming of. However, they report that these roles have struggled to make a meaningful difference as they are hamstrung by the same systemic barriers: ‘in reality, there’s no additional care provision [accessible to] them, so it never achieves anything’.

3.2 Care packages can make a huge difference, but continuity of care remains a challenge.

There are numerous examples across the country of positive engagement between ASC and adults experiencing homelessness, and access to care can make huge, immediate differences to health and wellbeing. However, improvement and stabilisation can lead to care packages being inappropriately withdrawn. Effective care and support must recognise that, for those with particularly high levels of complex care needs, improvements sustained as a result of care are contingent on that care continuing, and decisions to withdraw can be directly harmful to the adult in question.

Similarly, social care may also withdraw in the event of a successful accommodation placement, even where that accommodation is not designed to meet the person’s care and support needs. Members report care packages instated while people are sleeping rough that are withdrawn entirely once they approve a placement into their service. This is often despite significant prior collaborative negotiation and reassurances that care packages will remain in place where services are not able to meet the level of need presented. This can ultimately lead to a cyclical experience of homelessness as people find themselves at risk of eviction because of behaviours associated with their unmet care and support needs. As well as placing the person’s wellbeing and trust in services at risk, this can also stunt effective care or avoidably prolong its delivery, leading to higher rates of spending for the provider, social care, and to public spending more widely.

3.3 Funding for homelessness support is at odds with long-term care delivery.

For years, Homeless Link members have reported significant funding challenges which undermine their ability to deliver effective support to adults experiencing homelessness. This includes patchwork, insufficient funding which is focused on the bricks and mortar of a service rather than on supporting the people housed within it. Funding is largely delivered through MHCLG, meaning funding is often narrowly focused on housing. While this can work effectively for some with lower needs, many of those housed in the sector became homeless due to underlying, unmet care and support needs, meaning effective support would more appropriately be delivered through the Department of Health and Social Care.

There are some examples where integrated funding across housing, health and social care has been trialled, but in the existing infrastructure these have had mixed results. Where it works, integrated commissioning can be a fantastic way to bring professionals together towards a common goal, and some areas reported that this had been as successful as hoped. However, where it is delivered without sufficient strategic buy-in, members report wasted money and duplication caused by the lack of a ‘clear and focused approach’. The message is clear that integrated approaches require genuine buy-in from partners across sectors and significant strategic support and oversight to ensure success, which DHSC are best placed to coordinate.

What We Do

Homeless Link is the national membership charity for frontline homelessness services. We work to improve services through research, guidance and learning, and campaign for policy change that will ensure everyone has a place to call home and the support they need to keep it.

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