Homelessness, Addiction, and Mental Capacity

National Mental Capacity Forum Webinar

Wednesday 29th April 2026

- **The Webinar will begin at 12pm**
- **We are a large group, so cameras and microphones of delegates are disabled**
- **Please use the Zoom Q/A function to pose questions; we will address as many as we can**
- **A recording and a copy of all slides will be made available to all delegates.**

National Mental Capacity Forum Webinar

Homelessness and Mental Capacity

Brendan Kelly

Trinity College Dublin

Guardian, 13 March 2010

- **MC was found dead on 9 January last year, having died from heart disease. Ulcers in his stomach were a strong sign of hypothermia**
- **The 59-year-old, who had schizophrenia, lived in a dirty, damp and freezing flat, with mould growing on the floor and exposed electrical wires hanging off the walls**
- **His boiler had broken, the bathroom ceiling had collapsed, and neighbours began to complain about the smell**
- **His brother, AC, describing the scene as "squalor", said: "Even an animal couldn't have lived in that"**

- **The disturbing circumstances of MC's death have exposed serious flaws in the way mental health law is implemented in the case of vulnerable people**
- **Everyone knew the conditions MC was living in, but he refused to move for cleaning and refurbishment work to be done**
- **Despite four years of pleading from his family, NHS care staff would not intervene – wrongly thinking they would be violating his human rights**

Am J Psychiatry 130:9, September 1973

LETTERS TO THE EDITOR

"Dying with Their Rights On"

SIR: The old medical school saw of "dying in electrolyte balance" is not easily forgotten. Each of us remembers the compulsive chemo-clinician who, preoccupied solely with the patient's sodium, calcium, magnesium, potassium, and a host of other electrolyte levels, scarcely noticed the patient slowly slipping away. Even though the patient died, the fact that he was in perfect electrolyte balance when it happened was some sort of morbid clinical triumph.

This not-see-the-forest type of vision has now permeated psychiatry. In the zeal to impeccably protect the patient's civil lib-

Would any reader of the *Journal* who has knowledge of such cases please send them to me at the address below.

REFERENCE

1. Hodge P: A troubled life and a violent death. Psychiatric News, March 21, 1973, pp 1, 31

DAROLD A. TREFFERT, M.D.
Superintendent
Winnebago State Hospital
Winnebago, Wis. 54985

ELSEVIER

Social Science & Medicine 61 (2005) 721–730

SOCIAL SCIENCE & MEDICINE

www.elsevier.com/locate/socscimed

Structural violence and schizophrenia

Brendan D. Kelly*

'Structural violence' describes political, economic & social circumstances that shape:

- **The landscape of risk for mental illness**
- **The likelihood of receiving care**
- **Opportunity to exercise decision-making capacity**
- **Contrasting outcomes for people with mental illness in different circumstances around the world**

For the purposes of section 2, a person is unable to make a decision for himself if he is unable—

(a) to understand the information relevant to the decision,

(b) to retain that information,

(c) to use or weigh that information as part of the process of making the decision, or

(d) to communicate his decision (whether by talking, using sign language or any other means).

Circumstance

Delegation

Emotion

Take Home Points

- **Continue to presume capacity even in situations of extreme**
- **Apparent capacity can change rapid**
  don't be surprised if this
- **Focu** **key areas for this**

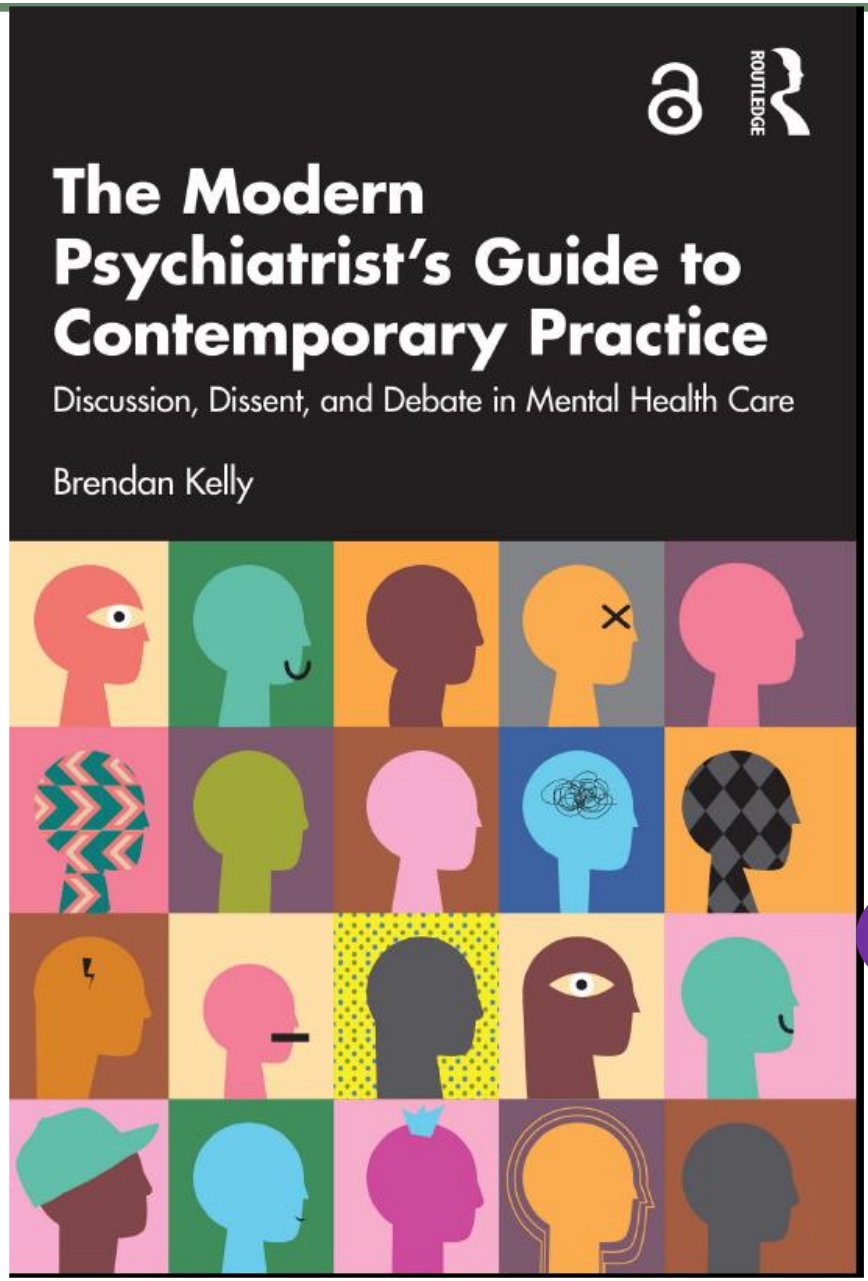
Change the world!

ssible – *but you are the best person to do it*

y deadlines set by senior colleagues, managers, judges,
ote of them, but do your job, and only provide an assessment when
happy you have optimised capacity and you understand the situation – you are the professional here, so stand your ground – they can all wait

Open access!
Free online!

https://www.taylorfrancis.com/books/oa-mono/10.4324/9781003378495/modern-psychiatrist-guide-contemporary-practice-brendan-kelly



2024

National Mental Capacity Forum

NIHR | Policy Research Unit in Health and Social Care Workforce

KING'S College LONDON

Homelessness, substance use and mental capacity

29.4.26

Jess Harris & Stephen Martineau
on behalf of study team

Health & Social Care Workforce Research Unit (HSCWRU)
King's College London

Study outline

Title: Use of the Mental Capacity Act 2005 (MCA) with people experiencing multiple exclusion homelessness (MEH) in England (Oct 2023 – Mar 2026) Webpage

Methods: Evidence reviews; national expert interviews (n=13); national practitioner survey (n=674); study site interviews with people experiencing MEH (n=32) and practitioners (n=46)

Outputs: Guidance & Tool, Animation, Summary Report; open access article(s)

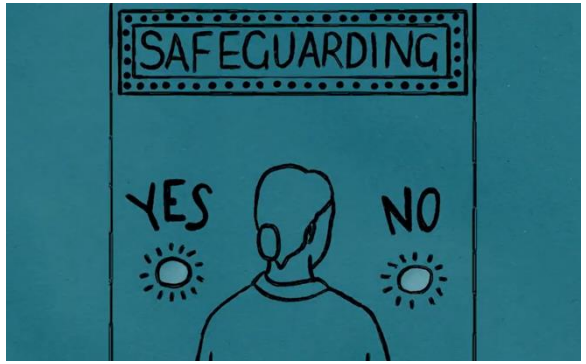
Purpose:

- ✓ Explore **practitioner approaches** and the **views of people experiencing MEH**;
- ✓ Co-produce **guidance**; **prompt national debate**;
- ✓ Ultimately, **improve understanding, support** and **outcomes for people experiencing homelessness**.

Research Team: Kritika Samsi (PI), Jess Harris, Stephen Martineau, Alex Ruck Keene KC (Hon) (King's College London), Michelle Cornes (PI) (University of Salford), Bruno Ornelas (Collaborative Safeguarding Hub / MHCLG), Stan Burridge (Lived Experience Lead; Expert Focus), Sam Dorney-Smith (University College London), Sophie Koehne (Pathway), Nathan Davies (Queen Mary University of London).

Why research homelessness & mental capacity?

- Multiple Exclusion Homelessness (MEH): overlap of **long-term / repeat homelessness and other disadvantage,** including experience of adverse childhood experiences, 'institutional care', domestic and sexual abuse, substance use.
- **Factors / risks that contribute to *becoming / remaining* long term / 'street' homeless prompt capacity concerns:** mental illness, brain injury, autism spectrum disorder, learning disabilities, complex trauma, substance use.
- Negative past experiences of statutory services / stigma/discrimination contribute to mistrust and **deter seeking / accepting help, increasing inequalities / exclusion**.
- **Decisions prompt concerns about capacity in this population:** Refusing health treatment or not remaining to receive it, rejecting care, support or accommodation (eg, shelter in extreme weather), not saying 'no' to exploitative associates, managing money (eg, prioritising substance use over basic nutrition or rent).
- People die while homeless in mid 40s; deaths rising annually; 'deaths of despair' (suicide / alcohol/drugs) main cause.



No prior research, but Safeguarding Adults Reviews (SARs) report assessments not done, done well or documented; research on adult safeguarding found '**presumption of capacity**' / freedom to make '**unwise decisions**' **reasons not to safeguard someone at high risk of harm** (despite duty: s.42 Care Act 2014).

Outline of emerging findings

Evidenced gaps, disputes, challenges and uncertainties in how practitioners are thinking about and assessing mental capacity, and following up an assessment, when people experiencing MEH are 'making decisions', or 'refusing engagement' about care or support.

- **Practitioner perspectives** on these, and outline what could help.
- **Perspectives of people experiencing MEH**, including reflections on substance use, decision making, service 'refusal', and 'intervention'.
- **Flag two areas of uncertainty where national guidance welcomed:**
  - Substance use
  - Mental capacity as an 'off-switch' for service engagement

Evidenced national concern: gaps in practice

Findings from practitioner survey:

- ❑ **90% said people in this population do not have capacity assessed for decisions about health, care, accommodation or other needs.**
- ❑ **81% said this is a concern (15% 'don't know').**

*'The **assessments aren't carried out formally** and **blanket statements about a person's capacity are offered** despite a specific decision not having actually been assessed. **We spend so much time advocating for this, it's exhausting'*** **Survey**

*'You will see these **highly idealized theoretical situations being posited** … **Were Joe Bloggs not to have issues with addiction**, and were he to not be in the circumstances he's now, **then he would have capacity; therefore he has capacity'*** **Survey**

*'Our health systems **take refusal at face value, particularly if that refusal comes with a 'f— you'** and **don't interrogate capacity** when they should'* **3-B8 Social Worker**

Evidenced national concern: disputes in practice

- **32% practitioner survey respondents: 'frequently' practitioner disputes lead to service inaction:**

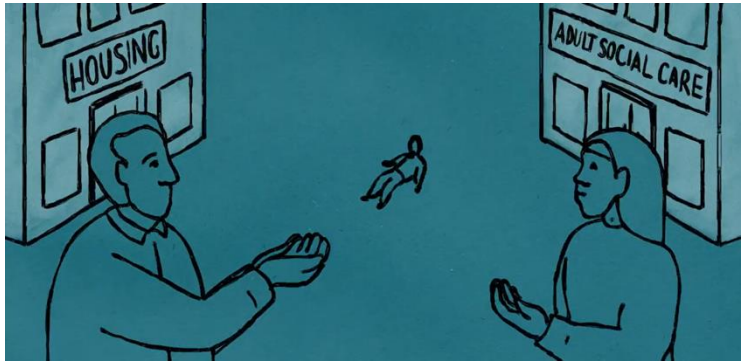
*'There is often **ongoing arguments** between* [services] *… that **prevents any actual beneficial assessments** being completed and the **applicant is left unsupported**'* **Survey**

Boundary disputes between services

- **Concerns about capacity for housing applications are often dependent on adult social care assessments; these may exclude other services' input and are regularly disputed:**

*'There's a **lot of friction between adult social care and the housing options team** with **mainly every case that comes forward where we question capacity**'* **1-B9 Housing Manager**

'Most of the time it will be a phone assessment … they're just going to rush through … as quickly as they can …' **Disputed?**
*'… **One in four. It's quite high**'* **2-A1 Housing Manager**



*'I've had to **try and work with*** [Housing] ***and it's been a challenge'** – for example, in instances where the person was said by housing to have 'made themselves intentionally homeless through their behaviour', and **I would say actually, they're not in control of their behaviour**'* **1-B4 Social Worker**

Challenges: Workforce

Concerns about some practitioner attitudes

- ❑ **Preconceptions / stigma contribute to failure to enquire beyond 'presumption' of capacity, or to perfunctory assessments; substance use can prevent curiosity – dismissed as a 'lifestyle choice':**

*'The kind of people they're looking at have **lots of other reasons why they might lack capacity**. So, they have **underlying brain damage … cognitive impairment … mental illness, which gets ignored** because **all anyone sees is the alcohol and drug use** on top, and nobody ever is willing to dig deeper … **'No, it's just drugs and alcohol''*** **3-B5 Addictions Psychiatrist**

*'A **failure to engage by the professional, where the person might be saying 'I'm fine'** and that 'I'm fine' means 'I'm anything but fine' … but **the practitioner's response is: 'Good. They're fine. Let's go. Close'.** And it's like actually you haven't explored anything'* **2-A11 Social Worker**

A stretched workforce

- ❑ **Attitudes may be due to a lack of knowledge, but also numbness / burnout:**

*'People with very complex needs who may not comply with treatment … **may be seen as a low value activity** … **I don't feel terribly bad if they decide to go'*** [leave the Hospital Emergency Department] **JH2 Doctor**

*'Colleagues who are not homeless specialists say, '**Oh, homelessness is a choice**' … **Numbness** … We don't want to think about how awful it must be … that's how we keep ourselves sane'* **SM5 Psychiatrist**

Challenges: System

Resource constraints / lack of suitable services influence assessments

- ❑ **Can affect thinking and outcomes of assessments because of pressure to respond if finding of 'incapacity'; (82% practitioner survey respondents said was challenge):**

*'A real **interplay with resources,** and we may not say that in a kind of honest and direct way. … **within the assessments that take place, or not assessing people, which actually allows us to kind of gatekeep resources. I mean that's a bold statement, but I've been doing this a long time** and I see it'* **3-A1 Social Worker**

*'I am concerned that **lack of service options may influence the outcome of a Capacity Assessment** - I am **specifically thinking of individuals who have a substance dependence**. **Rather than fully exploring** whether this could affect an MCA outcome, often the conclusion is that an individual is '**making an unwise decision**' '* **Survey**

[address problem of resources influencing assessments] '***Assessment conducted by a neutral agent** in the situation who has a good understanding of the Mental Capacity tests, who will document their reasoning and accept accountability for their decision'* **Survey**

Inaccessible / unaccessed client information across the system

- ❑ **In 'acute on chronic' cases, assessing someone without knowing the history is more likely to find capacity; services step away, unaware of long-term patterns of behaviour and risk:**

*'**Unless you really understand the context of the risk, it's very hard to risk assess**, which is really what capacity, at that point, is'* **SM5 Psychiatrist**

Challenges from MEH: life experiences / life skills

93% practitioner survey respondents said 'non engagement' is challenge to assessments

- **Some have experienced limited life options / negative experiences; may see decision as irrelevant and options as alien, or see all statutory services as a threat, so not 'engage' in assessment process:**

*'A young lad in [town]… had like **an upbringing which is sort of incomprehensible** … seen trawling through bins from when he was five. His dad died of drug addiction … He used to say … **'What other choices have I got?'** … just thought that was his destiny, to take drugs and then die, which he did before he was 30'* **1-B13 Drug and Alcohol Recovery Co-ordinator**

*'Sometimes the **stuff that we're trying to assess capacity for isn't a priority for the client** … how do we do capacity assessments in a way that the individual can see the point of them?'* **JH5 Senior Psychologist**

*'It just **feels safer not to talk to anyone**, to be on their own.'* **SM2 Occupational Therapist**

- **Some lack life skills; can be difficult to distinguish from an inability to make decisions and to then act on them at the material time:**

*''**They've been institutionalised for so long**, whether in prison or in other institutions, that they just don't have the life skills of, how do I maintain a tenancy? … **How much of that is 'capacity', and how much of that is what the person's been sadly exposed to, or not exposed to, in their life?'*** **3-B6 Social Worker**

Challenges from MEH & MCA: complexities/uncertainties

- **Complexity is typical within MEH; fluctuating capacity and executive dysfunction as well as substance use contribute further uncertainty; 'masked' impairments not identified where assessments not adapted beyond one conversation, at one time, in one setting:**

*'The thing that **we find really frustrating** is: **'Well, this person is eating their three meals a day, they've showered'** … **That lack of awareness of how artificial environments are, when you assess someone's capacity or someone's function** … **This person was laying in their faeces and urine before coming into hospital** … **we know exactly what's going to happen as soon as they leave** … We see with people with traumatic brain injuries and with alcohol-related brain injuries … **good language memory and language abilities, so they can mask quite well'*** **SM7 Inclusion Health Doctor**

*'… **it never is just substance misuse**, I don't think probably within my whole career I've ever worked with somebody who came into drug treatment services and **it's ever just been one issue**.'* **1-B2 Drug & Alcohol Service Manager**

- **Some reflected MCA's focus on empowerment, and on assessing one decision at one time, can be poor fit with the complexity of needs and the uncertainty of impairments / disturbances often found within MEH:**

*'When the Act was written, **it wasn't imagined that we'd be trying to do these really complex legal processes in these really muddy, messy situations** … **this person*** [experiencing MEH] ***has had presumptions made that they're doing fine, when they're not**, for lots of complicated reasons'* **JH5 Senior Psychologist**

- **Given these complexities and uncertainties, what would help support good capacity assessments?**

What would help?

Survey asked practitioners to rank options (from expert interviews) as 'high', 'medium' or 'low' priority to support good assessments with MEH population.

'High priority' were:

- ❑ **Multi-disciplinary input; include frontline expertise; challenge traditional hierarchies:**

*'I personally find it very difficult when **a doctor's seven sentence assessment is taken ahead of my detailed longitudinal relationship** … **the hierarchy should be of evidence, not of clinician'*** **3-B8 Social Worker**

- ❑ **Cognitive / neuropsychological assessments.**

- ❑ **Accessing information from other services.**

*'Often capacity assessments are not adapted appropriately … **collateral information is not sought after,** and conclusions are **unhelpfully based on single conversations which give an inaccurate picture of capacity'*** **Survey**

- ❑ **Advocacy for the individuals.**

- ❑ **Expert supervision / guidance.**

*'An **expert champion** in this decision-making space would be a really good role … A **capacity / ethical panel** … might **support development of assessment and decision making**…* [and] ***oversight and guidance for complex cases'*** **Survey**

Lived experience interviews

Face to face, mainly in hostels

Age	
18-25	2
26-35	6
36-45	15
46-55	5
56-65	4
66+	0
Total	**32**

(Not included: those unable to engage in conversations, unable or unwilling to engage with research, not engaging with services visited or any services at all).

Gender	
Female	12
Male	20
Non-binary	0
Other	0
Total	**32**

Ethnicity	
Black or Black British	5
White British	24
Gypsy, Traveller, Romany	2
White Other	1
Total	**32**

Homelessness experiences	
Hostel	28
Street sleeping	26
Sofa surfing	21
Bed in exchange for sex	7

	Physical Health	Mental Health	* Cognitive	** Care & Treatment	Substance Use
Yes	23	30	25	23	30
No	9	2	7	9	2

*** Memory problems, Brain injury, ADHD / ADD, Dyslexia, Autism Spectrum Disorder, Learning Disability.**

**** Prison, Young Offenders Institution, 'In Care' (looked after by local authority), Mental Health Inpatient.**

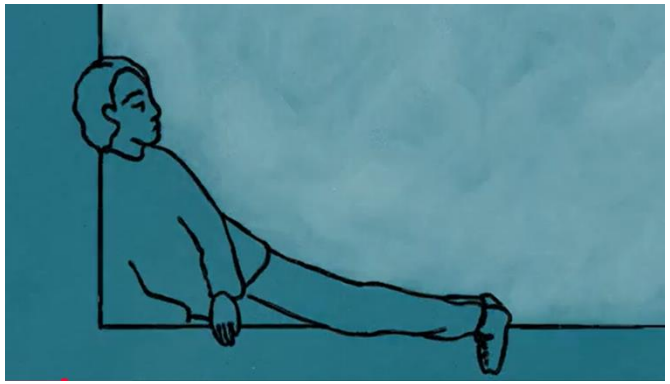
- We asked for **advice on a scenario featuring someone at risk but refusing support**; we talked about **aspects of their own experiences**: feeling (un)comfortable and/or 'engaging' within assessments, (not) understanding information; using substances and the impacts on making decisions; refusing or accepting support. Few were familiar with MCA or aware of being assessed.

Lived experience perspectives: refusal / non engagement

(93% practitioner survey respondents said 'non engagement' was challenge)

What might be going on for a person if at risk but 'not engaging' with services / is refusing support (eg, on street with injury / in extreme weather); What approach should practitioners take? Should services ever 'intervene'?

- **Mental ill health / suicidal feelings frequently mentioned, linked to substance use; calls for intervention where risk to life; reflection on how scary that might be:**



Should services respect somebody's decision to say, '*Go away*' or should they intervene?
'I think intervene. Because I've took a few overdoses and ended up back in the hospital … I've attempted suicide and stuff … *I would have that person there that would explain things to me,* ***'This is what happened to you, this is why you're here, but we're going to stay with you'*** … ***Like someone cares enough*** … [But] *you wake up and you don't know where you're at …* ***you get anxious … I've pulled that*** [canula] ***out with where blood is squirting and I've just left*** … ***I feel withdrawal's coming on****, you know?*
So, when you're at the height of your addiction …
Nothing matters.
So, who is making decisions about your health?
No one. **3U A2 Female**

'You ***lose trust in people and the agencies*** *because you think, well,* ***I've been on the streets and on my own*** *for that long …* ***shut down and try and block everything out, especially with the drugs … obviously you're not thinking properly … I don't think they should walk away and be left. It's a hard one … Imagine it being yourself: you'd be kicking, you'd be screaming, and you'd hate everybody, you'd be scared*** … [But] ***in the long run, I think you could be saving that person's life'*** **1U B6 Female**

Evidenced gaps, disputes, challenges and uncertainties…

Substance use: addiction

- **Practitioner uncertainty if it qualifies as a 'diagnostic' cause of inability to make decision (88% survey respondents: alcohol/drug use is 2nd highest challenge in assessments):**

"…we've had a massive conversation with a group of colleagues about ***at what point does somebody's drive to find a substance become the impairment of mind or brain? We did not find an answer'*** **JH5 Senior Psychologist**

*'****Is addiction an impairment for the purpose of the MCA?*** *Not intoxication … **I don't think the law is clear'*** **Survey**

'We ***treat addictions very differently to how we treat eating disorders*** *… in some ways quite similar of a compulsion … **it's very unclear'*** **3-B9 Social Worker**

- **Two case examples reflecting practitioner concern about what can be done:**

'*We had somebody in the community who was very unwell and needed to be admitted to hospital … and we had no ability … **they were refusing to go to hospital because they wanted crack, basically, and their addiction had overridden their ability to act in an appropriate way** to the medical issues that were going on, so a disproportionate weight was put onto their desire for crack. In the end, **we had to wait for them to become too unwell** – they couldn't refuse any longer – and then admitted them'* **SM7 Inclusion Health GP**

'… the example today of a ***gentleman with an active cellulitis, high risk of sepsis, being discharged home to a tent in freezing conditions****. That* ***for me isn't an 'unwise decision'****. That for me is somebody whose* ***behaviour's been driven by the need to 'use''*** **1-B10 Nurse**

Substance use: lived experience perspectives

- **We asked people's views, and own experiences of, substance use and decision making; when is it not simply an 'unwise decision'?**

*'Resisting, that's easier said than done. You can have the best intentions, but they are addicting in your brain, I need, I want, it's just always there … **I've seen people like that and you think, 'Oh God, somebody please help', it's either death … they don't want to help themselves obviously because some people are … too far gone'*** **1U B6 Female**

*'The **only thing you're thinking about is getting that drug**. You're not thinking about anything'* **1U B1 Male**

*'Me personally, **with my drug addiction my health is on a back burner** … I'm very ill … **You lose everything, your friends, your family, your self-dignity … Services need to engage with people with their drug addiction a lot more carefully … Being on this stuff … it destroys you'*** **3U-A4 Female**

'I had an addiction to heroin … I'm clean at the moment … happiest I've being in ages …
How would you have felt if somebody deprived you of your liberty and stopped you getting drugs?
***Like someone cared** … **A lot of people don't think people care**, and they don't drag themselves out of it because **they don't think there's anything to drag themselves out of it for**, but there is'* **1U B7 Female**

- **Are we listening to and incorporating lived experience perspectives?**

***'We need to get a lot better at … listening to recovered patients** who, with the benefit of hindsight, their opinion is that they didn't have* [mental] *capacity at that time, and I think we have to take that into account. What would that person think in six months' time if they've gone through detox and rehab and they're looking back?'* **2-A14 GP**

Capacity as an 'off-switch'? Lived experience views

What approach should services take if someone is seen as having capacity to refuse support, but is still at high risk?

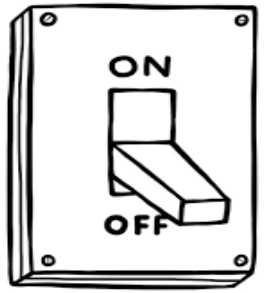
- **Strong call to 'respect' decisions but 'keep coming'; view not held uniformly:**

'I think that person needs … [someone] *to make them understand what's happening.* ***If they refuse that then try the next day, try another day, because you never know what this person's going through*** *… They might have a connection with your colleague or maybe someone else,* ***just try with different people****, you know?'* **3U-A1 Male**

'I'm more likely to stay there with them, you know, even if they're refusing it*. And I can say to them 'I respect you want your space,* ***I respect you, but I'm going to wait here with you until I know you're okay'*** *… Just sitting there and having someone with you really,* ***especially when you're homeless, you do feel quite alone'*** **3U-A3 Female**

'No, f 'em. They don't want help. You can't help people that don't want to be helped'*** **2U A6 Male**

Capacity as 'off-switch' to service engagement?



Should service engagement end with a finding of mental capacity in a person's decision to reject support, despite risks of harm or death? We found inconsistent practitioner views/approaches.

- **32% practitioner survey respondents said 'frequently' find capacity, but services remain involved**; study site examples where **statutory engagement continues if risks / unmet needs remain**:

  "Having capacity and therefore 'there is nothing more that can be done' … no one is really going to act in the current climate … That's the problem … Our team's response would be … it doesn't matter whether they have capacity … unless you're at a point where you're doing something extremely interventionist … We just have to help … understand why they're not making the kind of choices that are healthy for them' **3-A1 Homelessness Social Work Lead**

An 'ON / OFF' approach does not respond to our emerging research evidence: of uncertainty and disputes around establishing a 'reasonable belief' in assessments that are exploring the complexities of MEH.

Reminder: how do we **improve understanding, support and outcomes** for people experiencing homelessness and multiple disadvantage? How does our thinking about and application of the MCA help or hinder this?

Concluding thoughts

- ❑ Capacity assessments can be **rare, brief and non-recurring – poor fit with the complexities of homelessness and multiple disadvantage**; can a brief conversation at one time in one setting, or by phone, enable a good enough assessment?
- ❑ Need to **address influence of** (lack of) **resources** on assessments; how do we map service gaps if we fail to record unmet needs?
- ❑ **Practitioner disputes** about establishing 'reasonable belief'; can **inter-disciplinary learning** increase shared understanding?
  - ☞ Calls: strengthen practice with more **multi-disciplinary, longitudinal** and **cognitive assessments** and **expert/neutral** oversight.
- ❑ Practitioner thinking about mental capacity can be distorted by **viewing behaviour** (eg service rejection) **as unwise decision making**, rather than as response to / result of (eg) trauma, psychosis, brain injury, self-neglect; lived experience participants report **not all conversations or behaviours are 'decisions'**; are we incorporating **lived experience insight** into our thinking?
- ❑ Practitioner uncertainty where **national guidance would be welcomed** – eg **if / when substance use** (not intoxication or ARBD) **becomes an impairment/disturbance** of the mind/brain;
- ❑ A determination of capacity is often an **'off-switch' to statutory engagement despite high risks to individual**; alongside consideration of mental capacity, are we also using a safeguarding lens?

Disclaimer: This study is funded by the National Institute for Health and Care Research (NIHR) Health and Social Care Delivery Research (HSDR) Programme (Award ID: NIHR154668). The views expressed are those of the authors and not necessarily those of the NIHR or the Department of Health and Social Care.

Homelessness, Addiction, and Mental Capacity

Q&A and Reflections

Alex Ruck Keene KC (Hon), barrister, 39 Essex Chambers, and Professor of Practice at King's College London.

Closing Remarks
Margaret Flynn

Next NMCF Webinar:
Wednesday 13th May: noon – 1pm
Doing Good with DoLS: Using Conditions and Recommendations in the DoLS Process.