Adults with multiple complex needs in Brighton & Hove

2020

Part of the Joint Strategic Needs Assessment programme

NHS
Brighton and Hove

Brighton & Hove
City Council

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This Joint Strategic Needs Assessment (JSNA) looks at the needs of people within the city who have multiple complex needs. The gathering of information, analysis, consultation and development of recommendations were carried out in the lead up to the pandemic in 2020. As detailed in the report, the assessment was overseen by a multi-agency steering group with representation from partners across the city.

We acknowledge that there have been changes in circumstances between completion of the report and publication (in March 2023), not least the COVID-19 pandemic that deepened inequalities both nationally and in the city, but also led to stronger and more effective partnership working. There have been changes in the organisations who deliver support and in the way that services work together across the system. Please note that the provider of substance misuse services changed from Pavilions to Change Grow Live (CGL) in April 2020; In 2021 the Council contract for providing the community domestic abuse support service (DASS) was awarded to Victim Support, and the contract for providing the refuge units was awarded to Stonewater Ltd. The Fulfilling Lives multiple complex needs programme came to an end in 2022; and in 2021 the city received significant investment as part of the three year national Changing Futures Programme.

Despite these changes the findings of this report remain valid and the recommendations remain relevant. Over the last few months we have come together as the Brighton and Hove Health and Care Partnership and identified five key priorities – one of these is to improve outcomes for people with multiple compound/complex needs. The findings and recommendations of this JSNA inform and support this work

Contents

1. Introduction

This needs assessment is conducted as part of the programme of Joint Strategic Needs Assessments overseen by Brighton & Hove Health & Wellbeing Board. The overall aim is to assess the health and wellbeing of adults with multiple complex needs in Brighton & Hove. This means adults who have experienced at least two of the following needs:

- Homelessness
- Mental health
- Domestic violence
- Alcohol or substance misuse
- Offending.

Objectives are:

- To scope the size and characteristics of the adult population in Brighton & Hove who meet the agreed criteria of having multiple and complex needs
- To look at the risk factors associated with becoming an adult with multiple complex needs, including early complex trauma, protected characteristic groups and deprivation
- To assess how well local services are responding to the needs of adults with multiple complex needs and particularly those that have experienced complex trauma and, identify gaps in service provision and commissioning
- To identify barriers that lead to exclusion from these services.

The needs assessment makes recommendations for commissioners, service providers and decision makers regarding how to identify opportunities for early targeting of interventions and improving care provided to adults with multiple complex needs and responding to gaps in service provision.

2.National context

Adults with multiple complex needs are amongst the most excluded people in society. It has been estimated that 58,000 people in England have been affected by homelessness, substance misuse and offending, and that most of these will also have experienced mental health problems. Making Every Adult Matter (MEAM 2019) estimates that 85% will also have experienced some kind of childhood trauma. For women this can often follow them into adulthood in the form of domestic abuse and violence.

The services that are currently in place to help with these issues can also play a role in excluding people further. This is because they tend to work in silos and people with multiple complex needs can fall through the gaps. For example, someone with mental health problems who misuses substances to self-medicate their mental health symptoms, cannot access help with their mental health until they are abstinent, and substance misuse services may not help them unless they are getting support for their mental health problems. Or someone who has been released from prison may not get help with their accommodation needs until after they have left prison, putting them at risk of homelessness.

Successive government policy agendas have tried to address this through initiatives from the Social Exclusion Unit policies of the 1990/00s to the Making Every Adult Matter and Fulfilling Lives programmes of the 2010s. These look at how existing systems and services can work better together in a more co-ordinated way and address an individuals' complex needs in a holistic fashion, rather than by focusing upon each separate condition. The most recent work on this policy agenda has been led by the Lankelly Chase Foundation who have implemented a series of mapping exercises in England and Scotland to build a statistical profile of severe and multiple disadvantage. They have used this work to highlight the overlaps and gaps in the data systems working with people with multiple complex needs (Bramley G et al Hard Edges 2015 and Hard Edges Scotland 2019) with the aim of stimulating debate about the effectiveness of single systems working with this client group. This Joint Strategic Needs Assessment (JSNA) seeks to build upon this profiling work and give a local context to how effectively current systems are working for Brighton and Hove's population of adults with multiple complex conditions.

3. Who's at risk and why

3.1. Literature review

This literature review is based on an evidence search conducted by Brighton and Sussex Library and Knowledge Service.[a] The sources searched included CINAHL, Google, HMIC, NICE Evidence Search and PsychInfo. The search terms included multiple complex needs, homeless, substance misuse, offending, mental health, domestic abuse, complex needs, trauma, equalities and inequalities.

3.2. Definitions of multiple complex needs (MCN) and severe and multiple disadvantage (SMD).

The literature uses several terms to describe people experiencing complex needs: multiple needs, deep, chronic or extreme social exclusion, severe and multiple disadvantage and multiple exclusion homelessness. Often these terms are used interchangeably. Lankelly Chase (Duncan and Corner, 2012) makes an argument that Severe and Multiple Disadvantage (SMD) should be the preferred term used. SMD recognises the social nature of disadvantage and its relativity, rather than focusing upon individual needs. Whereas the term multiple complex needs, can lead to the interpretation that the problem lays with the individual, rather than with the relationship between the person and the system which is meant to help them (Duncan and Corner, 2012).

The Hard Edges Report (Bramley, G et al 2015) says that there needs to be an element of breadth and depth, to be included in the definition of SMD i.e. the individuals' unmet needs should be both multiple and complex or severe. It defined three levels of severe and multiple disadvantage:

1. SMD1: experiencing one only of these three specified disadvantage domains (i.e. homelessness only, offending only or substance misuse only)
2. SMD2: experiencing two out of three disadvantage domains (i.e. homelessness & offending, substance misuse & offending, substance misuse & homelessness)
3. SMD3: Experiencing all three relevant disadvantage domains. (i.e. homelessness & offending & substance misuse)

(N.B. Mental health was not included in the initial data analysis.)

The All Party Parliamentary Group (APPG 2015) also includes breadth and depth within its definition of AMCN. It describes a person with complex needs as having: needs that interact or exacerbate each other, so that several problems are experienced simultaneously. Two or more multiple needs can affect the individual's mental, social or financial wellbeing. The depths of the needs are also severe and/or longstanding and are difficult to ascertain, diagnose or treat.

The social factors and co-morbidities that are commonly referenced in definitions of AMCN are: homelessness, substance misuse, offending, and mental ill health (Bramley,

[a] Evidence Search: Adults with multiple complex needs. Frankie Marcelline. (31st October, 2018) Brighton UK: Brighton and Sussex Library and Knowledge Service.

2015; Fulfilling Lives, 2014; AVA, 2017). A person with multiple complex needs would typically experience at least two or more of these conditions simultaneously. Other characteristics identified by the Turning the Tide Report (Page and Hillberry, MEAM, 2011) and APPG (2014) include being routinely excluded from effective contact with services which are needed and tending to lead chaotic lives that are costly to society. The Multiple Exclusion Homeless Research Programme (McDonagh,T 2009-11) also includes experience of institutional care and participating in street cultural activities such as begging, street drinking, and survivor shop lifting or sex work. The AAPG (2014) identifies the broadest range of co-morbidities and social factors amongst AMCN in addition to the ones already cited. These include: dual diagnosis, physical health condition, learning disability, physical disability, employment problems, family or relationship difficulties, domestic violence, social isolation, poverty and trauma.

The Hard Edges report (Bramley, G et al 2015) has mapped the proportion of people likely to fall into the defined categories of complex need i.e. homelessness, substance misuse, and the criminal justice system. It found 67% of single homeless people had also been offenders; 33% of homeless people were also offenders and people who misuse substances. These proportions are only best estimates because this study did not include people with mental health problems as a defined category, due to the lack of national data, (although mental ill health was included as a primary aspect of the quality of life profile of people with SMD). It also found that 78% of people with disadvantages in all three domains were male, reflecting the highly gendered nature of some areas of disadvantage.

In contrast a study by Groundswell (2018) of homeless people found lower proportions with overlapping conditions. They estimated that 17% of homeless women had a combination of alcohol, drugs and mental health support needs, and 13% of homeless men.[b]

McDonagh et al (2011) reported on four primary research projects into the complexities that interact with homelessness. This found that 47% of the sample (1,286 multiple exclusion homeless people across seven UK cities) had experienced homelessness, institutional care, substance misuse and street activities simultaneously. Schneider et al (2007) found 3.5% of the general population had multiple needs, defined as two or more conditions from mental illness, personality disorders, severe alcohol dependency, learning disability and adult neurodevelopmental disorders; and 0.9% had chaotic lives defined as four or more from: difficulty with dealing with paper work, difficulty managing money, no formal qualifications, no personal confident and few friends, unemployed, low income and highly mobile. A 0.2% overlap was reported between the multiple needs and chaotic groups. A limitation noted by this study was the lack of available data to provide a robust basis for analysis.

The Gender Matters report (Bramley G et al 2020) aimed to profile women in England with Severe and Multiple Disadvantage by focusing on the domains of: homelessness,

[b] The sample population is not identified beyond being homeless.

substance misuse and violence and abuse. It differed from the Hard Edges report (2015) in the exclusion of the criminal justice system as a domain and including secondary domains of poverty, disability and social isolation. It also included disadvantages experienced “ever” throughout adulthood, rather than just those that were current within a single year. It also considered childhood adversity and used data from the general household survey. It found that this approach showed men and women to be affected in different ways by severe and multiple disadvantage, as primary and secondary domains coalesce around women in different ways. The experience of having multiple disadvantages was a cumulative one spanning the life course.

3.3. What are the risk factors for developing multiple complex needs as an adult?

3.3.1. Adverse Childhood Experiences (ACEs)

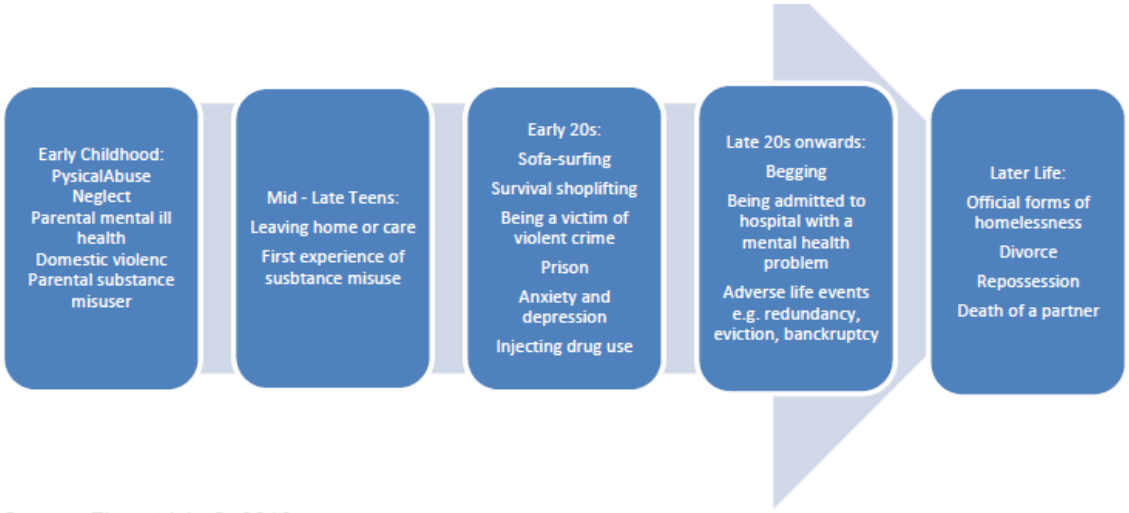
Adverse Childhood Experiences (ACEs) are key risk factors for adults that go onto develop multiple complex needs. ACEs are highly stressful and potentially traumatic events or situations that occur during childhood and/or adolescence. They can include maltreatment, violence or coercion, adjustment, prejudice, family adversity, inhumane treatment, adult responsibilities, bereavement and survivorship (Bush M. 2018). Experiencing ACEs increases the risk of health harming behaviours, poor mental and physical health. Compared to those with no ACEs, those who have experienced four or more are: twice as likely to binge drink or have a poor diet; three times more likely to be a current smoker; four times more likely to have low mental health; five times more likely to have underage sex; six times more likely to have unplanned/teenage pregnancy; seven times more likely to be involved in violence; eleven times more likely to use alcohol or drugs and eleven times more likely to be incarcerated (Bush M. 2018) (Bramley G et al 2020).

Not everyone exposed to one or more ACEs will experience a negative health outcome or have complex multiple needs as an adult. ACEs have a social gradient and are more common in low income groups. They are also more likely to cause a negative impact if multiple ACEs are experienced over an extended period (Bush M. 2018). Those at increased risk of developing AMCN as a result of childhood adversity include: people who experience childhood poverty; have parents in the criminal justice system; have parents who misuse substances; have parents with mental health problems and/or experience homelessness and domestic abuse amongst parents (Good M and Marriott C. 2018).

Public Health Wales published a report (Bellis et al. 2015) on the impact of ACEs on adults’ health and lifestyles. It states that evidence demonstrates that chronic traumatic stress in early life alters how a child’s brain develops and can fundamentally alter nervous, hormonal and immunological system development. This can lead to individuals being in a permanent state of readiness for further trauma; as well as increasing their risk of developing cancer, heart disease and mental illness. The PHW report estimates that the levels of ACEs in the population of Wales is comparable to England, 47% and 48% having one ACE respectively and 14% having 4 or more ACEs in Wales and 9% in England.

Fitzpatrick (2013) summarise ACEs in Figure 1, as the first stage in a life course pathway towards becoming an adult experiencing multiple exclusion homelessness (another term which includes the overlapping groups of people experiencing multiple complex needs).

Figure 1: The life course of multiple exclusion homelessness experiences



Source: Fitzpatrick, S, 2013.

Public Health Wales (Lisa C G, Di Lemma et al. 2019) reviewed the evidence on interventions to prevent and address ACEs across the life course and found seven cross cutting themes to inform a multi-sectoral response. These included:

1. Promoting social development, cohesion and positive relationships across the life course.
2. Promoting cognitive-behavioural and emotional development in childhood, through targeted parental and youth programmes
3. Promoting self-identity and confidence in children and adults
4. Building knowledge and awareness about the causes and consequences of ACEs amongst the public and professionals
5. Developing new skills and strategies for those affected to cope with adversity
6. Early identification of adversities by therapeutic and interfacing services to identify and support parents, children and those affected through the life course
7. A collaborative approach across sectors and organisations

Figure 3. Overview of the key theme of an ACE-informed approach, developed from potential interventions aiming to prevent and respond to ACEs (Public Health Wales 2019)

Evidence based programmes cited as effective interventions at different stages of the life course are shown in Table 1.

Table 1

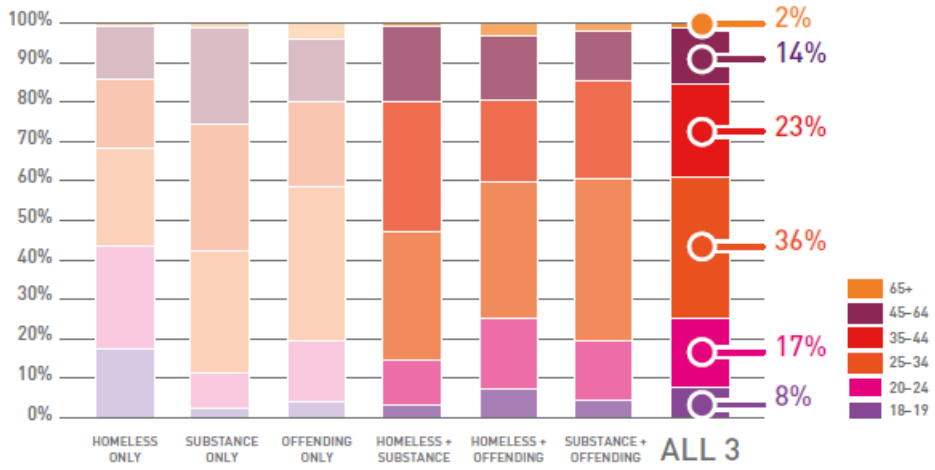
Summary of evidence-based programmes	Examples
Parenting programmes	Incredible Years, Nurse Family Partnership, Triple P, Parenting for Life Long Health
Building relationships and resilience • Mentoring programmes • Community based interventions • School based interventions	• Big Brothers Big Sister • Communities That Care (CTC) Multi-Dimensional Treatment Foster Care • SAFE DATES, Good Behaviour Game, Promoting Alternative Thinking Strategies (PATHS), Families and Schools Together
Early identification of adversity	Safe Environment for Every Kid (SEEK), Family Check Up and Every Day Parenting (USA)
Responding to Trauma and Specific ACES	Trauma Recovery Model for children, Child-Parent Psychotherapy (CPP), Infant Parent Psychotherapy (IPP), Multi Systemic Therapy (MST), New Beginnings Programme (NBP for parental separation)

Source: Di Lemma L, Davies A et al. Responding to Adverse Childhood Experiences Public Health Wales. 2019

3.3.2. Age

The Hard Edges report (2015) found the most common age group for all multiple complex needs categories in 2010 was 25-34 years, apart from homelessness, followed by the 35-44 year old age group. The 25-44 years age band is most marked in the substance misuse and/or offending group. The homeless only category was the youngest age group with over 40% under 25. Whereas the substance misuse category was the oldest, with 25% aged 44-64. There were very few people aged 65 or over in any of the categories (Brambley et al. 2015). This age breakdown was similar to the findings of the Multiple Exclusion Homeless Survey in 2013 (Fitzpatrick et al). This age profile may have altered by 2019 following the impact of austerity and welfare reform over a prolonged period.

Figure 4. Age profile of each SMD category in 2010 based on composite of three main sources



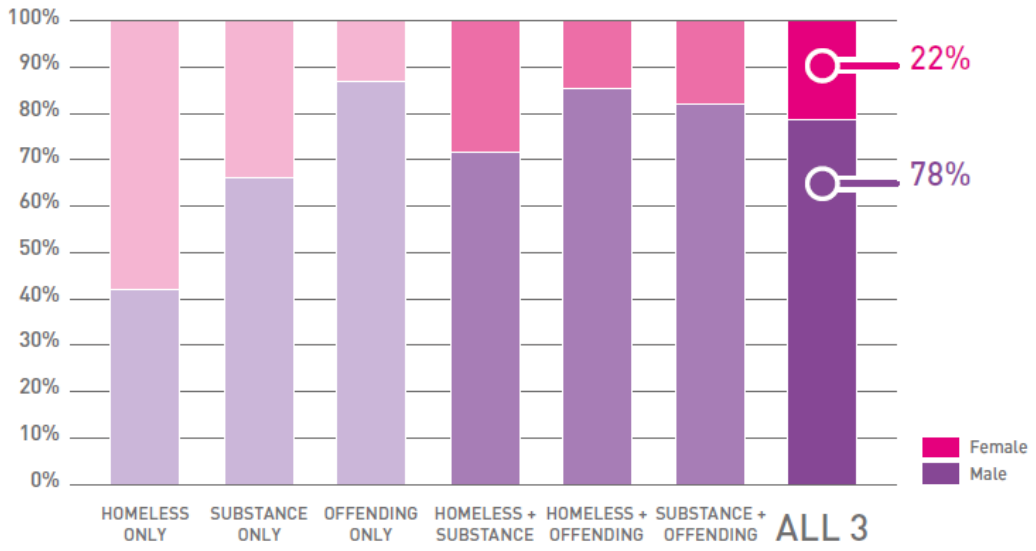
Source: Composite of SP, OASys and NDTMS

3.3.3. Gender

Source: Hard Edges. Mapping Severe and Multiple Disadvantage. 2015

When analysed from the offending, substance misuse and homelessness perspectives, multiple complex needs are a predominantly male preserve. The gender breakdown in 2010 is shown in Figure 5.

Figure 5. Gender composition of SMD categorised based on composite of main sources



Source: Composite of SP, OASys and NDTMS

Women

The Lankelly Chase (2016) gender profile of the overlapping factors that lead to severe and multiple disadvantage in Figure 5, shows that 22% of women with SMD experienced all three conditions of substance misuse, offending and homelessness. The majority of women experienced one or two of these disadvantages and the majority of them were to be found in the homeless domain. This compares to a St Mungo's study of its female homeless clients in 2013, which found 27% of them had overlapping physical, mental health and substance misuse complex needs.

Compared to men in the three disadvantaged groups (substance misuse, offending, homelessness), women were more likely to be on medication for mental health problems; have a dual diagnosis; have no qualifications; have significant financial problems; have significant family relationship problems; have had significant adverse childhood experiences and be the victims of domestic violence. They were also 12% more likely to be living with their own children than men (men 4%) and 34% were either not a parent or no longer had contact with their children (men 44%).

The Breaking Down the Barriers (AVA 2019) report also shows that women are at increased risk of experiencing adverse life events compared to men, with 1 in 20 experiencing physical and sexual violence, compared to 1 in 100 men, across their life course. 50% of these women will also have a mental health problem, 20% will be homeless and 30% will have an alcohol problem.

The risk factors identified by Lankelly Chase (2016) as placing women at the greatest risk of disadvantage are summarised in Table 3.

Table 3. Risk factors for women becoming severe and multiply disadvantaged

Single parent	Living in social/rented housing
Having a young mother	Living in an urban/ deprived area
Having a black mother	Being isolated
Parents with a disability, long term illness of mental health problem	Alcohol/drug dependence
Being a migrant woman	Traveller women
Being sexually exploited/a sex worker	Domestic violence
Women who have lost their children to care	Women who have become involved with the criminal system

Source: Lankelly Chase. 2016.

Homelessness and women - Violence, trauma, substance misuse and domestic abuse are part of complex and interrelated problems contributing to women's homelessness.

Women tend to be the hidden homeless. The London CHAIN database showed that 15% of all recorded rough sleepers were female and estimates that 70% of women lived in hidden homeless situations. Homeless Link estimates 30% of those using homeless projects are women but only 7% of accommodation provision is women only and these services are being reduced.

Young women are at risk of becoming rough sleepers due to the combination of inadequate housing options; welfare benefit reform; reduction or lack of women only provision and lack of preventative family services contributing to relationship breakdowns.

27% of homeless women have mental health, physical health and substance misuse needs. Homelessness can lead to children being taken into care. St Mungo's found that of the 50% of its female clients who were mothers, 79% had had their children taken into care or adoption (National Housing Federation,2017).

Roos et al (2013), reports that if a woman experiences emotional abuse as a child, there is a strong association with becoming homeless and having an Axis I or II disorder.[c] For men who experience emotional and sexual abuse as a child, there is a strong association with homelessness. Axis I and II disorders are most strongly associated with emotional abuse in childhood. Roos et al (2013) calculates an attributable[d] fraction for ACEs leading to a lifetime of homelessness, as 45% for men and 61% for women.[e]

Bramley et al (2020) report that the majority of men and women with complex combinations of disadvantage live in social rented accommodation, with a third living in

[c] The five diagnostic axes specified by DSM-IV-TR are: **Axis** I: Clinical **disorders**, including anxiety **disorders**, mood **disorders**, schizophrenia and other psychotic**disorders**. **Axis II**: Personality **disorders** and **mental** retardation .

[d] In epidemiology, the attributable fraction for the population is the proportion of the incidents in the population that are attributable to the risk factor i.e. the proportion of cases of lifetime homelessness that can be attributed to the risk factor of Adverse Childhood Experiences.

[e] Cited in PHE. Evidence Review; Adults with Complex Needs (with a focus on street begging). January 2018.

the private rented sector. Becoming homeless was the most feared outcome for women as a result of partner violence, substance misuse, debt and poor mental health.

Domestic abuse and women– 37% of women who have experienced violence and coercive control had a common mental health disorder. In a risk factor approach women and girls are more likely to be visible as clients of mental health services, violence, abuse and children's services. Whereas women are more likely to be hidden if only the male dominated domains of offending, substance misuse and homeless are considered, (78% of men experience all three disadvantages). This is because some areas of disadvantage are highly gendered e.g. criminal justice system, but the gender profile will be different if mental health is included as a domain (Lankelly Chase 2016).

The Gender Matters report (Bramley et al 2020) found that the two domains of disadvantage most affecting women were being a victim of interpersonal violence and abuse and poor mental health, as opposed to poor mental health and substance misuse for men. Women living in poverty were also much more likely to experience interpersonal violence and abuse and poor mental health.

The MEAM response to the National Commission into women facing domestic and /or sexual violence and multiple disadvantages (2018) included a review of **what was not working** for women who were facing domestic violence and /or sexual violence and multiple disadvantage. This included a lack of understanding of women's past experience such as the impact of trauma; a lack of community provision for women which impacts upon the ability to offer diversion from custody; imprisonment which can lead to separation from family, loss of accommodation and aggravation from existing trauma and mental health issues; a lack of quality "through the gate services" to support women in prison and upon their release; a lack of appropriate accommodation and unequal outcomes for Black and Minority Ethnic Group (BAME) women (MEAM et al 2018).

Crisis surveyed 480 single homeless people in 2014 and found that 61 per cent of women had experienced violence or abuse from a partner (compared to 13 per cent of men) (Mackie and Thomas, 2014).

Sex work and women - 20% of women experience physical and sexual violence across their life course compared to 1% of men. Many women are forced into sex work to survive homelessness. A quarter of St Mungo's female clients have been involved with sex work compared to 2% of male clients and over a third of those women who have slept rough (National Housing Federation, 2017). Women are also at greater risk from men if placed in mixed accommodation (National Housing Federation, 2017).

Eaves (Bindel et al 2013) found that 72% of the women involved in sex work had suffered some form of violence during childhood. Sex work itself can leave women vulnerable to abuse and violence in adulthood. In a recent DrugScope and AVA report on improving services for women involved in sex work and substance use, all but one of the women interviewed described experiences of violence alongside experiences of drug dependency, poverty and homelessness. As with other groups experiencing

trauma, women commonly use drugs and alcohol to numb their traumatic experiences (DrugScope).

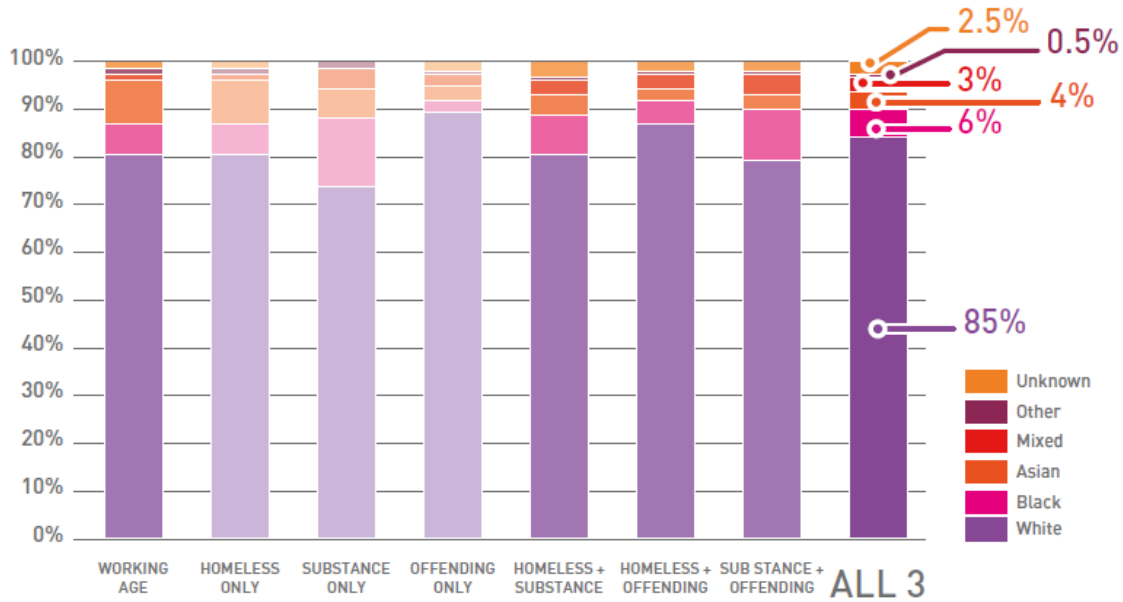
The Sex Workers Needs Assessment 2016 stated that the Oasis Sex Work Outreach project had found that a third of sex workers in the city had an Eastern European nationality (Brighton & Hove City Council 2016)

Interventions need to consider gender differences because men and women experience MCN differently. Women are more likely to experience anxiety and depression, compared to antisocial behaviour, personality disorder and alcohol dependency in men (Good and Marriott. 2018)

3.3.4. Race and ethnicity

The Hard Edges report (2015) found that the population of adults with multiple complex needs was predominantly white, in line with the working age population of England. This was most strongly the case in the substance misuse only group and the least the case in the homeless group. Black and mix-raced people were over represented in the homeless group, as well as to some extent in the offender and homeless and offender only groups. People of Asian ethnicity were under represented in all the multiple complex needs groups apart from homelessness only (Bramley et al. 2015). This suggests that Asian ethnicity may be a protective factor against developing severe and multiple disadvantage or that services are not reaching people from Asian ethnicity with multiple complex needs.

Figure 6. Broad ethnic group composition of SMD categories (percentage of each SMD category)



Source: Composite of SP, OASys and NDTMS with PSE benchmark for working age population

Although studies in England have found no significant relationship between ethnicity and prevalence of adverse childhood experiences or poor adult mental wellbeing, there is evidence that the cumulative experience of racial prejudice creates significant

adversity and has lasting impact on mental wellbeing of BAME young people (Young Minds, 2018). Children and young people experiencing racial prejudice may develop symptoms of traumatic stress. Children in a BAME family are also more likely to be living in poverty

The cumulative impact of risk factors that may lead to young BAME developing multiple complex needs as adults include:

- Mixed white and black Caribbean children being twice as likely to be excluded permanently from school as the school population as a whole;
- Black Caribbean children being twice as likely to be excluded from school for a fixed period and three times more likely to be permanently excluded, as compared to students from all other ethnic backgrounds
- BAME children are over represented in secure children homes, training centres and young offender institutes compared to children from all other ethnic backgrounds.

By the time of adulthood black and mixed heritage people are more likely to be remanded in custody than white people. Some of the BME population is disproportionately likely to be in the criminal justice system - 25% of the prison population are BME but only 14% of the general population (MEAM, 2017).

The Social Exclusion Unit found that people from BME groups are more likely to be unemployed than the majority population, making them more vulnerable to social exclusion. They are also more likely to be homeless or live in overcrowded accommodation. However, BME groups are less likely to sleep rough and are more likely to be part of the hidden homeless, staying with friends or relatives.

The adult migrant population in the UK are also at risk of homelessness but are less likely to report experiencing multiple exclusion homelessness i.e. homelessness and substance misuse and offending/prison and participating in street culture activities like begging. (National Housing Federation, 2017). The reasons for migrant homelessness are different to the deep social exclusion and relationship breakdowns experienced by settled BAME communities. The homelessness disproportionately experienced by migrant groups is due to a range of factors including a lack of support networks, language problems, lack of understanding of the British system and not being entitled to benefits and services. These include limited availability of legal advice and support on immigration issues. Refugees or asylum seekers who have experienced torture or war have higher rates of mental disorder; refugees from Eritrea and Somalia represented 2% of rough sleepers in London in 2013 (Race Equality Foundation in National Housing Federation, 2017).

The International Migrants JSNA 2018 does not identify issues specifically to do with multiple complex needs but it does highlight issues around homelessness and mental health that are also pertinent to this JSNA. It states that migrants are more likely than others to live in private or rented accommodation, and overcrowded houses in poor condition. Their access to housing and benefits is also determined by their immigration

status. They may also be placed in temporary accommodation away from their communities, which can increase their isolation.

Housing was frequently cited as a problem for migrant mental health in stakeholder survey/interview responses in a 2010 study of the South East of England: it was suggested that insecure and overcrowded accommodation exacerbated depression, anxiety, poor sleep, PTSD and domestic violence.

Local stakeholders identified the following factors associated with migrant homelessness:

- Women may have been sexually exploited or trafficked for sexual exploitation
- Fleeing from domestic violence
- Having physical or mental health conditions
- Having substance misuse issues
- Being isolated
- Not engaging with services

These are all common risk factors for people developing multiple complex needs, but migrants face the additional complexity of not being able to access benefits or health care services, depending upon their immigration status; or if they are undocumented migrants, they might avoid contact with healthcare services.

In terms of mental health, the JSNA highlighted the following issues:

- Depression and anxiety are twice as common amongst refugees, compared to economic migrants, placing them at increased risk of PTSD
- Young male migrants may have unrecognised or unmet mental health needs, particularly those who are isolated or living alone
- Migrants may not understand the concept of mental health and may lack the language skills to talk about it
- There is insufficient mental health support to meet the needs of migrants, particularly asylum seekers and refugees. Limiting mental health talking treatments to six sessions, might also mean their needs are not being met.

3.3.5. Sexual orientation and trans status

Having an LGB sexual orientation or being trans (LGBT) is a risk factor for youth homelessness (Homeless Link 2018). The Count Me in Too survey from 2008 found that a quarter of LGBT respondents said they had experienced difficulties in obtaining accommodation and 22% reported that they had been homeless at some point in their lives. A third of those who defined themselves as bisexual, queer and other had experienced homelessness, compared with 22% for lesbians / gay women and 19% for gay men. Those more likely to have experienced homelessness also included LGBT disabled people, people who were HIV positive, people on low incomes and people with mental health difficulties (Browne K et al, 2008).

The 2007 mental health needs assessment for working age adults in the city identified higher risks among the LGB population. Count Me in Too found that 79% of the city's LGBT population reported some form of mental health difficulties. Bisexual, queer and

BME LGBT people more frequently reported experiencing mental health difficulties, as did those who feel isolated and those on a low income (Browne K et al, 2008). Bisexual people have high rates of mental health problems, including depression, anxiety, self-harm and suicidal thoughts. This has been strongly linked to experiences of biphobia and bisexual invisibility (Barker et al. 2012). Dual diagnosis clients in the substance misuse service are more likely to identify as LGB (17%) compared with 11% for all clients in treatment.

The Trans Needs Assessment 2015 stated that local and national research had consistently indicated high levels of mental health needs in trans people. Stakeholders identified mental wellbeing as the highest area of concern around health and wellbeing. In the community research, only 4% of respondents reported said they had not experienced some form of mental health issue in the past five years. These local findings data are similar to the national Trans Mental Health Study 2012 in which participants reported high rates of current and previously diagnosed and undiagnosed mental ill health, including depression (88%), stress (80%), anxiety (75%).

The Brighton & Hove trans community research survey found that 63% of respondents had experienced domestic violence (including emotional abuse, verbal abuse, physical abuse/violence and sexual abuse), which in many, but not all, cases were related to their trans identity.

The Brighton & Hove Trans Scrutiny Panel report 1 noted that concerns around domestic violence for trans people included a lack of safe spaces for those who are homeless or suffering from domestic violence. However, since these interviews were conducted, the council, in partnership with RISE and some housing providers, have been successful in gaining funding for a 15-month pilot project to support LBGT people in dispersed accommodation. If access to services was achieved, there was a concern that services may present difficulties for trans clients and that staff in refuges should be trained. Stakeholder interviews identified needs for a better understanding by domestic and sexual abuse services of the needs of trans people and noted that there was no refuge service for trans men suffering domestic violence. However, since these interviews were conducted, the council, in partnership with Brighton Housing Trust and RISE, have been successful in gaining funding for a 15-month pilot project to develop a refuge project for gay, bisexual and trans men.

National research indicates trans people are vulnerable to housing crisis and homelessness. Most focus group participants in the Brighton & Hove community research reported that they were living in housing that they considered insecure or unsuitable for their needs. They commonly described experiencing frequently moving to remain safe, living in temporary housing and sofa surfing. More than one in three local community survey respondents had experienced homelessness (compared with one in five trans respondents to a national survey). 13% reported that they had been homeless within the previous five years. Furthermore 12% classified their current housing status as "other" (which included homeless) and 2% as temporary accommodation. Trans people's vulnerability to homelessness is a result of a range of factors including family breakup and harassment by neighbours. More generally, the high cost of private rental

sector and limited availability of affordable housing in Brighton & Hove were also cited by research participants as key factors affecting homelessness and people's ability to access secure housing

No trans respondents to the 2012 Health Counts survey, based upon their weekly alcohol unit consumption, were drinking at increasing or higher risk drinking levels, compared with 17% of all survey respondents. In addition, 35% (6/17) of trans respondents said that they never drink alcohol. These findings contrast with the national Trans Mental Health Study 2012 which used a screening tool and concluded that 62% of participants may either be dependent on alcohol or consuming at harmful levels. As part of the Comprehensive Assessment Process completed by all people entering treatment for alcohol and drugs use, clients are asked their gender and also if they identify as transgender. A review of all clients in drug and alcohol treatment as at 31st October 2013 found that fewer than five clients had indicated that they were transgender.

Following on from the publication of the Lankelly Chase Hard Edges Report in 2015, The LGBT Foundation based in Manchester is carrying out research into how LGBT people experience severe and multiple disadvantage, as this perspective was not considered in the original report. They say that several studies report that LGBT people may be over represented in some areas of SMD or may experience them differently. For example, previous studies show that as many **as 1 in 3 homeless youth are LGBT** (Crisis, 2005), that **LGBT people are more likely to be substance dependent** (University of Central Lancashire, 2014) and that **LGBT people are more likely to face mental health challenges such as depression and anxiety** (King et al 2008). It is not known though how these factors interact to affect the lives of LGBT people, or if there are other factors not yet researched within current SMD literature (for example, domestic abuse or sex work) that may constitute severe disadvantage for LGBT people (LGBT Foundation).

3.3.6. People with learning disabilities

The Brighton &Hove JSNA for Adults with Learning Disabilities 2011 reported that nationally an estimated 35-75% of people with mild learning disabilities were at risk of developing mental health problems. Often mental health problems in young people with learning disabilities may be undiagnosed, this can lead to unemployment and higher rates of anxiety and depression and have long lasting psychological impact into adulthood (Sigfrid L and Hendriks M, 2011). The Gender Matters report (Bramley et al 2020) found that the link between poor mental health and having a learning disability was strong for both genders.

Nationally people with mild learning disabilities also have higher levels of substance misuse than their peers. Often local services will not know, or will not have assessed them for learning disabilities, meaning that they can be a challenging and complex group to support, especially when combined with mental health problems. People with learning disabilities and substance misuse are very vulnerable and at risk of abuse and exploitation and involvement in crime. If they do not get the right support from substance misuse services, they may stay in the service and live in temporary

accommodation for many years. Traditional recovery models often do not support these clients appropriately (Sigfrid L and Hendriks M, 2011).

It is estimated that 20-30% of offenders have learning disabilities but there are no clear pathways for supporting people with learning disabilities who have offending histories. There are no specialist services available outside of offender services (Sigfrid L and Hendriks M, 2011).

3.4. In what ways does the system fail to meet the needs of Adults with Multiple Complex Needs?

Barriers to accessing services for adults with multiple complex needs can arise both because of the individual's characteristics and due to the way services are configured and delivered. The literature cites several barriers to adults with multiple complex needs accessing services (Rosengard et al 2007; Bellis A and Wilson W. 2018; Terry L and Cardwell V. 2016; Tennant et al. 2017; Dwyer P. 2015; Luchenski S et al. 2017). These include

- Lack of accessibility
    - Opaque referral systems
    - Inflexible access criteria, such as age limits that hinder the continuity of care
    - The need for a proof of address to be able to access services and benefits
    - Service targets that disincentivise working with the seriously disadvantaged
    - Clients left to navigate multiple complex organisations by themselves
    - Placing responsibility for issues like homelessness on individual actions rather than due to structural issues
    - People with complex needs are less likely to be able to help themselves, which is a condition for being able to access welfare support
    - Direct/indirect costs to the client
    - Geographical inequalities of provision
    - Transport issues
    - Institutional discrimination
    - The media reinforcing stigma and stereotyping

- Service provision misaligned with client needs
    - Serial treatment and parallel care in silos rather than within integrated organisations
    - Perception that needs are being assumed and not asked
    - Services fail to recognise specific needs of women (particularly those homeless as a result of domestic abuse)
    - The current process for defining vulnerability groups can consign some homeless people with complex needs to the street
    - Unrealistic care plans
    - Lack of trauma informed trained staff

    - Inappropriate services such as over reliance on medical as opposed to social responses to dual diagnosis
    - Experiencing trauma can make people distrust traditional services
    - Lack of continuous flexible support that isn't time limited
    - Service provider fear, poor awareness and judgmental attitudes

- Communication issues
    - Lack of understanding/knowledge of other services by clients/staff
    - Trust/territorial issues
    - Poor co-ordination between agencies
    - Incompatible IT services.
    - Different agencies have different priorities
    - Language, communication and cultural barriers

The barrier to young people accessing services for their multiple complex needs include the same issues listed above and their complex needs have also been described as being a consequence of the complexity in which the care system is organised rather than of the young people in need of assistance (Smith N and Albakri M, 2018). The obstacles to accessing services for young people overlap with those of adults and include:

- Funding silos
- A lack of understanding of the role of different professionals and the systems they work in
- The lack of a shared theoretical framework e.g. between social workers and psychiatrists/doctors
- Gender of the therapist can be a barrier if they are from the opposite sex

3.4.1. Equalities barriers

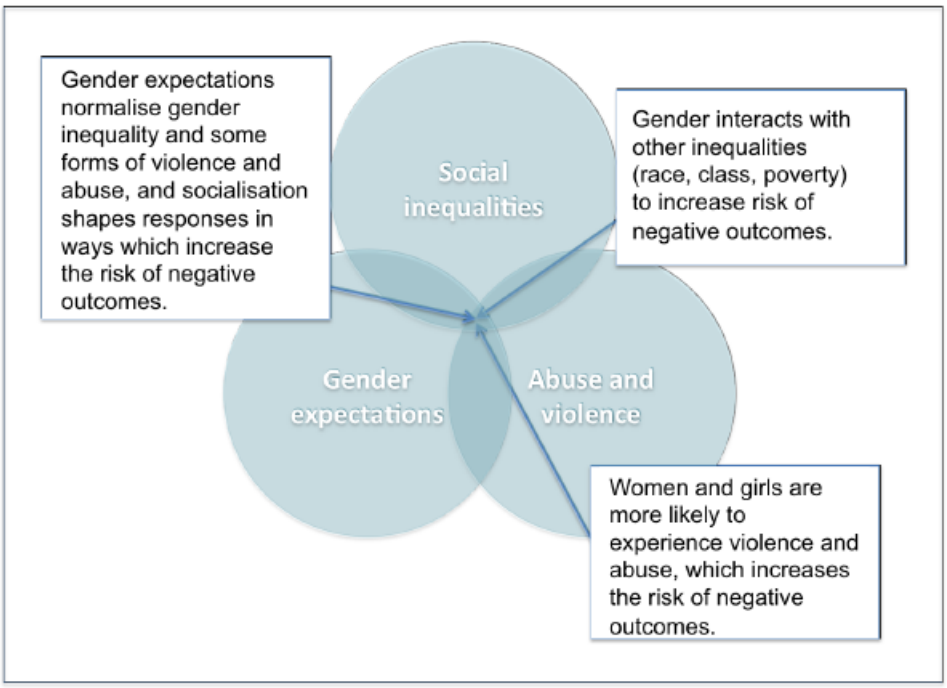
Most of the studies concerning adults with multiple complex needs, do not consider the barriers to accessing services through the equalities lens. However there has been some evidence reported on this in relation to women and BAME groups.

3.4.2. Women

The risk factors which expose women to the possibility of developing multiple complex needs have already been outlined. It is also important to examine the way in which women experience services to highlight any gender-based inequalities that are inherent in the current system of care and treatment for women with multiple and complex needs.

Figure 7 shows how gender expectations can "normalise" the inequalities faced by women and girls; when these are combined with social inequalities, violence and abuse, it can lead to negative outcomes.

Figure 7. Social context which increases risk to women and girls (McNeish and Scott 2014)



Source: Women & girls at risk. Evidence across the life course. McNeish D& Scott S. 2014

Boys and girls respond differently to adversity – boys externalise their response through anger and antisocial behaviour, and girls internalise with depression and self-harm. The girls' response can make them appear invisible to services, increasing the risk of further abuse leading to long term difficulties. Those girls who respond contrary to gender expectations may find themselves ending up in the Criminal Justice System, with a more punitive response than that given to boys or men, because they are perceived as going against gender norms. Violent women become isolated from help and are perceived as doubly deviant (McNeish D and Scott S. 2014). Girls also tend to do less well in the Criminal Justice System which has historically been designed around young men. They often develop anxiety and depression but this can be overlooked and go untreated. By contrast if girls respond with anger and disruptive behaviour, they may get an inappropriate response from staff that see them as manipulative delinquents and may place them in even more restrictive settings, which may re-traumatise them.

As young women transition from teen to adult services, they also face the double inequality of being inappropriately treated by services that are designed for men and geared towards adults (McNeish D and Scott S. 2014).

Due to the social invisibility of some women's needs, they tend to enter homelessness services at later stage than men; meaning that their problems have escalated and they may be less ready to start engaging with recovery (AVA 2017).

Other ways in which the complexity of women's needs may be overlooked include women who are the victims of violence not being considered to have complex needs or be in need of person centred co-ordinated care. Also, most substance misuse services

in the UK are mixed gender and are less likely to address the barriers to women taking up treatment- such as childcare and financial concerns (Greenfield and Pirard. 2009

3.4.3. BAME

The risk factors for developing AMCN in the BAME population have been previously outlined in section 3.3.4 and these clearly overlap with this section. BAME communities may be less inclined to engage with mainstream services for a range of reasons but inequalities affecting the BAME population with multiple complex needs arise because of language barriers - BAME, refugees, and asylum seekers may be unaware of the services that are available and what they can offer them. BAME women also face the inequality of being socially invisible. This is exacerbated by race and class and age. Older BAME women face ageism, sexism and racism.

3.5. What is the evidence base for interventions that provide support to adults with complex needs?

The evidence is scarce for structural interventions that can prevent the exclusion and promote the recovery of people with multiple complex needs. The most recent systematic review was carried out by the Lancet in 2018 (Luchenski S et al. 2018) and was based on an evidence synthesis of health and social interventions for inclusion health target populations, including people with experience of homelessness, drug use, imprisonment and sex work. 727 full text systematic reviews were assessed, and 72 studies were included in the qualitative synthesis, of these 10 were on women and 9 on young people.

The Lancet systematic review (2018) made recommendations for practice, policy and research. For practice it recommended the following as the most effective interventions with the AMCN population group:

Practice

- Multicomponent interventions with co-ordinated care, that include health and non- health services. The best results come from holistic interventions carried out in partnership, that are designed around the whole person (Rankin and Regan. 2004; Gallimore et al 2009; Social Exclusion Taskforce. 2006; Good and Marriott. 2018).
- Service user involvement should be standard practice to ensure equity, acceptability and relevance. Peer worker programmes are an acceptable and effective method to involve service users (Social Exclusion Taskforce. 2006; Rosengard. 2007).
- Working with AMCN requires active engagement and outreach. To be effective this should include motivational interviewing and psychologically informed engagement by trained community nurses and peer workers (Gallimore et al 2009).
- Staff training, technical assistance and monitoring of adherence to protocols should be used to address barriers to accessing services, such as communication problems, bureaucracy or stigma. The media should be

encouraged to give more positive messages to the public about people with MCN (Rosengard. 2007).

- High quality comprehensive services should be delivered in the community and on the streets, as well as in institutional settings like prisons.
- When assessing health and wellbeing, use measurements that provide objective outcome evaluation that is also meaningful to the clients and involve them in developing appropriate measures. Rosengard (2007) also warns against using the definition of a successful outcome as exiting from services.
- Service values that people with MCN want to see implemented include: listening, developing trust and acceptance, being supportive, unbiased, open, honest and transparent; having inclusive spaces and places. Encouraging client responsibility for their health, involvement in decision making; accessibility, fairness and equality for all.
- Improved recording and sharing of data (Social Exclusion Taskforce. 2006)

Effective interventions for **women** identified in the Lancet systematic review (2018) include:

- Gender sensitive interventions such as structured counselling and social support, therapeutic communities, case management, integrated programmes and advocacy and empowerment.
- Effective interventions for excluded women address the role of motherhood, trauma and violence, and substance misuse. Education and empowerment are key aspects for recovery.
- To support women the interventions should be delivered in the community and institutional settings.

The MEAM report (2017) also identified specific interventions that have been shown to be effective for **women** facing domestic or sexual violence or multiple disadvantages and include:

- Recognising the value of gender specific services
- Trauma informed care
- Psychologically Informed Environments (PIES)
- Focusing on early intervention and prevention
- Strategically engaging with voluntary organisations and women with lived experience.

Trauma informed approaches have also been recommended as effective service models for women who have multiple complex needs (Bear L et al. 2019; AVA 2019). The characteristics of trauma informed services include holistic and wrap around women centred services. They foster trusting relationships and include peer support; create a sense of safety, choice and control. They also identify the impact of trauma on the individual by listening, understanding, responding and checking that the services are also responding to individuals in these meaningful ways.

Some of the barriers to delivering a trauma service to women include: fragile funding streams, difficulties in making the cultural shift to deliver trauma informed services and the difficulties of delivering this approach in traumatic environments like a prison.

Effective interventions for **young people** under 25 years are scarce but promising results have been reported for family-based therapy, cognitive-behavioural therapy, and brief interventions for a range of outcomes. Foster care might help to reduce criminal activity and improve mental health. There are no evidence-based transition support services available for looked after young people reaching the end of their care.

Other service principles identified as being a prerequisite for providing an effective service to adults with multiple and complex needs in other literature reviews include:

- Early interventions (Rankin and Regan. 2004; Gallimore et al, 2009) and systematically identifying what works (Rankin and Regan. 2004)
- Better co-ordination of multiple agencies through a Single Point of Contact (Rankin and Regan. 2004; Rosengard. 2007; Gallimore at al. 2009)
- Flexible open access to services, which provide a fast referral and immediate response, which is not time limited (Gallimore et al.2009; Terry and Cardwell. 2016)
- Link workers to negotiate and overcome bureaucratic fragmentation (Rosengard. 2007; Gallimore at al. 2009)
- Using a social care approach (Gallimore at al. 2009)
- Good relationships between clients and staff, including working across professional boundaries and providing aftercare (Gallimore at al. 2009; Terry and Cardwell. 2016)

Lankelly Chase (Good and Marriott 2018) have also identified effective interventions for the whole family. These include implementing whole family approaches; interventions to prevent youth homelessness; involving men more in parenting; implementing universal interventions for the family e.g. Sure Start, Children's Centres, Health Visitors and routinely including questions on domestic violence and abuse.

Policy and research

The Lancet Systematic Review (2018) also includes some upstream interventions and areas of research to improve services for adults with multiple complex needs. Reducing poverty and deprivation, especially amongst families with children will help to prevent adults developing multiple complex needs. Excluded groups need to be prioritised within the proportionate universalism framework, and for the provision of stable housing. There are no systematic reviews on effective interventions in high income countries for sex workers. Research is also needed on effective interventions for supporting young people under 25 years who are transitioning to adult services.

The King's Fund has recently reviewed what improvements could be made to the health and social care system for people who are sleeping rough (Cream J et al 2020). This group have extensive multiple complex needs that are not being met and have some of the worst health outcomes. To be effective health interventions need to be place based

and intertwined with housing and others that are supporting the needs of homeless people. "*A population health approach is needed to address the full range of factors that influence the health & wellbeing of people sleeping rough" (*Cream J et al 2020). People who have experienced sleeping rough, need to be involved in co-producing services.

There is also a role for commissioners contracting services to ensure they are effectively co-ordinated. Staff need to feel supported, so that there is a safe, supportive environment that enables staff to work flexibly in the client's best interest and that enables them to share issues and sense of purpose across the health and social care system. Links between services are crucial. The NHS Long Term Plan, Sustainability and Transformation Plans and Integrated Care Systems, all have a role to play in bringing health and social care services for people who sleep rough, closer together at a local level (Cream J, 2020).

Evidence from Scotland

In 2019, Lankelly Chase published a report on SMD in Scotland largely based on the methodology used for the Hard Edges Report published in 2015. The main difference between the reports is that the Scottish one includes five domains of SMD, rather than three, by also including mental health and domestic violence and abuse. Scotland also has a different, broader, definition of homelessness than England, which will include more people in datasets. It utilised 12 datasets and considered people from the perspective of currently and ever having experienced severe and multiple disadvantages.

Thus, this report covers the same areas of multiple complex needs as this JSNA and enables some comparisons to be made (with caveats about methodology). The main findings may be equally applicable to people experiencing SMD in England and included the following:

- Violence was an ever-present threat throughout the life course of people with SMD
- The majority of individuals in the mental and domestic abuse domains were female but men had the most complex forms of SMD
- There is growing evidence that childhood trauma lies behind adult SMD. The red flags for this are: truanting, school exclusion, early substance dependency, Looked After Children, unsettled childhoods with lots of moving
- Prison was seen as a "safety net," providing respite from the streets and an opportunity to get health care needs met
- People with SMD faced high barriers to accessing mental health services
- In some areas refuges wouldn't accept women with addictions or chaotic lives, yet all the women with SMD in the study had experienced domestic abuse
- People with SMD need help from voluntary organisations to access the benefits they are entitled to
- The proportion of young adults with 2-3 multiple complex needs was increasing
- The crisis nature of services militated against a "strengths based" approach focusing on a positive future; and there was little support for developing relationships, which was the main motivator for Recovery.

4.The level of need in Brighton & Hove

4.1. Estimates from Lankelly Chase of three needs (homelessness, substance misuse and offending)

Our starting point in considering the level of need in the city was the estimates of severe and multiple disadvantage published in 2015 in the report from the Lankelly Chase Foundation - “Hard Edges: Mapping severe and multiple disadvantage” which profiled severe and multiple disadvantage (SMD) across England (Bramley G and Fitzpatrick S et al. 2015.) Severe and multiple disadvantage was a term used to signify the problems faced by adults involved in the homelessness, substance misuse and criminal justice systems in England. The data was not available to look at other elements of disadvantage. However, the authors found that poverty was almost universal, and mental ill health common.

Figure 8. Ranking of number of recipients of substance misuse, offending and homeless services

In Brighton & Hove, 20 per 1,000 working age adults were estimated to receive services across at least one of the three domains.

In 2010/11, this gave a total figure of 3,790 adults and 1,500 with two or more (420 with all three, 1,080 with two and 2,290 with one). These findings are illustrated in Figure 8. Brighton & Hove ranked 61st highest (worst) of 151 local authorities in England.

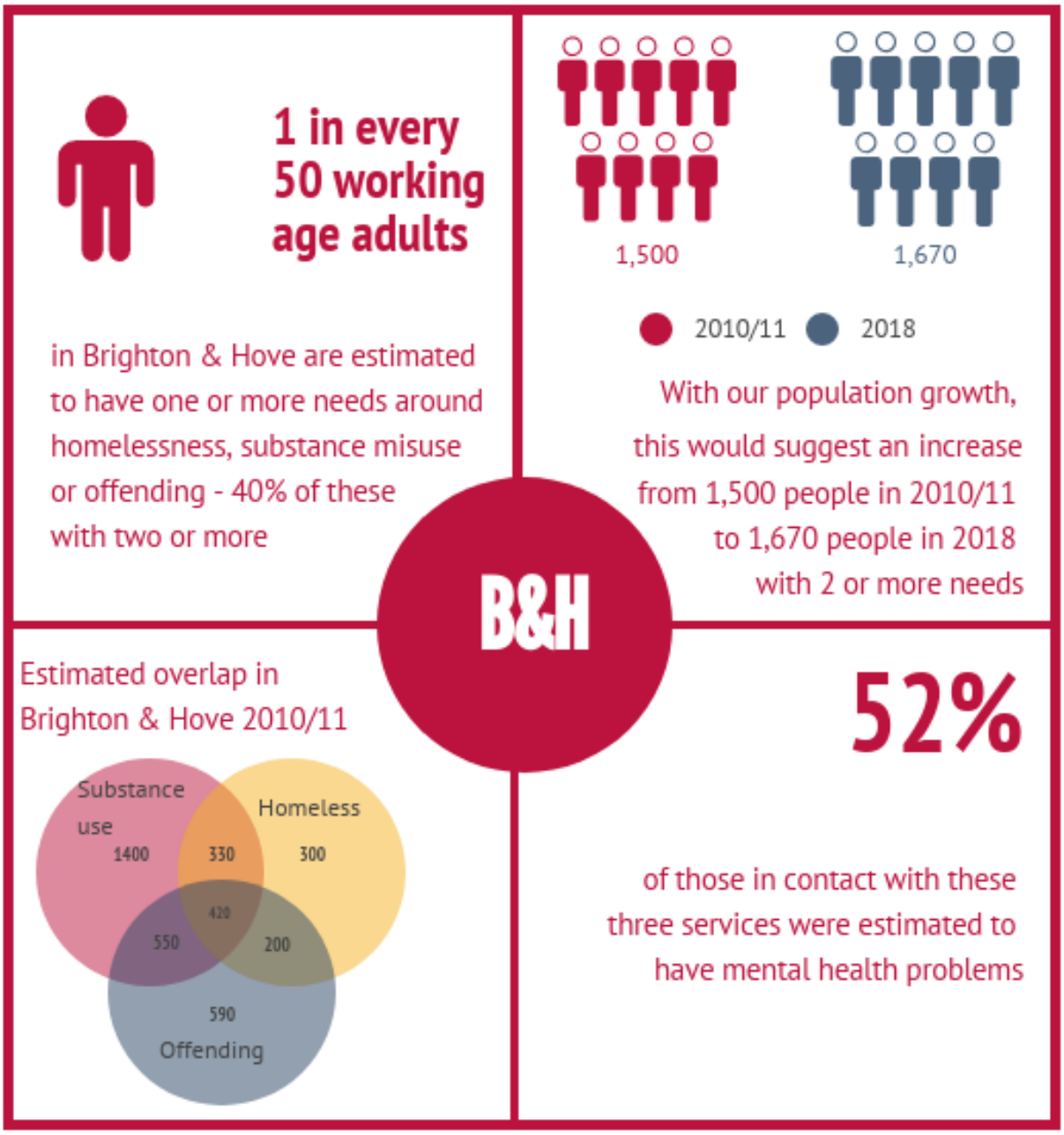
The report also estimated the number of adults receiving support for at least one of these issues, who also have mental health problems. In Brighton & Hove this estimate was 1,970 adults (52% of those with SMD). The authors note however, that the incidence of mental health problems may be significantly greater than is recorded in the data used. Thus, these figures may underestimate the overlap between mental health problems and severe and multiple disadvantage.

Applying these estimates to the latest mid-year population estimates for the city from the Office for National Statistics, in 2018 we would estimate:

- 4,180 adults estimated to receive services for any of substance misuse, homelessness or offending.
- 1,670 to receive two or more of these services
- 460 to receive all three services
- 2,170 of the 4,180 adults to also have mental health problems.

Lankelly Chase Estimates

In 2015, the Lankelly Chase Foundation - in their report "Hard Edges: Mapping severe and multiple disadvantage" profiled the problems faced by adults involved in the homelessness, substance misuse and criminal justice systems in England with estimates for local authorities (for 2010/11). The data was not available to look at other elements of disadvantage. However, the authors found that poverty was almost universal, and mental ill health common.



4.2. Local data analysis - methodology

For the needs assessment, we undertook to present the data from different local services working with individuals with the five identified needs: homelessness, substance misuse, offending as well as domestic violence and mental health, which the Lankelly Chase report did not present.

We were aware that there would likely be significant issues in terms of completeness of the data (including reporting and recording issues); definitions used (that these would differ between services and that a lot of this information would be self-reported); a lack of joined up/linked data meaning that we would be unlikely to be able to present a complete picture due to the likely overlap in people attending different services. However, we felt it important that we present a clear picture of what information we do have in local services to help inform the needs assessment, and to provide evidence from which to base recommendations.

4.3. Local data analysis – services and data available

Ten datasets were received from six different organisations (see Table 4). Among these, homelessness was the primary focus for four of the lead organisations, while one organisation/dataset each had a focus on one of: substance misuse (drugs and alcohol); mental health; offending or; domestic violence. Brighton Housing Trust's Fulfilling Lives project works with clients with multiple complex needs and the A&E data relates to Brighton & Hove residents or persons registered with a Brighton & Hove GP practice whose reason for attending A&E related to one of the five identified needs.

Table 4: Organisation / datasets received as part of the AMCN needs assessment

Organisation	Dataset / service	Primary client group
Brighton & Hove City Council	Pavilions	Substance misuse
Sussex Partnership NHS Foundation Trust	CMHN	Mental health
NHS	Arch Health Care	Homelessness
Brighton & Hove City Council	B'think database	Homelessness
Brighton Housing Trust	In-Form database	Homelessness
RISE	Oasis case management system	Domestic violence
Brighton Womens Centre	Inspire	Offending behaviour
Brighton Womens Centre	Women's Accommodation Support Service (WASS)	Homelessness
Brighton Housing Trust	Fulfilling Lives	No primary group
NHS	A&E - Royal Sussex County Hospital	Not applicable

It should be noted that not all services record all five needs. Table 5 provides a breakdown of which needs are routinely recorded by which service. The mental health trust (SPFT) for example only identifies 76 clients with two or more needs out of 2,427 clients – whilst information may be recorded within case notes, it is not routinely recorded on electronic systems.

Table 5: Information recorded by each organisation

Organisation	Database / Dataset	Domestic violance	Homeless-ness	Mental health	Offennding behaviour	Substance misuse
Brighton & Hove City Council	Pavilions	✓	✓	✓	✓	✓
Sussex Partnership NHS Foundation Trust	CMHN	x	✓	✓	x	✓
NHS	Arch Health Care	✓	✓	✓	✓	✓
Brighton & Hove City Council	B'think	✓	✓	✓	✓	✓
Brighton Housing Trust	In-Form	✓	✓	✓	✓	✓
Rise	Oasis case management system	✓	✓	✓	✓	✓
Brighton Womens Centre	Inspire	✓	✓	✓	✓	✓
Brighton Womens Centre	Women's Accommodation Support Service (WASS)	✓	✓	✓	✓	✓
Fulfilling Lives	Inform	✓	✓	✓	✓	✓
NHS	A&E	✓	✓	✓	✓	✓

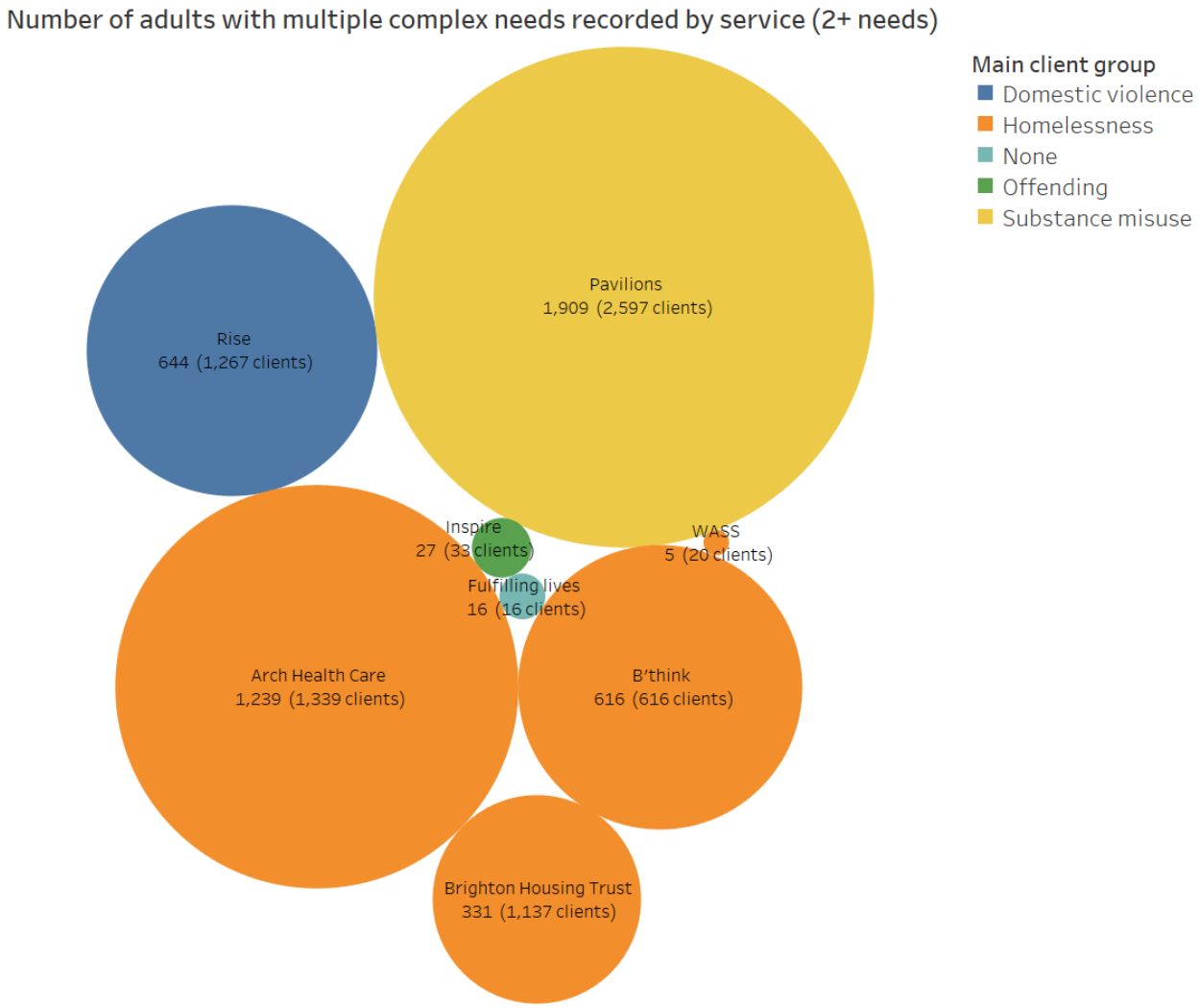
Not all services were able to provide data in the format required and/or for the dates required. Brighton Probation service, which covers the whole of Brighton & Hove, were only able to say that there were 237 offenders in the community of which they could only estimate that 17 had no fixed abode (NFA) and were unable to say how many clients have mental health, substance misuse or domestic violence issues because these are recorded on a different system. Brighton & Hove City Council Housing Services did not submit any data as their data would be duplicating that provided by other participating organisations, particularly Fulfilling Lives.

We asked for data on clients seen by services between April 2018 and March 2019.

4.4. Local data analysis – number of people with multiple complex needs

Figure 9 gives a summary of the number of clients identified in each service with two or more of the identified needs (homelessness, substance misuse, mental health, domestic violence or offending). The colour denotes the primary client group of the service. The total number of clients seen within the service is given in brackets.

Figure 9.

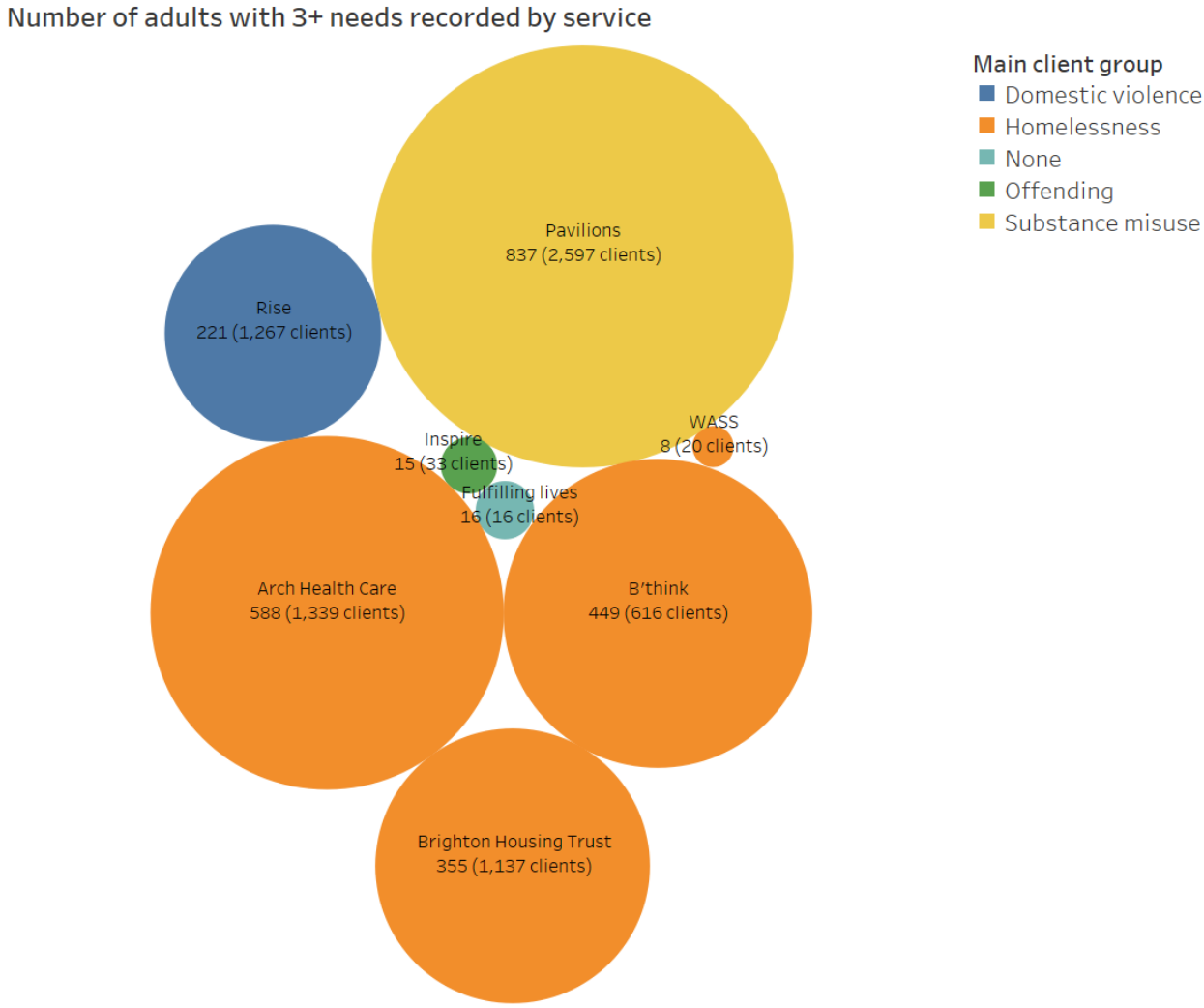


Service, sum of Number of adults with 2+ needs and sum of Number of clients. Color shows details about Main client group. Size shows sum of Number of adults with 2+ needs. The marks are labeled by Service, sum of Number of adults with 2+ needs and sum of Number of clients. The view is filtered on Service, which excludes SPFT.

Pavilions (drugs and alcohol treatment services) and Arch Health Care (homeless primary care) show the greatest numbers of individuals recorded with multiple complex needs – Pavilions with 1,909 individuals and Arch Health Care with 1,239 individuals. SPFT is excluded from the diagram as there is little recorded data of more than mental health conditions.

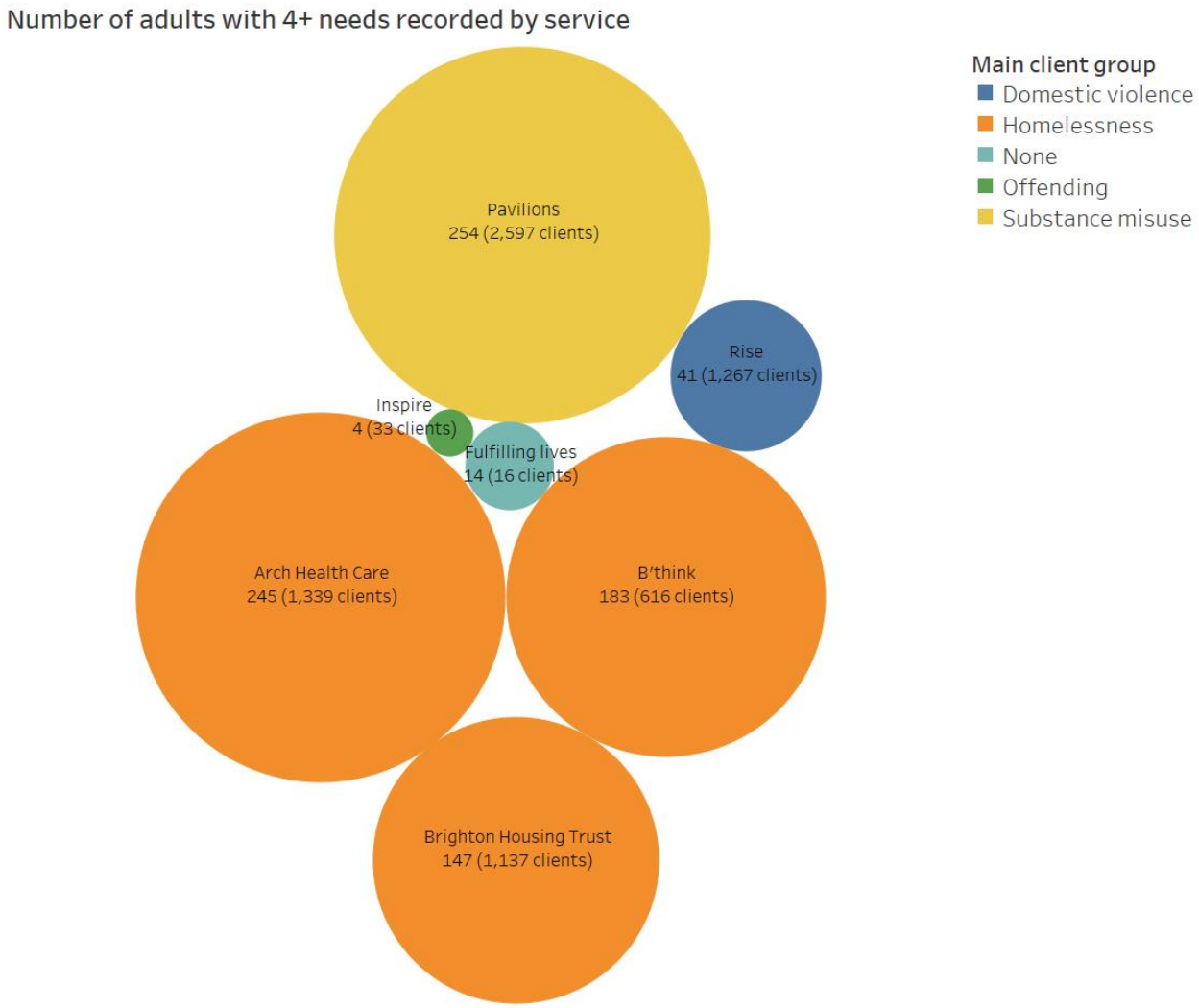
A similar breakdown for clients across these services with three or more needs is shown in Figures 10 and 11. For Pavilions and Arch Health, the two services with the largest number of adults with multiple complex needs, the number of adults with four or more needs is very similar (254 for Pavilions and 245 for Arch Health). The numbers for B'think and Brighton Housing Trust are also similar (183 for B'think and 147 for Brighton Housing Trust). As data is not linked across services, we do not know if these are the same people accessing these different services for their multiple needs.

Figure 10.



Service, sum of Number with 3+ needs and sum of Number of clients. Color shows details about Main client group. Size shows sum of Number with 3+ needs. The marks are labeled by Service, sum of Number with 3+ needs and sum of Number of clients. The view is filtered on Service, which excludes SPFT.

Figure 11.



Service, sum of Number of clients and sum of Number with 4+ conditions. Color shows details about Main client group. Size shows sum of Number with 4+ conditions. The marks are labeled by Service, sum of Number of clients and sum of Number with 4+ conditions. The view is filtered on Service, which excludes SPFT.

Figures 12 and 13 show the breakdown of clients in terms of the numbers of needs recorded for the client for each service. We can see there is no consistency in terms of the breakdown across services.

The percentage of clients with two or more needs recorded ranges from 3% of the mental health trust (SPFT) clients to 100% of Fulfilling lives clients (Figure 12). We would expect there to be some difference between services, due to their differing focus: Fulfilling lives for example is a service for adults with multiple complex needs also it would be expected that all clients have two or more needs.

However, SPFT does not routinely record other needs so this very low percentage is likely to be due to recording, rather than accurately representing the picture for that service.

So, if we exclude SPFT for this reason then the range is from 51% of clients receiving services from RISE to 100% at both Fulfilling lives and B'think.

Figure 12: Breakdown of clients by the number of needs recorded (% of clients), by service April 2018 to March 2019

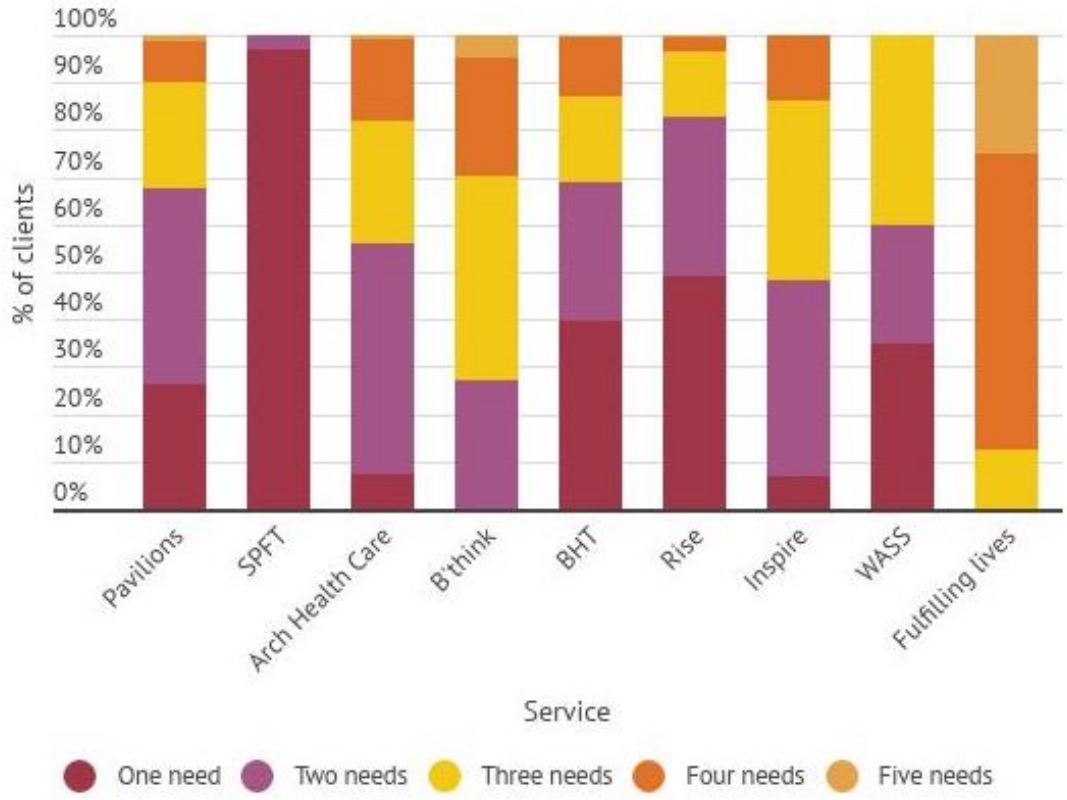


Figure 13: Breakdown of clients by the number of needs recorded (number of clients), by service April 2018 to March 2019

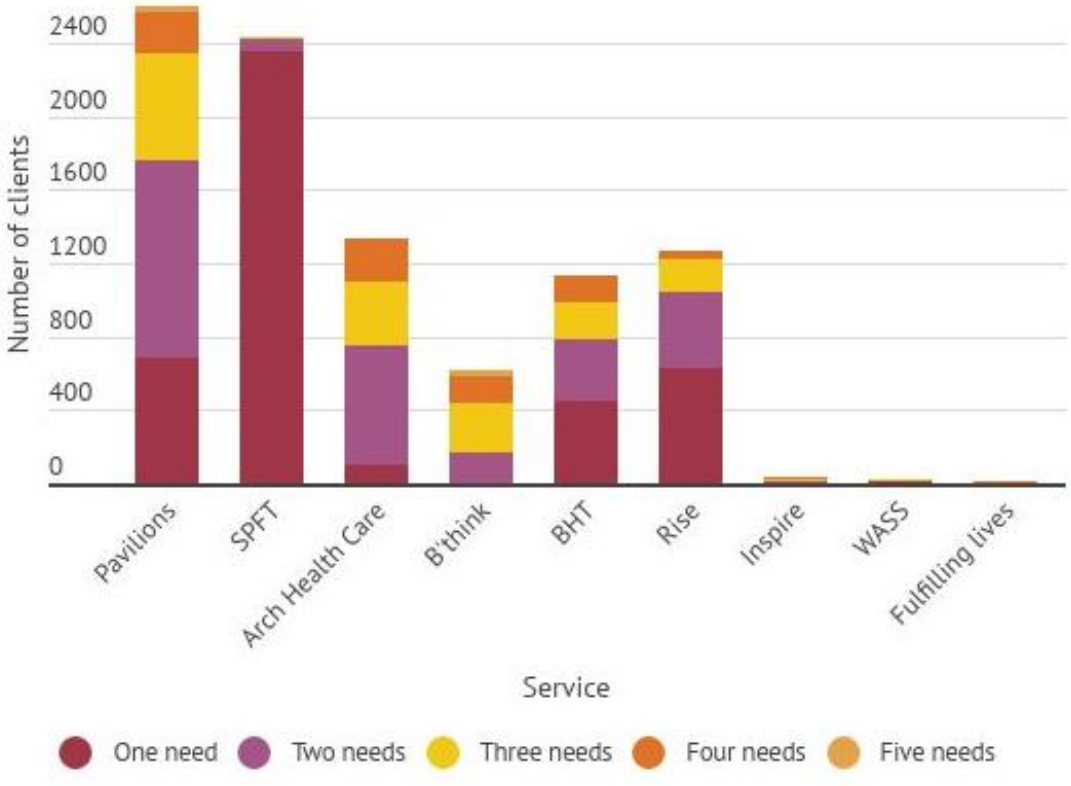


Figure Z: Percentage of clients with two or more needs recorded, by service April 2018 to March 2019

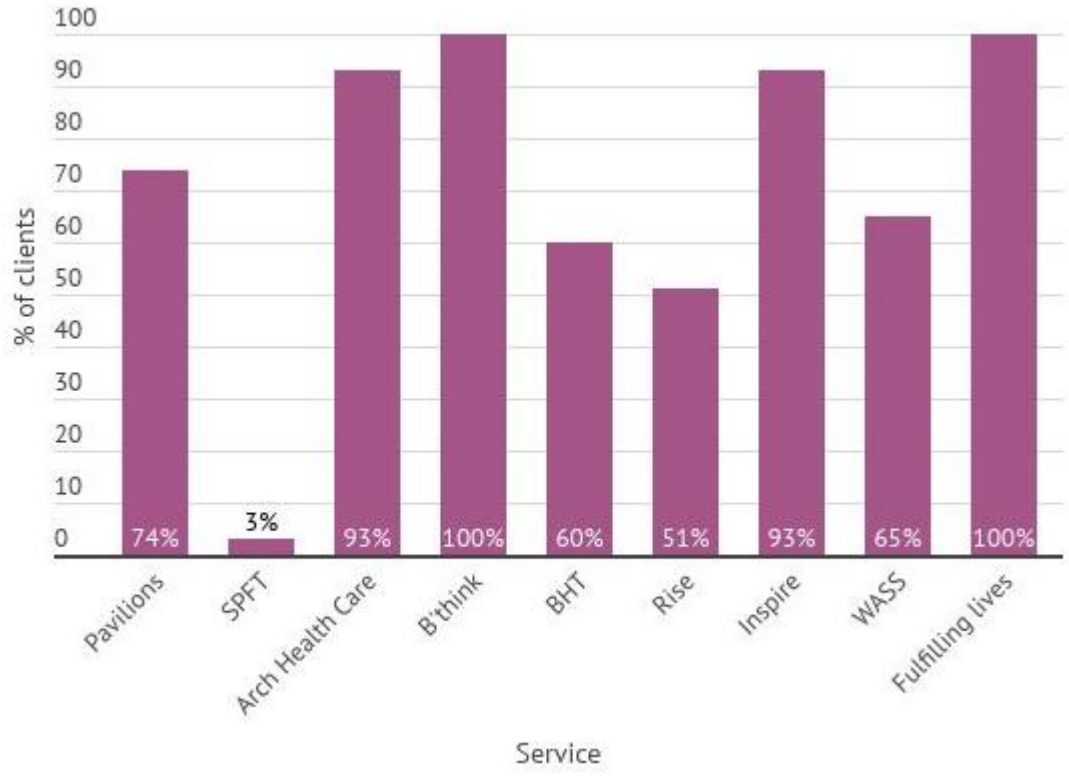
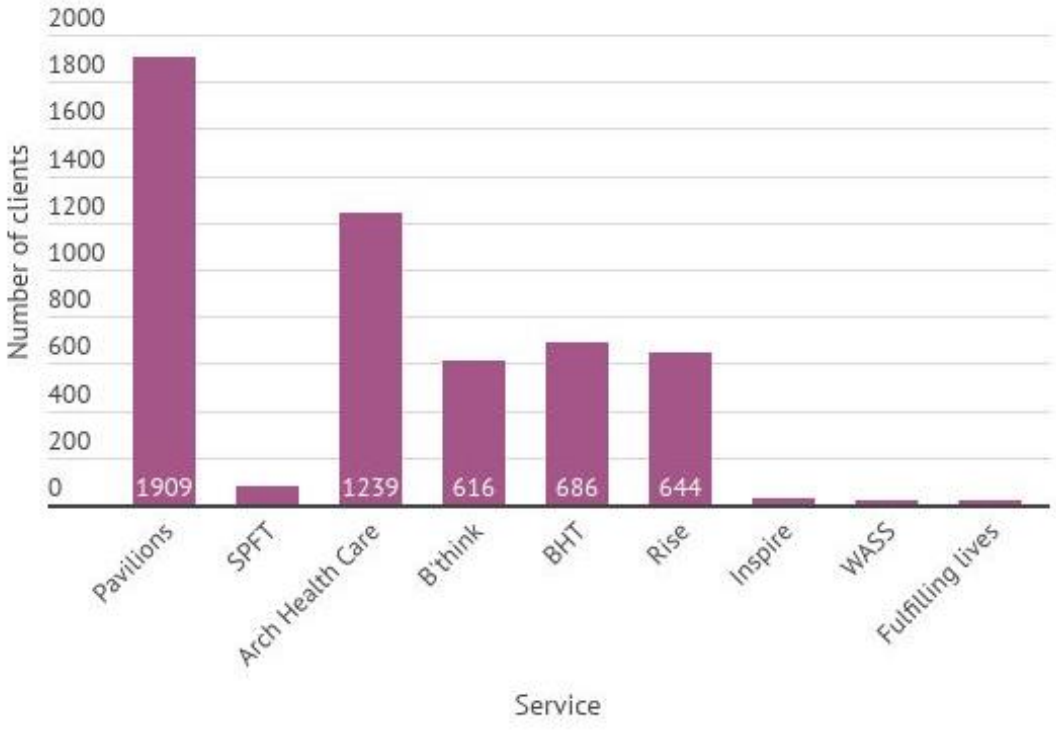


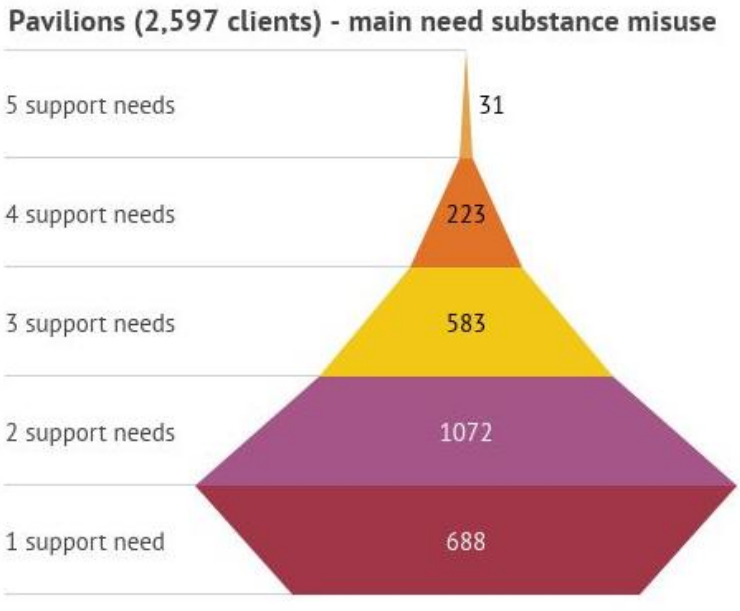
Figure ZZ: Number of clients with two or more needs recorded, by service April 2018 to March 2019



4.5. Local data analysis – number of people with multiple complex needs by service

4.5.1. Pavilions (substance misuse treatment service)

For the year ending March 2019, 2,597 people used Pavilions' services.



All clients (2,597 people) had a support need for substance misuse (drugs or alcohol) with three quarters (74%, 1,909 people) having one of the other four support needs, so falling under our definition of multiple complex needs.

Two out of five clients (41%, 1,072 people) had two support needs, over a fifth (22%, 583 people) had three support needs, nearly one in ten (9%, 223 people) had four support needs and less than 1% (31 people) had all five support needs.

Looking only at the 1,909 clients with multiple complex needs (MCN): While all clients had a substance misuse support need, 70% (1,336 people) also had a mental health need, 38% (729 people) were homeless, 27% (508 people) experienced domestic violence and 24% (458 people) had offending behaviour. Among those clients with three or more support needs (837 people) more than two out of five 42% (352 people) had support needs for substance misuse, mental health and homelessness.

Among all Pavilions clients:

Gender: two thirds (67%, 1,746 people) are male and a third female (33%, 851 people). Female clients are slightly more likely to have MCN, 76% of female clients compared to 72% of male clients. Among MCN clients, females are more likely to have a mental health need (81% compared to 64%) and or to have experienced domestic violence (40% compared to 20%) while men are more likely to be homeless (46% compared to 22%) and or have offending behaviour (30% compared to 13%).

Age: one in ten (10%, 263 people) is aged 18 to 24 years old and 7% (180 people) are aged 65 or older. The majority, four out of five clients (81%, 2,111 people) are aged 26 to 54 years old. The proportion of clients with MCN decrease with age. One in four clients aged 18 to 34 have MCN, compared to 71% of those aged 35 to 54, 60% of 55 to 64-year olds and only 44% of those aged 65 or older.

Ethnicity: 86% (2,225 people) are White British/UK and 13% (337 people) are BME. 13% of clients with MCN are also BME. However, White British/UK clients and BME clients are equally likely to have MCN. White British/UK (74%) and BME (73%).

Sexual orientation and trans: four out of five (80%, 2,085 people) are heterosexual and 15% (400 people) are LGBT. Among pavilions clients who have MCN the proportions are similar, (LGBT 17% and 79% heterosexual). LGBT clients are slightly more likely to have MCN than heterosexual clients (80% compared to 73%).

Disabilities: nearly two in five (38%, 993 people) have one or more disabilities. This increases to 45% (866 people) among those with MCN. Clients with a disability are more likely to have MCN than are clients without a disability (87% compared to 65%).

Employment status: a quarter (27%, 712 people) have an employment status of long-term sick or disabled. A further 27% (696 people) are unemployed while 25% (642 people) are in regular employment. However, among MCN clients the rate for those with a long-term sickness or disability (31%) and those unemployed (29%) increase while the rate for those in regular employment is lower at 21%. Looking at those who are long term sick and disabled and those unemployed four out of five (82% and 81% respectively) have an MCN. This compares to three out of five (63%) of those in regular employment.

Children: a third (32%, 832 people) have children aged under 18. For 64% (535 people) of these parents, none of their children live with them, with only 31% (259 people) having all their children living with them. Clients with or without children are equally likely to have MCN (75% and 72% respectively).

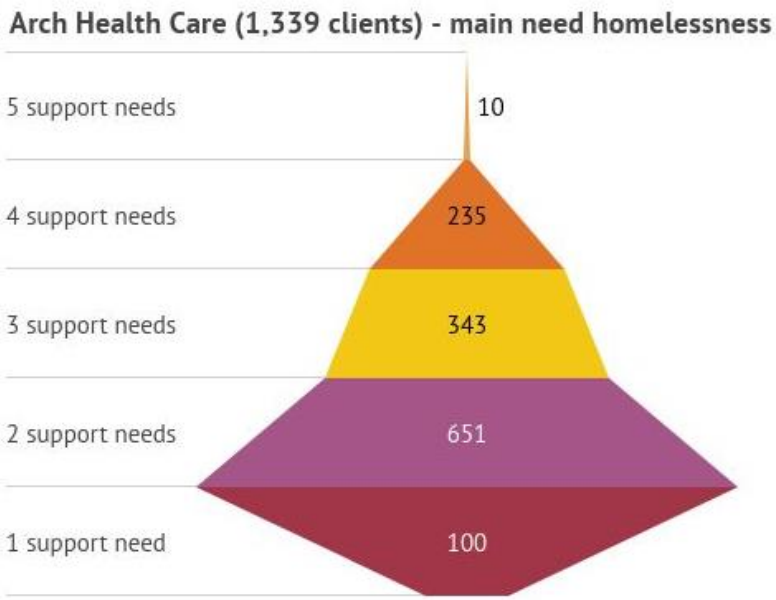
4.5.2. Sussex Partnership NHS Partnership Trust (SPFT)

A snap shot taken on 25 June 2019 shows 2,427 residents using SPFT mental health services (excludes older adults and those under tertiary services). Of these, mental health clients only 3% (76 people) also has one of the other four support needs recorded, however we know that information on the other factors are not routinely recorded on electronic systems but may be recorded within case notes. Seventy-two people (3%) have two support needs and only four people (0.2%) have three support needs. Fifty-eight clients (2%) have a substance misuse support need and 22 clients (1%) are homeless.

Among all SPFT clients just over a half (52%, 1,272 people) are female, just under a half (48%, 1,134 people) are male and 21 people (1%) described the gender as 'other'. Male clients are slightly more likely to have MCN (5% compared to 1%) with no clients who described their gender as 'other' having MCN.

4.5.3. Arch Health Care

For the year ending March 2019, 1,339 patients were seen by Arch Health Care. All patients (100%, 1,339 people) were homeless with more than nine out of ten (93%, 1,239 patients) also having one of the other four support needs so falling under our definition of multiple complex needs.

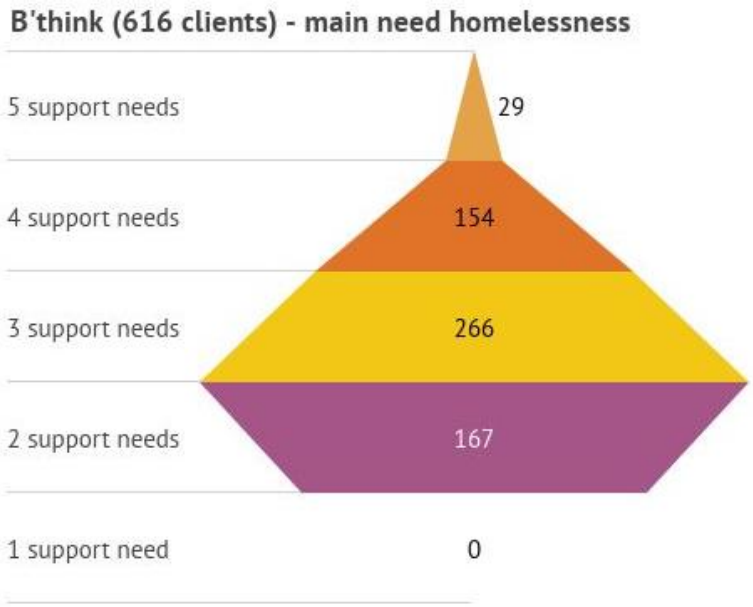


A half (49%, 651 patients) have two support needs, over a quarter (26%, 343 patients) had three support needs, nearly a fifth (18%, 235 people) had four support needs and less than 1% (10 people) had all five support needs.

Looking only at the 1,239 patients with multiple complex needs: While all patients were homeless, 72% (890 people) also had a mental health need, 65% (810 patients) had a substance misuse support need, 26% (322 patient) had offending behaviour and 5% (60 patients) had experienced domestic violence. Among those clients with three or more support needs (588 patients) more than nine out of ten 93% (549 patients) had support needs for substance misuse, mental health and homelessness.

4.5.4. B'think database

For the year ending March 2019, there were 616 people included on the B'think database. All people on the database were homeless and all people also had at least one of the other four support needs so falling under our definition of multiple complex needs.

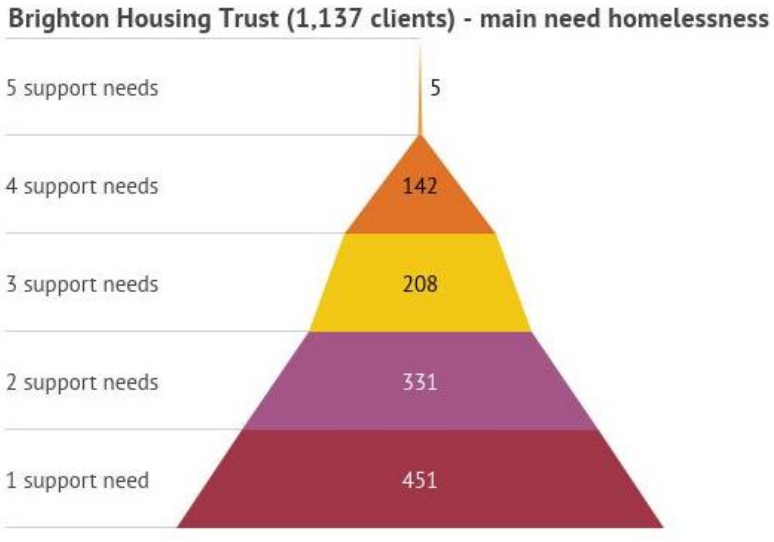


27% (167 people) had two support needs, 43% (266 people) had three support needs, 25% (154 people) had four support needs and 5% (29 people) had all five support needs.

Looking only at those people with MCN: Whilst all people were homeless, nine out of ten (90%, 554 people) also had mental health support needs, three quarters (75%, 465 people) had substance misuse support needs and over one in ten (12%, 71 people) had experienced domestic violence. Among the people on the database with three or more support needs (449 people) nine out of ten (90%, 406 people) had support needs for substance misuse, mental health and homelessness.

4.5.5. Brighton Housing Trust – In-form database

For the year ending March 2019, 1,137 people were included on the In-Form database. Of the 1,137 people on the database, 686 people (60%) had two or more of the other support needs so falling under our definition of multiple complex needs.



29% (331 people) had two support needs, just under a fifth (18%, 208 people) had three support needs, over one in ten (12%, 142 people) had four support needs and less than 1% (5 people) had all five support needs.

Of those with an MCN (686 people), 85% (580 people) had a substance misuse support need, 81% (557 people) had a mental health support need, 68% (464 people) were homeless, 33% (227 people) had offending behaviour and 7% (51 people) had

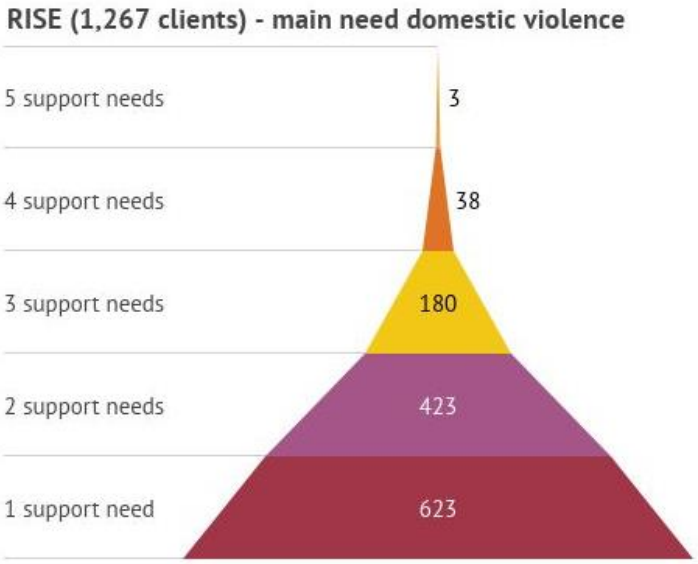
experience domestic violence. Among those clients with three or more support needs (355 people) nearly three quarters 72% (256 people) had support needs for substance misuse, mental health and homelessness.

Among all BHT clients on the In-Form database, three out of five are male (59%, 666 people), two out of five are female (41%, 851 people) with six clients (1%) identifying as transgender. Male clients are significantly more likely to have MCN, 71% of male clients compared to only 46% of female clients. Among In-Form's MCN clients, males are more likely to be homeless (79% compared to 41%) and or have offending behaviour (42% compared to 13%). Females are more like to have a mental health need (91% compared to 77%) and or to have experienced domestic violence (19% compared to 2%).

4.5.6. RISE

In the year ending March 2019, 1,276 people used a RISE service. Of these, a half of clients (51%, 644 people) had two or more support needs so falling under our definition of multiple complex needs.

A third (33%, 423 people) had two support needs, 14% (180 people) had three support needs and 3% (38 people) had four support needs. Three clients had all five support needs.



Looking only at the 644 clients with MCN: While all clients had experienced domestic violence, four out of five (79%, 510 people) also had a mental health support need, a third (33%, 211 people) were homeless, a quarter (26%, 165 people) had a substance misuse support need and 23 people (4%) had offending behaviour.

Among all RISE clients, nine out of ten (89%, 1,131 people) are female and one in twenty (4%, 57 people) are male. For 79 clients (6%) their gender is unknown. Male clients are a little more likely to experience MCN, 58% of male clients compared to 52% of female clients. Among RISE's MCN clients, males and females are equally like to have a mental health support need, to be homeless and or to have offending behaviour. However, male clients are almost twice as likely to have a substance misuse support need, 48% compared to 25%.

4.5.7. Brighton Women's centre – Inspire

In the year ending March 2019, for 33 women referred to Inspire their cases were closed. Of these, 27 women (82%) had two or more support needs so falling under our definition of multiple complex needs. Twelve women (36%) had two support needs, 11 (33%) had three support needs and four women (12%) had four support needs. No women had all five support needs.

Looking only at the 27 women with MCN: While all clients had offending behaviours, 21 women (78%) also had mental health needs, 14 women (52%) had experienced domestic violence and 11 women (41%) were homeless. No women had a substance misuse support need. Among the 15 women with three or more support needs, 13 women (87%) have support needs for offending behaviour, domestic violence and mental health.

4.5.8. Brighton Women's centre - Women's Accommodation Support Service (WASS)

For the year ending March 2019, 20 women were referred to WASS. Of these, five women (25%) have two support needs and eight (40%) have three support needs. No women have more than three support needs. Of the women with MCN (13 people), all are homeless, 12 (92%) have a mental health need and nine (69%) have experienced domestic violence. Of the eight women with three support needs, all are homeless, have a mental health need and have experienced domestic violence.

4.5.9. Brighton Housing Trust – Fulfilling Lives

In the year ending March 2019, 16 people had used services provided by Fulfilling Lives. All 16 clients had MCN. Two clients (13%) have three support needs, ten clients (63%) have four support needs and four clients (25%) have all five support needs.

All 16 clients have a mental health need, while 15 clients (94%) also have a substance misuse support need, 14 (88%) have offending behaviour, 11 (69%) have experienced domestic violence and ten (63%) are homeless.

4.5.10. Accident and Emergency

Data covers the time period 1 April 2018 and 31 March 2019 for all attendees (visits not people) at the Emergency Departments (ED) at the Royal Sussex County Hospital (RSCH) and the Princess Royal Hospital (PRH).

Included in the data were the following fields, with data completed by different A&E staff during the attendee's journey through their A&E:

- NHS number of the attendee and episode number (both unique to the attendee)
- Reason of attendance (single option field)
- Chief complaint (single option field)
- Presenting complaint (free text)
- Special case indicators (max of three)
- Diagnosis (single options field)
- GP practice code
- If a specialist referral was made

By analysing these fields, it was possible estimate the number of attendees (visits not people) at A&E who were currently experiencing homelessness, mental health problems, domestic violence, alcohol or substance misuse and/or offending. Given the way the data was collected and the likelihood that some of those attending A&E would be unable or unwilling to share all details about themselves these estimates will be an under estimate of the real figure.

For the year ending 31 March 2019 there were 10,411 attendees at A&E at the RSCH and the PRH; of these an estimated 1,767 (17%) were currently experiencing two or more of homelessness, mental health problems, domestic violence, alcohol or substance misuse and or offending.

Among the 1,767 attendances who were currently experiencing two or more of homelessness, mental health problems, domestic violence, alcohol or substance misuse and or offending; 1,638 (93%) were experiencing two of the five issues and 129 (7%) were experiencing three or four of the five issues. None were experiencing all five.

Among the 1,767 attendees who were currently experiencing two or more of homelessness, mental health problems, domestic violence, alcohol or substance misuse and or offending;

- 1,435 (81%) had alcohol or substance misuse issues
- 1,293 (73%) had mental health problems
- 703 (40%) were homeless
- 234 (13%) were victims of domestic violence
- None were offenders.

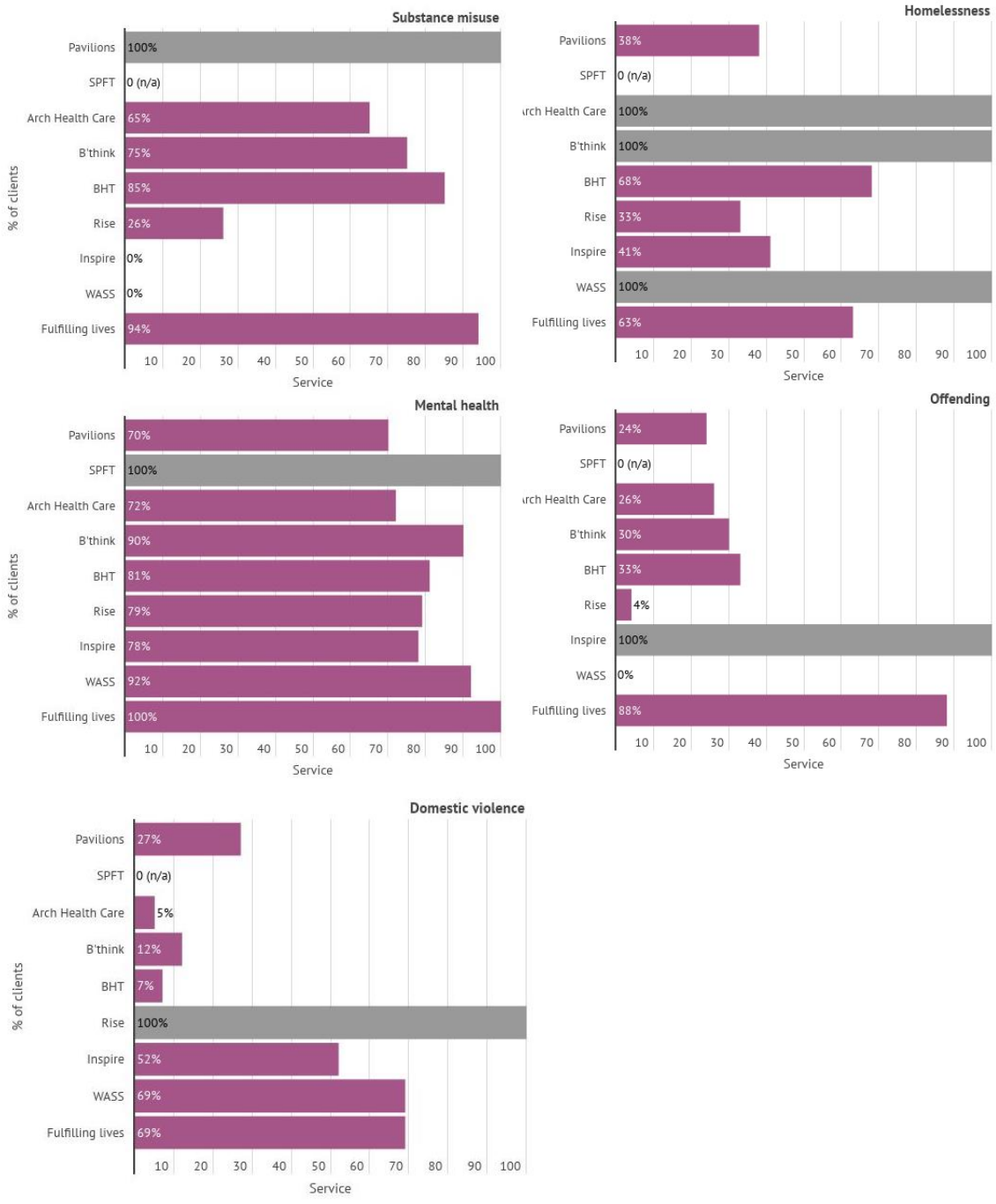
4.6. Most commonly identified needs

The most commonly identified need across services is mental health. Excluding the mental health service users, there ranged between 70% and 100% of those with multiple complex needs identified having a mental health need. Mental health was also the most consistently identified need across services. Others differed by service type.

- Substance misuse was a commonly identified need across services whose primary need was homelessness (between 65% and 85% of clients using services focussed around homelessness had identified substance misuse needs), excluding WASS (women's homeless service). However, for RISE (primary need being domestic violence), substance misuse was identified in 26% of clients.
- Homelessness was a need identified by between 33% and 41% of services whose primary need was not homelessness.
- Offending was recorded for between 24% and 33% of clients in substance misuse and homeless focused services, but only 4% of women receiving support from RISE. This reflects the findings of the literature review, that the criminal justice system is highly gendered towards men and women are less likely to be included in this category of complex needs.
- The picture was very mixed for domestic violence: between 5% and 17% of clients receiving support from services with a primary homelessness need had

domestic violence recorded. This was higher in substance misuse services (27%) and much higher for services supporting women for offending and homelessness (52% and 69% respectively).

Figure 14: The percentage of clients with multiple complex needs recorded, who had each identified need, April 2018-March 2019



Note: The grey bars denote where the service focus is on a particular client group, and so all clients will have that need identified (e.g. 100% of Pavilions clients have substance misuse identified as it is the substance misuse treatment service)

4.7. Deaths

Data from deaths registrations from the Office for National Statistics (ONS) for the years 2006 to 2017 were looked at to see how many deaths had multiple complex needs identified as a main or contributory cause of death (a death has up to eight causes of death recorded).

The following definitions were used:

- Homelessness: those listed with no fixed abode, or with a hostel listed as their address.
- Mental health: A Mental health, behavioural and neurodevelopment disorder diagnosis (ICD F01-F99) listed in any position of cause of death (excluding F10-F19 – Mental and behavioural disorders due to psychoactive substance use).
- Substance use: Using the Public Health England PHOF definition of deaths from drug misuse (F11-F16, F18, F19, X40-X44, X60-X64, X85, Y10-Y14) listed in any position of cause of death.

Domestic violence is not available within the deaths registration data.[f] Nationally domestic abuse deaths are not reported from ONS civil registration data but from police recorded crime. In Brighton & Hove, between 2010/11 and 2018/19 there were less than five domestic violence related murders recorded by the police, and seven domestic violence related attempted murders.

Over the 12 years of data, there were 108 individuals with multiple complex needs recorded as a main or contributory cause of death (105 had two of the above, and three had all three) (Figure 15 and Table 6)

The average age of death for those with multiple complex needs recorded as a cause of death was 43 years compared to the overall average of death of 77 years. This compares with an average age of death in 2018 in England and Wales of 45 years for men, and 43 years for women who are sleeping rough. (Cream J et al 2020).

Over two thirds (69%) of those with multiple complex needs identified as causes of death were male.

Of the 108 individuals there were 28 suicides (26% of all deaths identified) and 89 alcohol related deaths (82% of all deaths identified).

[f] Within the ONS deaths registration data, cause of death is recorded by ICD-10 code. There are ICD-10 codes that relate to “Adult and child abuse, neglect and other maltreatment”, however there were an extremely low number of records with these codes present and with no other accompanying information it is not possible to draw any conclusions or use these records in any analysis.

Figure.15. ONS Deaths Data for B&H, 2006-2017 where Multiple Complex Needs Conditions are a main or contributory cause of death

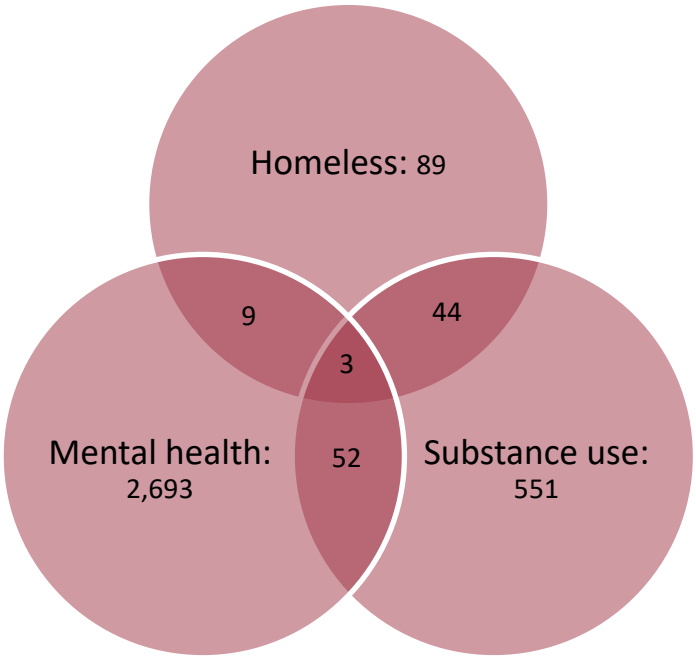


Table 6. ONS Deaths data for B&H by condition 2006-17

	n
Mental health	2,693
Substance use	551
Homeless	89
Mental health & Substance use	52
Mental health & Homeless	9
Substance use & Homeless	44
Mental health & Substance use & Homeless	3

4.8. Homeless health audit 2013

The Homeless Health Audit was originally developed by Homeless Link with funding from the Department of Health and is a questionnaire designed to be completed by service users with help from a support worker. The principal aim of conducting the audit was to increase local knowledge on the health needs of the homeless population while increasing the involvement of homeless people and homeless services in local commissioning processes.

The targeted population for the audit was the single homeless population. The questionnaire was completed in homeless services across Brighton & Hove using a non-random sampling strategy which aimed to include as many homeless clients as possible. When the audit was undertaken in 2013 services for homeless people in the city were provided by an integrated support pathway which categorised services into five bands. Band one provided the most intensive support to those with often the highest levels of need through to band five which provided the least intensive support to

people otherwise living independently. The bands which were used are summarised below:

- Band 1: Provides outreach and floating support for rough sleepers and those in emergency placement accommodation (including temporary B&B accommodation). Rough sleepers are likely to have the most intensive health needs of the homeless population.
- Band 2: Hostels which are staffed 24 hours a day, seven days a week.
- Band 3: Supported accommodation with support provided during office hours.
- Band 4: Low level floating support for people living in their own tenancy.
- Band 5: Crisis response and peer support for people otherwise independent of services. These clients are likely to have the least intensive health needs of the homeless population.

(Supported accommodation is currently categorised as offering either High, Medium or low support)

It is important to note that this pathway does not include homeless people with severe mental health conditions who are usually placed in mental health accommodation. This is likely to impact on the type and severity of mental health needs in the sample. Similarly, most over 65-year olds are usually placed in sheltered housing or other older people services meaning there are relatively few people in this age group in the integrated support pathway.

The questionnaires were completed by clients in 4 out of the 5 bands with 80 completed in band one services, 125 in band two, 68 in band three and 4 in band five. Some questionnaires did not report the service where they were completed. No band four services were asked to participate in the audit due to other competing projects already in their services.

In total 302 people completed the Homeless Health Audit questionnaire in services across Brighton & Hove between July and August 2013. The initial target number of responses was 304, which was estimated to be approximately 40% of all single homeless people accessing services in the City.

The following questions were used for this needs assessment:

- DO YOU EXPERIENCE ANY OF THE FOLLOWING MENTAL HEALTH DIFFICULTIES? Often feel stressed | Often feel anxious | Panic attacks | Feel depressed | Difficulty sleeping | Suicidal thoughts | Self harm | Hear voices | I find it hard to control my anger | I can be aggressive or violent towards others
- DO YOU HAVE A MENTAL HEALTH NEED OR CONDITION WHICH HAS BEEN DIAGNOSED BY A DOCTOR OR OTHER HEALTH PROFESSIONAL? Yes
- DO YOU TAKE ANY DRUGS OR ARE YOU RECOVERING FROM A DRUG PROBLEM? (by drugs this does not include medication prescribed to you for a specific medical condition): YES, use drugs
- DO YOU HAVE OR ARE YOU RECOVERING FROM AN ALCOHOL PROBLEM? YES

- PLEASE TICK IF YOU ARE WORKING WITH ANY OFFENDING SERVICES: currently with probation OR current community order OR Youth Offending service/YOT Or Other
- DO YOU HAVE ANY OF THESE BACKGROUNDS? (this helps us to understand how your past experience may have affected your health or services you've been able to access): Left prison within last 12 months OR Left prison more than 12 months ago
- There was no question in the survey covering domestic violence.

There were two questions on mental health which have been considered here, one of experience of any mental health difficulties and one on having had a mental health diagnosis. Both are presented, as from the qualitative information collected for this needs assessment it is clear that many people with complex needs have a mental health need but not necessarily a mental health diagnosis.

It should be noted that the integrated support pathway for homeless people incorporates a pathway for offenders including hostels that have beds specifically for people on probation which will be reflected in the figures for offending.

When considering any mental health difficulty 91% of respondents have two or more needs (our definition of multiple complex needs), 58% with three or more needs and 20% with all four needs (Figure 15)

When limiting to those with a diagnosed mental health condition, 80% had two or more needs, 43% three or more needs and 13% all four needs (Figure 16).

Figure 15.

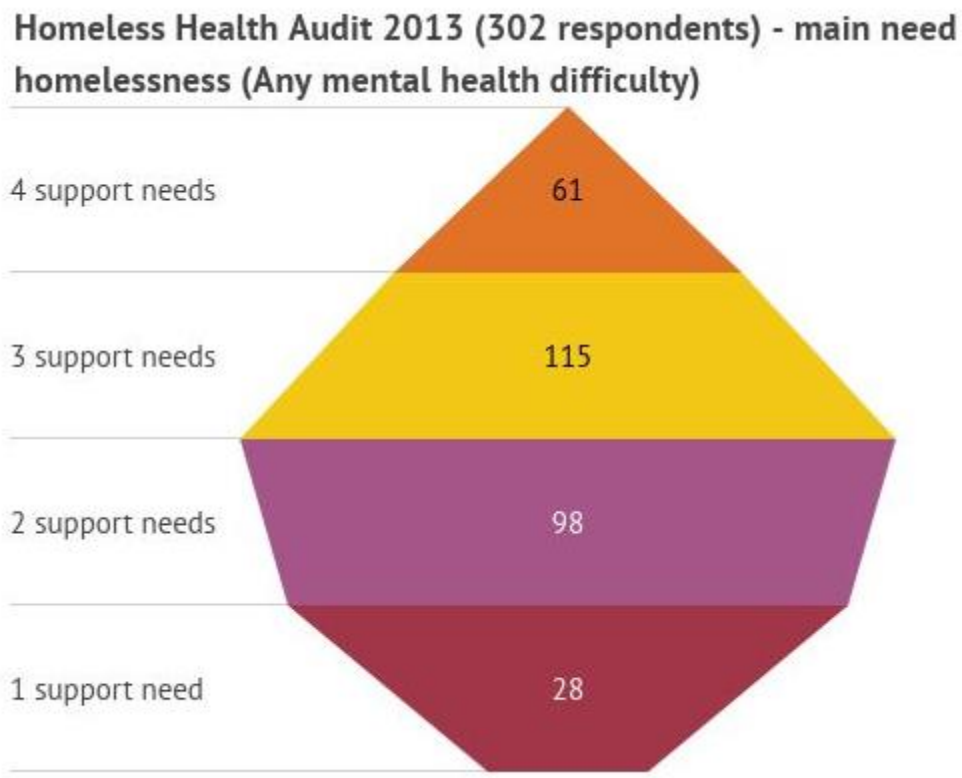


Figure 16.

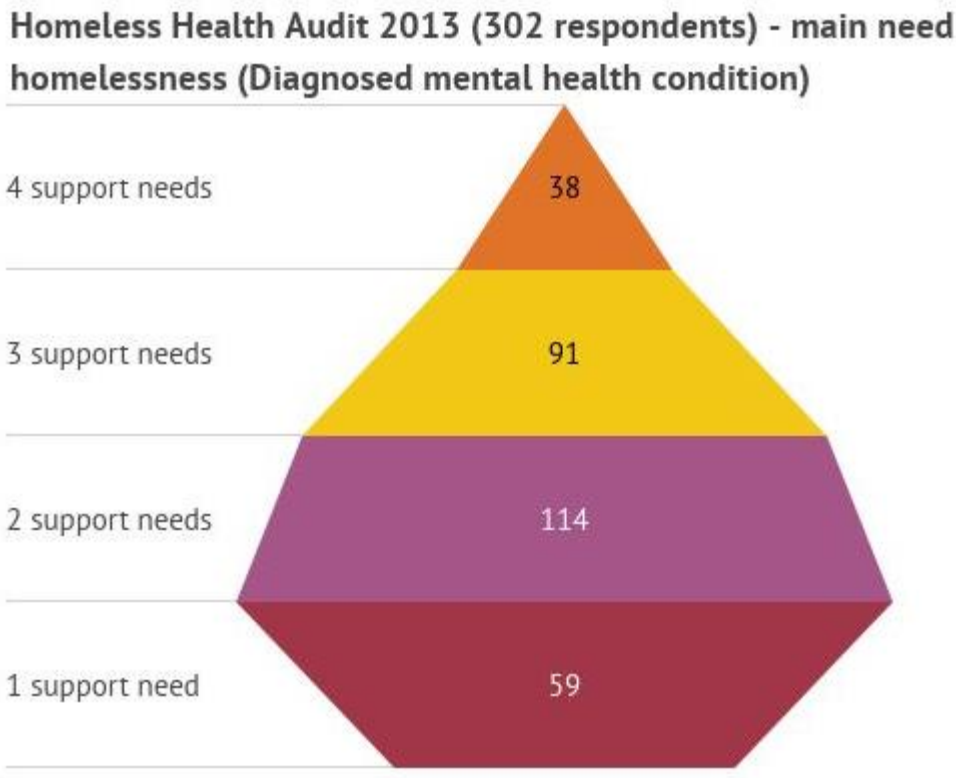


Figure 17. Proportion of respondents to homeless health audit by multiple complex need conditions

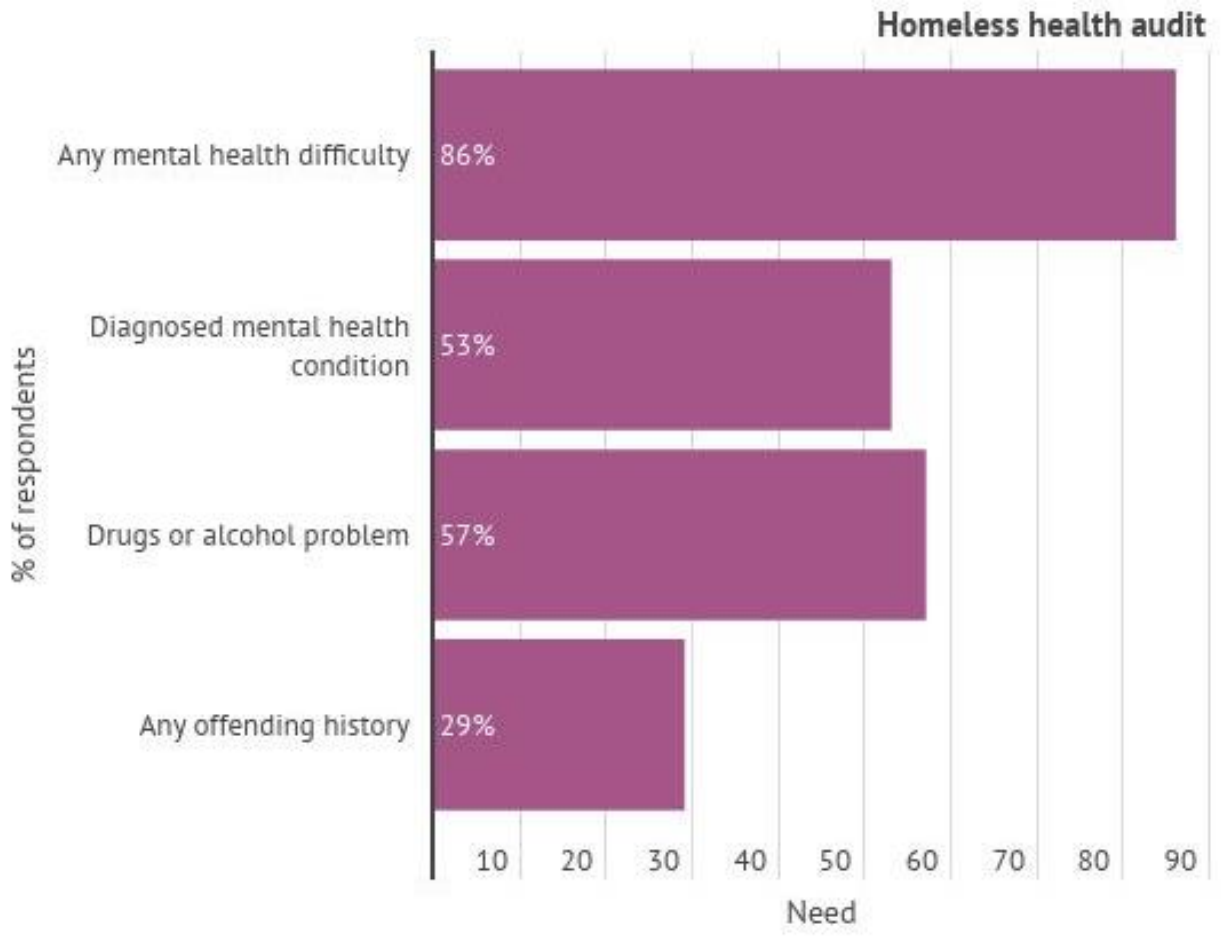


Table 7. Number and % of homeless health audit by mental health and other complex needs conditions (excluding domestic violence).

Needs	*Mental health difficulties*		*Mental health diagnosis*	
	Number of respondents	*Percentage*	*Number of respondents*	*Percentage*
Homelessness only	28	9%	59	20%
Homelessness + mental health	82	27%	51	17%
Homelessness + substance misuse	12	4%	52	17%
Homelessness + offending	4	1%	11	4%
Homelessness + mental health + substance misuse	93	31%	53	18%

Homelessness + mental health + offending	18	6%	11	4%
Homelessness + substance misuse + offending	4	1%	27	9%
Homelessness + mental health + substance misuse + offending	61	20%	38	13%
Total	**302**		**302**	

RECOMMENDATION – a repeat of the survey is being planned for 2020, we recommend that a question on domestic violence is added to this survey.

5. Professional voice

5.1. Methods

Qualitative research was undertaken for the needs assessment to understand how health and social care organisations view the population with multiple complex needs in the city, how they feel the system is meeting their needs and where improvements need to take place, including challenges and facilitators to this. Semi-structured interviews were conducted with sixteen individuals from the following organisations: Brighton Housing Trust/ Fulfilling Lives, CCG, Pavilions, Primary Care, Equinox, RISE, ARCH, Brighton Women's Centre, BHCC HASC, Independent psychologist, Brighton Housing Trust, Sussex Partnership NHS Foundation Trust, Mind, Probation.

Ethics approval for the interviews was gained from University College London (UCL) and all interviews conducted by a Public Health Registrar. The following questions were asked during the interviews:

1. Can you tell me about your role?
2. Can you tell me about the clients your organisation works with?
3. Thinking about the clients you see, how would you describe a client with 'multiple complex needs'?
4. How does your organisation manage the care of adults with 'multiple complex needs'?
5. Can you give me an example of what you think is working well?
6. Can you give me an example of some of the challenges?
7. What works well for adults with multiple complex needs in the city?
8. What could be done differently to improve the care of people with multiple complex needs in the city?
9. Are there any issues we haven't already covered which you would like to raise?

The full interview guide is provided in Appendix 10.1

5.2. Describing a client with multiple complex needs

The characteristics of clients with multiple complex needs described by organisations included experience of trauma, behavioural issues, co-existing needs and multiple disadvantages.

Trauma

- Adverse Childhood Experiences : abuse, neglect, care system
- Bereavement, domestic abuse, imprisonment and loss of family/children
- Multiple traumas, leading to PTSD
- Most clients had received no counselling for their past traumas

Behavioural issues

- Challenging behaviour can result in difficulty engaging with services e.g. not keeping appointments, not meeting thresholds, using substances. Which can lead to withdrawal of the service and loss of trust by the client.
- Behaviour may be a result of undiagnosed physical, mental and neurodevelopmental issues and learning difficulties

Other co-existing needs

- Autistic Spectrum Conditions
- Learning disabilities (LD) and difficulties- it was felt people who were homeless and had LD were not having their needs met due to lack of LD outreach. More support was needed from LD services
- Physical health needs – abscesses, cellulitis, infections and injuries from violence

Multiple disadvantage

- It was felt multiple risk factors compounded upon each other to create multiple disadvantages, making it hard for organisations to get to the root cause of issues
- Stigma and discrimination, particularly for people with mental health problems and homelessness, made them unwilling to engage with services
- The multi-agency working required for this client group is very time consuming.

Other key characteristics were:

- Entrenched long term problems
- Frequent crises
- Homelessness
- Heavy alcohol and drug misuse with periods of relapse
- Underlying mental health problems – often undiagnosed
- Few personal resources
- High levels of risk that prevent services from working with them
- Isolated, with no/few relationships or friendship groups revolving around substance misuse, making it hard to reduce or stop own consumption
- Prone to self-neglect, with difficulty keeping accommodation clean and managing money
- History of unemployment or lack of education

Direct Participant quotes

'We've come across… third generation unemployed who come from abusive backgrounds, who never had a starting point really, never built up what gives you stability, basically they don't have a place of safety, they don't have safe people to be with'

'*It's the early years that cause the problems'.*

'There's a bedrock of early trauma and abuse… including issues of neglect and attachment'.

'A large proportion are traumatised, they may not meet the mental health criteria in terms of statutory mental health services but they have complex PTSD'

'Behaviour becomes the most profound thing that professionals are dealing with rather than what's behind the behaviour'

'People who've never had much of a structure in their life and find themselves multiply disadvantaged and unable to access other services'

'Quite often we are all saying we need to get your housing and your food, the basics sorted out … and start to build from there. But the problem is one of the barriers to getting housing is their mental health problems, so how do you address their mental health problem when they're in insecure housing. It's a bit of a circular argument'.

'In complex cases there are a set of issues which are interlinked and interconnected which can be challenging to get to the root cause of and untangle and separate out and support appropriately'.

'Often they've had negative experiences of any form of treatment, usually to do with stigma and how they are viewed just by their address or by identifying as homeless or with a drug dependency issue'.

'[This group] need more from [services] to enable them to change'

5.3.Multiple complex needs and specific groups

Women

Women were perceived as a high risk group, particularly when on the streets, with high levels of vulnerability. Characteristics include:

- More complex needs, perhaps characterised by unmet mental health needs
- Relationships characterised by sexual violence, exploitation, domestic abuse
- Lack of insight into their sexual exploitation for money or substances. Instead viewing the men involved as a source of safety from other risks
- Losing children to the care system, with no aftercare; leading to trauma, sense of bereavement and distrust of engaging with services
- Difficulties presented in supporting pregnancy in homeless accommodation and access to terminations for substance misusers
- Women are less visible to services because they display less violence and aggression making their mental health needs a lower priority. Mental health services need to be more gender informed.

In order to improve care for women in the city, participants stated that there was a need to have a gender informed approach, where practitioners are skilled and understand the structural inequalities that affect women.

Direct participant quotes

'I am constantly shocked at the level of need in the women we are working with'

'For a lot of women in services, their life is exploitation, they are exploited from all areas'.

'We encourage [women] to take responsibility for their choices but really try to encourage people to see when they are potentially at risk of harm'

'So the level of trauma upon trauma with the women we work with makes it much harder to get to a place where therapeutic progress is possible'.

'[I am] constantly astounded by how little thought is put into the fact that these women have often had children taken away, and that that is seen as a given, without really thinking about how that impacts on the person, and what that might mean in terms of their increased substance use, increased aggression'.

'*Often it can be a challenge for a woman to have her needs met, because a lot of services are set up to work with a discrete need*'

Young people

Issues raised by organisations relating to young people with MCN included;

- Likely to have drug and alcohol issues; family issues and be care leavers
- This is a high risk time and services need to support those who aren't ready to enter adult services
- Sharing accommodation with older entrenched drug and alcohol users should be avoided

Black, Asian and Minority Ethnic People (BAME)

This group is less visible in terms of MCN within Brighton & Hove, and it is a challenge to incorporate the needs of the different communities when thinking about the MCN cohort.

5.4.What are the challenges?

The key challenges identified by organisations in managing the care and treatment of people with multiple complex needs included:

- Information sharing
- Multi-agency working, care co-ordination and commissioning
- People with a dual diagnosis
- Substance misuse issues
- Housing
- Mental and physical health

Information sharing

All participants cited information sharing as being important to help meet clients' needs and its absence as a major challenge with this group. The difficulties faced included:

- Not all organisations collect data on the MCNs their clients present with.
- Organisations have different IT systems, databases and risk indicators, which hinders co-ordinated care
- Clients risk re-traumatisation by repeating their stories to each agency as there are no shared records.
- Lack of accurate information about mental health diagnoses can make it difficult to safely manage clients.
- Concerns about client confidentiality was a barrier to information sharing

Many participants noted that the ideal solution would be to have a shared database and clinical records, although it was acknowledged that there wasn't a digital solution for

this. Examples of good practice included the police contacting mental health when detaining someone and SECAmb having access to care plans.

Direct participant quotes
'[information sharing can be] a real barrier to be able to work creatively with people with very complex needs'

'it's not always anything to do with what the client wants around why information isn't shared, that's just how the system works and therefore that's what people do'

Multi-agency working, care co-ordination and commissioning
Although there were many examples of effective multi-agency working in the city, it was felt there were still things that could be improved such as co-ordinating care. Difficulties agencies faced with co-ordinating care included:

- Organisations withdrawing care if they felt this was being provided by other services
- More mental health input needed in multi-agency meetings, so that agencies e.g. probation, aren't left feeling unsupported as the main contact
- Co-ordination is needed for safeguarding concerns

Some of the difficulties facing people with MCN were exacerbated by commissioning arrangements:

- Organisations tended to be commissioned to work on one need at a time, leading to siloed funding arrangements and provision.
- Although there are many services, these could be better coordinated.
- Clients bounce around the system, not meeting the criteria for multiple different services.
- Lack of co-located services and their spread across the city make it difficult for clients to walk to.
- Reductions in funding lead to services cutting back to core services rather than working with partners

Direct participant quotes
'When it comes to joint working we know that people with multiple complex needs… find it difficult to keep to schedules, difficult to keep appointments and if they have multiple appointments to get to multiple different services, they will struggle to get their needs met.''

'It's very difficult to commission for [them] because they overlap on those different systems all of which have a slightly different criteria for accessibility, so they bounce between systems, which doesn't help'

'*We know that working with this client group if you see one need at a time it can be one step forward and three steps back. There's a real need to look at the whole person and how each of their needs might interrelate with the others'*.

'It's like a full time job being a homeless person with support needs'

Dual diagnosis

Dual diagnosis was cited by most participants as the biggest challenge facing this client group, both in terms of the majority experiencing issues with both mental health and substance misuse, and the barriers client face in getting support from services when they have both conditions. The barriers identified included:

- Mental health services not seeing clients when they are actively using substances but in the absence of anything else, this is often a form of self-medicating to cope with trauma and mental health problems.
- Lack of flexibility in services – it would help if mental health services worked jointly to gradually increase their input as substance misuse support gradually decreased. Mental health engagement, harm minimisation and support needs to be in place alongside substance misuse services.
- Lack of a specialist mental health team to work with trauma and motivational interviewing with this client group.
- Clients lack insight about the interactions between mental health and substance misuse on their health.

Suggestions made by participants to improve the current service included:

- Change the commissioning model to reflect the overlapping conditions
- Single Point of Contact into the service, with a single pathway and co-located workers.
- Mental health telephone service accessible to people who misuse substances
- More local locked rehabilitation services

Direct participant quotes

'The idea that you can't work with someone around their mental health and stabilisation and trauma whilst they are using is the major barrier to any work being done. How can you expect people to give up the one thing that actually manages their state? Sometimes badly, sometimes well. We expect them to give that up'

'It can be chicken and egg mentality. Which came first? Which I think is the wrong discussion to be having. With substance misuse and mental health, quite often in terms of accessing a service it will be, well we can't support a client with their mental health until they're reduced their substance misuse and vice versa. If we step back from that and apply a client's life history to that and ask the question, why are they using, I think we're in the right area then. We're getting back to trauma, to the numbing of the difficulties they've had, it's more of an empathic and congruent response, more of an understanding of where they have come from and why they are using, rather than making a judgement on which one should be treated first, if at all.'

'The fact of the existence of the conditions is that nearly everyone who has a drug and alcohol problem has a mental health problem… but the way services have been commissioned… it has created a divide that doesn't need to be there, and isn't there in individuals.'

Substance misuse

Issues raised by a few participants concerning substance misuse included:

- A reduction in outreach services due to funding cuts
- A reduction in mental health resources
- Better joint working with primary care needed e.g. one client was prescribed 17 controlled substances; an example was given of the difficulty of reducing illegal substances when they are being "topped up" by prescribed medicine.
- Concept of recovery needs to be more flexibly interpreted for Assertive Outreach Team patients.
- The city lacks outreach for poly-drug users. Some clients would benefit from a more flexible intervention.
- Substitute prescribing should be piloted in the community.

Housing

All participants reported housing was a major issue for this client group. Most clients were in insecure or inadequate accommodation, which made it difficult to work effectively with them. Specific issues identified included:

- A lack of young people and gender specific housing
- A lack of drugs free accommodation – those who are abstinent start using again
- No sharing of information to help prevent clients being evicted multiple times
- Need for more housing options: High support, long term placements with therapeutic support, long term harm minimisation option that can manage challenging behaviour and substance misuse/dual diagnosis
- Lack of independent accommodation means people relapse on waiting lists, or don't get enough support at each pathway stage to move into independent accommodation
- Those in their own accommodation can lack self-care skills and are vulnerable to exploitation
- Women are not deemed as a priority for accommodation, as living on the streets is perceived as a lifestyle choice. They are also seen as having voluntarily given up their accommodation if they go to prison.
- Housing and mental health needs are not aligned. Someone may receive mental health support but then be housed out of area, denying them continuity of care and the full range of support they need
- Housing support workers are left with high levels of responsibility for adults with MCN when other agencies decide not to engage with a client.

Housing First was seen as a good idea in principle for this client group, although the amount of quality housing available was limited. Housing worker skills could also be improved, This had already begun with the commissioning of a psychologist to work with the housing team. A tagging system for allocating a person with complex needs to the person with the best skills to manage them was also suggested.

Direct participant quotes

'People without a roof over their heads are difficult to find, they're difficult to support, it's hard for them to feel safe and until they feel safe, how can they engage?'

'Our clients face difficulties because the service they need doesn't exist, particularly accommodation based services. It's a bit like trying to best fit a client, when actually it's quite often because a service hasn't been commissioned.'

'Because we are a residential service, we can't not work with her, not that we would choose not to, but other services coming in and supporting her kind of leave and go back to their other clients, but the staff team we've noticed have really absorbed some of the responsibility of working with her'

Mental health and wellbeing (including trauma)

Clients with multiple complex needs have very high mental health needs. These can compound their other complex needs and is closely connected to physical health. It was felt eligibility thresholds made it increasingly hard to access services and the prolonged process exhausted clients. Issues raised by participants included:

- Setting eligibility thresholds at an organisational level, so that the gaps are clear to commissioners
- More gender informed mental health services
- Mental health services can feel remote from the clients and staff. There needs to be more shared responsibility for mental health and creative problem solving
- Many clients are suspicious of mental health services due to past negative experiences, they disengage, fall off the radar and get discharged
- Many clients have self-reported diagnoses that are difficult to unpick.

Trauma

As cited previously many of this client group have experienced trauma. It was felt a lot of crises could be de-escalated with a more trauma informed approach. Participants made several suggestions about how organisations could improve the support they can offer for trauma:

- Staff need to be supported to work in a psychologically informed way. This needs to be embedded in clinical supervision and reflective practice.
- The city's response to trauma needs to be co-ordinated, with a common language, clear roles, joint training and a multi-agency plan for trauma.
- Trauma services needed to be extended to include those that have experienced ACEs, bereavement, PTSD (not just domestic abuse).
- Support needed includes trauma stabilisation, emotional regulation, self-soothing techniques, EDMR, mindfulness, telephone support lines.
- Trauma services need to be provided across mental health, drug and alcohol services

Direct participant quotes

'So those people who have a history of trauma, how much do people get asked about that and then what is the response, because what you don't want is people you know unpacking all of that and then getting an unhelpful response to it.'

'People who have a level of challenge in their lives because of trauma but don't meet the threshold for our service, and fall outside of CBT type approaches- that's a group that is not well served'

Other challenges for adults with complex needs with mental health services were outlined by participants.

- Personality Disorder Services will only see clients in group settings, which excludes many who have challenging behaviour. An assertive engagement model is needed, which is designed to work with multiple complex needs.
- Lack of rapid response from Mental Health Rapid Response Service
- Secondary mental health services are seen as the sole place for clients to go but the majority are supported through primary and third sector care
- Clients access services via multiple routes because services tend only to engage at a crisis point. MDT working and risk management across organisations would improve this.
- Mental health triage needs to take more account of the complexity of social situations. Sometimes complex clients' mental health issues don't meet the threshold for secondary care but primary care treatments such as 8 sessions of CBT are insufficient and clients may find it difficult to go to their GP for the treatment of anxiety and depression. So they fall into a gap between services.
- Access to long term counselling would be beneficial for some.
- Long waiting lists mean people deteriorate and go back on the streets before they can be seen by the Neurobehavioural Assessment Service.

Primary Care

Multiple Complex Needs is not a well understood concept in primary care. Clinicians are used to coding medical conditions and find it hard to identify those with complex needs such as domestic abuse and homelessness. They tend to medicalise social conditions.

Most primary care work is with a very "visible" group of people with multiple complex needs. They are usually seen in a crisis and can be very frustrating to manage as they tend to turn up late or not at all or don't respond to letters. There is also a less visible group that they become aware of through A&E attendances and safeguarding alerts. There is a "Special Access" service in primary care for this group but only one practice delivers it.

Ways in which it was felt primary care services could be improved for adults with MCN included:

- Engaging with them better on the prevention agenda and following up those on the SMI Register who miss their annual health checks
- Train reception staff to manage challenging behaviour and look at better methods of communicating and arranging appointments
- Provide a trauma informed response within primary care
- Making sure GPs have the most recent information on the clients' contact with mental health and substance misuse services.
- Generic GPs find it hard to stay up to date about the range or services available to people who are homeless. Better integration with benefits agencies, housing support and social prescribing would help, although there's a risk this group would be excluded due to their complexity.

- It is hard to manage the medications of homeless people when GPs don't have access to all the information.

Direct participants quotes
I think part of the problem is that we're aware of [other needs] but feel helpless to do anything about them'

'It's almost recognising that they are complex and have different needs, instead of being bolted on to normal primary care'

5.5. What works well for adults with multiple complex needs?

Multiagency working and care co-ordination
Examples of multi-agency working that was felt to work well were characterised as follows:

- People are clear who is doing what; shared workload; feeing supported
- Some organisations had specific care co-ordinators e.g. Assertive Outreach Team, Mental Health Homeless Team
- Brighton Women's Centre and Probation Service take on the role of care co-ordinator where it is absent
- "Team around the family" model works well for women
- "One Stop Shops" for clients, avoid multiple appointments
- Single rather than multiple care plans with conflicting priorities
- Embedding staff within other agencies e.g. adult social care, mental health and voluntary sector; including secondary mental health care within primary care and substance misuse services
- Multi-agency working can offer a new perspective if clients have been in the services for a long time.
- Effective multi-agency meetings included Complex Risk Management Meetings; Arch Homeless Health Meeting.
- Care Co-ordination by accommodation services works well as they have the most client contact and can be more directive with care teams. However this does leave them holding a high level of risk
- DWP has a MCN marker for these clients, which shows the need to work with their key worker and helps to prevent claims breaking down.
- Hostels and substance misuse services jointly run needle exchanges together
- External outreach into hostels e.g. substance misuse and oral health
- B'think database, enables common language to be used and shared understanding of where people are at.
- Just Life helps people to appointments, shopping, tidying their rooms and providing moral support.

Holistic care
It's important to look at clients' needs as a whole - involve clients more and invite them to case conferences. Help them to understand that the difficulties they experience may

be related to their childhood experiences. Involving people with lived experience can also be helpful. The Fulfilling Lives volunteer programme and training peer researchers with lived experience are good examples of this.

Direct participant quote

'*That can really help to challenge stigmatising practice… by having an expert by experience in the meeting can really help to challenge some of that quite questionable use of language or assumption about particular groups'*

Primary Care

Effective ways of working with adults with MCN in primary care were described as follows:

- The Arch approach to this client group
- The SCFT Homeless Health Team hostel clinics, enable a positive relationship to be built with NHS staff
- Housing support within primary care
- Monthly meetings with practice attached adult social care workers
- Weekly primary care team meetings to discuss clients with MCNs and make care plans. The wider practice team including receptionists should be involved too.
- Using flags in notes to highlight the risks for the most challenging clients
- Having mechanisms in place with mental health and substance misuse services to resolve issues when things go wrong.

Staff

The city has lots of good workers trying to solve problems within limited resources. When staff are well trained they are reflective, work in a psychologically informed way and look after their own wellbeing. Clinical supervision and debriefs are also important

Women

The Probation Service was cited as an example of a service that works well for women. It has a women's lead in the organisation and weekly women only reporting slots. There was also felt to be a lot of provision for women in the city, including the women only hostel. The co-location of services within the Brighton Women's Centre also works well.

Following the above interviews it was agreed to increase information relating specifically to the BME community. Additional interviews were held with two local services providing support to migrants and the BME community. Key points from the interviews included;

People the organisations work with:

- Anyone from the BME community including migrants and asylum seekers
- General comment that it is not helpful to put all BME communities together as one group
- Multiple complex needs clients are mainly a combination of mental and physical health needs including trauma. Clients with other specific needs are usually referred to the appropriate agency.

Issues & needs:

- Important to consider significant stigma linked to mental health needs, for example for men in relation to change in professional status. Mental health is the big gap.
- Issues with referrals to other organisations and people being either too complex or not meeting thresholds. Uncertain immigration status influencing an agency's commitment.
- Need better information sharing between agencies and greater interpreting service capacity
- Travel costs to services may be prohibitive as many people live in the more disadvantaged parts of the city and can't access the advocacy and other services on offer. Knowing where help is available and actually receiving it are two very different things.
- Fear of attending the NHS results in late presentation of physical symptoms
- Housing quality and homelessness are issues particularly if placed out of the city. Resettled families generally do better than other families.
- Understanding and addressing trauma is the main need for migrants, particularly asylum seekers and refugees
- Relevant services need more workers from BME backgrounds
- Good support for women around DVA but not male perpetrators
- There is a need for more support for BME men.
- Acknowledge and understand the barriers faced in accessing health services including gate keeping and charging and referral pathways.
- Services should be included at strategic and planning level as an integrated rather than a bolt-on service.

6.People with lived experience voice

6.1. The voice of people with lived experience

This section describes the results of community engagement research, which aimed to gather the opinions of Brighton and Hove residents with multiple complex needs. Both quantitative and qualitative methods were used to attempt to provide insight into individual's experiences. Although individuals with MCN did not directly participate in the planning of the research, local organisations that already work with them were closely involved in the planning and execution of the project.

6.2. Methods used in the community engagement project

The community voice was harnessed using a variety of methods in order to recruit the widest possible range of individuals to participate. These included individual interviews; focus groups and an online and paper questionnaire.

a. The sample

The target population was defined as people aged 16 and over living in Brighton & Hove, who were experiencing at least two of the following: mental health difficulties; substance/alcohol misuse; offending; homelessness and domestic abuse. Participants were recruited through statutory and non-statutory organisations who were involved in this project.

b. Face to face engagement

The face to face engagement was carried out in a community setting familiar to the participant. It was undertaken by peer researchers from Fulfilling Lives (supporting people with multiple and complex needs - Brighton Housing Trust), the Service User Involvement Worker from Mind in Brighton and Hove (for better mental health) and support staff for RISE (freedom from abuse & violence). Peer researchers and the other facilitators involved in this project had received prior training through these organisations and were required to hold a Disclosure Barring Service check. They also had the requirement to adhere to the Information Governance arrangements of their sponsoring organisations. Participants were offered an individual interview or a focus group, depending on the organisation's capacity and number of individuals involved. They gave informed consent to participate in the project and were made aware that their responses would be anonymous, they could change their mind about participation and could leave the session at any time during the process. Participants were each given a £10 Love to Shop voucher in recognition of the time they had spent engaging in the project.

i. Face to face interviews

Participants were interviewed using a semi-structured format (template in appendix 1a). They were asked which difficulties they had experienced and which services they may have used. They were then asked follow-up questions on the ease of accessibility, usefulness of the services they had experienced and their general satisfaction with

service provision in each area of support. Up to six areas could be explored, depending on needs identified, including mental health difficulties; substance/alcohol misuse; probation; homelessness services and domestic abuse services). The interview concluded with questions on how services generally work for the individual in the city and if the person feels that there is any intervention that may have helped during their journey.

ii. Focus groups

The focus group sessions lasted up to one hour. The session involved 4-8 participants and one facilitator. The focus groups followed a semi- structured format (template in appendix 1b) and included group discussion around the Brighton & Hove services that the participants have used in the last two years and how well they are working for specific groups of people.

iii. Questionnaire

The questionnaire was available on paper or via a link to an electronic version (see appendix 1c). It consisted of 12 items, covering areas such as difficulties participants may have experiences, services used and their satisfaction with the services, communication between services, and how well the services are working for specific groups of people.

c. Analysis

Focus groups and interviews were recorded and transcribed or had a note taker present. Data was anonymised by the facilitator/peer researcher and submitted to the Public Health team. On receipt the data was aggregated and quantitative data summarised. Qualitative data was analysed using framework analysis.

6.3.Results

A total of 43 people from the target communities were engaged with as part of this project. 26 took part in four focus group sessions, 15 had one-to-one interviews and two people filled in the on-line questionnaire. 35 of the participants were engaged through Mind, 4 through Fulfilling Lives and 2 through RISE.

a. Face to face interviews

The number of MCNs experienced by the fifteen participants in face to face interviews are summarised in figure 1 below. In order to be eligible to participate, people had to experience at least two needs out of a maximum of five. One participant experienced all five needs.

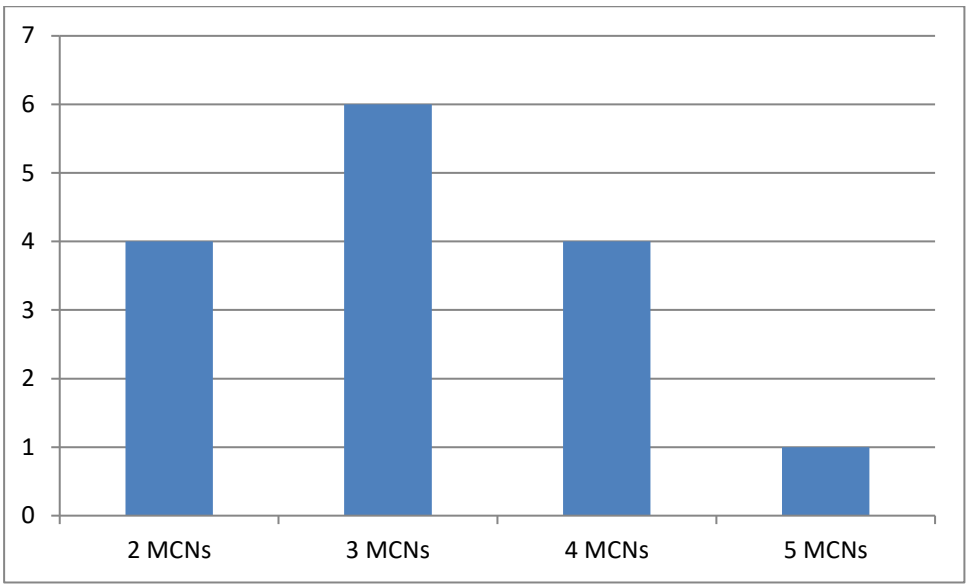


Figure 1 Number of multiple complex needs in individual interview participants (n=15)

The time that participants had spent living with their MCNs is summarised in table 1 below. The majority of participants had lived with their needs for greater than ten years.

Table 1 Length of time individual participants have lived with their MCNs (n=15)

Time living with MCNs	Number of participants
<1 year	0
1-5 years	2
6-10 years	3
10 + years	10

Quantitative results

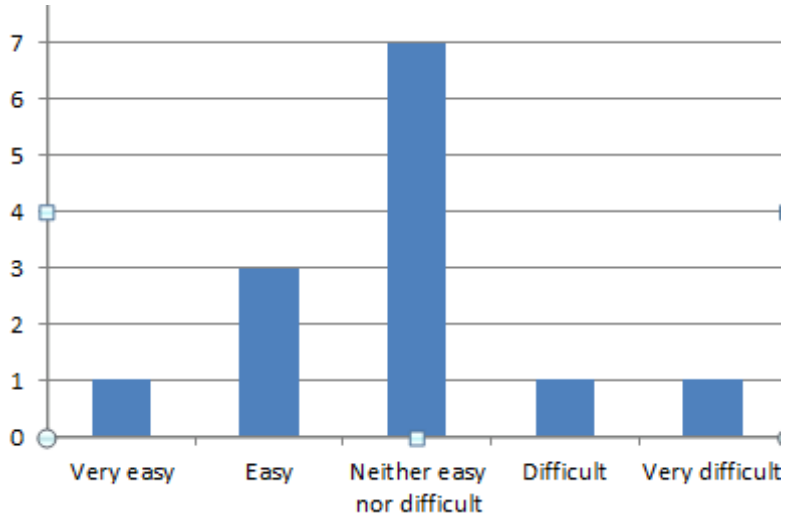
Participants were asked whether services they had engaged with had asked their opinion on their care and invited them to meetings about their support, the results are summarised in table 2 below.

Table 2 Opportunities for participants to be involved in their support

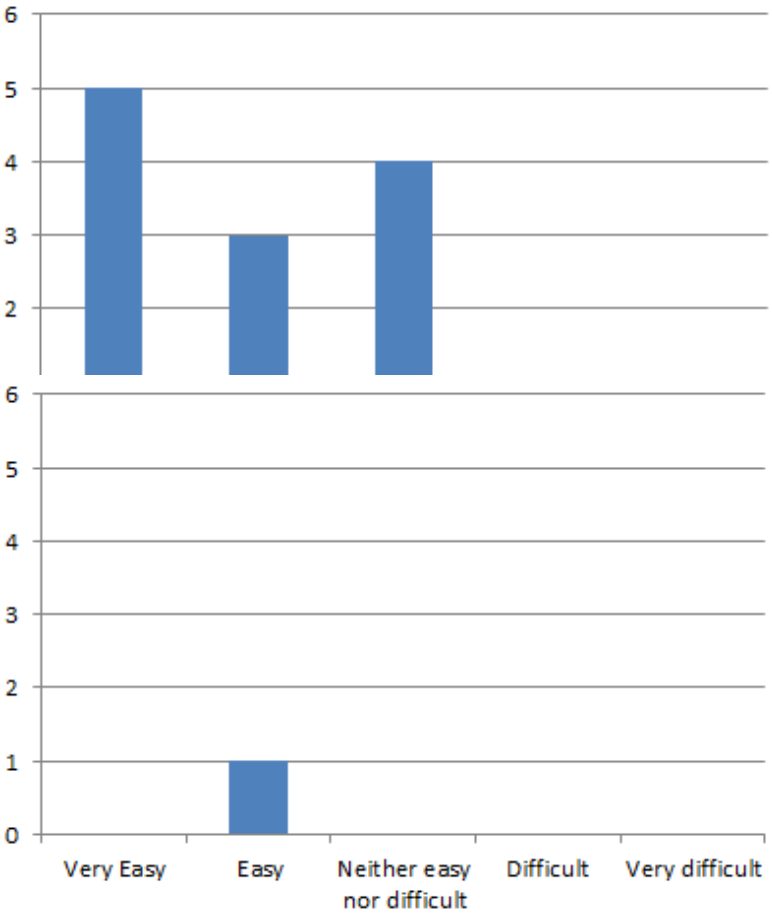
Service area	Asked opinion on care?		Invited to meetings about support	
	Yes	No	Yes	No
Mental health service	5	1	5	3
Substance/alcohol misuse service	5	0	4	0
Probation	1	0	1	0
Homeless service	2	4	2	3
Domestic violence service	5	0	4	0

Participants were then asked how easy they found accessing support from services relating to their varying needs. Their responses are summarised in figure 2a-e.

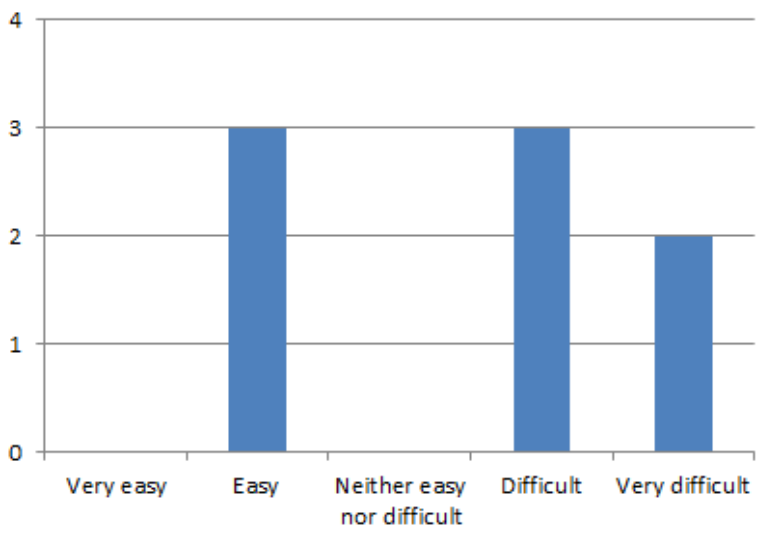
Figure 2 Accessibility of specified support services



a. Mental health services

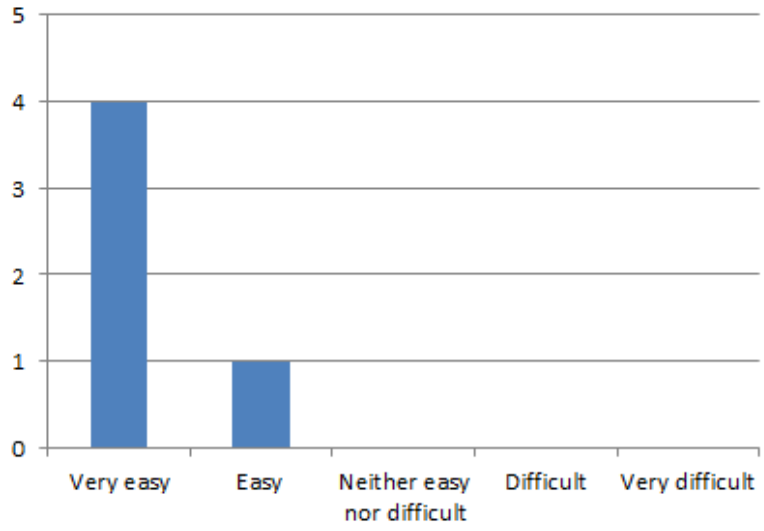


b. Substance/alcohol misuse services



c. Probation services

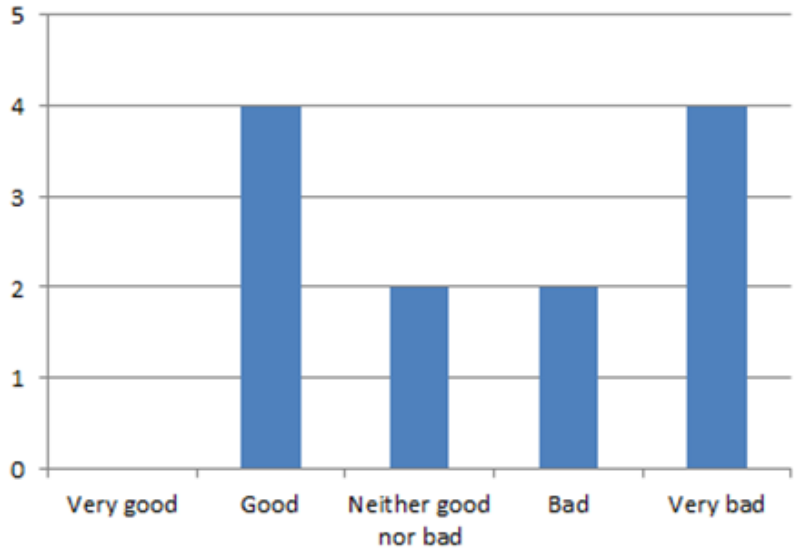
d. Homelessness services



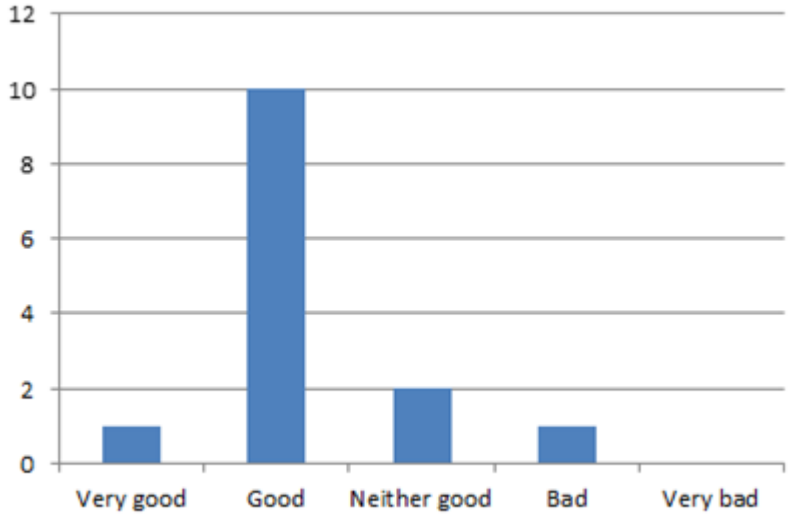
e. Domestic abuse services

Participants were asked how good services in Brighton & Hove were at talking about the different types of support that was offered. Responses are summarised in figure 3a-d. No individuals answered the question on probation services; therefore, it is not included in this section.

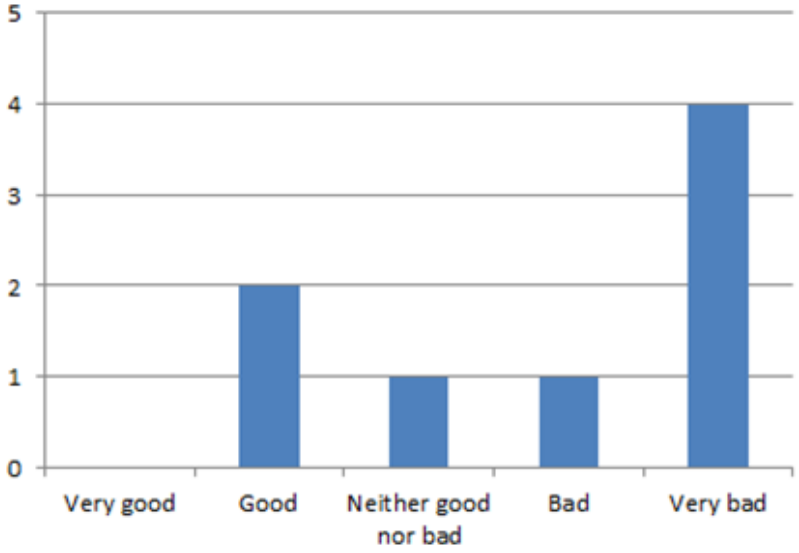
Figure 3 Perception of how good services are at talking about support for various needs



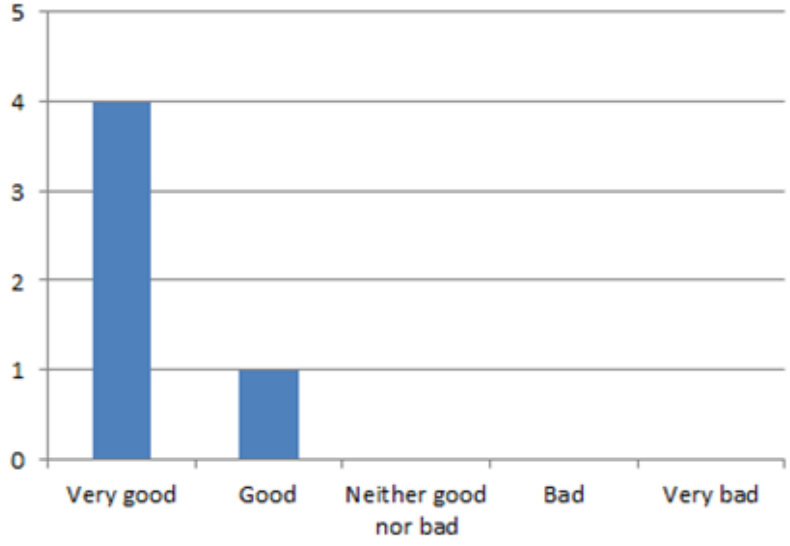
a. Mental health support



b. Substance/alcohol misuse support



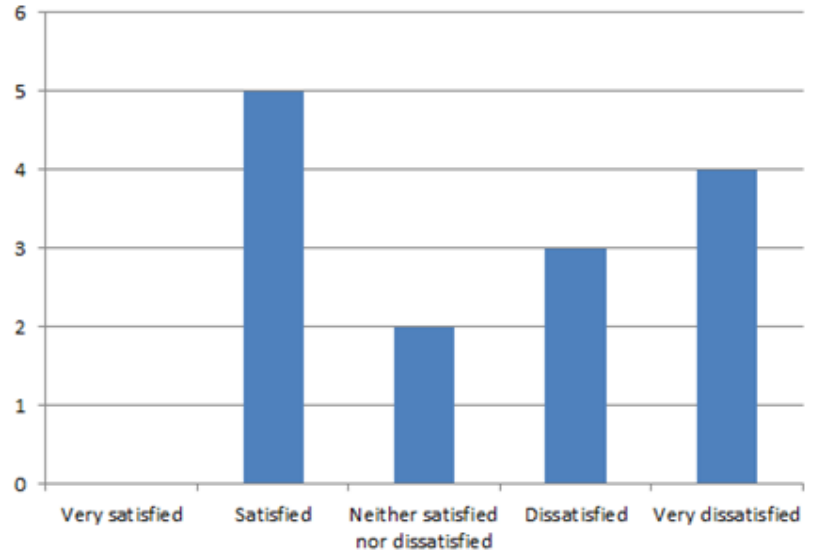
c. Homelessness support



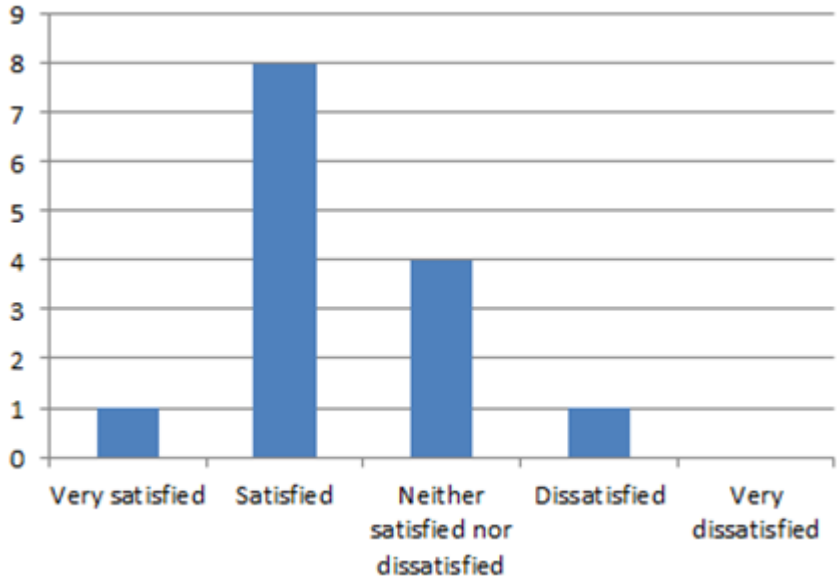
d. Domestic abuse support

Participants were then asked about how satisfied they were with the specific services that they had utilised and their answers are summarised in figure 4a-d. No participant answered the question with regard to probation services, so this was not included.

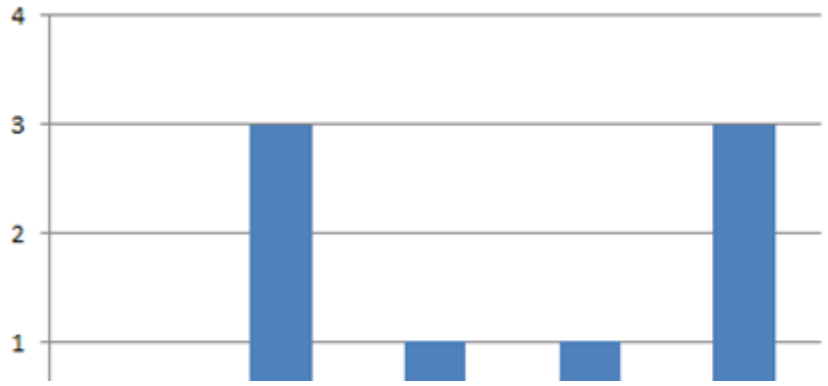
Figure 4 Satisfaction of participants with services they had utilised



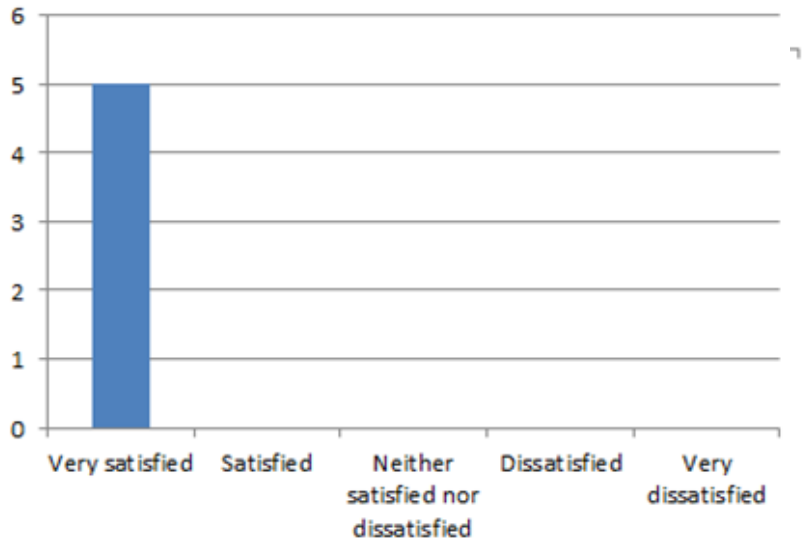
a. Mental health services



b. Substance/alcohol misuse services



c. Homelessness services



d. Domestic abuse services

Qualitative results

Interview participants discussed the strengths and areas for development of the support services that they had utilised and the answers were grouped thematically. Results are in tables 3 and 4. Again probation services are not included as no participant answered questions on these services.

Table 3 – Strengths of services - interviews

Strength	Service referred to
Helpful teams	MH, SM
Home visits	MH
Having a diagnosis means you can access services	MH
Good joint working/communication between services	MH, H
Lots of services available	MH, SM
Good awareness of client's problems	MH
Staff have lived experience	SM
Easy to access	SM
Trusting relationships	SM
Supportive, non-judgemental workers	SM
Flexible/home visits	SM, DA
Practical support	H, DA
Enjoyable and sociable interactions	H
Able to be open and honest with workers	DA

Feeling of control	DA
Support not time-limited	DA
Confidentiality assured	DA
Sensitive staff	DA

MH=mental health SM=substance/alcohol misuse, H=housing, DA=domestic abuse

Direct participant quotes around strengths of services:

- 'There are lots of different services available and I think that this is a good thing as one size does not fit all' (MH)
- 'The joint work between GP to Pavilions and then ATS and Mind especially was all really good and it is clear that they were all talking together in order to help me the best they could' (MH)
- 'I feel that my worker genuinely cares for my wellbeing and understands what I've been through' (SM)
- 'As long as you know where to go for support and about all the different services you are really "spoilt for choice" as we have loads of different services in the city and there is basically "something for everyone"' (SM)
- 'I needed support to move from a private flat with an abusive landlord to a council flat and without Fulfilling Lives and my social worker they wouldn't have listened to me and helped. My FL worker bought me to all the meetings so I could speak at them and that really helped.' (H)
- 'They communicate with each other to find you the best place for you and then you are given the best and most appropriate place for you to be – the system has worked for me.' (H)
- She delivers practical advice and does maps with me and I learn visually so this helps.' (DA)
- 'It helps that it is not a limited time so that I can build trust and become comfortable talking to her' (DA)

Table 4 Areas requiring development - interviews

Areas requiring development	**Service referred to**
Can't access service due to other difficulties (e.g. drug/alcohol use or mental health problem)	MH, SM
Lack of staff experienced in dual diagnosis	MH, SM
Services overlook additional needs	MH
Needs are 'too complex'	MH
Long wait for referral	MH, SM
Poor communication/services not joined up	MH
Lack of control of care	MH, H
Lack of support	MH, H
High staff turnover	MH, SM
Assessment/diagnosis only, not continuing care	MH
Some staff not supportive or understanding	SM
Inappropriate or inaccessible venue	SM
Lack of appropriate accommodation (venue, quality, safety)	H
Hard to navigate pathway	H

MH=mental health SM=substance/alcohol misuse, H=housing, DA=domestic abuse

Direct participant quotes around areas that require development:

- 'I often self-medicate for my MH and also ("looking at it from the other way") my MH can be much worse as a result of my drug and alcohol use proving that all too often it is really important to work with both things at the same time to really help someone otherwise it just won't be a permanent solution. Basically, I think that just addressing one thing at a time means that the person often relapses or continues to be at risk.' (MH)
- 'The clinic takes a lot of time, it is stressful and a bit of a barrier. Lots of people and I have walked out because of how long you have to wait.' (SM)
- 'Not enough experience in staff to help those of us with MH problems in SM services and dual diagnosis' (SM)
- 'I didn't find them supportive, they didn't understand that I couldn't stop using Ketamine because my life was so shit' (SM)
- 'I did get my own council flat but was not asked which area, which if my ex-partner was around (the area) would've been a bad idea and unsafe for me.' (H)
- 'I felt that I had no control and housing had all the control and power whilst debating behind closed doors and corresponding by letter. I didn't have my say.' (H)

Participants were asked a final question about whether they feel any intervention could have changed their life course. The majority of participants were not able to answer this question and as the interviewers were concerned it may lead to distress, it was dropped from the interview as the process progressed.

b. Focus group sessions

Focus group participants discussed the strengths and areas for development of the support services that they had utilised and the answers were grouped thematically. Results are in tables 5 and 6. Focus group participants did not discuss probation or domestic abuse services, so these are not included below

Strengths	**Service referred to**
Wide and diverse range of services	MH
Advocacy services	MH
Services work well if you have a diagnosis and are in Recovery	MH
Services work well if you are able to engage and attend	MH
Staff with lived experience	SM
Staff with experience of dual diagnosis	SM, H
Opportunity to volunteer	SM
Staff try their best with limited resources	H

MH=mental health SM=substance/alcohol misuse, H=housing

Areas requiring development	**Service referred to**
Long waits for referral	MH
Can't access service due to other difficulties (e.g. drug/alcohol use or mental health problem)	MH, SM

Poor joint working between MH & SM services	MH, SM
GPs often unable to help as not kept updated	MH, SM
Difficulties with prescriptions	SM
Not enough MH support in SM service (particularly residential)	SM
Many hostels not appropriate if in recovery	H
Lack of availability of appropriate/safe housing	H

MH=mental health SM=substance/alcohol misuse, H=housing, DA

c. Online questionnaire

Two individuals partially completed the online questionnaire, answering 9 of the 25 questions – they both concluded their responses at question 9. Due to the limited number of participants in the online questionnaire, answers to questions that may have impacted on their anonymity have been excluded from this analysis.

Both participants had experienced mental health problems, homelessness and domestic abuse and one had additionally experienced substance and/or alcohol misuse. They had both experienced these conditions for more than 10 years.

They had both utilised mental health and domestic abuse services in the last two years, and one had utilised substance misuse/alcohol services. They both agreed that the support services talked to one another about their care.

They were asked which of the following areas worked well in supporting them, and if those areas could still be improved. The results are as follows:

Table 5 Areas of support that worked well and/or could be improved

Areas	Total responses (n=2)	
	Works well	Could be improved
Being involved in meetings about your care	1	0
Being asked to give your opinion about your care	2	0
Referrals between B&H services involved with your care	1	1
B&H services talking to each other about your care	1	2
Being able to use the B&H services that you need	2	2
Getting the support you need for as long as you need it	1	2

6.4. Summary of findings from the community engagement project

The findings from the community engagement project have been summarised in the following word clouds (where size of font=number of this response).

Figure 5 Successes across the system *DD = dual diagnosis

Figure 6 Challenges across the system *DD=dual diagnosis

Limitations of the project

A limited number of participants had experience of utilising probation services; therefore this area was not explored in the qualitative work. The use of peer researchers may have led to bias in the results due to their perceived lack of independence from the services that were being reviewed by participants. Low numbers of participants in the online questionnaire meant that not all data could be reported in order to maintain anonymity. Some questions were dropped during the interview process due to concern around their potential impact on the interviewee.

7. Service provision

This section covers key services in the city in respect to the prevention, care, treatment and support of adults with multiple complex needs (MCNs). It is not possible to include all services, but those with a particular focus / interest on MCNs are included.

7.1. Sussex Community Foundation Trust Homeless Team

The Homeless Team is an Integrated Primary Care Team, providing a wraparound health service for people sleeping rough, or living in hostels, emergency or temporary accommodation. The service is accessible to homeless people aged 18 and above, regardless of gender, who are not engaging/struggling to engage with other health care providers such as their GP. The primary focus is around physical health needs, with support if necessary, from housing, engagement workers, mental health and substance misuse teams.

The service aims to break down barriers so that patients feel able to engage with their health needs. This is achieved by motivating and empowering them to make decisions about their own health care and building their trust in services. The service aims to provide equitable care for patients with multiple complex needs, including palliative and end of life care. They also minimise harm and reduce risk, by highlighting concerns as they arise. It also supports and educates other staff groups who may struggle to understand/judge the behaviour of some of the patients.

The team consists of

- **Hospital in-reach nurse** – Makes sure the hospital stay is not filled with fear and that the right diagnostics are completed, and appropriate services are in place for discharge to the community
- **2 WTE Band 6 Occupational Therapists** Help patients to develop their self-esteem and provide meaningful occupation, to reduce isolation and fear.
- **One 0.5 WTE Band 7 Occupational Therapist** focused on the prevention of rough sleeping
- **Physiotherapist**-Provides individual programmes of care and group work, as well as support with long term chronic pain management
- **Advanced Nurse Practitioner**
- **Sister in Charge**
- **1 WTE Band 5 nurse**
- **Health Care Assistant**

After an initial assessment each patient has an individualised care plan. This supports their mental health, substance misuse and many chronic health conditions such as diabetes, liver failure, heart failure, cancer, and COPD. Patients are supported around diagnostics, health management and engaging with other services, including on safeguarding issues. The service can advocate for the patients and help write reports if their homelessness and/or housing arrangements is putting their health at risk. The service supports patients to navigate through many services and coordinate their care

around their needs linking in other services as required. They will tend to have a main point of contact within the team who supports the coordination of their care.

7.2. ARCH

Arch Health Community Interest Company is a Brighton & Hove based social enterprise which was set up to provide integrated healthcare services to homeless people in the city. Arch is a specialist clinical service which takes a lead on the development of the integrated care pathway for homeless people, this includes taking a central role in the delivery of the 'Hub & Spoke' model which was commissioned in 2016.

The key elements of the Hub & Spoke model are:

The specialist GP surgery (Arch Healthcare). Based in the School Clinic on Morley Street the surgery has approximately 1400 patients and provides a full range of primary care services.

Hospital In-reach team. Arch works with partners SCFT to deliver an in-reach service at BSUH. This team works with around 450 homeless inpatients per year, supporting them during their stay and ensure a safe discharge once their treatment is complete.

Health Engagement. Arch works with partners Justlife to deliver non-clinical support to homeless patients who have specific health needs. This health engagement team has a caseload of 70 patients at any one time and they offer support with attending appointments, general well-being activities, benefits advice, advocacy and a wide range of interventions which enable people to stay healthy.

MAHHM - The Multi Agency Homeless Health Meeting. This is a fortnightly meeting chaired by the Arch GPs and attended by stakeholders from across the health, housing and social care setting. This is a meeting where the most complex and vulnerable people are discussed with the aspiration that a multi-disciplinary approach can help to unblock pathways for the patient. This meeting has been running for over 5 years with many successful outcomes.

Outreach services - Arch nurses deliver outreach clinics in a variety of contexts around the city including Firstbase day centre and other homelessness services. Arch GPs also engage in regular street outreach, working closely with the SCFT nursing team to visit homeless patients wherever they are in need.

City wide leadership - Arch provide leadership through the temporary accommodation action group (TAAG) and the frontline network as well as involvement in the Homeless Operational Forum and contributing the rough sleeper strategy board. Arch is also committed to workforce development for both clinical and non-clinical staff through individual projects and the provision of an annual Homelessness and Health Conference.

In January 2019 Arch was awarded an Outstanding CQC rating achieving outstanding in all 5 areas of the inspection.

Arch work also with Just Life Foundation who provide the Pathway Plus homeless hospital discharge service for Brighton & Hove.

7.3. Assertive Outreach Team

The Assertive Outreach Team works with people aged 18+ with a primary diagnosis of psychosis associated with significant impairment in psychosocial/daily functioning and have a history of difficulty engaging with traditional mental health services and need to be referred by existing services (usually assessment and treatment/early intervention/forensic). Patients are also commonly affected by drug or alcohol misuse, difficulty in sustaining tenancies or contact with the criminal justice system. Service users may have had experiences of mental health services where it has been difficult for other teams to keep in touch and provide support. They are also more likely to have experienced several hospital admissions over time and to have been subject to the Mental Health Act. They also usually present with a degree of risk to themselves or others. The team aims to prevent relapse, reduce hospital admissions, maintain tenancies, improve daily living skills, support family and social networks and improve quality of life.

Assertive Outreach team is a multi-disciplinary of nurses, social workers, occupational therapists, Psychologist, Support workers and Psychiatrists. This means that the team can offer a holistic and therapeutic approach to meet the needs of our service users. Each person is allocated a care coordinator and a core care team of 3-5 people who will spend time getting to know the individual and finding out their priorities and needs. It also aims to involve carers and other people providing support.

The Assertive Outreach team offers a flexible and responsive approach focussing on the individual's priorities. It can provide support with practical daily living tasks; housing needs; money matters; medication management issues; interpersonal and social skills; general and physical health care; psychological input, vocational needs and family work.

The team will work with people in crisis and maintain contact throughout hospital admissions. It has close links with other SPFT teams, social services, housing providers, probation and other statutory and non-statutory services.

7.4. Forensic Healthcare

Sussex Partnership NHS Foundation Trust Forensic Healthcare services provide a comprehensive pathway of interventions for adult mentally disordered offenders, including inpatient and community support, focusing on providing evidence-based interventions for both mental health difficulties and for behaviours that pose a risk to others.

The services provided include:

- Forensic outreach and liaison services (forensic community mental health teams) including statutory follow up / support and risk reduction consultation
- Offender Personality Disorder Partnership (OPD) – this incorporates the Pathways and Intensive Risk Management Services (IIRMS). The Pathways service offers consultation and training to the National Probation Service (NPS), to assist with their work with high risk offenders with a personality disorder who have been screened into Her Majesty's Prison and Probation Service (HMPPS) OPD pathways.

- Inpatient (low and medium secure) services for those detained under the Mental Health Act, particularly part 3 of the act
- Liaison and diversion services - assessment of need and specialist support
- Mental health in-reach / integrated care to prisons covering Brighton area

7.5 Early Intervention in Psychosis Service

Sussex Partnership NHS Foundation Trust Early Intervention in Psychosis Service is provided for Brighton residents registered with a GP aged 14-64, with a suspected first episode of psychosis. It provides a comprehensive multi-disciplinary clinical care and support, including three years assertive outreach. People experiencing first episode psychosis, also often have complex psycho-social issues including substance misuse, homelessness and offending.

The multi-disciplinary team includes psychiatrists, pharmacist, psychologists, occupational therapists, nurses, social worker, employment specialist and support workers.

7.6. Mental Health Homeless Team

The Mental Health Homeless Team is an ageless service which works alongside Child and Adolescent Mental Health Services with under 18s and the Specialist Older Adults Mental Health Service for those over 70 years. The service provides mental health assessment and treatment for entrenched rough sleepers in the city, and for people living in emergency accommodation.

The Mental Health Homeless Team has low referral threshold for people with mental health problems. It supports people with common mental health problems and will also see people who are not registered with a GP Practice due to the nature of their co existing issues such as substance or alcohol misuse, and/or homelessness. The service also works with clients who have symptoms of severe and enduring mental health problems. These clients often display negative symptoms and do not engage with services using an assertive outreach mode. The service also supports clients with the positive symptoms of severe and enduring mental health problems. Clients frequently have a history of substance misuse and contact with the criminal justice system.

7.7. Brighton & Hove Assessment and Treatment Service (ATS)

Brighton & Hove Assessment and Treatment Service (ATS) is the secondary care mental health service covering the City. The ATS works with people aged 18+ who have severe and enduring mental health problems, usually coupled with high risk behaviours, and often including co-occurring problems such as substance misuse, domestic violence, housing problems, offending behaviours and physical health conditions. The ATS works with people under the expectation that they will ‘step down’ to less intensive interventions and support services as their circumstances improve. There is a strong emphasis on multidisciplinary team working and close working with statutory agencies, third sector partners and community organisations. The ATS uses a recovery-focused model of mental health care, which requires people wherever possible to take responsibility for their own recovery, in partnership with services.

7.8. The Haven at Mill View

The Haven at Mill View is a dedicated mental health crisis assessment facility located on the Mill View Hospital site in Hove. It is available 24 hours a day, seven days a week and provides support and assessment for adults over the age of 18 in East Sussex, West Sussex and Brighton and Hove, who are experiencing a mental health crisis.

The Haven is run by a team of dedicated NHS staff and provides:

- A 24/7 mental health crisis facility
- An alternative to attending A&E for people experiencing a mental health crisis
- An alternative to hospital admission

Referrals are accepted from any Sussex Partnership urgent or crisis team across Sussex and neighbouring mental health Trusts for a patient who is registered with a Sussex GP or resident in Sussex.

External referrals are accepted from other agencies:

- SECAMB
- Sussex Police
- Sussex Community Foundation Trust
- Acute hospitals (via Mental Health Liaison Team or MH Senior Nurse Practitioner)
- Other partner organisations including primary care where the person would otherwise be directed to A&E.

7.9. Community Rehabilitation Team

Formed in 2017, the Community Rehabilitation Team supports clients with a primary diagnosis of psychosis whose needs could not be supported by the Assessment and Treatment Service (ATS) and who didn't meet the threshold of the Assertive Outreach Team (AOT). Clients have a history of numerous admissions to inpatient services. Clear identifiable rehabilitation goals are set and they need to be be willing to engage in achieving these goals.

The team includes: Consultant Psychiatrist, Psychologist, Occupational Therapists and Nurses who act as Lead Practitioners for the duration that the client is with the Rehab Team. There is also a small team of support workers. On average clients are on the caseload for three years. There are approximately 80 clients. Admissions for clients using the service have reduced considerably and by linking clients into other community services their quality of life has increased. Clients have been supported to move to independent accommodation, college and employment. The team also offers short term support for clients from ATS who require quick, practical support that ATS were unable to provide such as more intensive support following discharge from hospital.

7.10 Crisis Response Home Treatment Service (CRHT)

The CRHT provides a responsive crisis resolution and home treatment services to all adults aged 18 and over with a functional mental health problem who are experiencing a mental health crisis and would otherwise need to be admitted to hospital. They also offer intensive home support for those people suitable for early discharge from hospital where needed. Referrals are accepted from colleagues within secondary mental health services only.

7.11. Probation (KSSCRC)

The Probation Service is for anyone who has been sentenced for an offence. It aims to reduce re-offending, aid rehabilitation and protect the public. This is achieved by supervising offenders from prison on licenses in the community and those on community-based sentences. This involves enforcing non-compliance with Supervision Orders, supporting people to stop reoffending and managing risk.

7.12. The Coracle

The Coracle provide accommodation for former rough sleepers aged 18 and over with a local connection, who have low to medium support needs (including previous offending history, previous substance misuse, mental ill health and homelessness).

The service aims to give the residents somewhere safe to live and help them to rebuild their lives and look for work, volunteering opportunities and hopefully look towards to moving to independent living in the future. However, there isn't a set move on time and residents can stay as long as they want provided, they are engaging with the service

It provides 32 beds for former rough sleepers across two projects. Residents are referred to specialist support agencies e.g. Mental Health Team, Pavilions/ Oasis, RISE. Residents are also accompanied to appointments e.g. Hove Polyclinic, Family Court, medical appointments, benefit appointments, job fairs. Two Occupational Therapists run groups with residents and a physiotherapist from Arch healthcare supports the residents.

Each of the resident is assigned a mentor/ key worker to work towards their goals and works with them in a therapeutic person-centred way.

7.13. RISE

RISE is a Sussex based charity that supports people affected by domestic abuse and violence. The services support women and LGBT people who are escaping and recovering from domestic abuse and violence.

Both the women’s refuge and LGBT refuge support have short term funding for specialist staff to support people with multiple complex needs. The community project team includes an assertive outreach worker and another specialist works with homeless women in a multi-agency setting.

The refuges provide a holistic service helping residents to manage their escape from domestic violence and abuse, including the practicalities of relocation. The specialist workers (temporary additions to the regular staff complement) have some capacity to

support with liaison and advocacy e.g. with housing, substance misuse and mental health services in addition to domestic violence and abuse.

Within community services, the outreach and homelessness workers work actively with the homelessness and other services to reach women with multiple complex needs who may otherwise not access domestic violence and abuse specialist services, offering casework, advocacy, liaison and general emotional support.

7.14. Brighton Women's Centre

Brighton Women's Centre aims to empower women, promote independence, and reduce inequalities through the provision of integrated and holistic services in safe women only spaces. The Centre is open to all women aged 18 and over with all health and social issues.

Services are provided through three open access hubs across the city, which include the following;

- Peer to peer support
- Inspire – case work and support for women with multiple vulnerabilities in the criminal justice system
- ToyBox, Ofsted registered pre-school and childcare
- Women's Accommodation and Support Service (WASS), support and case work for women who are rough sleeping, homeless or insecurely housed
- Holistic therapy
- Wellbeing activities including a course on boosting self-esteem, creative writing, and table tennis
- Mental health case work supports available from Community Routes
- Case work and support for women with musculoskeletal disorders due to early trauma
- A Foodbank
- Free sanitary hygiene items

7.15. Oasis Project

As part of the commissioned drug treatment services in the city, the Oasis Project delivers drug and alcohol treatment services to all women aged 18 and over. It supports women involved with the sex work industry and criminal justice system. It also provides services to children whose families are affected by drug and alcohol problems.

Many of the women the service supports are experiencing domestic violence and have housing problems. They provide holistic services in response to the issues they are presented with, these include care co-ordination and group interventions for women.

Oasis also provides a Sex Work Outreach Project (SWOP) to identify women involved with sex work. Women with complex needs are supported through case work, focusing on their priorities which may include sex work. Most of the women supported have at least two multiple complex needs.

A service is also provided to men with drug and alcohol problems whose children are engaged with Children's Services. Some of these men are likely to have complex needs.

7.16. Brighton and Hove Recovery Service (Change Grow Live)

Change Grow Live took over the Drug and Alcohol Community Service in April 2020. They provide community treatment and support for Brighton & Hove residents aged 18 and over who have a drug/alcohol misuse problem.

A range of services are available. These include

- Comprehensive assessment of needs including mental and physical health and medical review if necessary
- Opiate Substitute Treatment and prescribing
- Community alcohol detox programme
- Individual care planning and review with a care coordinator
- Psychosocial groupwork
- Facilitated access to mutual aid
- Mental Health Nurses working in liaison with local mental health services
- Partnership working with criminal justice system
- A&E liaison team
- Women only premises (Oasis) with specialist outreach for sex workers and provision for parents e.g. crèche, young carers' group
- Referral to inpatient detox and / or residential rehab as required
- Needle Exchange
- Street Outreach
- Hostel and homeless day centre in reach
- Families and carers support team

With regards to people with multiple complex needs

- Mental health liaison nurses offer reviews of Pavilions clients' unmet mental health need and referral to or joint assessment with, SPFT mental health services, and joint working as required
- Joint working (including outreach as required) with hostel teams, homeless outreach services
- MDT formulation of multi-agency care for people with complex needs, attended by ASC and other teams as required
- Criminal Justice workers engaging with clients with probation and other drug related court orders
- Commitment to joint working and information sharing to provide holistic support in partnership with other organisations; clients aware of and consenting to information sharing and joint planning
- MARAC attendance and information sharing

There is no time limit to the duration of treatment and support if the client continues to engage. Clients can also re-engage with the service immediately after discharge.

7.17. MENDOS

MENDOS is based in Hove and is provided by Rethink. It offers information, advocacy and support to people with mental health problems who are involved with the criminal justice system.

7.18. Survivors Network

The main aims of the service are;

- Survivors are more in control of their lives
- There is a greater understanding of healthy relationships
- People are more able to speak out about sexual violence
- Survivors have better health and wellbeing
- Survivors are more able to develop healthy relationships
- Survivors are more aware of the options available and more able to access support
- Survivors have a better experience of the Criminal Justice System
- Supporters of Survivors are more able to provide support

There are no services specifically for AMCN, however they can access the following services, so long as they are not substance affected during the sessions

- 26 weeks counselling for self-identified women who have experienced sexual violence at any point in their lives.
- Drop-in group running 9 times a month in Brighton for self-identified women aged 16 or over who have experienced SVA
- Helpline one evening a week
- Independent Sexual Violence Advisor (ISVA) service for people of any age or gender wanting to report sexual crimes to the police
- Therapeutic support - any gender for age 14-17, self-identified women only for age 18 or older

7.19. South East Fulfilling Lives Project: Systems Change for people with Multiple and Complex Needs

The South East Fulfilling Lives Project started in 2014 and is funded until July 2022 by the National Lottery Community Fund. The Project is one of 12 projects across England funded to (i) provide intensive support for people experiencing multiple disadvantage* (ii) involve people with lived experience of multiple disadvantage at all levels (iii) challenge and change systems that negatively affect people facing multiple disadvantage.

The Project operates in Brighton & Hove as well as in Eastbourne and Hastings and works on two levels: an immediate level – directly with people who are most in need right now; and on a lasting level – changing systems to enable people experiencing multiple disadvantage to receive the support they need at the right time. The work of the project is informed and directed by people with lived experience – working in staff teams, identifying and researching needs and solutions, being involved at a strategic governance level, and providing support and aspiration to peers.

The project is led by BHT and the delivery (client facing work) is undertaken by subcontracted partner organisations. The Brighton & Hove team is delivered by Equinox and consists of 2 frontline workers (one Specialist Women's Worker and one Specialist Dual Diagnosis Worker) and an Area Lead (Team leader).

The Specialist Workers carry small caseloads of 7-10 clients, providing assertive, specialist and personalised interventions. The project has identified five key tools and approaches that are key to supporting engagement and improving outcomes for those with the most complex presentations:

- **Effective multi-agency case coordination**, (the team around the individual); the team are trained in the Adaptive Mentalisation Based Integrative Therapy (AMBIT) https://manuals.annafreud.org/ambit/index.html model and this has proven very useful in using mentalisation to better understand a range of perspectives and formulate joint support plans.
- **Psychologically informed practice and environments**. An understanding of the psychological make up of individuals is key to providing targeted and appropriate support.
- **Multi-disciplinary risk assessment and support planning**. Managing high risk presentations and working closely with other agencies in sharing decision making and case formulation is key to supporting this cohort effectively.
- **Asset-based assessments and plans**. Strengths and protective factors are often overlooked by professionals and this can reinforce stigma and make individuals feel disempowered.
- **Trauma responsive practice**. A snapshot of the project's caseload in 2017 revealed that all had experienced complex (multiple) trauma, often starting in childhood and continuing throughout their lives. Clients who have experienced trauma often present with behaviours that many services find it difficult to manage. Effective support for those with the most complex needs requires an in-depth understanding of the impact of complex trauma on an individual's ability to form relationships and a willingness to flex the support offer in order to accommodate individual needs.

The workers receive ongoing 1:1 clinical supervision as well as line management support to enable them to practice safely and effectively.

*The project defines multiple and complex needs as those experiencing at least three coexisting difficulties (of homelessness, substance misuse, mental ill health & offending)

The Fulfilling Lives client facing work is due to end in June 2021**.**

7.20. Street Impact Brighton

Street Impact Brighton (SIB) is about helping people off the streets for good. That means very focused support for the person, whether that be with stable accommodation, with a tenancy or re-engaging with family where appropriate. The SIB team also focuses on supporting people to link in with better healthcare and access to skills, work and training opportunities that will help them successfully sustain a home and a better quality of life.

It works with 100 named individuals in Brighton who all have histories which involve prolonged or repeat episodes of rough sleeping as well as complex issues around alcohol, drug use, mental illness and/or physical health issues.

The SIB represents a new approach to financing homeless interventions. The project is a Social Impact Bond which has social investors putting up the funds to meet the scheme's running costs and is reimbursed on a 100% payment by results basis by Brighton & Hove City Council. This is backed by the Ministry of Housing Communities and Local Government (MHCLG).

Payments are received when the following specific outcomes are met:

- Accommodation sustainment
- Improved health and wellbeing
- Sustained engagement in formal treatment for those who have substance misuse
- Education, Volunteering and Employment

SIBs is not looking to replace or replicate services that people already have strong links to, but to support services, filling any gaps with targeted personal support and funds to help people really sustain their recovery.

Key factors underpinning the programme are:

- Understanding where someone is now and what they need (with support and access to services) to get where they want to be – housing, health and work
- A holistic case management approach involving relevant agencies and dealing with work, health, relationships and other areas of need as well as someone's accommodation
- A personalised, flexible and assertive outreach approach over a sustained period, backed by funds, to develop relationships that will bring people off the streets
- Access to independent accommodation as quickly as is feasible.

The two aspects of the SIB approach that have enabled it to sustain long term outcomes for some of Brighton's most entrenched rough sleepers have been:

- **Consistency**- it has a consistent presence. A client/ worker relationship that sustains from street to home is unusual, but vital for such a complex client group.
- **Freedom to innovate**- because of the focus on the outcome, SIBs has greater freedom to individually tailor its approach to achieve the end goal. This has been really important in enabling it to take creative steps that carry risks of failure, but which have often succeeded in unlocking long-held issues with some very challenging clients. This kind of approach is harder to take in more traditionally commissioned services, where costs and time spent with each client is more directly influenced by commissioning frameworks and contractual expectations.

Since the beginning of the programme, 92% of the SIB cohort has achieved accommodation entry and/or sustainment outcomes, with further 44% maintaining long-term accommodation for a minimum of 12 months.

Street Impact Brighton is a three-year programme – March 2018- March 2021.

7.21. YMCA Supported Accommodation

The YMCA has two accommodation settings in Brighton & Hove that can support people with multiple complex needs.

George William Mews

A service for 18+ single adults with support needs that include mental health difficulties, substance misuse, learning disabilities.

William Collier House

A service for single homeless people with multiple needs (addictions, mental health, learning disability, rough sleepers etc).

7.22. Brighton Housing Trust (BHT)

BHT provides essential services across Brighton & Hove, Eastbourne and Hastings, and in East and West Sussex. The organisation provides services for people with multiple and complex needs, including day centre provision, supported accommodation and specialist mental health and addiction services.

Homelessness Services

First Base Day Centre

First Base offers a range of services to support people who are sleeping rough or are insecurely housed in the city, to get off the streets and find a place they can call home.

We work with our partners in the city to ensure that through working together we can improve health, reduce crime and realise opportunity.

Phase One

Phase One is a 52 bed, high support hostel for single homeless people with complex support needs.

The project works with clients who are largely vulnerable, chaotic and entrenched and are pre-contemplative about change. We work to increase self-esteem and create a space where service users can begin to address the issues at the root cause of their homelessness, make the changes necessary to lead more settled lives, and realise their aspirations. We use a client-centred, psychologically informed model of support.

We work with clients who are using alcohol and substances and encourage them to take positive steps towards their recovery. The project has an internal accommodation pathway, with 9 spaces in the structured Recovery-Focused Flats attached to the project.

Specialist Mental Health Services

Shore House

Shore House is an innovative service which provides accommodation and 24-hour intensive support for 20 people with a range of mental health diagnoses, and those experiencing the effects of complex trauma.

Shore House is part of the Mental Health Tiered Accommodation Pathway, jointly commissioned by Brighton and Hove City Council and the Clinical Commissioning Group.

As a specialist high-support mental health service it works closely and effectively with Sussex Partnership Foundation Trust mental health teams including assessment and treatment teams and the Mental Health Rapid Response Service.

The accommodation comprises 20 individual client rooms, and a variety of communal spaces including a large shared kitchen and garden.

Archway

The Archway Project is a 24-hour residential service in Hove, comprising a five and a nine-bed house, for people with mental health support needs.

Both projects have a recovery and person-centred focus, working collaboratively with residents to enable people to move on to independent living.

The projects are funded by the Clinical Commissioning Group and regulated by the Care Quality Commission.

Addiction Services

Detox Support

The service provides a detox programme for six residents. The work aims to achieve on-going abstinence and prevent homelessness, by providing support to enable clients to achieve healthy independent living.

Clients learn the specific recovery skills needed to manage cravings as they are detoxing, communicate safely with others and to maintain motivation during and after detox until they progress to BHT's Recovery Project.

The service does not provide an alcohol detox, so if clients require one, the care coordinator will arrange for this to take place prior to starting the Detox Support project

Recovery Project

BHT's Recovery Project aims to support clients to achieve healthy independent living, free from alcohol and drugs.

The service provides safe housing and a rehabilitation programme to enable residents to sustain abstinence and rebuild their lives following addiction.

We explore the individual circumstances of each client in order to prevent relapse and prepare clients for the Move On stage of recovery, to reintegrate further into the community, take part in education, training and work, and lead a healthier life free of alcohol and drugs.

Move On

The BHT Move On Project provides safe and supported move on accommodation for men and women who have been through a rehabilitation programme, or who have experience of recovery and meet the criteria of the project.

Priority is given to those who are completing the programme offered by BHT's Recovery Project.

Residents are required to remain abstinent from alcohol and drugs during their stay, and to actively engage in education, training or employment activities.

7.23. Southdown

Southdown provides a range of services including housing and community support which can be accessed by people with multiple complex needs. These include:

Southdown Homelessness Prevention and Mental Health Support

Previously known as Community Links and Community Connections, the Southdown Homelessness Prevention and Mental Health Support Service provides short-term, flexible support to prevent homelessness and improve people's mental health and wellbeing.

Southdown Community Engagement Service

The Community Engagement Service works in close partnership with Primary and Secondary Clinical Services and other key providers in Brighton and Hove to ensure integrated pathways for people accessing support, in particular for those who are facing complex situations. Community Engagement Workers support people with severe mental health challenges and complex lives. They also signpost for individuals struggling with substance misuse or for those involved with the Criminal Justice system whose risk or re-offending is connected to their mental health.

7.24. Route One

Route One provides a dynamic, flexible approach to supporting people with mental health and complex needs, incorporating the recovery model, trauma informed care and working within a psychological informed framework. It also provided accommodation to 60 adults with mental health and complex needs, including dual diagnosis.

7.25. St. John's Ambulance – Brighton Homeless Service

St. John's Ambulance helps homeless and vulnerably housed people. Service provision includes: primary healthcare, first aid, nurse-led service, podiatrist, basic health assessments and a mobile treatment centre.

7.26. Equinox Brighton Women's Service

Brighton Women's Service is a female-only residential project providing nine high-, multiple-, and complex-needs beds and ten medium- to low-needs beds for women who have experienced homelessness and have support requirements involving issues surrounding drugs and alcohol, offending behaviour, mental health and/or domestic abuse.

It has created a positive, supportive environment at residences in Brighton in which women with these needs can develop the skills and resilience to move on to independent living and live happier, fulfilled lives. The primary goal is to engage positively with service users so that they can identify their own needs and benefit from appropriate support and treatment services.

It works with service users to prioritise the issues they want to address and supports them to develop a recovery plan that meets their individual needs. This may include working with substance misuse agencies, engaging in activities such as education or creative activities, counselling, support with money management or debt advice, and addressing any physical and/or sexual health issues they may have. It works with local GPs and Arch Healthcare to ensure all women have access to primary healthcare services. Where women are mothers they also work closely with Social Services and the wider family to ensure they are able to maintain safe access.

8. Conclusions and Recommendations

8.1. Conclusions

It was clear from the beginning that this needs assessment would not be straightforward and that there would be several barriers to overcome if the original objectives were to be met. It soon became apparent, particularly in relation to the data and information available, that it was unrealistic to expect to be able to replicate at a local level the national work that had previously been done to provide estimates of the numbers of people living with multiple and complex needs. But at the same time, it was acknowledged that as a result there would be learning to inform future information sharing between agencies and any future needs assessment should it be repeated.

Despite the above challenges, the representatives of the agencies involved have been very committed to the needs assessment. In particular, information colleagues across all agencies have gone to great lengths to identify and analyse the relevant information and to present it in an understandable format to the external reader.

The first task for the steering group overseeing the needs assessment was to agree the definition of the population. After a great deal of discussion the following definition was agreed;

People aged 16+ experiencing at least two combinations of housing issues/homelessness, substance misuse, offending, mental health and domestic abuse issues with an overarching focus on complex trauma and equalities

The steering group discussions did cover the inclusion of specific groups in the definition and some information relevant to these groups has been collected but it soon became apparent that for the purposes of understanding the scope of the work the above definition would provide the parameters for the work to enable it to be delivered.

It is also important to acknowledge that for some organisations Severe and Multiple Disadvantage is a preferable description to Multiple Complex Needs as the former has more of a sense of social injustice and allows for a more positive asset-based approach.

One of the main areas of discussion was about adverse life experiences and their relationship with multiple and complex needs. Information and research about Adverse Childhood Experiences (ACEs) is increasing all the time and much more detail is available elsewhere. From the perspective of this needs assessment the key conclusions were;

- that complex needs in adulthood are linked to both childhood and adult adverse experiences
- that it is important to understand the potential impact of ACEs on an individual's life-course so as not to blame adults for the consequences of their childhood experiences
- that although interventions needed to address ACEs as a primary cause lie outside of this JSNA it is still important to emphasise both the link between ACEs and adults living with multiple complex needs and the importance of addressing

the wider social determinants of health and wellbeing as underlying causes of ACEs.

As regards issues with the current services for people living with multiple complex needs the negative features of services identified included;

- Existing silos and barriers between professionals prevent a truly joined up approach to the support for people with multiple complex needs.
- Once someone acts as care-coordinator other services may pull back from providing support
- There is no central organisation of services for people with multiple complex needs
- There are too many different services for people to deal with
- Women with multiple complex needs are a hidden population
- Dual Diagnosis remains an issue. There are issues for both mental health and substance misuse services and the ways they work together. And it is also an issue for those people with mental health and substance misuse issues, but who don't have a definitive diagnosis.
- Access to housing and being housed out of area
- Issues around the requirement for people with multiple complex needs to meet the access thresholds for individual organisations to receive help, whereas it is clear that taking an holistic view of their needs they should be provided with services.

Some of the positive features noted were;

- Complex risk management meetings
- "Care-navigators" are the right idea
- Care-coordination by certain organisations
- Flexibility of some people and organisations to meet people's needs urgently
- Staff commitment and the quality of their support to people with multiple complex needs

Taking all the above the steering group agreed that the principles of service delivery for this group, or any new commissioned service should include;

- A trauma informed approach. This will have clear implications for staff training
- A service that can meet the different needs of both men and women
- Access to services because of the combined level of a person's multiple needs even if the level of need falls below individual organisational thresholds
- An identified person to be the key point of contact for that client and coordinate a multi-agency response
- Appropriate support and supervision for staff. Frontline non-clinical workers must be supported and should be able to access clinical support from their colleagues when they require it. The AMBIT model supported by a Multi-disciplinary Team is considered good practice.

It was found that the key components of service delivery for people with multiple complex needs should include;

- Easy to access services
- Active engagement and outreach
- No requirement to meet a single threshold
- No time limit on support
- Staff with lived experience
- Helpful teams
- Trusting relationships
- Supportive, non-judgemental workers

8.2. Recommendations

Inevitably recommendations tend to focus on gaps. But it is important to acknowledge all the good work that is already taking place across the city and the commitment and energy from staff across local agencies to supporting people with complex needs, sometimes despite the organisational barriers they have to overcome. Naturally the following recommendations apply to the population included in the scope of this needs assessment but the priority for local services is to meet the needs of those people living with the most severe and multiple disadvantage who are often living with three or more of the five needs included in the definition.

1. To explore the feasibility of developing shared information systems across local services which will benefit both service user and service providers.

This system will need to address the many existing data gaps for people with multiple complex needs such as for offenders, people with learning disabilities, migrants and asylum seekers, people from the LGBTQ community, young people and other protected characteristics. This will require support from commissioners.

As has been highlighted there were significant data gaps relating to some services, to various groups of people and around equalities. Some organisations were not able to record some of the 5 factors on their systems.

The local Fulfilling Lives service initially aimed to develop shared data systems between partner organisations but has subsequently moved to services asking about additional specific needs to ensure they are being identified.

A suggestion for further consideration is the possible development of a new single measure as an indicator of an individual's overall complexity.

2. Information held by organisations on their clients and patients with multiple complex needs should be comprehensive, up to date and shared appropriately and in a timely manner between organisations when it needs to be.

Within some organisations and across organisations data on clients is not always collected in a consistent way or format which leads to client information often being incomplete and potentially out of date. It was noted that some organisations' databases are dynamic and continually update the information held on their clients. This makes it difficult for them to look back at their clients' historic data to assess change.

3. To promote successful information sharing, all organisations need to work to build trust between clients and their own and other organisations.

This is a fundamental part of developing an integrated information and support system. It is also an integral part of information governance.

4. People with lived experience should be engaged by local organisations in a broad range of roles related to service design and delivery.

The evidence shows that if services are to be equitable, acceptable and relevant, they need to involve service users and Peer Worker programmes. When asked about service strengths in the service user focus groups, substance misuse clients gave staff with lived experience as an example. *'I feel that my worker genuinely cares for my wellbeing and understands what I've been through'* (SM)

Peer workers are already a key element of some services that work with people with multiple complex needs in Brighton & Hove.

There is wide agreement about the importance of people with lived experience being involved in service delivery. This includes but does not necessarily mean being employed by the organisation. Service user involvement and peer worker programmes should be considered as standard practice.

5. **That each person living with multiple complex needs should have an identified lead professional/practitioner (care-coordinator or keyworker equivalent) who coordinates the multicomponent interventions being provided.**

One of the areas identified as in need of improvement in the service user focus groups, was around co-ordination of care. Some of the participants commentated that the care pathway was hard to navigate, services were not joined up and that they lacked control over their care. The evidence shows that the best results come for clients when there is holistic care, carried out in partnership. Successful delivery though needs a lead professional to work across the complexity of the different services involved in the holistic care. The stakeholder interviews also highlighted the importance of good care co-ordination. They felt it was important to know who is doing what when there are lots of people involved. If you share the burden and the workload, you feel more supported.

Ideally this person would be nominated by the client and would be the person who has the best relationship with them. It does not have to be the most senior member of the team. Equally important is that this person is supported by a multi-agency group. Nobody can be expected to be an expert in all the areas relevant to this client group and therefore the ability to be able to confidently refer to colleagues in other organisations is paramount to effective service delivery.

6. To develop a more inclusive approach to supporting people with multiple complex needs with all levels of combined mental illness and substance misuse.

Progress has been made locally over the last five years in the provision of services for some groups of people with combined mental illness and substance misuse (also

referred to as dual diagnosis). There is an existing local co-existing conditions group which meets regularly.

As the substance misuse data shows 70% of the 1,909 clients with multiple complex needs also had a mental health need. The level of need will vary greatly but treatment and support services need to be able to provide support for people across the spectrum of combined mental health and substance misuse. The evidence showed that in the three disadvantaged groups (substance misuse, offending, homelessness), women were relatively more likely to have a dual diagnosis.

People with lived experience identified many positive features about good joined up practice, but they also highlighted issues with accessing services in general because of their substance misuse or mental health problems. They also highlighted a lack of staff experienced in dual diagnosis.

Professional stakeholders acknowledged the good work that takes place but also highlighted the many issues related to dual diagnosis including the difficulties in getting services to accept certain clients e.g. "*With substance misuse and mental health, quite often in terms of accessing a service it will be, well we can't support a client with their mental health until they're reduced their substance misuse and vice versa."* For this client group services need to work together in a flexible manner to develop an integrated approach to meeting the individual client's needs, particularly for the most complex cases.

The evidence suggests that the direction of travel for commissioners and providers should be ever closer working and ultimately an integrated mental health and substance misuse service. Meeting this approach will require further, ideally integrated, training for both mental health workers about substance misuse and vice versa.

7. Services should practice a trauma informed approach.

Adverse Childhood Experiences (ACEs) play a significant role in adults going on to live with multiple complex needs. It is estimated that up to 48% of the English population experience one ACE, and 9% up to 4 or more. They increase the risk of health harming behaviours, including poor physical and mental health. The stakeholder interviews all identified trauma as having a role in their clients' history. "*There's a bedrock of early trauma and abuse… including issues of neglect and attachment".* Training staff in a Trauma Informed Approach is an effective way of supporting adults with Multiple Complex Needs as a result of ACEs. This builds knowledge and awareness about the consequences of ACEs amongst professionals; as well as collaborative approaches across sectors and organisations. Women in particular will benefit from trauma informed approaches. Many of them have complex trauma as a result of their own negative childhood experiences, which is then compounded by the loss of their own children to the care system as adults.

Staff across a wide range of agencies should be supported to understand the impact people's Adverse Childhood Experiences and adverse adult experiences can have on behaviours, health and wellbeing and enable staff to respond appropriately. This will

require training at all levels across all services to develop a shared learning and understanding of the local approach to trauma.

8. Addressing the housing needs of men and women with multiple and complex needs is a priority.

The lack of housing is a citywide issue. However, the findings from the interviews with both people with lived experience and the professional stakeholders reinforced how much of a priority need it is for this client group and how stable housing for people with multiple complex needs is fundamental to the delivery of effective services. It is also important not to place people out of the local services' area of provision unless there are compelling reasons to do so. The feedback from people with lived experience suggests they want to be more engaged in the discussions about their accommodation.

A range of accommodation options is required within the city to meet the range of care and support needs people present with. People with lived experience highlighted the need for suitable accommodation for people in recovery from substance use. It is also needed for those who are not yet in recovery but who need the benefit of stable accommodation to enable them to begin to consider engaging with recovery services. The "Housing First" model is considered an example of good practice.

The report has highlighted how women are often the hidden homeless and that there is a lack of suitable accommodation for women. Young adults, including care leavers, are sometimes being placed in adult hostels. There is a lack of transitional accommodation and support into adulthood. This is one of the key factors contributing to young women being at risk of becoming rough sleepers and consequently being exploited and abused.

9. Services need to be gender informed and culturally sensitive and provide services which meet the needs of both men and women.

Naturally services should be delivered in an equitable way across all groups. However, as is clear from the information presented here people with severe and multiple disadvantage both suffer inequity both as a group and in respect to their own characteristics.

Women experience multiple complex needs differently to men, which can lead to them being overlooked by services. They are more likely to develop anxiety and depression as a result of their experiences, rather than the anti-social behaviour, personality disorders and alcohol misuse often shown in men. Women are also more likely to have been the victims of interpersonal violence and abuse than men. Homeless Link estimated that 30% of its homeless project clients were women but only 7% of accommodation was specifically for them. 79% of their clients' who were mothers, had also had their children taken into care.

The stakeholder interviewees felt that to improve care for women in the city there needed to be a gender informed approach, where practitioners are skilled and understand the structural inequalities that affect women.

Services have tended to focus mainly on men. As is clear from the evidence in this report women with multiple complex needs may not be so apparent to services. Women have been described as the hidden homeless. Women are more likely to have experienced violence and to be looking after children who may be taken into care. Services need to address the gender specific aspects of clients with multiple complex needs including parenting, trauma and violence.

The report has also highlighted the need for services to be culturally sensitive. At the time of writing this is being borne out by the COVID-19 pandemic and the increased risk of infection and mortality being seen in the BAME community. As this report has highlighted BAME communities may be less inclined to engage with mainstream services for a range of reasons including language barriers and racism.

10. The physical health needs of people with multiple complex needs must be addressed alongside their mental health and substance misuse needs.

People with multiple complex needs suffer from a range of different morbidities and die prematurely. As has been highlighted the average age of death for local people with multiple complex needs is more than 30 years earlier than the general population. This gap reflects the consequence of a range of social determinants on health and wellbeing both in terms of health behaviours, such as high rates of smoking, and a range of often long-term mental health and physical health conditions, including blood-borne viruses and liver disease, which are more common amongst some groups of people with multiple complex needs. Engaging with primary care and other health and wellbeing services is a fundamental part of addressing these needs.

Primary as well as secondary healthcare services will need support to develop a truly flexible approach to enable people with multiple complex needs to access the services they need. Adopting a flexible approach will be more straightforward for some organisations than others, and primary care commissioners will need to support this approach to service delivery including through staff training on a trauma informed approach.

Both professional stakeholders and people with lived experience reported that GPs are often unable to help people with complex needs because they do not have the latest information about the person. This emphasises the need for the timely sharing of information by other agencies with general practices.

9.Appendices

9.1. Professional voice interview questions

UNDERSTANDING AND IMPROVING THE CARE OF ADULTS WITH MULTIPLE COMPLEX NEED

Topic Guide

1. **Can you tell me about your role?**

2. **Can you tell me about the clients your organisation works with?**

3. **Thinking about the clients you see, how would you describe a client with 'multiple complex needs'?**

Prompts

- *What proportion of your clients do you estimate have MCN?*
- *What sort of needs do they have?*
- *Is there anything in particular apart from their 'conditions' that characterises your clients with MCN?*
- *Explore differences in definitions for purposes of clarity across organisations*

Definition of MCN for JSNA: People aged 16+ experiencing <u>at least two</u> combinations of housing issues/homelessness, substance misuse, offending, mental health and domestic abuse issues with a an overarching focus on complex trauma and equalities.

4. **How does <u>your organisation</u> manage the care of adults with 'multiple complex needs'?**

a. Can you give me an example of what you think is working well?
b. Can you give me an example of some of the challenges?

Prompts

- **Meeting the specific needs of women (mental health/domestic abuse/sex workers)*
- *Considering adverse childhood experiences*
- *Groups with unmet needs (people with LD, young homeless people)*
- *Shared decision-making between AMCN clients and services*
- *Referrals between services e.g. eligibility criteria*
- *Information sharing between services*
- *Co-ordination of care between services*
- *What assets does the organisation have e.g. skills that can be used for benefit of this group?*

5. **What works well for adults with multiple complex needs <u>in the city</u>?**

6. **[In an ideal world] What could be done differently to improve the care of people with multiple complex needs <u>in the city</u>?**

7. **Are there any issues we haven't already covered which you would like to raise?**

9.2. Models of Care – national examples

<u>Adults with Multiple Complex Needs – Examples of service models</u>[i]

<u>MEAM Approach</u>[ii]

MEAM is a coalition of CLINKS, Homeless Link and Mind. It has seven core elements that should be considered in all local areas but does not prescribe a particular way these elements should be achieved.

1. Partnership and audit
2. Consistency in client identification
3. Co-ordination for clients and services
4. Flexible responses from services
5. Service improvement and gap filling
6. Measurement of success
7. Sustainability and system change

<u>Changing Lives</u> [iii]

Changing Lives is based in the North and Midlands of the UK, and is a core partner of the Newcastle & Gateshead Fulfilling Lives programme. It provides specialist support to 6,000 people per month with multiple complex needs.

Service provision includes:

- Short and long term housing for vulnerable people; emergency accommodation; Housing First; semi-independent living and independent tenancies
- Recovery services for substance misuse
- Community outreach – including the street homeless
- Specialist services for women offenders/ at risk of offending – holistic, trauma informed interventions to meet women's specific complex needs
- Support for sex workers and the sexually exploited

- Services for victims and survivors of domestic abuse – refuges, advocacy, move-on, support and sanctuary
- 20% of the workforce are experts by experience
- Staff have a trauma informed approach and use Dialectical Behaviour Therapy
- The work is delivered by Psychologically Informed Environments (PIEs)
- Strengths based approach
- Person centred priorities
- Assertive and persistent offers of support
- Non-judgmental staff

Inspiring Change Manchester (ICM)[iv]

This is a Fulfilling Live programme consisting of the following elements

- Getting Real Opportunity of Work (GROW) Traineeships. – Provides paid work opportunities for people with multiple disadvantages that can lead to a career.
- Housing First
- GM-think - Multiagency database which lets services across Greater Manchester share information quickly and securely. Organisations can co-ordinate work and prevent people retelling their story to each new service. Individuals are involved in their own support planning by updating their goals and achievements.
- No Wrong Door – Co-production with people with lived experience.
- Lived Experiences involvement in: Xchange, Women's Voices and Core group, enable service users to participate in the programme
- Women's Voices – A group which aims to develop equal opportunities for women and runs campaigns
- Membership: ICM – A membership system is being developed for ICM so that it has a less transactional and assets based approach and moves beyond the provider/user relationship.

Manchester has also been developing a local authority led Trauma Informed City policy approach

https://www.manchestersafeguardingpartnership.co.uk/resource/adverse-childhood-experiences-aces-resources-for-practitioners/

https://www.manchestereveningnews.co.uk/news/greater-manchester-news/how-trauma-training-harpurhey-school-17145382

Birmingham Changes Futures Together[v]

This is a Fulfilling Lives programme consisting of the following elements

- In-reach Outreach Service
- A Navigator Service
- Lead worker Peer Mentor Service

- Care Navigator Service
- Liaison and Diversion Service (for offenders)
- No Wrong Door Network – Including shared IT system
- Management and Co-ordination of Bridging Fund
- Co-ordination, support and implementation of Housing First
- Every Step of the Way – delivered by Birmingham Mind, supporting individuals with lived experience to participate in the programme and influence local systems
- Promotion and delivery of PIEs training

Blackpool Fulfilling Lives[vi]

- Navigators link clients to key services
- Assistant Navigators – Front line workers with lived experience
- Volunteers
- Therapeutic activities – Life skills, social activities
- Personalisation Fund
- Housing First
- Lived experience "Multiple Disadvantage Friendly" accreditation scheme. Organisations are assessed and agree to an action plan to ensure true co-production in service design

Fulfilling Lives (FLIC)

This service has a focus on women with complex needs.

- Housing First housing model for women, for women with multiple disadvantages and domestic abuse. Five high risk women are prioritised by Islington MARAC and the service is managed by a domestic abuse organisation – Solace Women' s Aid
- Team Around Me case conference tool - FLIC, in collaboration with Pause Islington, have created the Team Around Me model – a new structure for holding case conferences or multi-agency meetings for clients experiencing multiple disadvantage who need a multi-agency response

The Blue Light Project

The Blue Light Project was originally developed by Alcohol Concern as a means of supporting and motivating high impact dependant drinkers, who are not in touch with treatment services and have complex needs. It has developed the Blue Light Manual - a framework that services can use to target interventions. The Blue Light approach involves bringing key agencies such as police, housing, mental health, hospital and others together with the specialist alcohol services. This allows the identification of key individuals (often known to most or all services in the area), and the development of consistent, jointly owned interventions.

The key principles of this model of care include

- Building strategic ownership of the need to tackle the client group

- Training of specialist and non-alcohol specialist staff in the Blue Light approach
- 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

9.3. Impact of COVID-19 on local services for people with MCN

The work on this JSNA began before the COVID-19 Pandemic of 2020. It was felt by the JSNA Steering Group that as this has had such a massive impact on the way services to people with multiple complex needs were being delivered during this time, it was important to capture this, so that any positive or negative lessons can be learnt.

ARCH

Many ARCH patients have multiple complex needs, and navigating new systems, as well as managing their own anxiety and vulnerability has made this an extremely challenging time. *Many people rely on their contact with Arch Health as an important aspect of their personal support network so switching almost all appointments to telephone calls made engagement much more difficult and less beneficial for people who felt safest in the company of their regular clinician.*

There has been a huge drop in wider support for people during the pandemic with the closure of day centres and other vital services. The disruption to many healthcare services has left people more vulnerable, more isolated and in some cases with deteriorating mental and physical health. ARCH patients usually benefit from the many support services in the city who will opportunistically notice deteriorating health and encourage patients to contact ARCH. Without these 'eyes and ears' all over the city health needs may have gone unnoticed and conditions may have worsened before people seek help. Some of those with multiple and complex needs have found compliance with self-isolation and social distancing guidelines extremely difficult leaving themselves and others exposed to the virus.

For some drug users the reduction and fluctuating level of supply of street drugs has led to erratic usage and unsafe injecting, all of which can be more harmful.

The Care and Protect model of homeless accommodation has had a positive effect on the physical and mental health of those people living in the hotels, as well as caring for and protecting people from COVID19. The availability of food, somewhere safe, warm and dry to sleep, wash facilities, support staff and onsite clinicians, has led to many health benefits for those who would have otherwise lived on the streets during this time.

Fulfilling Lives

The impact of COVID-19 on Fulfilling Lives clients has been considerable.

- Other services clients engage with are no longer offering face to face or outreach sessions, including domestic abuse and substance misuse.
- FL has maintained face to face contact (although less frequently) through the use of PPE and social distancing. Clients report this has stopped them feeling abandoned and find the interactions positive
- Some clients have reconnected with their families during the pandemic, while others have remained estranged, compounding feelings of abandonment
- FL workers can be the only face to face contact for some clients, besides pharmacists, drug dealers or sex work clients. This FL contact has been invaluable

Substance misuse

All Opiate Substitution Treatment (OST) prescribing was reviewed in line with clinical guidelines, consideration of the impact of lockdown and patients' health status. When assessed as safe, pharmacy attendances were reduced. Pharmacists were given the responsibility to remove supervised consumption as they saw appropriate, often in consultation with the prescriber. Where risk and other circumstances dictated, daily supervised consumption has continued.

Some clients have managed well with this and felt empowered and trusted to manage their prescriptions.

Impacts have included

- According to CGL data there has been an increase in numbers in treatment since the start of the pandemic and CGL outreach workers are reporting clients with MCN are engaging better over the phone than in person
- Moving onto methadone and buprenorphine and substance misuse treatment due to lack of income for illicit drugs
- Clients continuing to engage with FL support
- OST titration model carried out over the phone which has enabled some clients to adhere to the titration regime more easily

Criminal justice

Individuals have continued to be released from prison into homelessness. Prisoners within two months of release are being released early but liaising with prisons about arrangements is proving difficult. If prison visits continue not to be allowed pre-release video calls about housing will be arranged.

Clients are engaging better with probation and therefore abiding by their licence agreement, though a change to phone call appointments from doorstep visits may impact this.

Reduced desire or ability to recall for non-attendance, heavier reliance than usual on updates/support from third sector services

Mental health support

Some clients are feeling the impact of the wider changes due to lockdown. Some are currently struggling with panic attacks and starting to feel a bit more isolated. Some who experience anxiety have had that anxiety decrease as they felt less pressure to go outside.

Positives

- Maintaining face to face contacts
- Good engagement with Mental Health Homeless Team
- Adult Treatment Service Interface – good way to keep in contact with secondary care

Negatives

- Some services not engaging face to face has had a negative impact on some clients
- Community mental health services continue to be difficult to engage with

Women

- Some refuges have paused referrals and stopped outreach work. RISE has stopped face to face work
- Clients having to adapt to telephone support
- FL has focused on maintaining face to face contact and supporting clients with credit for phones/mobile data

Other sectors

Primary care

Some clients have found engaging with GP appointments on the phone positive and much easier to access than going there physically; although they don't get as much support from workers by this method

Anxiety about hospital appointments has increased for some clients, leading to cancelled appointments.

A number of clients have engaged positively with the recovery community online, including AA meetings on Zoom

RISE

Evidence shows that domestic abuse and violence against women increases both during and after natural disasters and disease outbreaks like the COVID-19 Pandemic (Dominelli, L. 2015; Maglajlic, R., 2019; Reese, D., 2004). In the UK, Refuge has seen a 25% increase in calls to its domestic abuse helpline, and a 150% increase in visits to its online helpline. Women's Aid has reported a 41% increase in visits to its live chat service since the lockdown began.

Local impact

- Increase in helpline calls. Three times greater than the week before lockdown and peaking at 80 a week in early May.
- Increase in referral rate, with a doubling in early May. 19 referrals per week at end of June is four times higher than pre-lockdown
- Cases are more complex with increased mental ill health and suicidal ideation
- BAMER cases are have high levels of anxiety and people with disabilities are becoming social isolated
- Some COVID-19 housing services have not been gender sensitive, placing women who have experienced domestic violence in the same accommodation as perpetrators.

Services that continue to be provided by RISE locally include.

- Refuge
- Helpline
- High risk/high need
- Therapy – some online groups for adolescents and plans for more to move online
- Remote working – Hospital, Criminal Justice Workers, BME and LGBT+ workers. Case work and community projects.
- Homelessness assertive outreach service continues and RISE Community Ambassadors

Funding has been negatively impacted by the pandemic by limiting the ability to fund raise and slow confirmation of funding streams from the MOJ. BHCC has extended funding for six months and a similar request has been made to the Big Lottery but the financial future is precarious and may lead to some redundancies.

Sussex Partnership Foundation NHS Trust

The main changes in the delivery of services to mental health patients are outlined as follows:

- Most service interactions moved from face to face to online, which may have unintended consequences for those patients with the most complex needs and challenges around engagement with statutory services
- Community mental health provision was encouraged to risk assess each patient intervention, to establish whether face to face assessments would be more clinically effective given the patients' circumstances and risks
- SPFT contacts with patients with psychosis increased during lock down, reflecting their higher levels of need.
- Referrals to secondary mental health care services declined during the lockdown period but have been back to near pre-COVID levels since mid-June.

Positives

There have been positive developments for this patient group as a result of Covid- not least the health and social care system working more closely together and the ability to make swifter decisions. For example the development of Havens / Urgent Care Lounges across Sussex and the expansion of the Sussex Mental Health Line

Department of Work and Pensions (DWP)

Many people with multiple complex needs will require support from the DWP. During the pandemic their experience of using this service will have changed dramatically due to the

Impact of: heightened demand on the service; the proportion of the workforce shielding, and the necessity to cease previous working models and procedures to ensure public health and social distancing.

Caseloads have typically risen by 150% with daily new claim volumes increasing between 2 and 8 times what would have been expected 12 months ago. All face to face contact has been paused except for very urgent cases, meaning that increased need for engagement with higher numbers has moved to telephony - with a sizeable portion of this carried out by staff working from home. There has been an increased incidence of clients reporting risk of suicide and domestic abuse. This has required training and support for home workers to enable them to respond appropriately, linking to known services, ensuring safeguarding and providing wellbeing for staff.

10. GLOSSARY

A & E	Accident and Emergency
ACEs	Adverse Childhood Experiences
AMCN	Adults with Multiple Complex Needs
APPG	All Party Parliamentary Group
AVA	Against Violence and Abuse
BAME	Black, Asian and Minority Ethnic Groups
B & B	Bed and Breakfast accommodation
BME	Black and Minority Ethnic Groups
BHT	Brighton Housing Trust
CHAIN	Combined Homelessness and Information Network
CINAHL	Cumulative Index of Nursing and Allied Health Literature
CMHN	Community Mental Health Nurses
COPD	Chronic Obstructive Pulmonary Disease
CPP	Child Parent Psychotherapy
CQC	Care Quality Commission
CTC	Communities That Care
GP	General Practitioner
HMIC	Health Management Information Consortium
HMPPS	Her Majesty's Prisons and Probation Service
ICD	International Classification of Diseases
iSVA	Independent Sexual Advisor
IPP	Infant Parent Psychotherapy
IRMS	Intensive Risk Management Service
JSNA	Joint Strategic Needs Assessment
KSS CRC	Kent Surrey and Sussex Community Rehabilitation Company
LGB	Lesbian, Gay and Bisexual
LGBT	Lesbian, Gay, Bisexual and Trans

MAHHM	Multi Agency Homeless Health Meetings
MARAC	Multi Agency Risk Assessment Conference
MCN	Multiple Complex Needs
MDT	Multi-Disciplinary Team
MEAM	Making Every Adult Matter
MST	Multi Systemic Therapy
NBP	New Beginnings Programme
NICE	National Institute for Health and Care Excellence
NDTMS	National Drug Treatment Monitoring System
NHS	National Health Service
NPS	National Probation Service
OASys	Offender Assessment System
ONS	Office for National Statistics
OPD	Offender Personality Disorder Partnership
PATHS	Promoting Alternative Thinking Strategies
PHE	Public Health England
PHW	Public Health Wales
PIES	Psychologically Informed Environments
PTSD	Post Traumatic Stress Disorder
SEEK	Safe Environments for Every Kid
SMD	Severe and Multiple Disadvantage
SP	Supporting People
SPFT	Sussex Partnership Foundation NHS Trust
SVA	Sexual Violence and Abuse
UCL	University College London
UK	United Kingdom
USA	United States of America
WASS	Women’s Accommodation Support Service

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