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Executive summary

Introduction

Severe Multiple Disadvantage (SMD) refers to people with two or more of the following issues: mental health issues, homelessness, offending and substance misuse. SMD can include other sources of disadvantage, for instance poor physical health, and for women, domestic and sexual abuse - and for Black, Asian and Minority Ethnic (BAME) people, community isolation. Nottingham has the 8th highest prevalence of SMD in England - currently it is estimated that over 5,000 of the City's citizens experience SMD.

SMD mainly originates in adverse childhood experiences, approximately 85% of people facing SMD have experienced childhood trauma. This effects mental health which can lead to issues such as homelessness, substance misuse and offending. Services working with people facing SMD struggle to meet needs, because they are mainly set up to deal with single issues. The consequence for people facing SMD is their *other* issues prevent them successfully engaging with single issue treatment or support. For example substance misuse may lead to exclusion from a mental health service. Instead they tend to end up at "blue light services": e.g. A&E, Ambulance calls outs, arrests and custody. The economic cost of this "siloed" and unconnected approach is high - one source estimates across England it is £10.1 billion a year.

Unmet need and gaps

Given the nature of multiple disadvantage there is not sufficient cross sector collaboration and coordination between mental health, housing, criminal justice and substance misuse services – as well as social care and the DWP. This lack of coordination and collaboration exists at all levels from ground level staff to strategy

and commissioning. Part of this lack of collaboration is a lack of data sharing which causes people facing SMD to have to keep repeating their story and this contributes further to their alienation from services.

As SMD is primarily a consequence of trauma, a mental health response is central to meeting needs but often people facing SMD cannot get access to the mental health services they need especially psychological intervention. Nor is there sufficient psychological understanding of people facing SMD from the wider workforce.

Where SMD results in homelessness, appropriate housing solutions are not often available. Hostel provision has limited success especially for people facing SMD whose needs are most acute. Housing First has a good evidence base as an alternative but there is not enough provision.

Citizens facing the most acute SMD, can benefit from specialist support from a dedicated SMD service. Opportunity Nottingham aims to provide this until 2022 but after this a replacement will need to be found. Evidence suggests people facing SMD must be involved in developing their own solutions to the disadvantages they face. This includes individually through strength based approaches and collectively through ensuring the system is service user led or informed.

Recommendations for consideration by commissioners

The following measures for consideration by commissioners have the potential to reduce both the incidence of SMD and its negative impact. They build on the five Opportunity Nottingham System Challenges for Nottingham City – available here: http://www.opportunitynottingham.co.uk/latest-news/news/system-change-challenge-join-in/

1. **Once Opportunity Nottingham ends in 2022, continue to respond to multiple and complex needs by building on its legacy through considering developing a jointly commissioned specific SMD Service.**
   This service will work with people facing SMD who have the greatest level of need and will build on the success and learning of Opportunity Nottingham and the Fulfilling Lives programme. Evidence therefore suggests it should be a multi-disciplinary team containing as a minimum the following elements:

   - A team of Coordinators/Navigators
   - Mental health specialists able to provide psychological interventions and support Psychologically Informed Environments (PIE)
   - A Lived Experience Team that includes staff to support Expert Citizens and Peer Mentors, and focuses on connecting people to positive social networks
   - Gender and Culturally specific elements – which may include posts hosted by specialist agencies
   - A Practice Development Unit – to promote good practice and collaboration more widely
   - A Social Worker working as a “trusted assessor” to support access to care services

2. **Ensure the "system works as one" through development of a strategic "Board" responsible for reducing SMD beyond the end of Opportunity Nottingham in 2022.**
   This SMD "Board" should oversee service provision and continued system change. This is needed because resolving SMD involves different sectors (principally: mental health, homelessness, substance misuse and criminal justice, but also other sectors such as the DWP and Probation). SMD will only be reduced if senior representatives from these sectors collaborate to ensure a unified approach. Therefore, the highest priority must be given to ensuring genuine and consistent representation from all sectors, with time allowed for this by individual organisations. The Integrated Care System and other strategic initiatives should be used to lever support from all sectors.

   The Board would oversee implementation of point one above but also ensure coordination of the wider number of people facing SMD, who will benefit from a coordinated approach but whose needs would not be sufficiently high to qualify for the new SMD service as described in point one above.

3. **Increase over time the number of Housing First Units in Nottingham to 200 as part of the legacy to support SMD once Opportunity Nottingham ends.**
   This figure is based on evidence from Homeless Link that Housing First is suitable for approximately 10% of people facing multiple exclusion homelessness. So, 200 units would be sufficient for approximately 10% of the Nottingham SMD 3/4 cohort. To ensure this is a successful initiative it will need to be linked to the wider housing strategy, especially housing supply and be backed by tenancy support operating at a low resident to worker ratio.

4. **Understand the centrality of addressing mental health issues to enable people to move away from SMD. This will be underpinned by the wider goal of ensuring Nottingham becomes a city where the wider workforce apply a psychologically informed approach.**
   This will include:
   a) All services working with people facing SMD taking a psychologically informed (sometimes referred to as trauma informed) approach. This should not only include any specific SMD services, but also single issue services that work with people facing SMD including; homelessness services, substance misuse services and the DWP. The use of a psychologically informed approach should be monitored through use of an appropriate tool, such as the PIZAZZ or the Homeless and Inclusion Health standards for commissioners and service providers (Pathway, 2018).
   b) Mental health specialists should be included as part of a multi-disciplinary approach in any service substantially working with people facing SMD. This includes substance misuse services and the Rough Sleeper Outreach Team

c) The recommendations from the CCG funded research by Sheffield Hallam University: Understanding the Mental Health Needs of Homeless People in Nottingham (2018) should be implemented.

5. **Ensure flexibility in the way we work with people facing SMD by providing gender and culturally responsive support in recognition of the diverse forms multiple disadvantage takes.**
   Evidence suggests the mainstream definition of SMD (mental health, homelessness, offending and substance use), can lead to some group's disadvantages being overlooked, including women and BAME people. Therefore, services need to be gender and culturally responsive and commissioners should monitor this. Additionally, gender and culturally specific services able to work with people facing SMD service should be considered.

6. **Support the long-term wellbeing and independence of service users by challenging stigma and by building on their strengths, skills and positive networks.**
   Ensure that positive outcomes are sustained by commissioning services that take a strength based approach, focus on skills development and enable supportive positive networks. Without such emphasis, people facing SMD will not be able to build their own resilience and the costly and ineffective "revolving door" experience will be in danger of continuing.

7. **Minimise the likelihood of SMD occurring by recognising the origins of SMD mainly begin in early life, and by equipping services for children to respond.** Eighty five percent of people facing SMD have early life trauma and adverse childhood experience. The best long term solution therefore is early intervention through better services supporting children and young people. These should respond to ACE's and trauma and identify and support young people at risk of moving into the SMD group.

8. **Ensure the system works as one and tackles stigma through a "no wrong door" approach, by continuing the work of Opportunity Nottingham to increase data sharing**. This involves supporting systems to improve data sharing (where consent is given) that prevents constant retelling of stories and enables more efficient interagency working, speeding up delivery of services. The inclusion of "Facts about Me" (a form to record hopes and aspirations) will also contribute to tackling stigma and focussing on strengths.

9. **Develop a service user led system, whereby people facing SMD are able to directly have a significant say in how services should be working.** This includes ensuring participation is meaningful, is supported with time and resources and is backed by a widely accepted participation standard for Nottingham City.

10. **Ensure the Criminal Justice system is fully engaged in and trained to reduce SMD, recognising that people facing SMD can present anywhere.** In economic terms it is in the criminal justice system where a positive approach to reducing SMD will make the biggest difference - this is where the greatest cost savings will be made. The previous nine measures listed above if implemented, will reduce offending. Where it does occur and a prison sentence is given, “Through the Gate Support” (meeting prisoners at the point of discharge) is also an essential component of any coordinated support network for people facing SMD.

What do we know?

1) Who is at risk and why?

Most of us understand that people who are homeless, or offenders or drug misusers must also face a wider set of challenges. It is hard to imagine a person who has fallen into a hard drug problem, for example, who isn't dealing with early problems stemming from childhood or who isn't facing a new set of problems as a result of their drug taking. Despite the common sense of this, we still categorise people in separate boxes defined by single issues. (Bramley et al., 2015)

What is Severe Multiple Disadvantage (SMD)

This document refers to **Severe Multiple Disadvantage** (SMD). It is acknowledged that the term **Multiple and Complex Needs** (MCN) is often used to describe the same group, sometimes this is abbreviated to multiple needs. However, SMD is the term most commonly used in national academic literature and policy documents and so for consistency this is the term used in this chapter, unless reference is being made to a document that refers to the term MCN.

SMD is generally considered to be an experience of two or more of the following sources of disadvantage simultaneously:

- Mental health issues
- Homelessness
- Offending
- Substance misuse.

Within this group of people there are some differences between people who face two sources of disadvantage, and people who face three or four who will generally have a "higher level of need". Where it is relevant to make a distinction, people facing two sources of disadvantage are referred to for succinctness as SMD 2, and those facing three or four disadvantages are referred to as SMD 3/4.

People facing SMD will be much more likely than the general population to have other needs too, such as long-term health conditions or disability and be subject to domestic and sexual abuse. The Making Every Adult Matter (MEAM) coalition of charities - Mind, Clinks and Homeless Link - characterise people facing SMD as "People facing multiple disadvantage experience a combination of problems including homelessness, substance misuse, contact with the criminal justice system and mental ill health" (MEAM, 2018:5). It is important to note also that as well as the four "needs" MEAM consider the likelihood of experiencing SMD to be increased both by growing up in circumstances of material deprivation and experiencing abuse or neglect in early life. (MEAM, 2018).

The emergence of the concept of Severe Multiple Disadvantage

People facing SMD were identified as a specific group in the early years of the current century, though at that time described as Adults Facing Chronic Exclusion. This group were recognised in the Social Exclusion Task Force report, Reaching Out: An Action Plan on Social Exclusion (2006). This report referred to "about 2.5 per cent of every generation seem to be stuck in a lifetime of disadvantage" (The Social Exclusion Task force, 2006:3). This group is described in the evaluation of the Adults Facing Chronic Exclusion programme, (a cross-government collaboration with four sponsoring Departments) as "The client group lived chaotic or isolated lives and were hard to reach and difficult to engage. The chaos of their lives was marked by their rough sleeping, prostitution or drug and alcohol misuse and their isolation by a reluctance to venture out of their homes or engage with family, friends and neighbours because of domestic abuse, mental illness or personality disorders" (Cattell et al., 2011:9).

It has been the case that of the four sources of disadvantage it is in the homelessness sector where people facing SMD have most strongly been identified and this was behind the emergence of a second related concept referred to as "Multiple Exclusion Homelessness" (MEH). MEH was the subject of an extensive research programme that ran from 2009 to 2012. The homelessness of people experiencing MEH was considered not just to be a housing issue but something that is inextricably linked with complex and chaotic life experiences. "Mental health problems, drug and alcohol dependencies, street culture activities and institutional experiences (such as prison and the care system) are often closely linked with the more extreme experiences of homelessness", (McDonagh, 2011:2).

Evidence of SMD

SMD has been most prominent in the homelessness sector, co-occurring disadvantages have been identified in other sectors too. So, for instance (Roberts et al, 2016) note that there is evidence that "Half of people with drug dependence were receiving mental health treatment in 2014 and adults with drug dependence are twice as likely as the general population to be using psychological therapy". Further, the link between offending and mental health, particularly in the prison population is recognised. For example, according to the Prison Reform Trust (2019) "26% of women and 16% of men said they had received treatment for a mental health problem in the year before custody". The Prison Reform Trust (2019) also note that: "Self-inflicted deaths are 8.6 times more likely in prison than in the general population" - and that "70% of people who died from self-inflicted means whilst in prison had already been identified as having mental health needs". Further, the overlap between substance misuse and offending is considerable, particularly in the prison population with over 55,000 people in secure settings receiving drug treatment in 2017/18 (Public Health England, 2019a) this issue also receives a great deal of media attention, especially in relation to New Psychoactive Substances (NPS) (Johnson, 2018).

Interaction between sources of Disadvantage – "a revolving door"

A key element of SMD is that the sources of each disadvantage don't act in isolation, they combine to make the overall problem worse. Much of the problem stems from most services being set up to provide treatment or support for each individual need or issue and not effectively collaborating with each other to provide a holistic approach. The consequence of

this “single need” approach for people facing SMD, is their other issues prevent them successfully completing treatment or support programmes or sustain accommodation. Common examples include people with substance misuse issues being refused mental health treatment because of their substance misuse or people with mental health issues being excluded from a homeless service because their mental health related behaviour leads them to “break the rules”.

The consequence of this is that people facing SMD tend to end up in so called “blue light services”; the Police and the Criminal Justice system and emergency and unplanned health care; Accident and Emergency and unplanned hospital stays sometimes including time as mental health inpatients. These services deal with immediate problems, “patching up” the person facing SMD, but do not deal with underlying issues. So on release or discharge the problem continues. It has been characterised as like being “stuck in a revolving door” or by an Opportunity Nottingham Expert Citizen as like being on a “hamster wheel” (Big Lottery Fund, 2018).

The impact of chronic homelessness

People facing SMD will tend to have a history of homelessness. The immediate reason for this can be varied, although amongst the most common is coming out of prison or a mental health inpatient facility with nowhere to live. Some people may experience long term rough sleeping but for most it will be periods of homelessness interspersed with periods in accommodation. A key characteristic is that accommodation is not generally sustained beyond the short term with people who suffer SMD either abandoning the accommodation or being excluded. The loss of accommodation is caused by other sources of disadvantage – mental health issues for which support cannot be accessed and substance misuse may lead to behaviour that put staff and other residents at risk and so lead to exclusion. Or - the person facing SMD feels unable “to cope” in the accommodation and so abandons it. This could be due to their mental ill health or in some cases the bullying and intimidating behaviour of other people connected to the accommodation. This is most likely to be the case in hostels, but it can also occur once a person has been rehoused from other people in the neighbourhood. Additionally, offending may lead to a period of imprisonment and so having to relinquish accommodation. Once a person is homeless again, offending becomes much more likely - or damaging behaviour occurs, that can lead to frequent use of A&E, ambulance calls out and other emergency health intervention, (Bowpitt and Kaur, 2018).

The Economic and Social Impact of SMD

There is an increasing body of evidence that the current single issue focussed, and disconnected approach is not only ineffective for individuals, it has serious economic and social costs to wider society. The report “Hard Edges”, which is the only nationwide attempt to map SMD (Bramley et al. 2015), included data showing Severe and Multiple Disadvantage to be conservatively estimated to cost £10.1bn per year across the SMD 1/2/3 populations. This comes from costs to criminal justice, mental health and homelessness services but does not include the even greater social costs caused by SMD for instance in the negative impacts on children who live with or have contact with parents who face SMD (Lankelly Chase, ibid.).

Further evidence from the Fulfilling Lives Programme supports Bramley et al.'s (2015) findings. The Report from CFE Research based on four years of Fulfilling Lives Programme data found - for people facing SMD "…….many of their interactions with public services are negative and/or avoidable. Few receive the treatment they need. This results in substantial cost to the public purse. When people first join the Fulfilling Lives programme they are each using, on average, over £25,000 in public services per year. Across all Fulfilling Lives beneficiaries this equals over £88.5million" (Lamb et al., 2019: Key messages). Changing this approach to achieve much better cross sector collaborative working underpins both MEAM and the Fulfilling Lives Multiple Disadvantage programme with its emphasis on "system change" (MEAM, 2019).

Demographic Profile:

Mapping of multiple disadvantage taken from data sets based on the four sources of disadvantage (homelessness, mental ill health, offending and substance misuse), tends to produce a cohort of people who are: 80% men, 80% white and most in their thirties and forties. Just considering these disadvantages provides therefore a skewed view. Particularly there has been some concern regarding under-representation of women. The local profile of people facing SMD is explored in the next section but below is evidence as to why the 80/20 gender balance is not accurate.

Hidden Need amongst Women

A significant feature of the data generated for the Hard Edges mapping is that those facing SMD appear to be predominantly men (80%). There is strong evidence however which shows that for several reasons, the prevalence of women facing SMD is rather higher than 20% and that women facing SMD are overlooked for several reasons (Moreton et al., 2016),

The first, is the way SMD is defined, - particularly in that it includes being an offender, but not being a victim of offending. This is significant for women especially in relation to domestic and sexual abuse and violence. According to research by Agenda this is a prevalent issue with one in 20 women having experienced extensive physical and sexual violence as both a child and an adult. These women face very high rates of problems like mental ill-health, addiction, homelessness, and poverty. (Scott et al, 2016).

Secondly, women experiencing multiple disadvantage do not typically present at specialist domestic and sexual violence services. The services which these women do come in to contact with, often do not have the required skills or capacity to support them. (AVA and Agenda, 2019). This can lead to women facing SMD feeling stigmatised when they do enter services. In their report on women with multiple needs, Rebuilding Shattered Lives, St Mungo's report that women tend to enter homelessness and other services at a later stage than men, and that the stigma and shame associated with multiple needs can mean women are less likely to ask for help and this can be a barrier to recovery, (Bindel et al., 2014).

Nationally research carried out by AVA and Agenda found that of 173 local areas in England and Wales, only 19 had access to support for women facing multiple disadvantage that could address all the following issues: substance use, criminal justice contact, mental-ill health and homelessness. (AVA and Agenda, 2017). This in turn compounds the problem in that women are less likely to appear in relevant data used to determine need. An example is the

way rough sleeper data is generally collected, which is based on assumptions that rough sleepers are thought to sleep mainly in doorways, city centres, and other visible locations – an assumption based on the rough sleeping strategies of men, not women. Women are more likely to seek to manage their homelessness through "survival sex", a much more hidden and less quantified issue compared to rough sleeping (Reeve, 2018). To some extent the projects in the Fulfilling Lives programme have taken steps to address this lack of visibility by taking a more gender responsive approach. So, data for the programme shows a different more balanced profile, with women composing 32.7% of all Beneficiaries.

In Nottingham however, compared to the national picture, the network of services that work with women facing SMD is relatively good, even though these services are not always specifically established as SMD services. So there are specific services for women with complex needs, including accommodation and domestic abuse services (Harris, 2016), but also outreach services, such as Jericho Road and POW (http://pow-advice.org.uk/). These services are likely to be picking up some of this hidden need and in terms of their approach they are well placed to do so. However their capacity to meet need may be an issue, and so it is important to consider this capacity when reviewing provision for women facing SMD.

Hidden Need amongst BAME people

Research by Opportunity Nottingham has also found hidden need amongst people from BAME groups, as similarly to women, they may be less likely to fit the SMD definition or not engage with mainstream services. This issue was found to be most prevalent amongst Asian people (Everitt and Kaur, 2018).

Groups at Particular Risk

A) Rough Sleepers

Not all rough sleepers face SMD, however most do. Data from CHAIN (Greater London Authority, 2019) he rough sleeper monitoring service in London, found that only 20% of rough sleepers did not have either a mental health or drug and/or alcohol support need. Further research by Opportunity Nottingham into persistent (i.e. repeat and long term rough, sleeping, found SMD to be a highly significant factor. This implies solutions for rough sleepers need to include intervention that impacts on the SMD they face, rather than just an accommodation based solution.

B) Street Activity

Because of its nature, begging and other street based activity tends to be predominantly viewed through the lens of anti-social behaviour. It is important however not too overlook the support and health needs of this group. Although evidence is limited, it does point to high levels of SMD in this group, even if homelessness is not always one of these issues. Research by Shelter Scotland about street begging found that although 60% had accommodation 77.9% were misusing substances, 62.4% had physical health issues and significantly 80.6% had mental health issues. The research found, "almost all of those interviewed had suffered severe trauma in their lives, including sexual, physical, mental or emotional abuse; alcohol or drug misusing parents; the death of a parent; relationship breakdown; mental illness; and institutional living.'" (Fitzpatrick and Kennedy, 2000).

C) Armed Forces

The Armed Forces Covenant requires all organisations and citizens to support the Armed Forces (Ministry of Defence, 2011). The report "Call to Mind" (Community Innovation Enterprises, 2017), points to issues relating to mental ill health, alcohol and drug use and homelessness amongst military veterans. In Nottingham information is limited as many organisations do not keep specific data however a short survey of Opportunity Nottingham and Street Outreach found that a small proportion of people facing Multiple Disadvantage have been in the Armed Forces (Opportunity Nottingham data shows it to be 4%). In terms of meeting need, there was a view expressed that veterans were generally able to refer to access relevant charities such as the British Legion and SSAFA – and this was usually helpful e.g. in moving people out of rough sleeping. So because of the existence of these charities and workers' knowledge of them, veterans wasn't seen as a particular unmet need, although going forward over reliance on charitable support may be problematic if the charities concerned had capacity issues.

SMD, Poverty and geography

The Hard Edges mapping analysed three data sets and they all showed that there are much higher concentrations of people with SMD in areas that also have the greatest poverty levels. Poverty is defined "as when a person's resources (mainly their material resources) are not sufficient to meet their minimum needs (including social participation)". (Webster and Kingston, 2014). The analysis in Hard Edges found however that poverty alone was not the sole determinant of SMD prevalence and a range of other factors also played a part. These are:

- Demographic factors: particularly a high proportion of 16 to 24 year olds and single person households, also high concentrations of small accommodation such as bedsits. However, poor quality housing and overcrowding were not linked to SMD concentrations
- Economic factors: high rates of poverty and/or unemployment
- Health factors: a poor health profile amongst the local population
- Institutional Factors: Especially presence of mental health hospitals and homeless hostels

These factors, described by the authors of Hard Edges as "poverty plus" mean that of the 24 Local Authority areas with the highest incidences of SMD, 19 are in the north or midlands - (Nottingham has the 8th highest incidence of SMD, a prevalence more than twice the national average).

Further, Hard Edges analysis also shows a close correlation between high incidence of SMD and high levels of deprivation, social mobility, average wages, number of care applications, mental health disorders and anxiety and healthy behaviour.

SMD, Adverse Childhood Experiences and Trauma

There is considerable evidence linking SMD in adults with adverse childhood experiences and early life trauma. Adverse Childhood Experiences (ACEs) are stressful experiences occurring during childhood that directly hurt a child (e.g. maltreatment) or affect them through the environment in which they live (e.g. growing up in a house with domestic

violence). ACEs include childhood abuse (physical, sexual or emotional); neglect (emotional or physical); family breakdown; exposure to domestic violence; or living in a household affected by substance misuse, mental illness, or where someone is incarcerated. (Gray and Woodfine, 2018).

People who have experienced ACEs are known to be at significantly higher risk of all the multiple disadvantage domains. So, individuals who had experienced four or more ACEs were 15 times more likely to have committed violence against another person in the last 12 months, and 20 times more likely to be incarcerated at some point in their lifetime (Bellis et al., 2015). Compared to no ACEs, adults who experienced four or more ACEs were at significant risk of mental illness, with over three times the risk of reporting current mental illness and six times the risk of lifetime mental illness (Hughes et al., 2018).

The data analysed as part of the Hard Edges research found that 85% of people with SMD had experienced traumatic experiences in childhood that stemmed from ACEs and that these increased markedly amongst those who had all three SMD domains included in the Hard Edges analysis: homelessness, offending and substance misuse. The prevalence of different kinds of traumatic experience is detailed below:

Background Experience/ACE	Percentage of SMD 3 who have experience
Left home before 18th birthday	47.0%
Ran away	41.9%
Parent(s) violent	29.3%
Parent(s) drug/alcohol	29.0%
Abused	24.4%
Neglected	17.9%
In care	17.8%
Starved	17.3%
Parent mentally ill	16.9%

Table 1: Adverse Childhood Experiences amongst the SMD 3 Population (Bramley et al., 2015)

Further the figures rise when moving from SMD 1 to SMD 3 as the example data below shows

Experience	SMD1	SMD2	SMD3
Parents drug/alcohol	9.1%	19.9%	29.0%
Ran away	10.3%	28.3%	41.9%

Table 2: Correlation between Adverse Childhood Experiences and SMD (Bramley et al., 2015)

Intergenerational Transmission of SMD

There is evidence of there being an intergenerational element to the transmission of the domains of SMD. The Revolving Doors literature review, (Good and Marriott, 2017) lists various research that shows intergenerational links across all multiple disadvantage domains, where a person's parent(s) have had the same issues. It is important however not to over-pathologise family influence and the same report also highlights research that shows for some people there is no generational link - that is, not all individuals who have a family member facing SMD go on to develop various disadvantages themselves (e.g. Perlman, Cowan, Gerwirtz, Haskett & Stokes, 2012). Even so the bulk of evidence does point SMD

originating in early life, and so it follows that help to families could be a key component of preventing SMD at source.

Education

The educational experience of people who face SMD is generally not positive. Analysis in the Hard Edges report shows almost half of people who face SMD have no educational qualifications. Further, data from the Fulfilling Lives Multiple Disadvantage programme also shows almost one third of programme Beneficiaries (where data is known), have issues with literacy. The table below shows that there are also other specific relevant factors that emerge in the education system. Bramley et al. (2015:29) describe these as "…. critical early warning signals for school age children and indicates a clear need for early intervention" Although no comparative data exists, to put the information in the tables 3 and 4 below in context, recent Department of Education shows that the proportion of persistently absent pupils across England is 8.7% (Department for Education, 2019a) and the proportion of pupils excluded from School (not permanent is 2.3%) (Department for Education, 2019b), whilst the proportion with no qualifications 1% (The Poverty Site, 2019).

Experience	Percentage of SMD 3 who have experience
Truanted	59.1%
Suspended	46.8%
No qualifications	45.2%
Bullied	24.5%
Dyslexic	16.4%
Other learning difficulty	14.6%
School Attendance significant problem	46.8%
Convicted under 14 years of age	18.9%

Table 3: Negative Educational Background Experiences of people facing SMD 3 (Bramley et al, 2015:29)

As with family factors there is also a consistency between the level of SMD and greater the chance of having had negative education experiences:

Experience	SMD1	SMD2	SMD3
No qualifications	26.5%	34.5%	45.2%
Suspended	10.3%	25.7%	46.8%

Table 4: Correlation between Negative Educational Background Experiences and SMD (Bramley et al.2015:29)

Trauma and Attachment Theory

There is growing awareness that people facing SMD experience trauma, particularly past trauma and its long term impact – (see box below). As a consequence, practice by professionals working with people facing SMD is becoming increasingly trauma informed, an approach sometime referred to as Trauma Informed Care (TIC).

Complex trauma and its effects?

Prolonged or multiple trauma (abuse/neglect) usually from caregiver in early childhood

Profound lifelong effects – physical health, mental health and social issues

Common among people with mental illness, prison histories, suicide attempts, eating disorders, drug and alcohol addictions

Likely to continue experiencing trauma into adulthood and throughout life

(Homeless Link 2014)

Although only one of many psychological approaches in relation to people facing SMD, TIC has become prevalent. The origins of this approach lay in Attachment Theory. This was developed principally by child psychologists working in the latter part of the 20th Century, most notably John Bowlby and Mary Ainsworth. Attachment theory asserts that from birth we learn how to relate to others and the world through our caregiver. We are also taught to understand our own emotions and how to control them. Many things are gained through this relationship which is crucial for a functioning personality. If all is well, the child develops a 'secure' attachment and is unlikely to have further issues. People facing SMD may however often lack this secure attachment because of the complex trauma they have faced. This manifests itself in not feeling safe/secure in self and with others, knowing how to deal with your own emotions or gauge emotions in others, low confidence and self-worth, how to engage social activity or have your needs appropriately met.

People with an insecure attachment may think that:

- Others cannot be trusted or want to hurt them
- The world is dangerous
- Life is unfair
- Life has no meaning
- They have no control or power
- They need to be on guard all the time
- They are a bad person and the abuse was their fault
- They cannot protect themselves

'Trauma-Informed Care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasises physical, psychological and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.' (Hopper et al, 2010:82).

Employment

Given the socio-economic backgrounds and early life trajectories of people facing SMD, low employment is not a surprise. The data analysed in the Hard Edges report found that most people facing SMD were either unemployed, only working casually or unable to work due to sickness or disability, as the table below shows. This is in contrast to the general population where the current percentage of adults in work is 76.1% (Office for National Statistics, 2019).

Employment Status	Percent of SMD 2	Percent of SMD 3
Long term limiting illness	41.9%	45.5%
Ever Long-term sick	35.7%	33.4%
Mostly unemployed	26.0%	22.7%
Mostly casual employment	24.8%	18.5%

Table 5: Employment Status and SMD (Bramley et al.2015:29)

Relevant employment data is also provided by the Fulfilling Live Multiple Needs programme, although it should be recognised that the projects on this programme are working principally with people who have the highest levels of SMD.

Employment Status	n=2094
Unable to work	70.1%
Unemployed	12.3%
Working/Self employed	1.9%
Other	15.7%

Table 6: Fulfilling Lives – Multiple Needs Data Collected between (Beneficiary Data July 2014 to Dec 2018)

Physical health

Whilst there is data concerning the physical health needs of people with single issues, for instance homeless people (Homeless Link Health Audit), there is no physical health data specifically regarding people facing SMD. Given the background factors that create SMD, it is not a surprise that people with SMD have considerable physical health issues, which stem from their prolonged homelessness, drug and alcohol misuse and poorer mental health. Further the complexity and chaos of their lives, means engaging proactively with health services is difficult. Engagement when it does occur tends to be unplanned and via Ambulance call-outs and Accident and Emergency (A&E) services. The Fulfilling Lives programme data shows for instance that, where data is known, 42% of programme Beneficiaries have a disability or long-term limiting condition. Further data shows high use of A&E, outpatient service and hospital stays, with evidence suggesting the vast bulk of these stays are unplanned stays, often following a visit to A&E (Lamb et al., 2019).

The principal evidence concerning health needs and people facing SMD comes from the Multiple Exclusion Homelessness survey included in Hard Edges (Bramley 2015). This found high prevalence of certain conditions when compared to the general working age population.

Condition	SMD 3	Working Age Population
Alcohol or drug related problems	43%	0.5%
Chest/breathing, asthma, bronchitis	25%	12%
Stomach/ liver/ kidneys/ digestive	32%	6%
Difficulty in seeing (excl normal glasses)	17%	3.5%
Difficulty in hearing	17%	5.2%
Hepatitis	1.9%	0.5%

Table 7: Health problems amongst people facing SMD compared to Working Age Population: Bramley et al., (2015:34)

Brain Injury, Autism and Learning Disabilities

Evidence from studies of homeless people show people facing SMD have high levels of brain injury. It is estimated that between 43-53% of the homeless population have a brain injury (Mackelprang, Harpin, Grubenhoff & Rivara, 2014; Hwang et al., 2008). Further, one study found homeless people are five times more likely to have had a hospitalised head injury (McMillan et al., 2015). Additionally, Homeless Link estimate up to 12% of homeless people have autism, compared to just over 1% of the wider population (The Westminster Homelessness and Health Coordination Project, 2018)

Brain injury and autism are often not diagnosed in the SMD population. They can both of course impact on mental health and behaviour, and may be a significant reason why people facing SMD are considered “problematic” or “hard to reach” and excluded from services or be involved in anti-social behaviour. (The Disabilities Trust, 2019; Churchard et al. 2019).

Though evidence is limited it is also likely that learning difficulties will be relatively high in the SMD population. Certainly it is higher for homeless people (McKenzie K et al, 2019), and in the Prison and probation populations (Talbot and Riley, 2007).

2) Size of the issue locally

Data Sources

There are just two large specific sources of data concerning people who face SMD:

1) The first is Hard Edges Mapping Severe and Multiple Disadvantage, published in 2015 by the Lankelly Chase Foundation. This mapping, is useful in relation to understanding the overall number of people in Nottingham who face SMD (Bramley et al., 2015), even though it contains some areas of under-recording which are discussed later in this section.

2) The second data source is the Fulfilling Lives Programme, of which Opportunity Nottingham is a part. Unlike Hard Edges this cannot be used for overall numbers as it only covers certain locations and does not include data from most people facing SMD in those locations, including Nottingham. It is still however, a valuable data source as a demographic profiling tool for Nottingham, as the locations included mostly have similar overall demographic profiles to Nottingham. Also, the projects making up the Fulfilling Lives data set

better reflect the overall demography of people facing SMD, as between them the projects support a diversity of different groups. SMD amongst women particularly is better reflected in the Fulfilling Lives data set compared to Hard Edges.

The Number of people facing SMD in Nottingham

The Hard Edges mapping used three data sources that recorded adults in contact with criminal justice, homelessness and substance misuse systems in England[1]. Some caution needs to be exercised in relation to the data in the Hard Edges, not just because it understates the number of women, but because data used was collected up to nine years ago. Nevertheless, it remains the only comprehensive attempt to map SMD.

The three data sets were compared and from this the Hard Edges researchers were able to identity people who appear in more than one of these. This enabled the researchers to produce a national figure of people facing SMD which was 222,000 people with at least two needs and 57,931 people with all three of these needs.

Significantly however, there is no unified national data set on the delivery of mental health services, so the researchers made separate estimates of the proportion of people with mental health issues based on the three data sets, accepting however that this methodology was almost certainly an understatement of mental health needs.

The Hard Edges researchers also produced data for need for in each local authority, and so the data for Nottingham can be identified and analysed. This shows **Nottingham has the 8th highest prevalence in England** of people facing SMD as the table below shows

Blackpool	306
Middlesbrough	281
Liverpool	238
Rochdale	226
Manchester	225
Kingston upon Hull	224
Bournemouth	220
Nottingham	**213**
Stoke on Trent	210
Newcastle upon Tyne	208

Table 8: Index of SMD – where an average authority has a score of 100. From Hard Edges Bramley et al. (2015:22)

This data In Hard Edges for Nottingham can be broken down to give an estimate of the numbers of people facing SMD in the city as outlined in the table below.

[1] Offender Assessment System (OASys), National Drug Treatment Monitoring System (NDTMS), Supporting People (Client Record and Outcomes for Short-Term Services)

	Number of people in Nottingham facing SMD
Two disadvantages	2980
Three disadvantages	1410
Four disadvantages	260
Total	**4650**

Table 9: Number of people in Nottingham facing SMD from Bramley et al., 2015 Data from Appendix J

This gives a figure for Nottingham of 4,650 people with between two and four disadvantages. It does not include people who face a single source of disadvantage, but it does include an additional estimate for people with mental health issues made by the Hard Edges researchers. An estimate was necessary as there was no primary source of relevant mental health data available to the Hard Edges researchers.

There are reasons however that it is likely that this an underestimate of overall numbers of people facing SMD in Nottingham and so some uplifts to this overall figure have been made:

1. **Under Recording of Mental Health Issues**

Firstly, without actual mental health data Bramley et al. (2015:26) assert that mental health needs are likely to be higher, "….as discussed elsewhere in this report, there are grounds for believing that the incidence of mental health problems may be significantly greater than recorded here. Thus, these initial estimates give a feel for a conservative estimate of the overlap between mental health problems and our SMD groups". So even though the above figure includes a mental health estimate, it is reasonable to assume this still understates actual levels of need.

It is difficult however to verify the actual level of under recording of mental health need in Nottingham. National and local data where it exists does indicates that the level of mental health issues in the SMD population is likely to be at least in line with the Hard Edges estimate if not higher. For example, national NDTMS data for England showed that 41% of people accepted for substance misuse treatment reported they had a mental health treatment need (Public Health England, 2019). However, this information only began to be collected in the last year and relies on self-reporting.

In the Criminal Justice sector mental health issues have received some attention in recent years, often in the media with some "headline grabbing" data. For instance, it was reported by the National Audit Office that Self-harm in prisons rose by 73% between 2012 and 2016. In 2016 there were 40,161 incidents of self-harm in prisons, the equivalent of one incident for every two prisoners (National Audit Office, 2017). There is though no comprehensive accurate data set in relation to the prevalence of mental health issues amongst the offender population and even where data exists it relies on self-reporting.

Similarly, the biggest data set about rough sleepers shows 50% have a mental health support need. This also however relies on self-reporting (Greater London Authority, 2018). One source of data that does confirm likely understatement of mental health issues is the CRESR Sheffield Hallam University MH study which found that three quarters of Nottingham's homeless population had a mental health issue (Reeve et al., 2018).

In terms of need estimation for people facing SMD therefore, although it is reasonable to assume some understatement of mental health need, without accurate alternative data it is necessary to err on the side of caution regarding the level of this. Therefore, only an additional 10% has been added to the number of people who have mental health issue over and above the Hard Edges estimation in Nottingham. This brings an additional 192 people into the SMD cohort.

2. Impact of Funding Reductions

As well as lacking mental health data, the second reason for assuming the Hard Edges figure for Nottingham may be an underestimation of overall numbers, is that the data used in Hard Edges was produced up to nine years ago. Since then, there have been significant cuts to services due to reduction in Government funding. Whilst there may have been improvements in service *effectiveness* during this time - service *provision* that could either prevent people from exiting the SMD cohort or entering it in the first place, has been effected by funding reductions. This is particularly a concern in relation to young person's services, because, as has been demonstrated in the previous section, there is a very close link between SMD and adverse childhood experiences and early life trauma.

Examples of funding reductions locally that may have increased the number of people facing SMD, include reductions in preventative floating support services. Nationally, it is known that whilst funding for late intervention services for children and young people increased by 12% between 2010/11 and 2017/18, funding for early intervention services decreased by 49% from £3.7 Billion to £1.9 Billion (The Children's Society et al., 2019). Whilst not all the impact of these reductions will have yet fed through in terms of increased numbers of people facing SMD, it is reasonable to assume some has. However, without actual data it is necessary to again err on the side of caution. For this reason, and following consultation with stakeholders and academic partners, it is considered an additional 5% (or 252 people) should be added to the overall figure of people facing SMD in Nottingham.

3. Hidden Groups

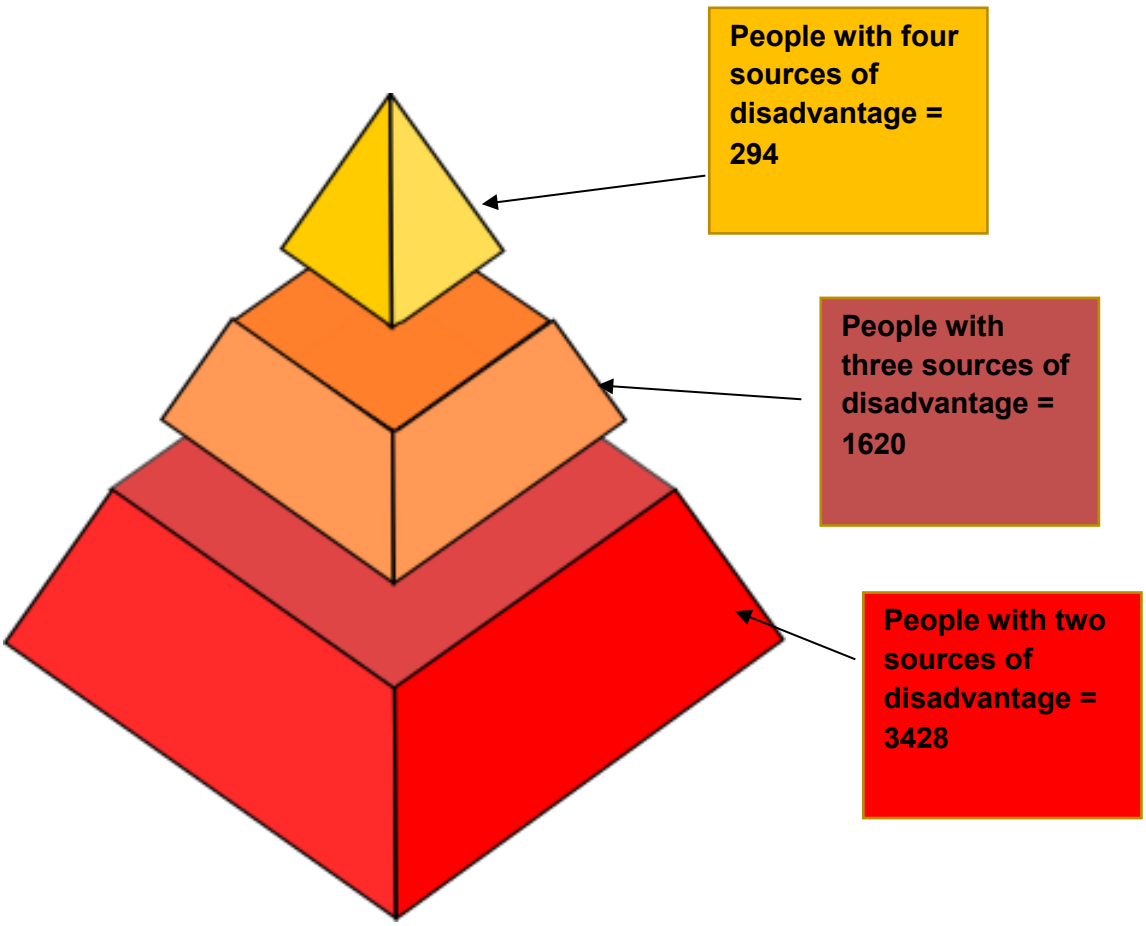
The third reason as to why the Hard Edges figure is a likely understatement is concerned with hidden needs amongst certain groups. Most significantly women, but also BAME people and other groups such as LGBT+ groups, although little data exists. The reasons for this have been outlined in the previous section, and although Nottingham is comparatively progressive in relation to specific service provision it is still reasonable to assume that there would be some people not engaging with the services included in the Hard Edges Dataset. Therefore, for this reason an additional 5% (252 people) has been added to account for hidden groups.

Adding this modest uplift based on the above three criteria provides an overall figure for Nottingham City for the number of people facing SMD as:

Original data from Hard Edges	4,650
Additional mental health need estimate	192
Increased need due to funding reductions since 2010	252
Additional need from hidden groups	252
Total Need	**5,348**

Table 10: Number of people in Nottingham facing SMD with uplift for under recording of people with mental health issues, the impact of funding reductions and "hidden" groups.

Figure 1 on the next page shows how this need manifests in terms of severity based on the same need level proportions as outlined in table 9.



Sources of Disadvantage:

- **Mental Health Issues,**
- **Homelessness**
- **Substance Misuse**
- **Offending**

***Figure 1: Estimated current annual SMD population in Nottingham (Data based on** from Hard Edges, Bramley et al. (2015), with uplifts added as described in pages 17 to 20 above.*

Demographic Profile

Because of lack of data as outlined above, accurate demographic profiling of people facing SMD is difficult. Additionally, the data that exists reflects contact with services and as has been demonstrated in the previous section, some groups are "hidden" from mainstream services as these groups are not necessarily well served by them. Having said this, there is enough data to provide some profiling estimates for Nottingham for some demographic characteristics and these are set out below. Mostly the Fulfilling Lives (SMD) programme data makes a useful proxy for Nottingham data as it as an aggregation of all data from the twelve Fulfilling Lives SMD projects. Between them the twelve projects have employed different approaches to service access and some of these involving targeting specific groups. Significantly as well, most of the projects operate in city/urban areas which will have similar overall demographic profiles to Nottingham. Fulfilling Lives data for this reason is particularly useful in relation to gender and age. The exception is ethnicity, as evidence suggests the Fulfilling Lives programme has an under representation from BAME people facing SMD (Robinson et al. 2017; Everitt and Kaur, 2019). Therefore, in relation to ethnicity, Opportunity Nottingham data only has been used as a proxy. Opportunity Nottingham data is considered more representative in relation to ethnicity as there is a culturally specific element to the service which seeks to work with BAME people (Everitt and Kaur, ibid.).

1. Gender

Hard Edges understates the level of need among women (Bramley et al. 2016), whilst locally the Opportunity Nottingham data set is too limited for overall city profiling in relation to gender as the project has concentrated on supporting only those considered to be the most "*chaotic*" using specific selection criteria . This means Opportunity Nottingham is likely to have engaged a disproportionate proportion of men compared to the overall SMD cohort in the City. Some confirmation for this is provided by data from the Emmanuel House Wellbeing Team which also works with people facing SMD. 60% of their Beneficiaries are women. The Fulfilling Lives (SMD) programme data is more balanced in relation to identifying women facing SMD as other projects work more inclusively with women compared with Opportunity Nottingham. It shows the following:

	Men	**Women**
Percent of People facing SMD	66	34

Table 11 People facing SMD - Gender (Fulfilling Lives programme data July 2014 to Dec 2018)

Note this data is based on needs as defined by the Fulfilling Lives (SMD) programme, which requires Beneficiaries to have at least two out of the four main needs. If Domestic Abuse were to be added as a fifth need then the balance between men and women would be rather more even. (Bramley et al. 2016).

2. Age

Fulfilling Lives data shows the following age profile for people facing SMD

Age Group	Percent of People facing SMD
16 to 19	1.8
20 to 29	16.9
30 to 39	28.5
40 to 49	24.8
50 to 59	10.3
60 plus	1.7

Table 12: People facing SMD – Age (Fulfilling Lives programme data July 2014 to Dec 2018)

It is significant to note that there is some gender variation relating to age in that women tend to be more heavily concentrated in the younger age ranges, so women make up 39% of the under 20 to 39 groups but 31% of those aged 40 to 49 and 19% of those aged 50 to 59.

3. Ethnicity

As mentioned at the beginning of this profiling section Opportunity Nottingham data can be used in relation to ethnicity because it includes a culturally specific element and so will be more reflective of the ethnicity of the people facing SMD in the City as a whole.

	Opportunity Nottingham Beneficiaries	Nottingham Census 2011 (Nottingham Insight, 2013)
Asian/Asian British	9.9	13.1
Black: British/African/Caribbean	12.1	7.3
Mixed Ethnicity/ Dual Heritage	7.2	6.7
White British	63.0	65.4
White Irish/White Other	6.7	6.1
Other	1.1	1.5

Table 13 People facing SMD – Ethnicity (Opportunity Nottingham Data July 2014 to Dec 2018)

4. Disability or Long Term Limiting Condition

Because of the nature of the disadvantages comprising SMD, disability is likely to be high and data shows this to be the case. Where data is known 41.2% of Beneficiaries of the Fulfilling Lives (SMD) programme were recorded as having a disability or long term limiting condition.

5. Problems with Literacy

The previous section showed most people facing SMD had poor experiences of education and so this will reflect in literacy issues in later life. The data bears this out. Where data is known 36.2% of Beneficiaries have problems with literacy. *(Fulfilling Lives SMD programme data July 2014 to Dec 2018).*

6. Employment Status

Fulfilling Lives data shows only a small proportion of Beneficiaries are working or indeed able to seek work. Whilst a much larger proportion are currently unable to work for reasons principally related to their health or the disadvantages they face.

Employment Status		Nottingham Census 2011
Unable to Work	69.8	5.7
Unemployed and Seeking Work	12.1	6.4
In Work	1.9	61.3
Other	16.1	3

Table 14 People facing SMD Employment (Fulfilling Lives programme data July 2014 to Dec 2018)

3) Targets and performance

Introduction

The Public Health Outcomes Framework (PHOF) is very relevant in relation to people facing SMD and a significant proportion of the large number of indicators could be considered to apply. To provide focus however, certain PHOF indicators have been selected using the following two criteria:

1) Indicators that are considered most relevant in relation to people facing SMD.
2) Nottingham has values in relation to the selected indicator that is in most instances significantly negatively variant from the national average and so may link to the City's wider strategic priorities

Altogether the JSNA considers three outcomes sets. In addition to the PHOF, there is the NHS Outcomes Framework (NHSOF) and the Adult Social Care Outcomes Set (ASCOF). However most relevant indicators in the NHSOF and the ASCOF are also included in the PHOF, and so it would be a duplication to consider these separately. There is one exception that appears in the NHSOF and ASCOF but not the PHOF. This is NHSOF indicator 2.1: Proportion of people feeling supported to manage their condition, (CCG Outcome Indicator Set).

PHOF Selected Indicators

0) Overarching Indicators

0.1i Healthy life expectancy at birth (male/female)

0.1ii Life expectancy at birth (male/female)

At the core of PHOF is life expectancy and healthy life expectancy. This is a particularly relevant indicator to include for Nottingham as healthy life expectancy in the city is low compared to England overall, indeed for women it is *the* lowest in England.

Life Expectancy	Nottingham	England Mean
Men	77.0	79.6
Women	81.1	83.1
Healthy Life Expectancy		
Men	57.0	63.4
Women	53.5	63.8

Table 15: Public Health Outcomes Framework Data Life Expectancy and Healthy Life Expectancy – Public Health England

No official sources of data exist for life expectancy specifically in relation to people facing SMD, but it is almost certainly significantly lower than the national and Nottingham city average. Data from the Fulfilling Lives (SMD) programme shows that as of end of 2018, out 3480 Beneficiaries where data is known 171 have died (Lamb et al., 2019). Locally Opportunity Nottingham data shows to the end of 2018 that 28 Beneficiaries had died since joining the programme. This represents 7.3 percent of all Beneficiaries. The average age of death amongst this group is just 45.04 years of age.

In relation to the healthy life indicator, there is also no official data for people facing SMD, however data from the Fulfilling Lives (SMD) programme and Opportunity Nottingham indicates it is almost certainly significantly lower than both England and Nottingham averages. Beneficiaries with mental health and substance misuse issues is 92% and 95% respectively, for the Fulfilling Lives (SMD) programme - and for Opportunity Nottingham it is 93% and 96% respectively. These issues are likely to impact on physical health and ultimately mortality. Indeed the proportion of Beneficiaries with a disability or long term limiting condition (where data is known) is 42% for the Fulfilling Lives Programme and 36% for Opportunity Nottingham.

Indicator 1) Wider Determinants of Health

1.07 - People in prison who have a mental illness or a significant mental illness

There is little official data relating to this indicator, but it has been included as it links directly to SMD because it includes two of the four core needs. The public health data set is blank for this outcome for both Nottingham City and the East Midlands. Evidence from several sources however shows a major correlation relating to mental health and offending. The CRESR research into Homelessness and Mental Health in Nottingham (Reeves et al 2018), found that homeless people with a mental health issue were 11 times more likely to also have an offending history, than homeless people without a mental health issue. Data from the Fulfilling Lives (SMD) programme shows 92% have a mental health issue and 81 % have an offending history. Data for Opportunity Nottingham shows 86.6% of Beneficiaries had both an offending history and mental health issues.

1.11 Domestic abuse related incidents

Table 15 below shows domestic abuse related incidents (survivor or perpetrator) relating to people facing SMD is significantly higher than amongst the general population. The data in the PHOF for Nottingham for domestic violence comes from recording by Nottinghamshire

Police and is rather low compared to the England average. This probably indicates a level of under recording, and the national average may therefore be a better benchmark.

Domestic Abuse Related Incidents	Prevalence	Measure/Source
Nottingham	1.75%	Notts Police/ONS
England (average)	2.5%	ONS Domestic Abuse in England and Wales to Mar18
Hard Edges Survivor	18.3%	SMD 3 only Hard Edges
Hard Edges Perpetrator	47.9%	SMD 3 only Hard Edges
Opportunity Nottingham Survivor	23.4%	Opportunity Nottingham Data
Opportunity Nottingham Perpetrator	11.4%	Opportunity Nottingham Data

Table 16 SMD and Domestic Abuse (Sources: various – see column 3)

1.15i - Statutory homelessness - Eligible homeless people not in Priority Need

Relevant data shows that overall non-priority need homelessness in Nottingham is relatively low. Sixty-four non priority households were accepted as homeless (0.5 households in every 1000 – (yr. 2017/18 MHCLG P1E Returns) putting the city slightly below the national average of 0.8 households per 1000. This however only includes households who have made a homeless application. In the city most households are not included in this data because they do not proceed to full homeless application due to prevention/relief action, or households do not engage with the City Council at all. Fulfilling Lives data shows homelessness to be very high amongst programme Beneficiaries. Seventy one percent are homeless when they join the programme, and this is reflected in Opportunity Nottingham data which shows 74% of Beneficiaries to be homeless on joining even though they may have accommodation at the point of entry to the programme.

Indicator 2) Health Improvement

2.10ii - Emergency Hospital Admissions for Intentional Self-Harm

Data on the PHOF shows Nottingham to have significantly higher rate of admissions for self-harm compared to the national average (Source NHS Digital), at 229.5 per 100,000 population compared to 185.5 per 100,000 population. Directly comparable data for people facing SMD is not available but Opportunity Nottingham data suggests it is very high. Firstly, admission rates amongst Beneficiaries are high, at 2.7 per beneficiary per quarter. Secondly, although Opportunity Nottingham does not record the reason for admission, levels of self-harm are recorded, and this is also very high. Opportunity Nottingham data shows that 40.6% of beneficiaries have been recorded as a high risk or immediate risk to physical safety as a result of deliberate self-harm or suicide attempt at some point on the project, (Opportunity Nottingham internal data).

2.16 Adults with a substance misuse treatment need who successfully engage in community-based structured treatment following release from prison

Data in the PHOF shows that in Nottingham this outcome is lower than the national average, with 23.8% (96 people) engaging in treatment on release compared to 32.1% for England overall (Calculated by Public Health England: Evidence Application Team using data from the National Drug Treatment Monitoring System (NDTMS)). Data for Opportunity Nottingham shows that 65.7% of Beneficiaries receiving a prison sentence engage in treatment after

release. This is 41.9% higher than the average for the city and so would suggest support for the Opportunity Nottingham of case management and support.

2.18 - Admission episodes for alcohol-related conditions

PHOF data shows Nottingham to be significantly worse than the national average with 881 admissions per 100,000 population compared to 632 per 100,000 population for England as a whole. Opportunity Nottingham does not collect directly comparable data, but it is known that overall there is an average of 469 hospital admissions per year by Opportunity Nottingham Beneficiaries. It is not known how many of these admissions are alcohol related conditions, but the likelihood is, that it is high as it is known that 211 Beneficiaries have issues with alcohol and for 80% of these, this is at the severest level of misuse[2]. Further a study by Opportunity Nottingham (Opportunity Nottingham, 2017 unpublished) investigating factors involved in Beneficiary deaths, showed chronic alcohol consumption coupled with non-engagement in treatment to be the most common background factor (see table 16 below).

Indicator 4) Healthcare and premature mortality

4.03 Mortality Rate from cause considered preventable

Nottingham is significantly worse than the national average for preventable deaths, with a rate of 263.8 per 100,000 population compared to the England average of 181.5 per 100,000 population. Data is not directly available for Opportunity Nottingham Beneficiaries regarding all causes of death, though the table below sheds some light. Also, given that the average age of death of the 7.3 percent of Opportunity Nottingham Beneficiaries who have died is just 45.04, (as well as the evidence already considered previously in this section) - it is highly probable that almost all deaths in people facing SMD would be considered preventable.

National Health Service Outcomes Framework (NHSOF)

Most relevant outcomes in the NHSOF are included in the PHOF above, however there is one particularly relevant outcome that does not appear in the PHOF, although it does appear in the ASCOF

2.1 Proportion of people feeling supported to manage their condition

This outcome is part of the CCG Outcome Indicator Set (February 2019). This indicator measures the degree to which people with health conditions that are expected to last for a significant period feel they have had enough support from relevant services and organisations to manage their condition. National CCG (Source GP patient Survey) data shows for the period January to March 2018 in Nottingham City CCG area an indicator value of 57.0 against a national average of 59.6 for the same period. No data exists in relation to this outcome specifically relating to people facing SMD, however overcoming lack of support, or where it exists fragmentation of services, is a key component of the Fulfilling Lives

[2] Drug/alcohol dependence; daily abuse of alcohol or drugs which causes severe impairment of functioning; inability to function in community secondary to alcohol/drug abuse; aggressive behaviour to others; criminal activity to support alcohol or drug use (taken from Opportunity Nottingham assessment procedure).

programme and Opportunity Nottingham. The importance of feeling supported is evidenced in the Opportunity Nottingham end of year four report (Bowpitt et al, 2018) where interviews with Beneficiaries highlighted the components of what Opportunity Nottingham Beneficiaries considered made a difference to them:

- Being available at critical moments in the lives of Beneficiaries
- Reaching out to the persistently elusive
- Giving time and space to listen to Beneficiaries' stories
- Being prepared to do what is needed in the interests of recovery
- Showing that you care in meaningful ways
- Standing alongside Beneficiaries as they confront the world of welfare bureaucracy
- Being trustworthy
- Letting Beneficiaries shape their own priorities
- Not giving up on anyone.

4) Current activity, service provision and assets

To understand current service provision, services have been divided into three categories. These are:

Group 1: Services with a specific brief to work with people who face SMD e.g. Opportunity Nottingham

Group 2: Services without a specific SMD brief – but working mainly with people who face SMD e.g. Emmanuel House and Drug and Alcohol services

Group 3: Services who work with people facing SMD as part of their regular service - but this is not the majority of their work e.g. DWP, Police, GP/primary health services

People facing SMD may appear at just about any service, and this JSNA needs to reflect this. In terms of distinguishing services however, it is important to make a differentiation between the extent to which services work with people facing SMD. This will help to understand the need for specialist services to work with people with higher levels of need as well as services working with specific groups e.g. women only services. It will also help to understand which non specialist services people facing SMD may use widely as well their attendance at generic services. This in turn could influence the response of all of these services e.g. the appropriate application of Trauma Informed Care.

It is important to note also that some services in Group 2 work with greater levels of people with very complex needs than some of those in Group 1. An example is POW Nottingham and London Road homeless accommodation.

• **Group 1: Services with a specific brief to work with people who face SMD**
• **Opportunity Nottingham**- a community-based service that supports people with multiple complex needs, • **Opportunity and Change**- a support service that supports people with multiple complex needs, • **Framework Complex Needs accommodation (Forest Rd, Men's and Women's**- supported accommodation, • **Clean Slate**- substance misuse service ,

- **Multiple Needs Tenancy Support**- tenancy support,
- **Somewhere Safe to Stay Hub**- rough sleeper service,
- **Central Refuge** (responding to complexity)- refuge for women with complex needs,
- **Trent House Probation Hostel**- probation hostel for offenders with NFA,
- **Emmanuel House**- homelessness day centre,
- **Liaison and Diversion Team**- service within the Bridewell which works with people who have multiple needs- signposts people to other housing,
- **Improving Lives**- supports adults with complex health and social needs

Group 2: Services without a specific SMD brief – but working mainly with people who face SMD

- Framework Social Exclusion Services (London Road)- temporary accommodation,
- Jericho Road Project- sex worker project,
- POW- sex worker project,
- YMCA- supported accommodation,
- AWAAZ- BME mental health support service,
- Nottingham Women's Centre- day centre,
- WAIS- domestic abuse service,
- NRN- substance misuse service,
- Double Impact- substance misuse service,
- The Health Shop- offers advice and support on a wide range of issues regarding substance abuse and sexual health ,
- Street Outreach- working with rough sleepers,
- Homeless Prevention Service,
- Mental Health Accommodation Crescent Recovery,
- NCHA services- social housing landlord,
- SEA- independent advocacy service,
- Michael Varnam House- service for homeless men and women with a primary issue of alcohol misuse,
- Aidan House- supported housing,
- Mental health Inpatient Facility(Highbury),
- The Friary- homelessness day centre,
- Tuntum housing- supported housing,
- Equation-provide practical tools and guidance to support the well-being and safety needs of survivors. ,
- Wellness in Mind- support for people who have low/mid-level mental health issues,
- The Big Issue- employer who employs people who are experiencing homelessness,
- Edwin House- detox facility,
- Adkam housing- supported accommodation,
- Safe Space Counselling- counselling service,
- Nacro- supported accommodation working with people with criminal convictions,
  Circles UK- service working with sexual offenders,
- Changing Lives,
- Sova,
- Bac-in- culturally specific service working with substance misuse,
- NEMS Platform One Practice,
- Mary Potter Centre- sexual health clinic,
- Aidan House- supported accommodation,
- The New Albion- supported accommodation
- DLNR CRC Probation service,
- National Probation service

Group 3: Agencies who work with people facing SMD as part of their regular service - but this is not the majority of their work
• DWP, • Police, • GP/Primary Care Health Services, • Housing Aid, • Citizen's Advice Bureau, • Nottingham City Homes and other Social Housing providers, • Safeguarding adults - Multi-Agency Safeguarding Hub, • Metropolitan housing- social housing landlord, integrated offender management, • Moving Forward, • JRH support- social care service which provides care/person assistants, • User Voice, • Nottinghamshire Victim Support- support for victims of crime, • IDVAs, • Wellness in Mind, • Nature in Mind, • Harmless-user led organisation that provides a range of services about self-harm • Real Lives- supports people with issues with mental health, • Nottingham University Hospital NHS Trusts, • Adult Social Services, • National Probation service, • the Crisis Team, Pohwer- Mental health advocacy, • Notts SVS Service-support for people who are victims of sexual assault

Table 17: Agencies in Nottingham working with people facing SMD

5) Evidence of what works

There is a growing body of evidence in relation to what works and people facing SMD. The evidence in this section has been drawn in the main from the work nationally of MEAM, Lankelly Chase, Revolving Doors and the Fulfilling Lives (SMD) programme. Locally information has been drawn from various documents from the Opportunity Nottingham evaluation programme, led by Nottingham Trent University and the CRESR Sheffield Hallam University research funded by Nottingham City Clinical Commissioning Group, titled; The Mental Health Needs of Nottingham's Homeless population – An Exploratory Study (2018).

Much of what works in relation to people facing SMD is considered in terms of achieving "**System Change"**. This is the core concept of the Fulfilling Lives (SMD) programme and is prominent in in the work of organisations concerned with achieving improvements in responses to SMD (Abercrombie, Harries and Wharton, 2015; Lowe and Plimmer, 2019).

A system in this context refers to the people, organisations, policies, processes, cultures, beliefs and environment that surround all of us. System Change is especially important in relation to SMD because people facing SMD interact across a complex network of services in different sectors (principally Health, Substance Use, Homelessness, Criminal Justice and DWP) and so change is "systemic" because it is needed not just in one area but across all of these sectors.

To achieve systemic changes **collaborative working** is needed at all levels of activity:

- Front facing (ground) level - how workers in different organisations respond to an individual
- Operational level - how whole services across different sectors interact with each other
- Strategic and commissioning level collaboration or joint commissioning

At ground level this is demonstrated by the **Multi-Disciplinary Team** (MDT) working developed by Opportunity Nottingham and other Fulfilling Lives (SMD) projects. In some fields such as domestic abuse through (MARAC) and children's services through the Common Assessment Framework, MDT's are standard practice and good practice indicates this should become the case for agencies concerned with people facing SMD. Successful MDT's involve developing a system for bringing workers from different organisations together with a level of accountability as to who agrees to do what and then monitoring and follow up action.

Other examples of this kind of cross sector working include **Liaison and Diversion Teams** and **Street Triage** where mental health professionals work directly with the Police. Similarly, mental health professionals embedded in homelessness services is also a successful model. An example, is the Leicester **Homeless Mental Health Service** (Leicester Partnership NHS Trust, 2019) which provides assessment, treatment and support to homeless adults over the age of 16 with mental health difficulties across the city of Leicester. In fitting with homeless people's lifestyles, which they recognised as being chaotic, Leicester Homeless Mental Health Service adapted their clinical practices to help improve homeless people's access to mental health services. A further example of good practice in collaborative working is where authorities work jointly in relation to legal functions, such as overlapping duties within **the Care Act and Homelessness Reduction Act.**

At operational level the **Practice Development Unit** (PDU) also developed by Opportunity Nottingham exists to bring workers together from the different sectors to understand each other better, provide peer support and achieve shared learning. The PDU is being recognised across the Fulfilling Lives (SMD) programme as a successful example of what works (Fleming, 2019).

At strategic level **the MEAM approach** is the biggest single example of collaborative working and has been implemented in over thirty local authority areas. The MEAM approach is a framework used by local partnerships across England to develop a coordinated approach to tackling multiple disadvantage in their local area, (MEAM Coalition, 2019b). It focuses on creating long-term, sustainable change to the way that complex problems and systems are approached and understood. In Nottingham the MEAM approach has not currently been developed partly because Opportunity Nottingham provides an equivalent approach. Thought will need to be given however, to how strategic collaboration continues from 2022, when the Opportunity Nottingham programme concludes.

Whilst working jointly as proposed by MEAM is increasingly seen as crucial in relation to what works, in some local authority areas this is being taken to a further level through joint commissioning a systemic approach for people facing SMD. Notable examples include Plymouth where the Local Authority and Clinical Commissioning Group **jointly commission**

the contract for provision of support to vulnerable adults. This contract does not specify outputs or outcomes to be achieved. Instead, it uses a set of agreed principles as the basis for how the system will function, including ongoing adaptation to support provision based on shared learning (Lowe and Plimmer, 2019 ibid.).

Including people with lived experience of multiple needs in both the design and delivery of services is also essential in terms of what works if system change is to be achieved. The system for people facing SMD is complex and can be difficult to navigate. Only by listening to people who have direct experience of how the system currently works can it be improved. In practical terms this means involvement (sometimes called coproduction when it operates at a deeper level) in recruiting staff, commissioning services, research and developing new ideas. Learning from the Fulfilling Lives (SMD) programme suggests for coproduction to be successful active support is needed to enable people to overcome the barriers to meaningful participation. The Opportunity Nottingham **Beneficiary Ambassadors** who support Expert Citizens are a good example of how this active support can be provided (Bowpitt et al., 2018).

Prevention is a further key element of any strategy for tackling SMD. As has been seen in the Who is at Risk section (Section 1) people who face SMD in adulthood usually have encountered neglect, trauma and adverse experience in childhood. This suggests much of the personal, social and economic costs could have been avoided if services had intervened sooner and more effectively. “SMD appears to be preventable therefore but early intervention needs to reach the people who were clearly failed the last time round” (Bramley et al. 2015b:6).

There is also an increasing shift in relation to system change and people facing SMD towards **strengths based approaches**. Taking a strengths based approach involves no longer seeing a person facing SMD as a “set of needs to be fixed” - but rather supporting them to achieve their aspirations and build on their strengths. It involves asking people ‘what does a good or fulfilled life look like for you?’ This enables people accessing services to be treated as a ‘whole person’, who can access holistic support that addresses multiple, interacting factors that impact their life, rather than “siloed” services that each deal with a specific ‘problem.’

In their research ‘Exploring the New World – Practical Insights for Funding, Commissioning and Managing in Complexity’ (Lowe and Plimmer, 2019) the assertion is made that to achieve a strengths based approach, workers need to be freed to do the “right things”, based on establishing a sense of shared humanity. Managers therefore need to trust well–informed workers to use their knowledge to respond authentically to the needs of other human beings. Importantly, this devolved decision making does not mean individuals are left to work unsupervised or unsupported. Workers still operate within clear boundaries that reflect what is safe and legal, and peer support and peer accountability is key in enabling sharing of learning and informed, fair decision making. To support this, commissioners need to work on the basis they are ‘purchasing’ the capacity for people and organisations to learn and adapt to deliver relevant support, rather than buying services.

To enable a strength based approach to be developed rather than a standard service there is a need for a personalised and tailored approach. Fundamental to this is the role of the **Personal Development Coordinator**.

Where Personal Development Coordinators have been found to be successful they have:

- Engaged those with the most entrenched needs, including those excluded from other services, and built positive and trusting relationships with Beneficiaries.
- Engaged groups of people services have found 'hard to reach' groups, such as women who face SMD
- Advocated on behalf of Beneficiaries, helping them to express their needs
- Achieved flex in services, and as a result helped Beneficiaries to get the help and support they need to be given a voice
- Reduced risky and negative behaviours, including offending and substance-misuse
- Reduced use of crisis and emergency services
- Enabled Beneficiaries to take greater personal responsibility
- Supported Beneficiaries to feel more confidence, safety, stability, valued and hopeful about the future

However, it's important to note progress isn't often rapid and is more likely to be incremental, because underpinning their work, Personal Development Coordinators **build trust** with Beneficiaries. Part of this involves "sticking with them" through relapses and periods of disengagement or time spent in institutional settings, principally prison and mental health inpatient facilities, (Lamb et al, 2019a;Bowpitt et al, 2018).

Peer Mentors are people with lived experience who provide Beneficiaries with additional support and guidance based on this experience. They have been found to have a positive impact in supporting people facing SMD. Peer Mentors may be volunteers or employed in paid roles. Outcomes achieved through peer mentoring include; offering hope to Beneficiaries that recovery is possible, helping to build trust and providing a bridge between services and individuals. Peer mentors also actively advocate on behalf of Beneficiaries and can contribute to system change by challenging traditional service protocols. The role can also be positive for the peer mentors themselves, giving the opportunity to learn new skills and develop confidence.

It is important to ensure peer mentor teams work closely with Personal Development Coordinator teams and that staff are bought into the concept. Effective training and ongoing support for peer mentors is crucial. Care is also needed to ensure volunteer mentors are not exploited (Bowpitt et al, ibid; Kiberd, 2019).

Peer mentors also help to integrate Beneficiaries socially so that they can begin to build their own **support networks**. These are a key part of ensuring a sustainable recovery for people facing SMD, particularly when they may no longer have access to a key worker. This is important as evidence from the Fulfilling Lives programme suggests a focus on ensuring **positive social networks and relationships** are important in achieving successful *sustainable* outcomes. Positive social networks can be found in a variety of settings depending on the persons individual interests and aspirations, for example support groups, gardening, drama groups, social events and drop-in light touch support sessions. This kind of activity links to the **importance of building confidence and self-esteem.** It also links to what is termed in health "social prescribing" (Kings Fund, 2017).

There is evidence from the Fulfilling Lives (SMD) programme that **Personal Budgets** can play a role in delivering a personal tailored service. Personal Budgets have been found to

help to engage Beneficiaries with services, support the development of trusting relationships between Beneficiaries and their Personal Development Coordinators, empower Beneficiaries to control their spending choices, plan better for their future needs and provide funds to deal with crisis situations, such as covering rent arrears. They were found however to be potentially counterproductive unless there was clear guidance and a consistent approach to use and availability.

Improving **access to services** has also been found to be a crucial element in what works for people facing SMD. People facing SMD are often considered "hard to reach" but this should be turned around, so it is services that recognise *they are hard to reach*. Because of the lack of joined-up approaches and collaborative working across different sectors for people facing SMD, a big frustration is constantly being asked to 'retell your story' (explain their experiences and issues), by every organisation and worker they interact with. This can mean revisiting traumas and the impacts of this. Some Fulfilling Lives partnerships have adopted **No Wrong Door** (NWD) models, which aim to produce a more joined-up system of support for people with multiple needs (Revolving Doors, 2019). The idea of NWD is that wherever a person with multiple needs turns up, they will be assisted to access appropriate services. This can only be achieved by creating a large network of agencies collaborating so that individuals experience a more seamless service. The Wellbeing Hub in Nottingham has some elements of an NWD approach, but NWD can also involve organisations operating **a common set of standards** in how they will treat customers, and **developing a data sharing system** to share information, such as Greater Manchester's system called GM-Think. This provides a single place to record details of beneficiary engagement with a range of different service providers (Inspiring Change Manchester, 2019).

There is also increasing understanding that to work successfully with people facing SMD there needs to be recognition of **diversity** so that services will need to be positively **responsive to differences based on gender, age, culture and other equality strands** if they are to be inclusive. Where needs are sufficiently high to justify it, services seeking to work with particular groups such as BAME people or women should be supported. Local good practice examples include Awaaz who operate a culturally specific strength based approach (Everitt and Kaur, 2019) and the Response to Complexity' (R2C) project for women facing SMD (Harris, 2016).

Housing First is a client-centred approach that works because it is not conditional on first addressing problematic behaviours. It was originally a response to street homelessness in the United States. There is growing national (Homeless Link, 2015) and international evidence (FEANTSA 2017), that Housing First can be successful for a significant proportion of people facing SMD who have a history of homelessness and have not successfully sustained other types of accommodation. Importantly, for people facing SMD, most of the Fulfilling Lives SMD projects where Housing First has been established have found a high level of tenancy sustainment amongst Housing First Beneficiaries. Other benefits of Housing First for Beneficiaries are: improvements in community integration, physical and mental health and reductions in substance misuse, antisocial behaviour and offending. (Bretherton and Pleace, 2015). All Fulfilling Lives SMD projects that have evaluated their Housing First programme felt it was having a positive impact on wider systems, reporting changes in the local housing processes and impact on regional housing strategies (MCN Evaluation, 2018). The most significant challenges to the successful implementation of Housing First

partnerships, is the lack of affordable, suitable housing in the right areas and providing sufficient levels of support particularly in the early stages of a tenancy. So case load sizes should be small. Homeless Link recommend no greater than seven. (Homeless Link, 2017a)

Given the high levels of trauma experienced by people facing SMD it is no surprise that underpinning most of what work in supporting people facing SMD are **Psychologically Informed Environments** (PIEs) (Revolving Doors Agency, 2019). PIE is about delivering services in a way that considers the emotional and psychological needs of those using them. PIEs focus on developing positive relationships comprise five elements: a psychological approach, the physical environment and social spaces, staff training and support, managing relationships and support a culture of learning and enquiry. Staff report they feel better able to manage challenging Beneficiaries and tackle complex cases because of working within a PIE approach. Other benefits for the workforce include enhanced skills, improved morale, increased resilience and lower levels of staff sickness, absence and turnover. PIEs can provide a common purpose, approach and language that can span diverse organisations and sectors. This may provide a key mechanism for reducing 'silo' working. Commitment and support to PIEs from senior and strategic managers is needed for the approach to be successful.

Within the PIE approach is the awareness of the value of being "trauma informed", recognising the extent and nature of adverse childhood experiences and the impact they have throughout a person's life. Good practice shows that a trauma informed approach spreads beyond specialist SMD services to the wider workforce who will encounter people who have experienced trauma whether they face SMD or not. A particularly comprehensive example of practice comes from Scotland which has developed **The Transforming Psychological Trauma: A Knowledge and Skills Framework for the Scottish Workforce** (NHS Education for Scotland, 2017). This includes trauma informed practice training for all workers at four levels (see table below).

Level	Who is Included	Examples
Trauma Informed Practice	All workers.	Examples could include shop workers, taxi drivers, recreation workers and office workers.
Trauma Skilled Practice	Workers who are likely to be coming into contact with people who may have been Affected by trauma.	Examples could include lawyers, GPs, teachers, support for learning staff, police officers, nursery staff, sports-club coaches, receptionists, dentists, judges, A&E workers, lecturers, housing workers, care workers and service managers.
Trauma Enhanced Practice	Workers who have a specific remit to respond to people known to be affected by trauma by providing Supports or interventions. Workers who are required to adapt the way they work to take into account trauma reactions to do their job well and reduce the risk of re-traumatisation	Examples could include mental health workers, specialist domestic abuse support and advocacy workers, educational support teachers, specialist police officers, forensic medical examiners, social workers, prison staff, secure unit workers, drug and alcohol workers.
Trauma Specialist Practice	Workers who have a specific remit to provide specialist interventions or therapies for people known to be affected by Trauma with complex needs.	Examples could include social workers with specialist roles / training, major incident workers, psychiatrists, managers of highly specialist services, psychologists and other therapists

Table 18: Practice Level Definition from The Scottish Trauma and Adversity Training Plan (NHS Education for Scotland and the Scottish Government 2018:11)

To embed a PIE approach and provide essential **access to psychological interventions** and access to mental health services, some agencies working with people facing SMD have appointed their own **"in house" psychologists and therapists**. Some of the Fulfilling Lives projects have done this and the case for this approach is also underlined by the success of the Psychology in Hostels Project in Lambeth (Rhodes, 2016).

6) What is on the horizon?

It is very difficult to predict how service use and outcomes for people facing SMD will look in up to ten years' time, because at the time of writing issues relating to Brexit give rise to the greatest level of political uncertainty since the Second World War. This in turn will have as yet undetermined but likely wide ranging social and economic implications.

Beyond Brexit, it is the impact and interaction between two significant contradictory forces that will determine future service use and outcomes. These are:

- Growing awareness of SMD and how to work successfully to reduce it.
- Insufficient service provision due to funding not being available for services, and particularly if austerity continues to have a prolonged impact.

1. Growing awareness of SMD and how to work successfully to reduce it

There is now much better understanding of what causes SMD and how to successfully reduce it. This will require a life course approach with action across a range of areas:

Early Intervention – a whole life course approach

As seen is in section three, the origins of SMD lie in trauma and adverse experiences in early life: childhood and young adulthood. Therefore the ability to work to reach the matter "at source" will possibly be the biggest factor effecting levels of SMD long term. This will likely include: providing adequate support to families; improving access to support in education for young people experiencing ACE's; better access for young people to mental health services; providing trauma informed approaches in youth offending and substance misuse services working with young people; and supporting young people through transition to adulthood - particularly those who have been in care.

Whilst early intervention of this nature will be key to reducing SMD in the long term, most of Opportunity Nottingham's Beneficiaries are over 30, so a timescale longer than ten years will be needed to fully embed an early intervention strategy for minimising SMD. This will create at least a medium term need for services that can work with adults to prevent SMD. Some emphasis will need to be on services that are able to identify and address problems early in their presentation – and so are able to head off crisis before it develops into the level of chaos that Opportunity Nottingham typically works with. However it is unlikely such a "safety net" would be able to avert all problems, and so there will also be need for some continued crisis provision able to work with a person with high levels of chaos as Opportunity Nottingham currently does.

Embedding SMD in National and Local policies and Strategies

Mental Health

Also key to success in reducing the incidence of people facing SMD in the future, will be the extent to which it has been recognised in local and national policy and strategy. Much of this focuses on recognition of the need for system change - particularly integrated cross sector working, potentially extending to integrated commissioning. In relation to future developments in policy and strategy that move matters in this direction, there are some positive indications:

Integrated Care Strategy (ICS)

Nottinghamshire was part of the first wave of Integrated Care Strategy (ICS) areas. According to a review of this first wave of areas by the Kings Fund (2018:1) the development of ICS's… "represents a fundamental and far-reaching change in how the NHS works across

different services and with external partners" Key drivers behind this are: *emphasis on integrated working with statutory and voluntary sector partners and a whole system approach, such as strategic planning, aligning commissioning and providing overall system leadership*. This augers well for people facing SMD, as this approach is in line with the kind of system change that is advocated by agencies that specialise in learning around SMD (Fulfilling Lives SMD programme, MEAM, Lankelly Chase). The challenge will be to ensure the needs of people facing SMD are given sufficient prominence in the ICS.

Locally, the ICS strategy: Everyone's Different, Everyone's Equal - All Age Integrated Mental Health and Social Care Strategy 2019 – 2024) does show that the severity of SMD in Nottingham has been recognised. So a key aim of the strategy is…. "Make sure that people with multiple and complex needs are able to access help from local services, particularly amongst vulnerable groups such as homeless people and victims of sexual violence" (The Nottingham and Nottinghamshire Integrated Care System, 2019:25).

Criminal Justice

Offending and societal responses to it, acts as a barrier to enabling people facing SMD to move forward. This is a crucial area to address, (Bowpitt et al 2019). Criminal Justice policy is shifting towards an approach that better recognises SMD and it hoped this will continue through any changes in government. Significantly, the Modern Crime Prevention Strategy (Home Office 2016) includes emphasis on the need to work with other government departments on cross cutting issues such as mental health". Practical examples which should benefit people facing SMD include the establishment of *problem solving courts* and the development of the Female Offender Strategy.

Locally this theme is picked up in the Police and Crime Plan (2018 to 2021), which recognised that "services are facing greater presentations by people with complex needs and so prioritises actions to tackle this such as: "PCC to continue building relationships with partners, health sector and Clinical Commissioning Groups to further enhance support for people with mental health issues" and "Invest in initiatives to address the complex needs of offenders who are at risk of street homelessness or street drinking"(Nottinghamshire Police and Crime Commissioner, 2018:4).

It could well be the case that the return of rehabilitation services to the public sector that has recently been announced, certainly with its recognition of the damaging impact of short sentences, will see further positive developments in relation to people facing SMD. (Ministry of Justice, National Probation Service and Her Majesty's Prison and Probation Service, 2019).

Substance Misuse

In the sphere of substance misuse the cross cutting nature of SMD, and how it is this that often compounds rather than solves problems is now recognised. The Drug Strategy (2017) asserts that research shows up to 70% of people seeking community based treatment also have mental health issues and that "We know that people with co-occurring substance misuse and mental health conditions are too often unable to access the care they need. We want everyone across the country to get the help, treatment and support they need to live a drug-free life" (Home Office, 2017:34). This approach is confirmed in recently published NICE quality standards regarding Coexisting Severe mental Illness and Substance Misuse

which includes a statement that people should not be excluded from mental health services because of substance misuse and vice versa (NICE, 2019).

At local level, the Nottingham Crime and Drugs Partnership (CDP) Strategic Assessment for 2018 does make reference to mental health and also the link between substance use and offending. However SMD (or multiple complex need) is not specially referenced as a concept requiring a specific response and compared to the national strategy could make more reference to greater integration of substance misuse and mental health services.

Homelessness

A key positive driver in the homelessness sector will be the government's aim to halve rough sleeping by 2022 and eliminate it entirely by 2027. Additionally there is evidence emerging that the Homelessness Reduction Act 2018 is having a positive impact in relation to people facing SMD because of its emphasis on preventative work and Personal Housing Plans. This enables the addressing of wider: "care and support needs that have been identified that cannot be met by the housing authority; or which require health or social care services to be provided alongside help to secure accommodation" (Ministry of Housing, Communities and Local Government, 2018:88). This is confirmed in Nottingham with the Homelessness JSNA chapter highlighting people with SMD as an unmet need.

Continued improvements in practice

In addition to most strategy drivers moving policy in the right direction to reduce levels of SMD in the future, practice is also moving in the right direction. This can be seen in the development of learning from the MEAM approach and the Fulfilling Lives SMD programme to ensure the embedding of: joined up commissioning; multi-disciplinary working at all levels; strengths based approaches; trauma informed approaches; Housing First; Personal Development Coordinators and other areas of good practice as set out in the previous section. It is likely the embedding this kind of practice as *the* standard approach, particularly if aligned with early intervention, should reduce the volume and intensity of people facing SMD.

2. Future Funding for Services

Possibly countering all of the positive development in the previous section is the potential for rising levels of SMD stemming from the impact of funding restrictions to the wider system. There are some early indications that this is already happening. This includes the increase in rough sleeping levels since 2010, although there was a small decrease of 2% in 2018 (Ministry of Housing, Communities and Local Government, 2019). Most rough sleepers have additional needs relating to SMD (Greater London Authority, 2019) and it is known that rough sleeping levels tend to be the "tip of the iceberg" of the much broader problem of rising multiple exclusion homelessness (Fitzpatrick et al., 2018). Further, evidence coming from the Fulfilling Lives programme also indicates increased demand across all areas, (Fulfilling Lives System Change Action Network – unpublished meeting notes 2019)

Insufficient levels of funding could impact across all sectors supporting people facing SMD:

Health and Social Care

In Health, as research by the Kings Fund states, “rising demand and constraints on NHS and social care funding have put services under pressure. Many hospitals have large deficits, and key performance targets are being missed all year round. Community, primary care and mental health services are also grappling with rising gaps between demand and the resources available, and there is evidence that access to and quality of care is suffering. Local authorities have seen significant reductions in their budgets, resulting in cuts to social care, and public health budgets have been squeezed” (Charles et al. 2018:12).

In the field of mental health, funding increases have recently been announced, “the NHS long term funding plans reaffirms that mental health funding – provided through a ring-fenced investment fund – will outstrip total NHS spending growth in each year between 2019/20 and 2023/24 so that by the end of the period, mental health investment will be at least £2.3 billion higher in real terms” (Charles et al., 2019). However, it appears much of this is only reversing funding reductions from earlier years as Kings Fund research states: Funding for mental health services has been cut in recent years. Our analysis shows that around 40 per cent of mental health trusts experienced reductions in income in 2013/14 and 2014/15. (Gilburt, 2015).

At the beginning of this section the importance of early life prevention in cutting off SMD at source was demonstrated, yet funding for preventative children’s services from government has reduced by 49% (Children’s Society, 2019). Therefore this is highly likely to build up increased levels of latent need. In adult services the impact of funding reductions particularly the loss of preventative services is likely to increase need. Reductions in other areas of local government spending could also have a negative impact. Education is an example, for instance special educational needs for proactive work with children in care. Also, Adult Social Care is struggling to meet demand and there is a danger that people facing SMD will miss out on duties owed to them under the Care Act (although in Nottingham innovative good practice is being developed in this area through the Opportunity Nottingham PDU). Evidence for the cumulative scale of funding reductions is provided by analysis from the Local Government Association which found that local services face a funding gap of £7.8 billion by 2025 (Local Government Association, 2018).

Homelessness, Substance Misuse, Offending and Welfare

In the homelessness sector there are on-going housing supply side concerns that could undermine positive developments such as Housing First. Social housing building rates are not sufficient to replace housing lost through right to buy (Fitzpatrick et al., 2018) and increasingly local authorities are concerned about their ability to support people to live in private rented sector accommodation through Local Housing Allowance cuts (Curry, 2019) Support to Criminal Justice services have been reduced impacting on both prisons and community services ability to reduce reoffending rates. Locally substance misuse service funding has been reduced, down by £1 million in 2018/19 (Barlow, 2018). Finally the impact of benefit reforms could have a negative impact. If the benefits system becomes too difficult for people facing SMD to navigate, then there could be increases in incidences of income being sought from informal and illegal sources, such as begging, sex working and shop lifting. Involvement in such activities however, could in turn make it harder for people to move always from SMD.

Summary

Looking to the future, improvements in practice such as developing trauma informed approaches, better understanding the need for early intervention to tackle ACE' s and integrated more efficient methods of working, have great potential to reduce the incidence of SMD. However this could be offset by commissioners and providers inability to act as needed due to continued restrictions in public spending.

The likely trajectory therefore is that there will continue to be a need for services working directly with people facing SMD (i.e. specifically commissioned - see section 4). There will also be continued need for other services who will have people who face SMD on their caseload, to work in ways that enable positive working with this group. This will include embedding Psychologically Informed Environments encompassing trauma informed and strength based approaches. The level of future need will depend how much improved practice is allowed to flourish, given the funding reductions predicted. The precise interaction between these two forces will need to be monitored closely.

7) Local Views

The following feedback is taken from consultation events held in the past twelve months with Opportunity Nottingham Beneficiary Ambassadors and Expert Citizens. Expert Citizens are a group of Beneficiaries who have made progress on the Opportunity Nottingham project, to a point where they are able to come together to inform and support its development and help to ensure that the voice of lived experience is heard. To the end of March 2019, 21 Opportunity Nottingham Beneficiaries had become Expert Citizens. Beneficiary Ambassadors have lived experience of at least one of the sources of disadvantage that comprise SMD. They are employed to support the Expert Citizens and ensure their voice is meaningfully heard. As far as possible in the text that follows Expert Citizens own words have been used.

1. General feedback

Expert Citizens value the holistic person centred and strength based support they receive from Opportunity Nottingham. Key to this has been that it is not time limited and there is continuity. The Expert Citizens recognise it can take a long time for individuals to build up trust with a worker, due to their past experiences. Therefore, having the option of long term support can put people at ease and enable them to go at their pace when addressing any issues that they face.

There is also emphasis on the value of having a positive support network particularly if positive outcomes are to be sustained. An example, is that the Expert Citizen groups itself is valued as, "being involved means you are more than just a set of needs". It is also valued for providing "structure to your day and relieves boredom."

The Wellbeing Hub has also been well received by the Expert Citizens, as having services within one building can make it easier for people to access them. The only criticism of the Wellbeing Hub was that accessible mental health services are an important missing segment.

Expert Citizens feel strongly that services are not always there when they are most needed, especially when a crisis occurs. “If you need help out of office hours there is often nothing available”. They felt the Mental Health Crisis Team couldn’t offer sufficient support. Due to lack of support out of office hours, the person having the crisis can become very distressed and can often end up being picked by the Police. Although it was acknowledged the Police can help Beneficiaries, it was felt the response would be much better if mental health expertise were available, or at least somewhere to receive some emotional support.

When Beneficiaries are self-medicating there is difficulty accessing mental health services due to needing to address substance misuse first. This feels like a “hamster wheel you just cannot get off, whereby you are looking to address your issues however you are unable to do this due to obstacles put up by services and so you carry on self-medicating”

There is also an issue with benefits as delays in receiving Universal Credit can help contribute to rent arrears and general debt. There is difficulty navigating the benefits system and this can be especially challenging for people facing SMD, to the point where they may disengage and return to homelessness. Therefore support is required to navigate the benefits system.

Expert Citizens felt strongly that honesty from services was important. “If staff were honest and realistic it would help to prevent false hope”.

Services should also look into hiring more people with lived experience to their workforce, as it helps to establish rapport and it is “easier to relate to your worker if they have had lived experience and can provide you with a role model”.

Women Expert Citizens felt that service providers didn’t always appreciate it can be especially difficult engaging with services that mainly work with men – especially if the source of your trauma comes from male violence, either recent or going back to your childhood.

2. Feedback about Specific Sectors

Mental Health

- Need to listen to individuals
- Everyone should get treated the same
- The system is not responsive
- Too much assessment
- Too complex to engage with – too many different numbers and teams to contact.
- The system is judgmental and gate-keeps access to services
- Strict time limits on staff and service users
- Not solution focussed
- Too much emphasis on medication
- Government funding / cuts to services
- Long waiting times
- Access to services at the weekend and out of hours.
- When sectioned can be taken away from city for appropriate care, however this isolates the individual from their family and social support

Substance Misuse

- Long waits for support from referral point
- Lack of drop-in support due to cuts in services
- Recreational use not seen as problematic – how bad does it have to be?
- Lack of public education of dangers of ‘mamba’ and ‘Spice
- Not enough support is offered?
- Time limits on support
- Who decides what to work on: them or us?
- Lack of signposting
- Can feel judgmental
- Not a personalised service
- Staff often lacks personal experience of substance misuse.

Offending/Criminal Justice

- Lack of support outside prison
- Prisoners ‘let out to fail’
- No signposting to support

What does this tell us?

8) Unmet needs and service gaps

Despite limitations concerning the availability of data, it can be asserted with some confidence that the number of people facing SMD in Nottingham is likely to be between five and six thousand (see Section 2). How are the needs of this group of citizens to be met?

Achieving Sustainable Positive Outcomes – What does unmet need look like?

Before the question of what is the scale of unmet needs can be answered, it is necessary to be clear about what is meant by unmet need in the context of SMD, i.e. what do people have a need for? Opportunity Nottingham has made a concerted effort to do this in seeking to define what is meant by a sustainable positive outcome, see box below:

Opportunity Nottingham: Definition of a sustainable positive outcome?

The beneficiary considers they are leading a fulfilled life in the community, so that they can see a future which includes their own positive goals - and have the motivation to seek to achieve these goals, and:

- Is living in stable housing and a plan is in place to enable this to continue
- Is not offending and is unlikely to return to offending
- Has addressed or is managing mental and physical health issues and consider this can be sustained without the need to return to Opportunity Nottingham
- Is abstinent or positively controlling substance misuse and is unlikely to relapse, or - if relapse occurs, will be able to obtain the necessary support themselves without further need for support from Opportunity Nottingham

It is important to note that the above definition sets a high bar and so may remain aspirational. Even so it is important to keep in mind as a long term goal.

Additionally, the above definition, considers the term *sustainable* outcome in relation to unmet need amongst people facing SMD. That is, need is only met where it is considered a person will seek (and be able to get) support before lapsing into crisis or chaos. Failure to tackle this “revolving door” problem is a major issue for people facing SMD.

SMD 2

The next issue to consider relates to the levels of intensity of SMD. Using the common definition of SMD (homelessness, offending, substance misuse and homelessness), section two shows that most people facing SMD have *two* of these sources of disadvantage (SMD 2). It is likely that mainstream services – i.e. commissioned single issue services will able to meet the needs of the SMD 2 group in terms of *how* they work - provided they apply the good practice outlined in section 5 “What Works” and commit to the Opportunity Nottingham system change agenda outlined in the final recommendation section of this document (Section 10).

Whilst services may be able to develop so that their knowledge of *how* to work with people facing SMD becomes standard practice, there will still likely be unmet need in terms of the overall *capacity* of mainstream services *to meet the scale of this (SMD 2) need.* This should feed into the relevant JSNA Chapters for each of the individual disadvantage areas.

SMD 3/4

The data in section two of this document shows nearly 2000 people with three or four sources of disadvantage (SMD 3/4). For this group single issue services even if operating to the good practice principles outlined in section five (What Works), will not be sufficient to meet need - and so specific SMD services will be needed. The question here is what kind of services are best to commission? People facing SMD need to connect with different sources of support and care: stable housing, substance misuse services, mental health, offender rehabilitation, benefits, employment/training/education (ETE), social network building. At present even services in the city specifically commissioned for people facing SMD do not deliver all of these elements. For instance the Complex Needs Accommodation services in the City provide accommodation for a period that learning from the Fulfilling Lives SMD programme would indicate is too short in most cases to achieve a sustainable outcome (Moreton et al, 2018). Nor is access to mental health specialists built in as a standard part of these services approach. There is currently access to a Clinical Psychologist for resident at the Complex Needs services but this is a temporary pilot funded by Opportunity Nottingham.

The key thing to consider in relation to SMD 3/4 is therefore how best to meet needs? The literature suggest there are three main approaches:

1. **Assertive Community Outreach (ACT)**

2. This is the provision of holistic support that seeks to meet all sources of disadvantage in one service through a single multi-disciplinary team. In the U.S, particularly in Housing First services where it is the most common approach it is sometimes referred to at the Assertive Community Outreach model (ACT). This approach is less common in the U.K, though is now beginning to be commissioned, most notably Plymouth (Lowe and Plimmer, 2019). The ACT approach is also applied in a few UK Housing First services (Housing First England, 2018). A key part of this approach therefore is access to permanent housing. This approach has the advantage of cutting out much of the fragmentation between services that causes so many issues for people facing SMD. It can however be a difficult approach to establish as being multidisciplinary it generally requires joint commissioning.

3. **Intensive Case Management (ICM)**

This is where support workers operate as Personal Development Coordinators, who in addition to providing intensive holistic support themselves, supporting people to access and engage with existing mainstream services. This method can be supported with systems to further facilitate access and communication, such as the development of a “No Wrong Door” network or data sharing systems. ICM is also underpinned by access to stable housing.

4. **Hybrid Approach**

This is based on an ICM service but also has additional multidisciplinary elements attached directly to it to overcome access issues. This is the approach that Opportunity Nottingham has developed with a team of Personal Development Coordinators, as a core service, with two mental health specialists and other additions including a Social Worker, Peer Mentors, a Lived Experience Team, Tenancy Support and Housing First. The projects outcomes suggest it has a significant degree of success (Bowpitt et al. 2018).

SMD 3/4 and Service Capacity

In relation to capacity, the evidence at present, (albeit with its limitations outlined previously) suggests Opportunity Nottingham works with approximately the 25% most acute people of the total of SMD 3/4 cohort. However there is a big question as to whether the remaining 75% of the SMD 3/4 cohort can have their needs met in mainstream services. So a further expansion of services specifically serving people facing SMD 3/4 is needed. Certainly during the next five to ten years, the volume of people facing SMD 3/4 will continue to be an issue. So this must be kept under review - and much will depend on the one hand; the impact of good practice and system change that Opportunity Nottingham has been pursuing and whether this can continue (e.g. through the Practice Development Unit), once Opportunity Nottingham has finished in 2022. Or - on the other hand; will these positive developments be swamped by further public sector funding reductions, even though there is developing evidence that the provision of the services developed by Opportunity Nottingham bring economic and social cost savings over the long term (Lamb et al. 2019, Bowpitt et al. 2018).

A further issue will be that additional consideration needs to be given to the 25% of the SMD 3/4 group that Opportunity Nottingham currently support once Opportunity Nottingham finishes in 2022. It is important to note in this context that whilst the Personal Development Coordinator role has been central to successful outcomes, this cannot be seen in isolation to the whole package of measures developed by Opportunity Nottingham, as outlined in the previous subsection (See Hybrid Approach). It should also include better methods for data sharing to improve efficiency, and cut the constant “retelling your story”, that people facing SMD have to do.

Meeting “Hidden” Needs: Women and BAME people

Any service developments must take account of groups whose disadvantages can be overlooked by the common definition of SMD, especially women and BAME people. There is clearly unmet needs amongst these groups and any response should recognise the needs for both gender and culturally specific SMD services and promoting gender and cultural responsiveness more widely. Any commissioned SMD services should show how this would be addressed.

Coordination and Collaboration

Successful working with people facing SMD requires collaboration across sectors. This doesn’t happen on its own, mechanisms need to be in place to facilitate joint working. At ground level this can be through multi-disciplinary team meetings, data sharing or no wrong door networks. There is also a need to collaborate at strategic level to ensure joint working is embedded as part of each organisations culture rather than be seen as an optional “add

on". At present Opportunity Nottingham fills much of this role, but once Opportunity Nottingham finishes there will be a gap and a danger that each organisation will return to inefficient "silo" working. The role of a successor "Board" to Opportunity Nottingham to continue Opportunity Nottingham's system change agenda could well be a major gap therefore. Certainly if there remains a need for system change in 2022 and beyond.

Access to Mental Health Services

Nottingham has better evidence than most cities in relation to mental health service access, through the Sheffield Hallam University Mental Health and Homelessness research (Reeve et al., 2018). Evidence points to lack of access to mental health services being the biggest problem in relation to people facing SMD. This is because, this lack of access has knock on consequences preventing successful outcomes in relation to other areas of multiple disadvantage: reducing substance misuse; sustaining housing; and moving away from offending. Consideration needs to be given to how to overcome this, should Coordinators try to connect people into specific mental health services or should SMD services employ their own mental health specialists who can directly apply psychological interventions, as Opportunity Nottingham has done.

One particular issue relates to co-occurring mental health and substance misuse issues as there is evidence both national and locally that mental health services have lacked flexibility to work sufficiently with people facing SMD. Additionally Nottingham could improve access to mental health services for rough sleepers as has happened in Leicester (see Section 5, What Works).

Psychologically Informed Environments

In addition to accessing mental health's services there is now understanding of the significance of trauma and adverse childhood experiences in relation to SMD. However trauma informed practice is not being developed consistently across all services who work with people facing SMD. Whilst some services have made good progress, others are yet to fully embrace the concept. To fully embed this approach monitoring the development of trauma informed practice would be needed at commissioning level.

Employment training and education - Building Positive Social Networks

Although some people facing SMD with the most acute needs, may need to receive long term care, it is not possible or desirable for most people facing SMD to receive support services on an ongoing basis. Therefore, to enable positive outcomes to be sustained and break the revolving door tendency, a focus is needed on ensuring people facing SMD build their skills, deal with boredom and have positive social networks to provide mutual support. Indeed for a large proportion people facing multiple disadvantage employment, albeit sometimes in the longer term, is real possibility (Smith, 2019). At present services do not focus enough on building skills and strengths, but rather deliver support, followed by "sign off" where a person is expected, (too often unsuccessfully) to be independent. The development through the ICS of "social prescribing" offers an opportunity to tackle this issue, but to be successful it will be important to ensure the ICS delivers initiatives that that reach people facing SMD.

Valuing Lived Experience

Enabling people with lived experience to be involved in a services design and delivery is always a good approach. When power is truly shared in relation to this it is sometimes called co-production. For people facing SMD this approach is even more important because the system concerned is complex, it doesn't just involve delivering one service but a multiplicity of services that are fragmented and can, from a beneficiary's point of view, work against each other. Indeed it could be said that it is *the system that is chaotic not the individual*. Only a person with lived experience can know what it feels like to be trapped in this chaotic system - and so their voice when it comes to understating how to escape it, must be heard. Yet there is evidence this is not fully the case – for instance the Opportunity Nottingham initiatives; "*the Pledge*" and "*Facts About Me*" are not yet widely adopted, despite almost universal agreement locally that they will bring about significant service improvements.

Criminal Justice Services have a vital role to play

The consequence of having a fragmented system that leads to a "revolving door" cycle for people facing SMD is too often offending. The way criminal justice services operate can do much to either reinforce or alleviate this. Whilst some positive changes lie in the realm of national government, such as ending short prison sentences, locally much can be done. This includes through the gate initiatives so people don't become homeless on release from prison and Criminal Justice services fully participating in collaborative cross sector working.

Housing First

The evidence base for Housing First as a long term and cost effective option to enable people to move away from SMD is well established (Pleace and Bretherton, 2019). However in Nottingham to date only a few units have been established. Homeless Link suggest that Housing First is suitable for between 10 and 20 percent of rough sleepers. If this proportion is extended to the whole SMD 3/4 cohort, who are in the main chronically homeless then there would be need to seek to expand Housing First in Nottingham to approximately 200 units (Homeless Link, 2017b). For Housing First to succeed however consideration needs to be given to ensuring a supply of housing as Housing First does not obligate tenants to move on. Additionally, staff to tenants ratio need to be low to support times when intensive support is needed. (Homeless Link 2017a).

Given the nature of multiple disadvantage there is not sufficient cross sector collaboration and coordination between mental health, housing, criminal justice and substance misuse services – as well as social care and the DWP. This lack of coordination and collaboration exists at all levels from ground level staff to strategy and commissioning. Part of this lack of collaboration is a lack of data sharing which causes people facing SMD to have to keep repeating their story and this contributes further to their alienation from services.

As SMD is primarily a consequence of trauma, a mental health response is central to meeting needs but often people facing SMD cannot get access to the mental health services they need especially psychological intervention. Nor is there sufficient psychological understanding of people facing SMD from the wider workforce.

Where SMD results in homelessness, appropriate housing solutions are not often available. Hostel provision has limited success especially for people facing SMD whose needs are

most acute. Housing First has a good evidence base as an alternative but there is not enough provision.

Citizens facing the most acute SMD, can benefit from specialist support from a dedicated SMD service. Opportunity Nottingham aims to provide this until 2022 but after this a replacement will need to be found. Evidence suggests people facing SMD must be involved in developing their own solutions to the disadvantages they face. This includes individually through strength based approaches and collectively through ensuring the system is service user led or informed.

9) Knowledge gaps

Data

The main gap in knowledge identified in constructing this document has been the lack of up to date comprehensive data regarding the overall scale and demographic profile of SMD in Nottingham. Of course the problem is not an overall lack of data. People facing SMD appear at a myriad of services, such as housing, substance misuse, mental health and criminal justice and the DWP. But like the system of support for people facing SMD - this data is fragmented, held individually by each agency and generally not shared.

Data has therefore has been used extensively from the Hard Edges report as this is the only national research that has mapped levels of SMD across England, (Bramley et al., 2015). Some of the data used for this mapping is however now up to nine years old. Further this data does not include a primary mental health source and so the researchers had to provide an estimate, which they state is likely to be an understatement of the actual level of mental health need.

Some of the lack of information about mental health is compensated for locally by the Sheffield Hallam University research; The Mental Health Needs of Homeless People in Nottingham (Reeve et al., 2018). But this research does not attempt to quantify the overall number of people who experience co-occurring mental ill health and homelessness issues.

There is also a need for better demographic data too, particularly concerning people facing SMD whose needs are more hidden, such as women, BAME people, people who identify as LGBT+, and military veterans. In the latter case, this is needed to comply with the Armed Forces Covenant.

Having said this there is good knowledge of the scale of need and demographic characteristics of people facing SMD, at the higher end of need (SMD 3/4), principally through Opportunity Nottingham's comprehensive data set. This shows how needs can be met through specific services for people facing SMD. For people at the lower end of SMD (SMD 2) however, there is less knowledge of the size of this group, and what additional needs they may have, and crucially - the capacity of existing services to meet the needs of this group.

Improving Policy and Practice

There is a considerable amount of emerging good practice in relation to commissioning and delivering interventions for people facing SMD, principally through the Fulfilling Lives SMD programme, but also other agencies such as MEAM and Revolving Doors. Locally Opportunity Nottingham will continue to add learning until 2022. There is though still a lot more to learn. It should be acknowledged that “what works” is a constant evolution rather than and end point. “The ability to adapt to change – the context in which social interventions are undertaken constantly changes, from micro–scale changes in personal circumstances to large scale social change. This means that the nature of the challenges and ‘what works’ to meet those challenges is continually shifting. Social interventions must be able to continually adapt to reflect these changes”. (Lowe and Plimmer, 2019).

Questions where more learning is still needed include;

- More evidence about what works - and how initiatives work
- How can the value of lived experience be best utilised
- How best to deliver psychological interventions and Psychologically Informed Environments
- To what extent can data sharing/no wrong door approaches work
- Can Housing First work at the highest end of the disadvantage spectrum
- To what extent does joint commissioning lead to better outcomes?

There is more knowledge needed about the impact of new strategic developments, especially the Integrated Care System and how this can improve outcomes for people facing SMD.

What should we do next?

10) Recommendations for consideration by commissioners

The following measures for consideration by commissioners have the potential to reduce both the incidence of SMD and its negative impact. They build on the five Opportunity Nottingham System Challenges for Nottingham City – available here: http://www.opportunitynottingham.co.uk/latest-news/news/system-change-challenge-join-in/:

1. **Once Opportunity Nottingham ends in 2022, continue to respond to multiple and complex needs by building on its legacy through considering developing a jointly commissioned specific SMD Service**

This service will work with people facing SMD who have the greatest level of need and will build on the success and learning of Opportunity Nottingham and the Fulfilling Lives programme. Evidence therefore suggests it should be a multi-disciplinary team containing as a minimum the following elements:

- A team of Coordinators/Navigators
- Mental health specialists able to provide psychological interventions and support PIE
- A Lived Experience Team that includes staff to support Expert Citizens and Peer Mentors, and focuses on connecting people to positive social networks
- Gender and Culturally specific elements – which may include posts hosted by specialist agencies
- A Practice Development Unit – to promote good practice and collaboration more widely
- A Social Worker working as a "trusted assessor" to support access to care services

2. **Ensure the "system works as one" through development of a strategic "Board" responsible for reducing SMD beyond the end of Opportunity Nottingham in 2022**

This SMD "Board" should oversee service provision and continued system change. This is needed because resolving SMD involves different sectors (principally: mental health, homelessness, substance misuse and criminal justice, but also other sectors such as the DWP and Probation. SMD will only be reduced if senior representatives from these sectors collaborate to ensure a unified approach. Therefore, the highest priority must be given to ensuring genuine and consistent representation from all sectors, with time allowed for this by individual organisations. The Integrated Care System and other strategic initiatives should be used to lever support from all sectors.

The Board would oversee implementation of point one above but also ensure coordination of the wider number of people facing SMD, who will benefit from a coordinated approach but

whose needs would not be sufficiently high to qualify for the new SMD service as described in point one above.

3. **Increase over time the number of Housing First Units in Nottingham to 200 as part of the legacy to support SMD once Opportunity Nottingham ends**. This figure is based on evidence from Homeless Link that Housing First is suitable for approximately 10% of people facing multiple exclusion homelessness. So, 200 units would be sufficient for approximately 10% of the Nottingham SMD 3/4 cohort. To ensure this is a successful initiative it will need to be linked to the wider housing strategy especially housing supply and be backed by tenancy support operating at a low resident to worker ratio.

4. **Understand the centrality of addressing mental health issues to enable people to move away from SMD. This will be underpinned by the wider goal of ensuring Nottingham becomes a city where the wider workforce apply a psychologically informed approach.**

This will include:

a) All services working with people facing SMD taking a psychologically informed (sometimes referred to as trauma informed) approach. This should not only include any specific SMD services, but also single issue services that work with people facing SMD including; homelessness services, substance misuse services and the DWP. The use of a psychologically informed approach should be monitored through use of an appropriate tool, such as the PIZAZZ or the Homeless and Inclusion Health standards for commissioners and service providers (Pathway, 2018)

b) Mental health specialists should be included as part of a multi-disciplinary approach in any service substantially working with people facing SMD. This includes substance misuse services and the Rough Sleeper Outreach Team

c) The recommendations from the CCG funded research by Sheffield Hallam University: Understanding the Mental Health Needs of Homeless People in Nottingham (2018) should be implemented.

5. **Ensure flexibility in the way we work with people facing SMD by providing gender and culturally responsive support in recognition of the diverse forms multiple disadvantage takes**

Evidence suggests the mainstream definition of SMD (mental health, homelessness, offending and substance use), can lead to some group's disadvantages being overlooked, including women and BAME people. Therefore, services need to be gender and culturally responsive and commissioners should monitor this. Additionally, gender and culturally specific services for people facing SMD service should be considered.

6. **Support the long-term wellbeing and independence of service users by challenging stigma and by building on their strengths , skills and positive networks**

Ensure that positive outcomes are sustained by commissioning services that take a strength based approach, focus on skills development and enable supportive positive networks. Without such emphasis, people facing SMD will not be able to build their own resilience and the costly and ineffective "revolving door" approach will be in danger of continuing.

7. **Minimise the likelihood of SMD occurring by recognising the origins of SMD mainly begin in early life, and by equipping services for children to respond.**

Eighty five percent of people facing SMD have early life trauma and adverse childhood experience. The best long term solution therefore is early intervention through better services supporting children and young people. These should respond to ACE's and trauma and identify and support young people at risk of moving into the SMD group.

8. **Ensure the system works as one and tackles stigma through a "no wrong door" approach, by continuing the work of Opportunity Nottingham to improve data sharing.**

This involves supporting systems to share data (where consent is given) that prevents constant retelling of stories and enables more efficient interagency working, speeding up delivery of services. The inclusion of "Facts about Me" will also contribute to tackling stigma and focussing on strengths.

9. **Develop a service user led system, whereby people facing SMD are able to directly have a significant say in how services should be working.**

This includes ensuring participation is meaningful, is supported with time and resources and is backed by a widely accepted participation standard for Nottingham City.

10. **Ensure the Criminal Justice system is fully engaged in and trained to reduce SMD, recognising that people facing SMD can present anywhere.**

In economic terms it is in the criminal justice system where a positive approach to reducing SMD will make the biggest difference - this is where the greatest cost savings will be made. The previous nine measures listed above if implemented, will reduce offending but where it does occur and a prison sentence is given "Though the Gate Support" (meeting prisoners at the point of discharge) is also an essential component of any coordinated support network for people facing SMD**.**

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