Literature review for people with MCN

Objectives

A neighbouring authority to East Sussex, Brighton and Hove, conducted an in-depth literature review about people experiencing MCN as part of a needs assessment in 2020.(24) As such, it was determined that the best use of resource in East Sussex would be to conduct targeted evidence reviews, answering specific questions, reporting on changes to the evidence base since the publication of Brighton and Hove's report. Some questions were deprioritised for review as a result of time pressure.

The questions to be addressed using published evidence were:

1. What is the prevalence and demographic makeup of people with MCN?
2. To what extent do services meet the needs of people with MCN: access and barriers?
3. What works for people with MCN?
    a. The aim of this question is to summarise key recommendations for commissioners and existing service providers based on published research and national guidance.

Key Questions

The questions answered as part of this evidence review were:

1. What is the prevalence and demographic makeup of people with MCN?
2. To what extent do services meet the needs of people with MCN: access and barriers?
3. What works for people with MCN?

The key questions for the evidence review were addressed by two members of the team. Reviewer 1 (MS) summarised findings for questions one and two, and reviewer 2 (NE) for question three.

Search Strategy

In March 2024, an evidence search was undertaken by the Sussex Health Knowledge and Libraries service,[1] using the same search terms as were used for the Brighton and Hove literature review.(24) The search terms were:

(multiple complex needs OR multiple compound needs OR multiple severe disadvantage) AND (homeless OR substance misuse OR addiction OR offending OR probation OR "mental health" OR domestic abuse OR trauma OR "post trauma" OR

[1] Evidence search: Adults with multiple complex needs. Frankie Marcelline. (13 March 2024). BRIGHTON, UK: Sussex Health Knowledge and Libraries.

adverse childhood experiences OR race OR ethnicity OR sexual orientation OR lgbt OR learning disabilities OR inequalities OR deprivation OR disadvantaged OR poverty)

The search sought to cover the period since the publication of the Brighton and Hove report, and used the date range of April 2020 to March 2024. The sources searched were Google (14), Google Scholar (4), National Institute for Health and Care Excellence (NICE) (1), ProQuest [APA PsycArticles®; APA PsycInfo; British Nursing Index; Health Research Premium Collection; MEDLINE®; PTSDpubs; Publicly Available Content Database (62)], PubMed (1), Requester (1), and The Mental Elf (4) [total 87 papers].

The results of the search were reviewed and a further three further papers (such as results for protocols retrieved as part of the evidence search) were identified through snowball searching and added.

This initial search was supplemented by additional searches by each reviewer.

Record review: What is the prevalence and demographic makeup of people with MCN? and *To what extent do services meet the needs of people with MCN: access and barriers?*

This review utilised evidence identified as part of the initial evidence search, supplemented by additional searching.

Approach

A two-step approach was taken to identify relevant materials to answer these two research questions.

Step 1. Revisiting retrieved documents

All retrieved documents were reviewed (or re-reviewed if previously reviewed by another member of staff) and included as eligible if pertinent to topics of prevalence, demography, or experiences of people with MCN.

Step 2. Identify additional guidance and evidence

a. Searches were run on Google Scholar and a bibliographic database, Trip, using two versions of Boolean operators and a period of 2020 to present. Only the first ten results generated in Google Scholar were reviewed, per each of the two searches. These searches generated an additional 54 documents, not deduplicated.
b. Targeted citation searching was also undertaken where a document reported on another paper which appeared highly relevant, or was a protocol for a study which had not yet been conducted.

Boolean searches used in Google Scholar and Trip

Search A: (multiple) AND (complex OR compound OR severe) AND (needs OR disadvantage) AND (prevalence OR demographic OR profile OR characteristic OR estimate)

Search B: ("multiple complex needs" OR "multiple compound needs" OR "multiple severe disadvantage" OR "severe multiple disadvantage" OR "severe and multiple disadvantage" OR "deep social exclusion" OR "chronic social exclusion" OR "extreme social exclusion") AND (prevalence OR demographic* OR profile OR characteristic* OR estimate*)

Inclusion and exclusion criteria

Papers were included if they were published between 2020 and 2024, as 2020 was the year the Brighton and Hove needs assessment was conducted. Papers were also assessed for location, and included only if specific to the UK. Some papers which predate 2020 were included when their subject was not otherwise reflected in included literature, or when they were not included in the Brighton and Hove report.

Record retrieval

The initial scoping review search identified 90 documents published since the Brighton & Hove's MCN needs assessment was conducted in 2020. Of those 90 documents, 16 were included as relevant, and two further papers were identified by snowball searching from included papers. An additional 30 papers were identified as eligible for conclusion from additional database searches, including the results of snowball citation searching. In total, 46 papers were reviewed and reported on for these questions.

Record review: What works for people with MCN?

This refined review expanded its scope beyond the results of the evidence search to enable integration of guidance with evidence-based recommendations, by focusing on documents published since the Brighton & Hove report which:

1. Offer relevant guidance on how best to support people with MCN and/or
2. Provide evidence of interventions designed to improve outcomes or engagement for people with MCN.

Approach

A two-step approach was taken, focusing primarily on records already retrieved in the initial scoping review with additional actions where time permitted.

Step 1. Revisiting retrieved documents

All retrieved documents were reviewed (or re-reviewed if previously reviewed by another member of staff) and included as eligible if they either:

- Report on research evidence for how to support people with MCN (e.g. systematic reviews, surveys, interviews and focus groups), or

- Offer guidance or recommendations on how to support people with MCN (e.g. NICE and other guidance documents and reports of large-scale programmes of support).

Step 2. Identify additional guidance and evidence

a. A Google search was run using Boolean operators which retained limitations on documents published before the Brighton & Hove MCN report but which adapted the 03/24 search to:
   - Include broader search terms for MCN,
   - Focus on guidance, guideline, policy, standards, 'best practice', 'statutory requirement', and related terms.

b. Targeted citation searching was also undertaken where a document reported on another paper which appeared highly relevant, or was a protocol for a study which had not yet been conducted.

Refined Boolean search in Google

(guidance OR guideline OR standard OR "statutory requirement' OR "best practice") AND ("multiple complex needs" OR "multiple compound needs" OR "multiple severe disadvantage" OR "severe multiple disadvantage" OR "severe and multiple disadvantage" OR "deep social exclusion" OR "chronic social exclusion" OR "extreme social exclusion") AND (guidance OR guideline OR standard OR "statutory requirement") AND national –jobs –court[2]

Inclusion and exclusion criteria

Documents not specific to people with MCN but which refer to a population highly likely to include them, were included where deemed relevant. Documents reporting on risks (rather than interventions) were included where there was no other evidence or guidance retrieved for that particular service or issue *and if* clear recommendations were given for intervention were included in the documents. Similarly, documents reporting on single service audits or interventions were included where findings were considered to be of relevance to similar services elsewhere *and* if there were no other documents offering guidance or recommendations for that particular service or issue. Given the pragmatic purpose of this evidence review, recommendations were not included in this report if they were deemed to be too abstract to be of use or if they were aimed at national actors such as central government.

Record retrieval

The initial scoping review search identified 90 documents published since the Brighton & Hove report on MCN was released in 2020. Of those 90 documents, 39 were initially

[2] '-jobs – court' were included in the search strategy after a pilot search drew a predominance of job adverts and court-based documents

deemed to be both relevant to MCN and providing evidence or guidance on supporting people with MCN. From these, a further 15 were excluded because they were not reporting on recommendations or evidence-based interventions, were too tangential or 'high level', or were not relevant to people with MCN; one of these was however replaced with a paper which it cited. Of the retained 24 documents one was a study protocol, which was replaced with the published findings. A total of 24 documents, therefore, were included from the initial search.

An additional nine documents were also identified that were not included in the Brighton & Hove report or found using the initial search strategy. Two of those dated from before the Brighton & Hove report publication and were therefore excluded. Of the remaining seven additional documents published since 2020, five were deemed not relevant while two were added to the 24 included documents. In total, 26 documents were closely reviewed and reported on.

The final in scope documents include a combination of: NICE and Government guidance, local and regional strategies, reports combining service and programme evaluations with evidence reviews and qualitative and quantitative data, and academic publications of qualitative and quantitative analyses and of systematic reviews and meta-analyses.

Results

Reviews of published Evidence

Prevalence and demography

The most recent national estimate of people with multiple compound needs was published in Hard Edges.(2) For this report, Lankelly Chase used the term 'severe and multiple disadvantage' (SMD) to describe the cohort of people with experience of two or more of homelessness, substance misuse, and offending; with people experiencing all three to be grouped as SMD3. The data analysed in Hard Edges was collected several years before the publication of the report, in 2010 to 2011. Despite the intervening time, no further national estimates have been produced since Brighton and Hove's needs assessment.(24)

Analysis reported in *Hard Edges* suggests that, in England, there is an estimated minimum 58,000 people experiencing concurrent homelessness, substance misuse, and offending in any one year.(2) The report further projected that an average local authority in England may have a minimum of 1,470 active cases of people experiencing two or more of the three needs over the year, and 385 experiencing all three disadvantages.

Furthermore, in Scotland there is an estimated minimum 5,700 people experiencing all three disadvantages in any one year. The data analysed in the *Hard Edges Scotland* report was collected from 2013 to 2018 and thus represents the most recent dataset available for estimating the prevalence of MCN at a national level.(29)

Bramley *et al.* highlighted that the concentration of SMD would be higher in northern urban areas, core cities, former manufacturing towns, some coastal areas such as major seaside resorts, and former port cities.(2) This was supported by findings from *Hard Edges Scotland*, which reaffirmed that individuals with SMD are more prevalent in urban and affluent areas compared to rural and deprived areas.(29)

East Sussex has two major seaside resorts and stretches of coastline in all five districts and boroughs, representing a potentially higher rate of SMD than the average local authority and the possibility of distinct geographical variation within the county.

Eastbourne and Hastings have been projected by Lankelly Chase to have above average prevalence of SMD, comparable to Brighton and Hove, whereas Lewes and Rother were projected as having below average prevalence, and Wealden as having very below average prevalence.(2)

Prevalence

National prevalence of people with MCN

Since the Brighton and Hove needs assessment was undertaken in 2020, there has been no new research estimating the national prevalence of people with MCN.(24)

However, preceding but not included in the publication of the 2020 Brighton and Hove report, Sosenko *et al.* showed that women experience multiple and severe disadvantage differently to men.(3) The report highlighted the scale of multiple disadvantage that better encompassed the female experience, reflecting this with a new definition of multiple and severe disadvantage. This consisted of four disadvantages: poor mental health, experience of interpersonal violence and abuse, substance misuse, and homelessness.

Sosenko *et al.* estimated that a minimum of 336,000 people in the UK were experiencing at least three of the four disadvantages, and observed an even gender split within this group.(3)

Furthermore, the report indicated that around 17,000 individuals were experiencing all four disadvantages, with approximately 70% of them being female.(3)

The analysis further forecasted that 1,973,000 individuals could be currently experiencing two of the possible four disadvantages.(3) This suggests that for close to 2 million people in the UK, just one more disadvantage could push them into the category of an individual with multiple compound needs, as per the definition adopted for this report.

It is important to note that the data utilised in the *Gender Matters* report was from the years 2007 to 2016.(3) The data predate major social, political, and economic changes. Therefore, the estimate of 336,000 people with MCN is likely to be conservative. The prevalence of MCN, when defined to include poor mental health, substance misuse, contact with the criminal justice system, homelessness, and domestic abuse, is likely to be higher than the existing estimates which relate to a narrower population scope.

Notably, there is no recent data from the 2020s estimating the national prevalence people with MCN.

Prevalence of the five disadvantages that contribute to MCNs

The Changing Futures evaluation report found that, by April 2023, 2,567 people had received support from the programme. Data for 1,250 of these recipients were analysed and showed that the self-reported lifetime experience of different forms of disadvantage were:(30)

- 92% had mental health issues,
- 85% experienced substance abuse,
- 77% faced homelessness,
- 64% were involved with the criminal justice system, and
- 40% experienced domestic abuse.

Moreover, the report highlighted that, with regards to multiple complex needs, 83% of the 2,567 recipients had experienced three or more of the disadvantages, and 62% had experienced four or more of the disadvantages.(30)

It is important to note that services like Changing Futures and Fulfilling Lives support people currently dealing with multiple disadvantage, however, McNeish *et al*. emphasised that the cumulative impact of multiple compound needs over the course of a lifetime could be just as harmful when they occur sequentially as when they occur simultaneously.(31)

Sosenko et al., in *Gender Matters,* revealed that the most common combination of three disadvantages (excluding involvement in the criminal justice system) was poor mental health, experience of interpersonal violence and abuse, and substance misuse.(3) The most prevalent combination of two disadvantages were found to be, for men, poor mental health and substance misuse, and for women, poor mental health and being a victim of interpersonal violence and abuse.

Tweed *et al.* studied co-occurring homelessness, psychosis, criminal justice involvement and opioid dependence in Glasgow between 2010 and 2014.(25) Using linked data from General Practice, homelessness, criminal, and substance misuse registers the authors found 536,653 individuals; of this cohort, 28,112 individuals (5.2%) reported experiencing at least one of the four noted experiences during the study period, and 5,178 individuals (1.0%) reported more two or more of these. One would expect the estimated prevalence to be lower than other estimates of MCN due to the narrowing of the eligibly criteria, for example, using psychosis instead of poor mental health, and using opioid dependence instead of substance misuse.

Poor mental health

The 2020 Brighton and Hove report found that the most identified need across services locally was mental health.(24) The authors found that between 70% and 100% of those with multiple complex needs were identified as having a mental health need.

The is supported by *Hard Edges*, which estimated that of people with SMD3, 92% will have a self-diagnosed mental health condition.(2) It is important to note that Bramley *et al.* also estimated that only 55% of people with SMD3 will have a mental health condition diagnosed by a professional.

Evidence published since 2020 suggests that the vast majority of individuals with multiple compound needs are likely to experience poor mental health as one of their needs.(3,30) Additionally, among the individually experienced disadvantages, poor mental health is the most commonly experienced, with a higher prevalence of poor mental health among women than men.

Sosenko *et al.* used the 2014 Adult Psychiatric Morbidity Survey (APMS) to estimate that poor mental health is the most common isolated lifetime experience of disadvantage, affecting 23.6% of adults in a sample of 7,546 representative of the general population.(3)

In McManus *et al.*'s analysis of the APMS dataset, young women have emerged as a significant high-risk group, and the gender disparity in mental health issues has become increasingly evident among young people in recent years.(32) Additionally, there has been a rise in mental illness rates among individuals aged 55 to 64, with men in this age group showing some of the highest suicide rates on record. Mental health issues are more common among individuals who live alone, have poor physical health, or are unemployed. Notably, those receiving Employment and Support Allowance (ESA), which is intended for individuals unable to work due to health problems or disabilities, show especially high rates of various diagnosed mental disorders.

Poor mental health has been identified as a frequent factor leading to MCN, often associated with adverse childhood experiences.(33)

Mental ill-health has been found to be both a cause and a consequence of multiple disadvantage.(34)

Substance misuse

In Brighton, substance misuse was a commonly identified need across people using homelessness services; between 65% and 85% of clients using services focussed around homelessness had identified substance misuse needs.(24) Contrastingly, substance misuse needs were identified in 26% of Brighton's domestic violence service clients.

This is echoed by Sosenko *et al.*, who report that homelessness is strongly associated with substance misuse, whereas being a survivor of domestic violence is less strongly associated with substance misuse.

The Brighton and Hove report also found that in their substance misuse service, 1,909 clients had at least two of the five disadvantages, with one being substance misuse needs (74% of 2,597 total clients).(24) Of this 1,909, 70% faced mental health challenges, 38% were experiencing homelessness, 27% had encountered domestic violence, and 24% exhibited offending behaviour. Among the 837 clients with three or more needs, 42% were in need of support for substance misuse, mental health issues, and homelessness.

Sosenko *et al.* found that only 1.4% of the APMS sample experience substance abuse as an isolated issue.(3) These authors suggested that substance misuse is often a consequence of an additional disadvantages or challenging life experience. This finding underscores the likelihood that individuals with substance misuse problems also have

other unmet needs and experience compounded disadvantages, as it is rarely an isolated experience. These authors also found that substance misuse predominantly affects men.

Furthermore, there is a known relationship between mental health issues and alcohol use.(35) People suffering from mental health challenges often turn to alcohol as a form of self-medication, which creates a harmful cycle of addiction. A significant proportion of drug and alcohol users report a concurrent need for mental health support. Drug misuse can result from, and in turn perpetuate, social challenges such as deprivation, creating a complex web of interrelated issues.

Regular alcohol intake is linked to various physical and mental health issues, including depression and anxiety, and is associated with increased rates of self-harm and suicide among individuals struggling with alcohol-related problems.(35)

Homelessness

Authors of the Brighton and Hove needs assessment found that homelessness was a need identified by between 33% and 41% of services whose primary service area was not homelessness.(24)

The prevalence of homelessness is a significant concern, often intertwined with other disadvantages. Similarly to substance abuse, homelessness is rarely a single isolated experience. Sosenko *et al.*, using APMS, estimated that only 0.5% of the general population experience homelessness without any other disadvantage, indicating that homelessness is commonly associated with other forms of compound needs.(3) Namely, if an individual experiences homelessness, then they are very likely to have other unmet needs and experience additional disadvantages, as homelessness is rarely an isolated experience. Tweed and colleagues found that the prevalence of homelessness in Glasgow amongst people on health, substance misuse, homelessness or criminal databases was 2.4%.(25) This is higher than *Gender Matter*'s finding of 0.5%, but it must be considered that Tweed *et al.*'s report is focussed solely on Glasgow, a deprived urban city, and uses a linked dataset biased towards MCN.

Friel *et al.* highlighted the detrimental impact of homelessness on mental and physical health.(36) Homelessness may cause harm directly, but also indirectly through exposure to negative influences such as alcohol and substances, as well as placing people experiencing homelessness in close proximity with other individuals likely to be experiencing addiction making recovery challenging.

This is echoed by Harland *et al.*, who interviewed people with MCN and found that individuals needed an environment where they felt free from the challenges they were attempting to overcome, such as substance use or criminal behaviour,(33) in order to make progress with recovery. Interviewees also most commonly described mental

health support as the intervention which could have prevented homelessness and issues related to MCN.

Individuals experiencing homelessness are at higher risk of experiencing a mental health condition compared to the general population, especially among those trapped in a "revolving door" cycle between hostels, prisons, hospitals, and the streets.(35) Everyone who faces homelessness will feel stress and anxiety, with many also reporting symptoms of depression. Homeless individuals are twice as likely to suffer from a common mental health condition, and the prevalence of psychosis can be up to 15 times higher. Additionally, they are more than nine times as likely to complete suicide compared to their housed counterparts.

Substance use can both lead to and result from experiencing homelessness.(37) Substance misuse problems are disproportionately prevalent among individuals experiencing homelessness, and often utilised as a coping mechanism for the stress of street life, to maintain warmth, or suppress memories of prior trauma and abuse. (38)

Sosenko *et al.* observed that substance abuse problems and homelessness rarely exist as isolated problems, suggesting that these issues are usually a consequence and a reaction to a disadvantage, such as being a victim of violence, having poor mental health, or being an offender.(3)

Involvement with the criminal justice system

Authors of the Brighton and Hove needs assessment found that offending was recorded for between 24% and 33% of clients in substance misuse and homelessness focused services, but only 4% of women receiving support from the domestic abuse service. On this basis, the authors reflected that experience of the criminal justice system is highly gendered towards men, and women are less likely to have this experience. Brighton and Hove's needs assessment further found that, in a service focussed on women who had been in contact with the criminal justice system, 27 out of 33 referrals were for women with two or more needs. Among that 27, 21 women (78%) had mental health needs, while 14 (52%) experienced domestic violence, and 11 (41%) were homeless. No women referred to the service reported issues with substance misuse. Of the 15 women who had three or more support needs, 13 (87%) required assistance related to offending behaviour, domestic violence, and mental health.

The 2024 evaluation of the Changing Futures programme found that one of the most detrimental disadvantages is being involved in the criminal justice system.(30) The authors found that individuals who have spent time in prison are at a higher risk of experiencing homelessness (92% compared to 70% with no prison experience). Additionally, the report indicates that individuals with a history of incarceration are

more likely to struggle with substance abuse issues (94% compared to 79% with no prison experience).

This aligns with findings made by HM Chief Inspector of Prisons, that a significant number of individuals encounter substance use problems while involved in the criminal justice system.(39)

The Prison Reform Trust found that 71% of women and 47% of men in adult prisons report experience mental health issues,(40) and similarly Favril *et al*. found that incarcerated individuals experience increased rates of mental health disorders and poor physical health.(41)

These findings support the observation made by Sosenko and colleagues that negative life experiences, such as being in prison, can lead to adverse outcomes like homelessness and substance abuse.(3)

Domestic abuse

The Brighton and Hove needs assessment found, that of those individuals (n=1,276) who presented to a domestic violence service, 644 clients experienced at least two of the five disadvantages.(24) Of this cohort, nearly four out of five individuals (79%) had a need for mental health support, a third (33%) were homeless, a quarter (26%) required assistance for substance misuse, and 23 individuals (4%) had issues related to offending behaviour. This mirrors *Gender Matters'* finding that domestic abuse and poor mental health are strongly linked.(3)

Among clients of Brighton and Hove's domestic abuse service, a significant majority were female, with 89% identified as women and 4% as men.(24) The gender of remaining clients was unknown. Male clients were slightly more likely to have two or more needs.

Among clients with two or more needs in the domestic abuse service, both genders showed similar rates for needs related to mental health, homelessness, and offending behaviour.(24) However, male clients were nearly twice as likely to require support for substance misuse, with 48% compared to 25% for females. This supports published research indicating that substance misuse issues more commonly affect men than women.(3,30)

Reports by the Department for Levelling Up, Housing and Communities suggest that domestic abuse is a largely female experience, even when factoring in the under-reported male population.(30,42) The Brighton and Hove needs assessment supports this.

Sosenko *et al.,* found abuse to be the second most prevalent single isolated experience, affecting 6.1% of the general population.(3) The discrepancy in comparative prevalence of this domain between studies may be attributable, in part, to variations in definitions

of experiences of violence. Sosenko *et al.* define experiences of violence broadly, to encompass anyone who is a victim of any interpersonal violence and abuse, including and beyond domestic abuse.(3) The report found that interpersonal violence and abuse affected an equal proportion of males and females.

Around 5% of adults aged 16 to 59 experienced domestic abuse in the year leading up to March 2022, according to the Crime Survey for England and Wales.(43)

Demographics

The evidence base describing the demography of individuals living with MCNs shows that this population is diverse and heterogenous group. While research commonly indicates that people with MCNs often share similar backgrounds, such as poverty, limited educational opportunities, family stress, and childhood abuse and neglect,(17) experiencing MCN means experiencing a unique set of personal needs and circumstances.

The evaluation of the most recent government-funded national initiative to support those with MCN, Changing Futures, found that, of the 1,552 of their 2,567 service users for whom data were available, 62% were male; 86% were White, and 60% were aged between 30 and 49 years.(30)

The evaluation of a previous national initiative to help those with MCN, Fulfilling Lives revealed a congruent demographic profile.(44) Among the 3,552 of the 4,073 recipients of the programme who consented to share their data, 63% were male; 84% White; and 57% aged between 30 and 49 years.

The 2021 UK Census found that 49% of the general population was male; 82% was White; and 26% aged between 30 and 49 years.(45)

Comparison with the census show that men and being aged 30-49 are overrepresented in dedicated MCN support services. White ethnicity is also over-represented, albeit only marginally.

Similarly, Tweed *et al.* found that the majority of people experiencing multiple disadvantages were White males aged between 30 and 50, residing in the most deprived areas of Scotland.(25)

The predominant themes emerging from the current research on demographics indicate that individuals with MCN are more likely to be male, of white ethnicity, and aged 30-49,(2,30,44) though Sosenko *et al.*'s research found the gender split to be equal.(3) Friel *et al.*'s evaluation of the Tackling Multiple Disadvantage project found the majority of recipients with MCN to be non-White, but the programme targeted a non-representative population of homeless people in London.(36)

Fulfilling Lives and Changing Futures were designed to be universal for people with MCN. Authors of the Spring 2024 evaluation of Changing Futures reflected that when services fail to consider the specific and tailored needs, they will be unable to effectively attract and engage women and individuals from minority groups, as they require specialised services to address their unique experiences.(30) The authors summarised findings from qualitative analysis as indicating that "the programme continues to mainly reach white men".

Welford *et al.* also stressed the need for specialised women's and culturally sensitive services.(17)

Targeted services are key to prevent inequalities in access. The demographics of service users of Fulfilling Lives and Changing Futures represent only the population to whom these services are accessible, and may not reflect the true MCN population. Sosenko *et al.* estimated that, in fact, women are more likely to be people with the most severe forms of MCN, particularly Black women.(3)

There is higher prevalence of particular disadvantages among minoritised ethnic groups: there is an over-representation of minoritised ethnic groups in prisons, with only 72% of the prison population being white,(40) compared to the national census figure of 82%.(45) Additionally, Finney found that Black individuals in England are more than three times as likely to experience homelessness than their White counterparts.(46)

The stereotype of someone with MCN as a White man may be more a reflection of service provision than need. These examples serve to highlight that the demographic data obtained from government-funded MCN initiatives may not accurately represent the demography of the true population with MCN, and that there may be a hidden need for assistance among women and minoritised ethnic groups.

Gender

Evidence indicates that over half of adult women have encountered at least one of the following: homelessness, substance use, poor mental health, or violence and abuse in adulthood, whereas only a minority of men have had similar experiences.(47)

Hard Edges authors estimated that, of people experiencing three needs, 78% were men and 22% were women.(2) However, evaluations of Fulfilling Lives and Changing Futures showed that over 60% of service users with MCN were male.(30,44) Sosenko *et al.* estimated that, of those who experienced at least three of the four disadvantages, 50% were male and 50% were female; and that, of those experiencing all four disadvantages, 70% were women and 30% were men.(3)

The discrepancy in estimates of prevalence by gender between studies may be attributable, in part, to variations in definitions of multiple compound needs. *Hard Edges* focussed on three needs only, homelessness, substance misuse, and offending,

which may bias estimates towards the male experience. A proportion of the discrepancies may also be attributable to accessibility. Women may actively avoid seeking services due to reasons such as shame, stigma, fear of losing children, or previous negative experiences; as a result, they may not be reflected in service-level data. Additionally, potential underreporting of multiple compound needs in surveys due to embarrassment or fear of negative consequences may lead to conservative estimates.(3)

The Changing Futures Evaluation Report found notable differences in individual needs among service recipients along the axis of gender, based on data from 598 male and 350 female clients:(30)

- Poor mental health – F: 98%, M: 91% **F**>M
- Substance abuse – M: 88% F: 86% **M~F**
- Homelessness – M: 84%, F: 77% **M**>F
- Contact with the criminal justice system – M: 72%, F: 61% **M**>F
- Domestic abuse – F: 81%, M: 26% **F**>M

Women using Changing Futures were more likely than men to declare mental health problems and experiences of domestic abuse, whilst men were more likely to have encountered homelessness or contact with the criminal justice system. Furthermore, the evaluation found significant gender disparities in the severity of MCN. Although women were less likely than men to access Changing Futures support, those who did had a more severe experience of MCN than men, with 43% of women in the Changing Futures programme experiencing all five disadvantages, compared to 18% of men.(30) This may support Sosenko *et al.*'s observation women face more complex and severe disadvantages than men, with 70% of women and 30% of men affected by all four disadvantages.(3) It may also suggest that women have a higher threshold for accessing services, only seeking help when facing acutely complex situations and needs.

Men and women with multiple compound needs have different experiences. Women were found to have a higher likelihood of experiencing significant adverse childhood experiences (ACEs) and were also more likely than men to have no qualifications.(42) Additionally, women were more prone to reporting significant issues in family relationships and receiving medication for mental health problems.

Gender and mental health

Poor mental health is more prevalent among women with MCN than men.(30,47)

Gender and homelessness

There is a notable intersection between gender, mental health, and homelessness. A recent study conducted by Groundswell found a significant disparity between mental health challenges faced by homeless women and the general population, with 64% of

participants reporting mental health issues compared to only 21% of the general population.(48)

Discourse about homelessness, particularly rough sleeping, suggests that it is mainly a male issue.(49) However, this narrative does not adequately reflect the experiences of women. Critics suggest that homelessness services align with this male-centric view, whilst assuming they are gender-neutral and suitable for all. Unfortunately, data collection on street homelessness often does not analyse information specifically by gender and tends to centre the male experience, as women may remain hidden. Consequently, the actual number of women experiencing homelessness is likely underreported, underestimated, and inadequately served. This aligns with Bretherton and Pleace's research on female homelessness in Camden, which found that the prevalence of homelessness among women in that area surpassed previous estimations, and was characterised by instances of domestic abuse and other forms of gender-based violence.(50) Bimspon *et al.* also found that women experiencing homelessness are far more likely to have been victims of intimate partner violence compared to men.(51) Many women may choose to remain "hidden" when sleeping rough to protect themselves from potential dangers, making it less likely for them to disclose their situation to support services.(52)

Friel *et al.*'s analysis of the Tackling Multiple Disadvantage initiative, which set out to aid rough sleepers with multiple disadvantages, engaged 448 participants of which 21% were women.(36) The 2023 rough sleeping snapshot found 15% of rough sleepers were female.(53) Nevertheless, Friel and colleagues suggest that female rough sleepers are likely still underrepresented in their sample group, hypothesising that, as the initiative evaluated was not specifically targeted towards women with MCN, the potential unsuitability of male-dominated spaces for potential female recipients may have resulted in women being unlikely to participate.(36)

Gender and domestic violence

Being a survivor of domestic abuse is an overwhelmingly female experience, and women are less likely to be a perpetrator.(42) While male experiences are likely to be under-reported due to perceived stigma, this under-reporting is considered unlikely to redress the gender inequity in experience of domestic abuse.

Some researchers have identified that experiencing domestic abuse may lead to drug and alcohol use disorders as a means of coping with trauma.(51,54)

Others have observed that the relationship between domestic abuse and other forms of multiple compound needs, such as homelessness, alcohol and substance misuse, and poor mental health, is bidirectional.(42,55) This means that while domestic abuse can lead to compound needs, these other forms of compound needs can also increase the risk of being a victim of domestic abuse. Homelessness, for example, has been

identified as a risk factor for experiencing gender-based violence, particularly among young people.(56)

Geographical spread of gender

Sosenko *et al.* observed that, in large cities, there were more men than women affected by multiple compound needs.(3) Conversely, in shire counties, and suburban and prosperous areas, the numbers of women affected were higher. This observation may be attributed to the higher number of male rough sleepers, who tend to be concentrated in large cities, central London, and coastal towns. Therefore, one might expect that in East Sussex there will be more men with multiple compound needs in places like Eastbourne and Hastings, but more women in the other rural areas of East Sussex.

Race

Bramely *et al.* found that the population of adults with multiple needs was predominantly White, in line with the working age population of England.(2) Furthermore, the report found that of those who were SMD3, 85% were White, and 15% from other ethnic groups.

Similarly, evaluations of Fulfilling Lives and Changing Futures initiatives found that in their service users, 86% and 84% people had white ethnicity, respectively.(30,44)

Lamb *et al.* observed that it is important to approach the evidence around the ethnic makeup of the population with MCN with caution.(6) Some people with MCN from minoritised ethnic groups may face taboos around mental health and substance misuse, leading them to be less likely to seek help, or to hide or downplay their problems. Other barriers may include a fear of not being understood, and language barriers such as unfamiliarity with the terminology of multiple needs and limited proficiency in English.

Individuals from various ethnic backgrounds may be more susceptible to experiencing SMD, but may be harder to identify. For example, drug use can be affected by cultural norms depending upon the substance in question, and established approaches to defining and categorising MCN may not be informed by ethnically diverse experiences.(57)

Asian population

People of Asian heritage are often found to be under-represented in MCN populations compared to the general population.(2,6) The Brighton and Hove needs assessment posits that the under-representation of people of Asian ethnicity in the majority of MCN clusters in *Hard Edges(2)* may indicate that Asian heritage is protective factor against developing multiple complex needs, or that services are not reaching people from Asian backgrounds.(24)

The Mental Health Foundation has noted that there are inconsistent statistics regarding the number of Asian people in the UK with mental health issues.(58) It is suggested that

mental health problems often go unrecognised in this group. This suggests that Asian individuals with multiple needs may be a hidden population requiring more tailored and targeted approaches to engage with support services, particularly Asian women.

In *Gender Matters*, Asian women were overrepresented in the group with no recorded experience of primary disadvantages, however they were among those experiencing poor mental health and socioeconomic disadvantage.(3) Bramley *et al*. describe that, within Asian communities, homelessness manifests differently.(59) While Asian households may have a lower chance of facing statutory homelessness, they encounter significant risks related to more hidden issues like severe overcrowding or 'doubling up' with other families.

Black population

A similar proportion of recipients of the Fulfilling Lives programme were of Black British, African or Caribbean ethnicity (4.4%) compared to this population in the UK Census (4.2% of the population).(44,45)

Sosenko et al. found that a higher percentage of overseas-born adults, as well Black British or those reporting a Mixed or Other background, experienced more complex levels of disadvantage, particularly among women.(3)

Discrimination, harassment, or abuse based on race or ethnicity in housing and other areas of life significantly increases the likelihood of homelessness, especially for Black individuals, as well as for those from Mixed and certain other ethnic backgrounds.(59) Overall, Black and minoritised ethnic communities experience markedly higher levels of homelessness in the UK.(59)

Racial trauma

Racial trauma significantly contributes to the severe and multiple disadvantages faced by individuals from ethnically diverse communities. Understanding racial trauma is essential, particularly in the context of severe and multiple disadvantage. It can be viewed as a fundamental factor that drives individuals toward certain situations or behaviours associated with SMD. Additionally, it serves as an amplifying factor in individuals' overall experience of disadvantage. Qualitative evidence shows that some individuals from minoritised ethnic communities feel their disadvantages stem not just from their actions or circumstances but rather "because of who I am, how I look, or where I come from."(57)

Age

Most sources report similar findings about the most common age groups among people with MCN. *Hard Edges* found that 59% of people with SMD3 were within the 25-44 age group.(2) It further notes that there were very few people in the MCN population (2%) aged 65 years or older. The youngest age group were people from the homelessness

only group, with 40% under 25. Conversely, the oldest age group were people from the only substance misuse category, with 25% aged 44-64. The authors caveat that the age profile may have altered by the time of the report because the data analysed was before austerity and welfare reform.

Similarly, the Changing Futures and Fulfilling Lives evaluations observed in their MCN service users that 60% and 57% people were 30-49, respectively.(30,44) *Gender Matters* found that adults facing the most complex combinations of primary and secondary disadvantages are predominantly found in the 25-44 age group.(3) Lamb *et al*. found that the average age of participants in the Fulfilling Lives program was 38.11.(6) There were very few individuals over 60, most of whom were men.

Younger age

The age profile of those accessing homelessness services is notably younger than the general population. Furthermore, younger individuals, especially women, are more likely to experience severe and multiple disadvantages while being homeless.(3) *Gender Matters* found that 64% of women facing all four primary disadvantages were under 35, whereas this age group constitutes only 31% of the general adult female population.(3) A similar trend is observed for men, albeit less pronounced, with a higher proportion of those experiencing three or four primary disadvantages falling within the 25-44 age range.

Qualitative research conducted as part of a needs assessment in Gateshead found that experiences of homelessness were common early in the journeys of people with MCN, involving stays in hostels, sofa surfing, living on the streets, and insecure housing.(33) Most first-time experiences of homelessness were reported to occur between the ages of 16 and 30. On average, individuals spent about 3 years homeless or living in vulnerable situations, with durations ranging from 6 months to 20 years.

Older age

An evaluation of Fulfilling Lives found that as people with MCN age, their challenges with substance abuse tend to worsen, and they are also more prone to unintentional self-harm.(6) The typical issues associated with aging are exacerbated for people with multiple needs, who experience poorer physical health and have lower levels of self-care.

It must also be noted, however, that very few homeless adults facing multiple primary disadvantages are over 65 years old.(2) Older age is generally linked to poor mental health, while homelessness is more prevalent among younger individuals(3). However, older populations of people with MCN are increasingly male. For example, among Fulfilling Lives service users in the 16-19 age group, 56% were male, but in the 50-59 age group, this increased to 78% male.(44)

Disability

Gender Matters reports that the prevalence of learning disability is markedly higher for both men and women who experience any of the four primary domains of disadvantage compared to the general population.(3) There is a strong link between poor mental health and learning disabilities for both genders. Additionally, among men, there is a very strong association between experiencing violence and abuse and having a learning disability. For individuals with between two and four of the core MCN disadvantages, the rates of disability are six to eight times higher than for those not reporting any of these experiences. Additionally, in this same comparison group, rates of learning difficulties are five to six times higher, and rates of chronic illness are two and half times higher.

Other demographic subgroups

This review found limited published evidence regarding the relationship between MCN and employment, being a veteran, being a carer, being care experienced, or being a member of the LGBTQIA+ community. The needs assessment conducted in Brighton and Hove found that the LGBTQIA+ population is at increased risk of homelessness, poor mental health, and domestic violence, and may be at higher risk for experiencing MCN; that people with a learning disability are at higher risk of having poor mental health, experience of the criminal justice system, and, among people with mild learning disabilities, substance misuse needs; and that there were high rates of unemployment amongst clients of the local substance misuse service.(24)

Barriers to service access for people with MCN

Across sectors, public services are buckling under pressures of high demand, under-investment, and the impacts of cuts to prevention measures, creating challenges for the general public in accessing support.(60) These challenges are amplified for people with multiple compound needs. This segment of the literature review highlights some of the key barriers which people with MCN face when seeking support identified in the current evidence base. The barriers have been clustered into two groups: service barriers, at the level of individual providers; and the structural barriers, regarding the obstacles created by broader national systems.

Service barriers

Service communication

The way services are designed is important. Many of the Fulfilling Lives service users had difficulty with literacy.(44) Referral forms for services can be complex, and there can be problems with completing these forms due to literacy issues or language barriers.(33) These obstacles contribute to a poorer experience and a heightened sense of isolation from available support systems.(33,44)

The traditional healthcare appointment model often falls short for individuals facing MCN. The Fulfilling Lives initiative noted that methods of communication, such as

sending appointment notices by mail or making phone calls, usually do not reach those who are homeless.(34)

Scheduling

Furthermore, evidence from the Fulfilling Lives programme showed that people with MCN are expected to remember their appointments and attend at designated times, with services often neglecting to make adaptations for the complexities in their lives.(34,61) Many appointments are held in clinical and institutional settings, which many with lived experience describe as uninviting and intimidating. Furthermore, a common theme amongst people with MCN dealing with substance misuse issues was that alcohol or drugs were their primary focus in the morning, rather than attending an appointment.

The requirements to remember appointments, attend at specific times, and tolerate long wait times often do not align with the needs of these individuals. Most services operate only on weekdays from 9 to 5, failing to consider the times when some groups might be particularly vulnerable,(62) and some services are not discreet or easy to access.(61)

Strict service requirements

Strict engagement requirements for services can act as barriers to support. What may be deemed as 'non-engagement' might instead highlight unsuitable services rather than issues related to the person with MCN. Some services have a 'treatment first' model, which prioritises recovery as the necessary first step before a person with MCN can engage in the service.(63) Some services have stricter engagement criteria and operate on a 'three strikes and you are out' policy in regard to non-attendance at sessions.(29,63) In mixed methods research by Sharpen, women with MCN expressed that services classified them as 'non-engaged' when they didn't attend sessions, but the participants felt that the services instead failed to understand their needs and connect with them effectively.(62) This in turn left the women feeling marginalised and overlooked.

An evaluation of the Fulfilling Lives initiative found that each person's journey towards progress and recovery is unique.(64) Setbacks and relapses are natural parts of this journey. A significant obstacle to maintaining involvement in services arises when these services fail to recognise this actuality, often leading to case closure for individuals. Evidence suggests a need for more services to reflect in their design and structures that some individuals may require more time than others to achieve their goals, in order to prevent barriers to access for people with MCN.

Harland *et al.* also found that people who experience homelessness often had difficulty registering with services and keeping appointments.(33) Furthermore, when treatment is offered, individuals with multiple needs are at a high risk of being discharged due to a lack of engagement. This often forces them to restart the lengthy referral process

anew.(6,61) Losing access to services can create significant barriers in obtaining the necessary support.(61) For instance, individuals might be discharged from mental health services due to frequently missing appointments or for presenting while intoxicated. Other common barriers include issues related to anti-social behaviour, and having referrals denied by services which are already familiar with the individual and believe they are not a good fit for the programme. In this way, people facing multiple disadvantages are often regarded by mainstream services as too complex and high-risk for effective support. Traditional support approaches often fall short for those dealing with these overlapping challenges.(63) A report by The National Lottery Fund stated that individuals with multiple needs are at a greater risk of falling between services, experiencing disrupted treatment, or being excluded from treatment due to their behaviour.(47)

The Fulfilling Lives initiatives in the UK has highlighted cases where individuals facing multiple disadvantages are denied assessments because their trauma-related symptoms, such as substance use, behavioural issues, or remaining in violent or abusive situations, are often viewed as 'lifestyle choices'.(17,34,61,64,65)

Staff training and capacity

Low and inconsistent levels of staff training can create a barrier to people engaging and staying involved with dedicated services. Research has found that there is a need for staff education on issues related to being a person with MCN.(17,33) Staff in Fulfilling Lives were unlikely to have lived experience of MCN, and thus were limited in their capacity to understand the unique experiences a person with MCN would have. Furthermore, Making Every Adult Matter reported that staff within services were frequently overlooking the role of trauma in a person with MCN;(61) asking about trauma and adopting a trauma-informed approach was not always a common practice, despite the centrality of such approaches to supporting a person with MCN.

Barriers to support are often intensified by societal stigma and negative service interactions, leading to distrust and social exclusion. Respectful and non-judgmental support is essential; many individuals participating in qualitative interviews in the North East of England reported feeling ignored and judged when seeking help.(33) Participants advised that addressing these complexities through better training can greatly enhance their experience, and that unresponsive services deter individuals from seeking help.

An evaluation of Changing Futures found that core services (like mental health and substance misuse services) struggle with capacity and staffing challenges, which limits flexible support and complicates the implementation of trauma-informed practices.(30)

Service fragmentation

Services which address multiple complex needs are often disjointed, segmented into specialist areas, and offering support for specific issues rather than the whole person.(30) This fragmentation, as described in the literature, is fuelled by bureaucracy,

funding structures and specialised professional practices, which can hamper effective responses to individuals with multiple needs.(6,63) Furthermore, because of the complex service landscape, providers may lack awareness regarding the range of available services.(66) As a result, the design of local services can act as a barrier for supporting those with MCN.

Intersectional effects of co-existing disadvantage

People with co-occurring substance misuse and mental health needs face unique barriers to accessing support. For example, mental health services may decline referrals for individuals with alcohol or drug dependencies, while substance misuse services may similarly reject individuals with primary mental health concerns.(6,17,33,63,64,67) This creates a catch-22 situation: affected individuals are unable to get a mental health assessment while under the influence of drugs or alcohol, yet they are unable to address their substance misuse without first treating their mental health condition, which leaves them without support. Qualitative engagement of professionals supporting people with MCN with co-occurring conditions found that 93% of staff respondents had observed clients facing difficulty accessing mental health services whilst having a concurrent substance misuse issue.(61) Conversely, 47% of this group reported people with MCN experiencing difficulty accessing substance misuse services whilst having a concurrent mental health need.

Consequently, individuals may feel perpetually redirected between services or, in some cases, completely unable to secure necessary support. Moreover, when clients are engaged with multiple agencies, evidence suggests there may be a tendency for service providers to resign responsibility, operating under the assumption that other organisations are addressing the client's needs.(63) This exacerbates the difficulties faced by individuals seeking collaborative and holistic care.

Another reported barrier for MCN people with co-occurring disadvantages is that referral criteria for housing services may preclude those with substance misuse issues.(33)

Language used

Some services use the term "Multiple Complex Needs", which encompasses a variety of experiences and circumstances. Although the label aims to help identify and support individuals with diverse support requirements, Stone *et al.* report that it can itself be prohibitive of engagement.(68)

Structural barriers

Barriers within the mental health system

Access to secondary mental health care typically requires a referral from a General Practitioner (GP). Guidance from NHS England states that individuals experiencing homelessness should not be required to provide identification or proof of address to receive primary care services from a GP. However, research conducted in Stoke on Trent

showed that around 75 percent of GP practices are not adhering to this guidance.(63) This indicates that homeless individuals may be encountering significant barriers when trying to access healthcare including mental health support. Moreton *et al.* described that people with MCN may have particular difficulty navigating complex mental health services, agencies and referral routes because of service turnover and the interplay of statutory and voluntary and community sector organisations.(34)

Fulfilling Lives evaluations found that mental health professionals can struggle with providing adequate support for individuals with complex needs.(17,62,63) As a result, some people may be viewed as too challenging for standard mental health services, yet not in need of specialised care. This situation creates a scenario in which individuals are expected to conform to the service's requirements instead of the system adapting to accommodate their unique needs. Consequently, this gap in support leaves certain individuals without the necessary resources, even when they require both mental health and substance use interventions.

In Harland *et al.*'s MCN health needs assessment in the North East of England, participants consistently identified a significant gap in the existing support services related to mental health, housing, and financial assistance.(33) Among these, mental health support was frequently cited as the most critical intervention that could have mitigated the risk of homelessness and complex needs.

Professionals working with people with MCN have reported that mental health services frequently operate under a rigid, diagnosis-driven model which does not adequately address the holistic needs of an individual facing multiple disadvantages.(61) This approach by mental health services often neglects broader personal circumstances, resulting in many individuals being excluded from necessary support.

Barriers within substance misuse services

MCN-specialist staff also report that local substance misuse treatment services can be inaccessible for individuals seeking help, with issues such as delays in access to prescriptions, long waiting times following referral, and insufficient outreach.(61) Many professionals feel unprepared to address co-occurring mental health and substance use disorders, sometimes resulting in quick referrals to mental health services when they felt their client presented with a mental health need. The lack of resources and time within substance misuse services prohibits high-quality support and personalised care for clients facing multiple complex issues, with staff prioritising core business. Additionally, funding and monitoring mechanisms for drug and alcohol teams usually emphasise client volume, rather than evaluating the holistic progress of individuals, creating perverse incentives.

Barriers within the homelessness system

People with MCN including homelessness, interviewed as part of Harland et *al.*'s MCN health needs assessment in the North East of England, reported being placed into

hostels which felt unwelcoming and unsafe.(33) Such experiences not only create barriers to accessing help, but further perpetuate the cycle of disadvantage faced by this group. Over half of participants described being discharged from hospital homeless; a fifth had left prison without accommodation; and there were also accounts of leaving care without appropriate housing. Participants highlighted that the lack of accommodation when leaving critical contacts with the health, social and criminal justice system increased chances of experiencing MCN.

Moreton *et al.*'s evaluation of Fulfilling Lives found that, like mental health services, substance misuse can be a barrier to accessing and maintaining accommodation for homeless people.(52) Having an additional substance misuse need is common for people who are homeless. Zero-tolerance policies on drugs and alcohol in supported accommodation can cause people who face addiction to be evicted, which can then reduce someone's chances of being housed in alternative accommodation. Some supported accommodations can house drug users, but this approach presents its own challenges; people with substance misuse issues may find it difficult to abstain if housed in close proximity to current users. If they decide to protect their recovery and leave the accommodation, it puts them at risk of homelessness again. A significant issue raised in this report is the growth of unregulated shared accommodation which should provide extra support for vulnerable individuals, but often leads to tenants living in substandard and unsafe conditions.

Barriers within the criminal justice system

An evaluation of the Fulfilling Lives programme highlighted a link between spending time in prison and poorer outcomes for individuals with MCN.(17) Successful reintegration after prison requires sufficient preparation, but this is often lacking, especially for those serving short sentences. There are flaws in the assessment and screening processes which delay the identification of individuals' needs, creating a barrier to timely support. Many individuals are released from prison into homelessness or to unsafe, inadequate accommodation. Without sufficient financial resources or supportive social networks, the likelihood of reoffending increases markedly after release. On release day, individuals facing multiple disadvantages often find themselves overwhelmed by a daunting list of appointments and tasks they must complete to secure housing, benefits, and medication; thus, frequently these are not achieved. Additionally, Friday releases can exacerbate the situation, as many necessary services are closed over the weekend. Missing an appointment might lead to being cut off from vital services or even being recalled to prison.

What works for people with MCN? Guidance and interventions to support people with MCN: a targeted evidence and guidance review

These findings are the results of a targeted review of guidance and evidence on how to support people with MCN, and focusses on identifying recommendations made in

published literature, rather than the findings which underpinned those recommendations. A combination of generic recommendations, applicable to all services, and others specific to services such as General Practice, Dentistry, Custody release and probation, Social Work and different components of homelessness support are described.

Recommendations applicable to all services

Service access and engagement recommendations for working with people with MCN

A 2020 literature review of models of service provision (undertaken as part of Fulfilling Lives) was retrieved from the initial scoping review.(63) This literature review was not included in the Brighton & Hove 2020 MCN report and included generic recommendations listed below as well as some specific to women and domestic abuse which are provided under the relevant sub-sections.

- Strict inclusion criteria such as the need for stability and active recovery as part of 'staircasing approaches' (those which require cessation of different types of drugs) should be avoided where possible due to their excluding nature.
- Lack of attendance at appointments should not be automatically viewed as 'non-engagement' made by choice but as possible reflections of service inaccessibility.
- Lack of attendance at appointments should not precipitate removal from services to the degree that it might for members of the general public.
- Efforts should be made to redefine what 'successful engagement' with a service looks like, taking account of the various impacts of social exclusion.
- Where possible service staff should take on advocacy and brokering roles (acting as what are sometimes known as 'navigators'), supporting people with MCN to access services by direct communication with other agencies and by supporting paperwork completion.
- Services should aim to be available outside of 9-5 hours for particular populations such as women with MCN (see also 'Differing service access needs for women' below).
- Services should ensure that they ask about domestic abuse (see also 'Addressing domestic abuse' below).

Trauma-informed practice

Government guidance on trauma-informed practice which was retrieved from the scoping review is highly relevant to people with MCN, among other populations.(69) The guidance highlights how Trauma-Informed Practice focuses on realising the '4Rs' through applying six principles:

'*There are four key assumptions that underpin TIP, known as the 4 'R's. An individual, programme, organisation, or system that is trauma-informed realises the impact that*

trauma can have; recognises the signs and symptoms of trauma (in both beneficiaries and professionals); responds to trauma by integrating knowledge of trauma into policies, procedures and practices; and seeks to actively prevent re-traumatisation by avoiding practices that could trigger painful and traumatic memories. In addition, there are six principles which inform TIP: Safety, Trust, Choice, Collaboration, Empowerment and Cultural Consideration (of individuals' demographic characteristics).'

An evidence review on the topic of trauma-informed care for people with MCN was found using the additional Boolean search which made the following recommendations:(70)

- Engaging staff and volunteers who have lived experience.
- Giving voice, choice and involvement in service design.
- Providing trauma-informed training to staff *where organisational support and trauma-informed ways of working are also provided* (anecdotal evidence from Scotland even suggests that, without the latter, trauma-informed training can have negative impacts on staff).
- Appointing an '*identified point of responsibility who is leading on and overseeing the work'*.
- Appointing trauma-informed and/or 'trauma and gender' champions acting as influencers and role models.
- Trauma-informed service delivery:
    - maintaining open communication with clients,
    - keeping consistent appointments,
    - giving sufficient notice if change is necessary.
- Ensuring the physical space is trauma-informed:
    - Clearly marked and easy to access exits from rooms (and buildings),
    - Well-lit rooms, corridors, exits and outside areas such as car parks,
    - Welcoming language on signs,
    - Preventing people from congregating outside of buildings,
    - Keeping noise levels low,
    - Having a system to monitor who is coming in and out of buildings.

Coproduction and codesign

In keeping with the government guidance on Trauma-Informed Practice, a research paper reported on the importance of accounting for trauma in co-production work with people with MCN, suggesting that co-production be augmented in the following ways:(71)

- establishing close partnership working between organisations,
- flexibility and transparency around power dynamics,
- paying particular attention to aspects of power that are less readily visible (e.g. differences in financial security or neurodivergence),

- addressing the potential for sharing experiences to retrigger trauma,
- providing training for those conducting co-production work in understanding trauma and its impact on an individual's sense of psychological safety, and
- securing long-term funding to enable projects to have enough time for the establishment of trust and delivery of tangible results.

Reducing early mortality

A qualitative study was identified in the search which provided recommendations to reduce early mortality in people with MCN:(72)

- The need for services that address together mental health problems with substance misuse problems (known as 'dual diagnosis') rather than services which provide only one or the other.
- Greater support during critical life events (such as bereavement) and significant transitions (such as leaving prison).
- Better collaboration and communication across services.
- Building a positive sense of community for people with MCN, fostered by peer support workers.

Differing service access needs for women with MCN

A King's Fund report emerged in the review which examined the reasons for lower uptake of MCN and other services by women with MCN, when compared with men with MCN.(73) Barriers were present due to domestic abuse, poor mental health, and stigma (particularly for mothers); and compounded by system and service provision and attitudes. The following recommendations were made:

- Women-only resources and physical spaces should be designed to encourage disclosure and attendance, being mindful that women should not risk encountering abusive partners or ex-partners.
- Staff should be trained in trauma-informed working and in handling disclosures of homelessness, mental health difficulties and domestic abuse.
- Services and staff should clearly communicate a non-judgemental attitude and the willingness to believe women's stories.
- Non-substance uses services should not limit access to those who are experiencing substance misuse as part of their MCN.
- Sofa surfing and other forms of homelessness that are not rough sleeping should be recognised as potentially abusive situations.
- Services, particularly assessment processes, should not require women to repeatedly explain the nature of their trauma to different practitioners or on different forms as this can be retraumatising.

Similarly, the Fulfilling Lives' *More than a Roof* report makes the following recommendations:(52)

- *'Local authorities and partners should develop specific pathways, services and strategies for women experiencing multiple disadvantage. The ideal approach should include: Female peer support workers and navigators with lived experience, with outreach services developed to engage with this more hidden group of women*
- *Smaller women-only supported accommodation, which is trauma-informed and includes options for women with children*
- *Independent accommodation options close to amenities (schools, shops, etc.) to help embed women in the community*
- *Discreet women-only services in multiple sites across the community (easily accessible but not known to the wider male community using services)*
- *Workers must have a good understanding of domestic violence and abuse in the context of multiple disadvantage. They should have expertise around assertive outreach and innovative engagement with women experiencing domestic violence and abuse, who are likely to often be in the presence of their perpetrator'*.

Finally, the *Multiple disadvantage and co-occurring substance use and mental health conditions* report describes how childcare limitations (alongside the issues raised above) can prevent women from attending services, and recommends that childcare provision like creches or similar facilities should be made wherever possible to enable women to attend services.(61)

Further recommendations are given below under 'Homelessness: supporting women'.

Addressing domestic abuse

No academic papers were found which addressed domestic abuse support for people with MCN, published since 2020. Two relevant documents were found through searching grey literature: *Multi-Agency Domestic Abuse Guidance* published by East Sussex Safeguarding Adults Board in 2023 and a Thematic Learning Review into the deaths of three local women, published by the Brighton & Hove Safeguarding Adults Board in 2023.(74,75) Together these documents make the following recommendations which are general to all services rather than specific to domestic abuse providers. Although aimed at supporting Domestic Abuse survivors with or without MCN, they are included in the absence of more targeted advice.

Working in a trauma-informed way

Trauma is predominantly relational so that distrust and a lack of sense of safety can create a barrier to engagement. To redress this it is recommended that practitioners work in a trauma-informed way which means:

- Being open, honest and predictable,

- Working collaboratively; offering choice and empowering individuals to make decisions,
- Viewing substance use, self-harm and/or aggression as likely indicators of trauma more generally, and
- Recognising strengths and understanding resistance.

Identifying domestic abuse

Common warning signs to look out for include:

- '*Changes in behaviour and physical presentation or incongruent behaviour*
- *Not communicating with or seeing friends and family*
- *Presenting as withdrawn with symptoms of anxiety and / or depression*
- *Person is never seen alone without their partner or family member*
- *Repeated health attendances or missed appointments*
- *Sexually transmitted infections*
- *Non-compliance with medication or over-medicating*
- *Inappropriate clothing to hide injuries, for example, wearing a polo neck or long sleeves in warm weather*
- *Injuries which may be explained as a fall or a tendency to bruise easily'*

Responding to disclosure

Where disclosure is made or wanted the following steps should be taken:

1. Using a private space to do so, ask about what's happening using open and direct questions such as 'I notice you have a bruise here, how did you get that bruise?', 'Is there someone in your life you're frightened of?', 'Who makes decisions about what you can and cannot do?'

2. Call 999 if the client or anyone else is in immediate danger.

The Making Safeguarding Personal (MSP) principles should also be applied:

- Showing a disclosure is believed,
- Clarifying which other agencies are involved and trusted professionals who know most about the person's situation, so they do not have to repeat information,
- Asking the adult or their advocate about next steps and desired outcomes,
- Not making assumptions or telling the person what to do,
- Clarifying consent for information sharing, highlighting from the outset duties to share information in certain circumstances,
- Ensuring safe contact arrangements are established from the start,
- Providing information and advice about the range of services available, including work-based support,
- Keeping the adult or their advocate informed throughout a professional's involvement.
- To ensure the safety of the person, it is important to:

- Ensure the person is seen or spoken to alone before enquiring into possible abuse. Never ask in front of a partner, child or friend,
- Allow sufficient time and ensure any discussions will not be interrupted,
- Ensure mental capacity has been considered including the need for further assessment and advocacy,
- Do not arrange meetings if the person lacks capacity unless an advocate is present,
- Document the person's responses, but not in client or patient-held records, or organisational systems which the perpetrator may have access to,
- If an interpreter is required, use professional interpreters, taking into account any cultural needs including the person's history and variations in dialect,
- Do not take action that will increase risk. Follow safeguarding procedures and seek advice from your line manager or safeguarding lead.

Confidentiality and data sharing

Confidentiality and data sharing should adhere to the GDPR and Data Protection Act 2018 which sets out that any personal information can be shared on the basis that it is:

- Necessary for the purpose for which it is being shared,
- Shared only with those who have a need for it,
- Accurate and up to date,
- Shared securely and in a timely fashion,
- Not kept for longer than necessary for the original purpose.

Consent to share data should always be sought if possible and if it is safe to do so. However, practitioners must make a decision as to whether sharing information about risks relating to domestic abuse without consent is necessary if it is to protect the vital interests of the victim and / or their family.

If consent is not obtained, disclosures can still be made under the Data Protection Act in accordance with the following principles:

- Decisions must be reached on a case-by-case basis,
- Decisions are based on a necessity to disclose,
- Only proportionate information is disclosed in the light of the level of risk of harm to an individual,
- Decisions are fully documented at the time a disclosure is made, identifying the reasons why the disclosure is being made, what information will be shared and what restrictions on the use of the disclosed information.

MARAC referrals

Any agency can make a referral to MARAC if a DASH form highlights domestic abuse is medium to high risk, that is with a DASH score of 14 and above, or where a worker involved makes a professional judgement that the risks are high enough for MARAC to consider the need for additional safety planning.

Where an adult is the subject of a safeguarding enquiry, the MARAC referral should include information on relevant history, progress of the enquiry, and clarify additional support being sought.

A MARAC referral does not eliminate the risks faced by the individual and does not replace the interventions carried out as part of a safeguarding enquiry. While referrals should not be made for resolving an immediate crisis, high risk cases should always be referred for consideration.

Consent is not always sought to make a referral, but action may be taken afterwards to ensure the victim is informed. This may include raising a new safeguarding concern. There is also a MARAC Victim Leaflet which professionals can use to explain the MARAC process and what will happen when they are making a referral. If it is safe to do so, someone being referred to the MARAC may want a printed copy of this leaflet, or they could access it online.

Housing for those fleeing domestic abuse

Accommodation should be available for those with MCN fleeing domestic abuse, including supported accommodation where needed. In particular, housing precarity following disclosure should be a trigger for provisions to be put in place.

Staff training

Bitesize training sessions for all services working with MCN on how to recognise victims of controlling and coercive behaviour.

Service recommendations for supporting people which MCN which includes homelessness

The NICE guidance on Integrating Health & Social Care for people experiencing homelessness makes the following service recommendations with respect especially to homeless people with MCN:(76)

- Appointments and contacts should be longer than those given to the general population.
- Services should aim firstly to build trust and to take a shared decision-making approach and which acknowledge and build on the individual's strengths.
- Services should aim to ensure consistency and continuity of care.

- Thresholds for attendance should be lowered and based on assessed need rather than biological age.
- Services should be codesigned where possible, to ensure accessibility and acceptability.
- Support should be offered to complete forms and in non-digital formats.
- Training should be provided to staff in how best to support people with MCN and to ensure non-judgemental and non-discriminatory practice.
- Where possible, assertive outreach (provision of services off-site in community and mobile locations) should be offered.

A qualitative study also recommended that hostels and hostel staff should not be viewed as expert 24-hour care providers, and that services should seek to make provision rather than relying on them.(77)

Recommendations applicable to specific services

Custody release, probation and community sentencing

One paper was identified reporting on suicide risk and substance use among those on community probation orders. No other papers were identified in relation to offending, nor guidance documents were identified. Hence this document was included although it is not specific to people experiencing MCN.

This paper made the following recommendations to prevent deaths:(78)

- Extra vigilance of offenders upon release from custody and/or community sentencing (both were associated with a heightened risk of drug-related death, particularly for women offenders).
- Extra vigilance of offenders in the event of enforcement actions after breach of probation terms (this was predictive of deaths (drug-related, suspected suicide and accidental).

General practice

A paper reporting on the Bridging Gaps project (increasing GP access for people with MCN) identified the following recommendations for primary care work with MCN:(79)

- Using a trauma-informed approach,
- Having a dedicated care co-ordinator to liaise with MCN patients – supporting swift access and outreach,
- Ensuring patients with MCN are visible in the system – having a list of patients with MCN and supporting patients with MCN to develop a simple ‘profile document’ if they chose to do so, such that they would not need to keep repeating their story,
- For women with MCN, ensuring outreach GP services are provided in women-only spaces rather than within regular homeless and substance use services.

A second paper reported more broadly on inclusion health groups (including MCN), finding that the offer of one-to-one support within services attended by MCN to register with General Practices improves access.(80) Specialist GP services for homeless people were also recommended in this paper.

Supporting contraceptive care

A third paper reported specifically on contraceptive care needs for women with MCN attending General Practices from which the following recommendations can be drawn:(81)

- Sensitive enquiry into potential need for contraception should be explored, amenorrhoea may lead women to believe they are not at risk of unplanned pregnancy.
- Where Long-Acting Reversible Contraception is being used, expiration should be checked and updates recommended.
- Contraception and pregnancy warrant sensitive conversation due to the possibility of previous removal of children from care.

Commissioning and local authorities

Two overarching commissioning recommendations emerged from reviewed documents, both of which can be considered to be trauma-informed recommendations:(52,61,63,76,77,82)

- Specialist services should be commissioned on an ongoing basis – (short-term delivery followed by cessation has harmful consequences beyond the lack of service such as lower trust in authority and services and greater disengagement).
- Joined-up commissioning is needed which responds to gaps in service provision and equips mainstream services to provide enhanced services including accessible and flexible referral pathways.

A report on trauma in the context of homelessness was retrieved, with evidence from both Fulfilling Lives and Oasis service users, including the following recommendations for Local Authorities:(82)

- *'A cross-departmental focus on homelessness prevention*
- *Local authorities committing to only commissioning homelessness services and support services that are person-centred, trauma-informed and psychologically-informed, where the individual is supported to make their own choices and identify what is important to them.*
- *Additional funding is made available to enable local authorities to appoint dedicated mental health professionals, who have an understanding of the traumas and other underlying issues experienced by people facing homelessness, in every local authority mental health service'.*

A second Fulfilling Lives report was retrieved, *More than Just a Roof*, which adds the following recommendations for Local Authority Housing Departments:(52)

- *'Local authorities need to be able to take responsibility for the quality of housing to which they refer people (whether in the private sector, social housing or their own stock)*
- *Individuals should never be made intentionally homeless as a result of leaving or refusing inadequate accommodation*
- *Temporary accommodation needs to be in a location that allows people to access their support network to ensure placements do not exacerbate disadvantage'.*

Commissioning for women with MCN

A number of documents make reference to the need for women-only services (often badged as 'gender-specific'). The 2020 literature review of models of care for people with MCN noted in particular that high levels of trauma and abuse among women with MCN warranted:(63)

- Women-only provision for female offenders,
- Domestic violence services that have capability to work with women with MCN,
- Commissioning of women-only drug and homelessness services (the latter is described in more detail under 'Differing Service Access Needs for Women'), and
- Commissioning facilities for childcare to enable women to attend services.

Commissioning services for people with co-occurring mental health problems and substance misuse

The report *Multiple disadvantage and co-occurring substance use and mental health conditions* found that, although specialist services are needed for a small number of individuals with co-occurring mental health problems and substance use (often known as 'dual diagnosis'), the time-limited nature of these services is problematic and that they can also be stigmatising.(61) Service-level recommendations from that report are given under the section *Mental Health and Substance Misuse Care*. The following commissioning recommendations were made:

- '*All commissioners should use their influence to strengthen local accountability around adherence to co-occurring conditions policies, in order to challenge poor practice*
- *Joint commissioning between health, substance use and homelessness is needed to develop truly shared outcomes and clear, visible pathways to achieve them*
- *Integrated Care Partnerships (ICPs) and Integrated Care Boards (ICBs) must view co-occurring conditions as a health inequality and consider integrating with substance misuse providers and other services that impact upon co-occurring conditions such as housing, criminal justice and the wider voluntary sector'.*

Commissioning homeless and hostel services

NICE guidance on integrating health and social care for people experiencing homelessness includes the following recommendations for commissioners:(76)

- Joint Commissioning - *'Commissioners of health, social care and housing services working together to plan and fund integrated multidisciplinary health and social care services for people experiencing homelessness, and involve commissioners from other sectors, such as criminal justice and domestic abuse, as needed'.*
- Needs assessment – '*Conduct and maintain an up-to-date local homelessness health and social care needs assessment and use this to design, plan and deliver services according to need. Include thorough engagement with service providers (including voluntary and charity sector service providers) and experts by experience'*.

A qualitative study was retrieved from the original search which found that the recovery focus of hostels can be at odds with the needs of people with MCN in hostel environments (see also 'Homelessness: End-of-Life Care' below) and difficulties for hostel staff in getting support from other services(77). The following recommendations are made:

- Hostels should not be commissioned just with a recovery focus – this can be inappropriate for those whose MCN are severe and for those needing palliative care, as well as putting pressure on hostel staff to move people with MCN into other housing before they are ready.
- Hostel staff training should be provided, including *'recognising signs of deteriorating health, building and maintaining useful relationships with other local services and engaging residents that currently are not accessing support'.*

Mental health and substance misuse care

Co-morbidity of mental health problems and substance misuse is widely known and reported on. The NICE 2016 guidance *Coexisting severe mental illness and substance misuse* (not reviewed here) is clear that the primary responsibility for assessment and guidance into appropriate provision lies with Mental Health services. The report Multiple *disadvantage and co-occurring substance use and mental health conditions* describes learning from two programmes including the insight that provision of specialist services can be problematic as they are often time-limited in funding, and they can act as a disincentive to mainstream services developing appropriate approaches and care pathways.(61) Recommendations from this report are also given under 'Commissioning and Local Authorities'. The following recommendations for both mainstream mental health services and for substance use services are made in that report, although their findings suggest that mental health services in particular need to make these adaptations:

- Long term shadowing or one-day-a-week placements between mental health and substance misuse services,
- Mental health services to allow substance misuse and homelessness staff to make referrals and vice versa,
- Employing 'dual-diagnosis' or 'specialist mental health workers' on an ongoing basis,
- Development of pathways that ensure GPs and others can refer into mental health care for patients with MCN deemed too specialist for Improving Access to Psychological Therapies (IAPT) services but not sufficiently 'severe' or 'high-risk' in need to be able to access specialist services.

Dental care

Three papers were found which addressed interventions to support oral health in people with MCN and were published since 2020. Poor oral health among people with MCN is compounded by smoking, drug and alcohol use, high sugar intake and poor nutrition. The following recommendations are relevant to dental care specifically:(83–85)

Settings and access

Interventions should be provided in settings that afford privacy and with staff who are trusted. Building trust and providing opportunities for communication are vital as a pre-cursor to accessing services. Peer support can also enable attendance for dental treatment, as can buddy systems in general -providing support with completing paperwork, remembering appointments and attending.

Community 'pop-up' venues and mobile vans improve access to dental care interventions. Drop-in services for all aspects of oral health should be provided to improve access, integrating oral health interventions with wider care and support. Slots that are not for named individuals but rather for any member of the MCN community to attend can also help with attendance and reduce a focus on 'Failure to Attend' removal from practice lists.

Some evidence suggests that oral health services and appointments are more likely to be attended if they take place in the morning when intoxication is less likely for those with substance use issues as part of their MCN profile.

Mobile dental services, compared to fixed-site outreach clinics, are more likely to provide care to young people, to rough sleepers, to those not in receipt of benefits and those needing emergency dental care. Location of fixed site and mobile dental services should be mindful of under-representation in dental access among MCN, with women, rurally-based people, and asylum seekers less likely to attend without dedicated provision.

Information and promotion of oral health

Staff training and use of documents that clearly explain available treatments to clients with MCN can also improve access and allow staff to promote oral health within their work.

Dental appointments

Where possible, dental appointments should be booked that are longer than the usual allotted check-up sessions. Rules on removal of clients following 'no-shows' should also be relaxed for those with MCN. Dental staff may benefit from training on working with MCN populations to reduce concerns.

Social worker support

NICE guidance on social work with people experiencing 'complex needs' was retrieved from the literature search. The definition of complex needs in this document is wider than that of Multiple Compound Needs, encompassing adults with complex needs needing significant support with activities of daily life and relying on multiple health and social care services.(86) The complex needs might pertain to health, disability, or social factors, or a combination thereof.

The guidance is included however, due to the lack of other research, report or guidance recommendations pertaining to social work and because the guidance does make reference to substance use, offending, domestic abuse and homelessness as contributing factors in those with complex needs.

Key recommendations from this guidance are:

- Organisations should provide greater time allowance for social workers to work with this population, and offer continuing professional development and access to psychological support where harm to staff occurs.
- Organisations and individual social workers (SW) should work in a multi-disciplinary way with health and other social care providers.
- Social workers should actively listen to the experiences of clients and plan support accordingly.
- Social workers should undertake careful needs assessment planning, preparation, execution and follow-up actions (detailed in the guidance).
- Social workers should undertake careful risk assessment to include plain language and terminology, attention to mental capacity, safeguarding policies and the opportunity for the client to review the risk assessment after completion (detailed in the guidance).

Homelessness: mental health interventions

One Fulfilling Lives report focused on a 'Trauma Stabilisation Intervention' pilot for women with MCN including substance use and mental ill-health. The intervention used an assertive outreach approach to offer trauma stabilisation which included learning about how trauma affects behaviour and acquiring emotional regulation skills.(87) Being flexible over location and nature of contact enabled and stabilised engagement for this small cohort of women.

Another Fulfilling Lives report evaluated a one-to-one psychotherapy service for people with MCN, finding improvements on the 'Homelessness Outcome Star' and the 'New Directions Team' measures compared to pre-treatment, but no improvement compared to those receiving Fulfilling Lives treatment as usual.(88) Where psychotherapeutic intervention is offered to people with MCN the following accommodations were recommended:

- A longer period of engagement to allow for the development of trust, and
- Flexibility over time and location of sessions including late arrival,

Homelessness: supporting women through commissioning and practice

An evidence report and strategy for ending homelessness for women in London was retrieved which makes a very wide-reaching set of recommendations aimed at different actors in the system and demarcating between prevention, intervention and recovery interventions. The following key recommendations are abstracted from across those domains:(49)

- To prevent homelessness when housing becomes precarious for whatever reason, women need advocates to support them in applying for housing - evidence suggests this markedly increases the chances of being housed,
- Provision and wide advertisement of women's only spaces where women feel safe to attend and can access support on issues such as abuse, violence, pregnancy and health,
- Immediate access to single-sex accommodation with female staff -evidence suggests women are much more likely to accept accommodation which is sex-specific to women and staffed by women also,
- Financial and housing support for women with no recourse to public funds,
- Provision of services for couples, even where there is an abusive element to the relationship as this can be the less harmful option for street-homeless women,
- Long-term support and wraparound care,
- Provision of mental health services, particularly those that support women who have had children removed from their care and victims of abuse,
- Gender-informed and trauma-informed commissioning to enable the provisions described above.

Homelessness: substance use support

A systematic review was identified by citation searching, the protocol having appeared in the initial scoping review search. Overall, the study reported on US-based interventions delivered to men that were either abstinence-focused or harm-reduction focused. The results suggest that many studies were of poor quality but that:(89)

'Contingency Management (CM), where vouchers are given to someone to stop using substances, works much better than conventional services. Group Work, Harm Reduction Psychotherapy, and Therapeutic Communities might work reducing substance use, with mixed results found for Motivational Interviewing and Talking Therapies (including Cognitive Behavioural Therapy). The evidence suggested that Residential Rehabilitation, ACT (Assertative Community Treatment), and ICM (Intensive Case Management) did not make a difference to substance use for this population'.

Homelessness: transitioning into housing

The Fulfilling Lives Report *More than a roof* makes a series of recommendations to support rough sleepers and other homeless people with MCN to transition into housing. These can be summarized as:(52)

- Support workers focused on tenancy transition (provided for at least 6 months) – supporting with life skills such as budgeting and cleaning and with finding community. Peer support workers are particularly recommended for the latter.
- Access to personal budgets that can be used for practical equipment (such as a kettle) and for social engagement to build a support network.

The NICE guidance document on integrating health and social care for people experiencing homelessness also highlights the transition into housing as a vulnerable time, reporting that for people with MCN (described in the document as those experiencing 'severe and multiple disadvantage') it is often the case that critical time interventions are not delivered for long enough so that:(76)

- Support for the transition period should be as long as needed.

Homelessness: end-of-life care

One study was identified which reported on end-of-life 'palliative' care for homeless people, and included as despite being published in 2018 there were no other papers or reports on this issue, nor was it included in the Brighton and Hove MCN report. This study made the following recommendation:(90)

- Training of staff supporting homeless people, particularly within hostel environments should be used to support: 1. Identification of the need for palliative care (particularly among young people with advanced liver disease related to alcohol use and hepatitis); and 2. Confidence to open up difficult conversations around palliative care.

Further publications suggested that services should appoint someone with the role of 'palliative care co-ordinator' facilitating 'in-reach' by General Practice and specialist palliative care practitioners.(76,77) In-reach is of benefit to people with MCN and homeless staff alike; in particular to prevent too great a burden on hostel workers.

Limitations

The evidence reviews conducted as part of this needs assessment were narrow in scope. They were targeted to specific, prioritised research questions so as to make the best use of limited staff capacity; they reviewed only evidence published since 2020, and so acted as an update on a previous evidence review conducted in a neighbouring authority; and the review focussed on best practice prioritised reporting recommendations over findings. As such, they do not serve as complete evidence reviews of published literature about MCN. The reviews were also conducted by two members of staff who used slightly different search strategies and may have taken slightly different approaches to inclusion and exclusion, meaning that this strand of evidence was not produced using one consistent methodology. The differences in definitions of MCN and related conceptualisations posed challenges to identifying and comparing evidence.