East Sussex's Multiple Compound Needs Health Needs Assessment.

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Introduction

Multiple compound needs (MCN), also termed multiple complex needs, multiple disadvantage, or severe and multiple disadvantage, describes the experience of having several support needs linked to social exclusion, and the multiplicative effects of these needs in combination.

The definition of MCN adopted locally, provided by Changing Futures Sussex, is the **experience of three or more of the following: homelessness, criminal justice experience, substance misuse, domestic abuse, and mental ill health**.(1)

A wide range of mainstream and Voluntary Community and Social Enterprise (VCSE) services in East Sussex support people with MCN. Additionally, there is a local specialist service supporting exclusively people with MCN, and other specialist services in which people with MCN make up a high proportion of the caseload. There is an appetite in East Sussex to improve outcomes for this population. There has been, however, very little information available about the size and nature of the local population with MCN, what their experiences are, and the ways in which their needs are met or unmet by local provision.

This needs assessment seeks to triangulate local and national evidence sources to improve local understanding of the East Sussex population experiencing MCN. It seeks provide evidence-based recommendations to commissioners and service providers to improve support provided to the residents with MCN and address unmet need, thereby reducing health inequalities for this marginalised group.

Background

Definitions

People with MCN are defined and conceived of varyingly by different organisations and researchers. Some differences are ideological, pertaining to which factors are considered most relevant; others relate to the availability of information to describe the group. For example, Lankelly Chase in the highly influential report *Hard Edges* described the population with severe and multiple disadvantage (SMD) including combined experience of offending, substance misuse and homelessness; the report excluded mental ill health from its quantitative research as a result of inadequate data sources.(2)

In East Sussex, the Multiple Compound Needs Board has adopted Changing Futures' definition of MCN as meaning **experience of three or more of homelessness, criminal justice experience, substance misuse, domestic abuse, and mental ill health.**(1) For the purposes of this report, the Changing Futures definition will be used.

Context of Multiple Compound Needs

National attention on people with MCN started in 1997 with the Government's creation of a Social Exclusion Unit (7). This department became the Social Exclusion Task Force which published *Reaching Out: An Action Plan on Social Exclusion* in 2007 (8). This paper provided the first true reflection that people with MCN are failed by a lack of partnership working and shared responsibility between the services they use. Further iterations of this national unit have continued to produce insights on the group since (7, 9).

In 2004, the Institute for Public Policy Research published *Meeting Complex Needs: the future of social care* advocates for support for people with complex needs as part of universal services, and a statutory requirement for the NHS and local authorities to collect data on multiple service use (10).

Research overwhelmingly shows that people with MCN are at high risk of poor health outcomes; particularly regarding mental health, isolation, and avoidable deaths (2, 11,12, 14, 15). 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). **This shows is that people with MCN have multiple areas of need which interact and having a compounding, multiplicative effect resulting in frequent crises and poor outcomes.**

Many people with MCN struggle to gain access and remain engaged with services, and some become high users of emergency services and have frequent contact with the criminal justice system.(16) This way of engaging with services is resource-intensive and does not

support clients towards long-term recovery. An evaluation of the Fulfilling Lives programme found that, before joining the programme, Fulfilling Lives service users use on average £28,800 of public services a year (16) . This estimate, in addition to being several years out of date, is an underestimate not factoring in all types of public service interactions. There are significant costs associated with supporting this population using existing systems and structures, which are failing people with MCN and costing the public purse. There are also significant social costs which extend beyond the individuals with MCN, and to their children, families, and wider communities.(2)

Local Context

In 2012, the National Lottery-funded Fulfilling Lives programme was launched to support people with severe and multiple disadvantage in England (17). Fifteen areas (including Eastbourne and Hastings) received funding, and support for beneficiaries ran from 2014 to 2022. In 2021, the legacy programme Changing Futures was launched, co-funded by the government and National Lottery. Changing Futures seeks to improve outcomes for people experiencing MCN at the individual, service, and system level. Sussex is one of the fifteen areas in receipt of dedicated funding, which has been extended until March 2025 (18).

The Rough Sleeper Initiative (RSI) is a government-funded programme supporting people sleeping on the street. The programme was launched in 2018 (19), alongside the Rough Sleeping Strategy (20), and provides funding to local areas to prevent rough sleeping and support rough sleepers into appropriate services (21). The RSI identifies people experiencing MCN as a priority cohort, and there is overlap between the RSI client group and Changing Futures service users, with some clients progressing into Changing Futures support from RSI. East Sussex is in receipt of RSI funding until March 2025 (22).

In anticipation of a potential cessation of funding, the East Sussex Multiple Compound Needs Board identified the need to improve its understanding of the number and characteristics of residents experiencing MCN in the county. This needs assessment seeks to meet that need.

The last related analysis conducted in East Sussex was a Homeless Health Needs Audit published in 2016 (23). Neighbouring Brighton and Hove undertook a comprehensive needs assessment for multiple complex needs, conducted in 2020 and published in 2023 (24).

Aims and Objectives

The overall aims of the MCN health needs assessment were to:

1. **Estimate the number of people with multiple compound needs** in East Sussex (noting the mobility of the population) to inform commissioning, bid-making, or service development or review; and compare prevalence estimates with published data,
2. **Describe the characteristics of the local cohort** to build a picture of the client base to identify additional inequalities and opportunities to tailor services; and compare demographic results with published data,
3. **Describe to what extent the population's needs are met or unmet**, and local stakeholders' and clients' perceptions of this; and compare local provision to national guidance and evidence about what works,
4. **Explore the population's experiences of services**, and barriers to access and engagement; and compare the experiences of local people to those reflected in the published evidence base,
5. **Understand the cohort's hierarchy of needs** and what matters to people with MCN, so as to determine the best opportunities for identification and referral into further support,
6. **Use data and insights to inform the development of a sustainable service delivery model** for people with MCN in East Sussex.

Methods

A full detailed methodology for each section of the needs assessment, including detailed discussion of limitations and materials used, can be found within the relevant appendices.

Literature review

To complete the literature, review a full search was undertaken by Sussex Health Knowledge and Libraries service. The search was limited to the time period after the recent Brighton and Hove needs assessment and so the search period was between April 2020 to March 2024. Records were reviewed against relevance to the search question buy two members of the ESCC public health team, with support from the needs assessment steering group.

Epidemiological assessment

To understand the level of need in this unique population this needs assessment took the approach of linking local data sets. This assessment focussed on the adult population (18+) with MCN only.

The team requested personalised data from local providers of services for the five needs identified for our definition of MCN. The personal data underwent a pseudonymisation process, which created a pseudo key, a code, for each person within the data. This was completed by one of the members of the Public Health Intelligence team who was not otherwise working on the project to increase data protection for each individual. This pseudo key coded data set was then returned to each provider so that they could provide the team with a data extract on details of clients' needs and circumstances without personal information attached. Using the pseudo key each data set could still be individually linked to other providers data. This process allowed for a bespoke linked data set for people with MCN in East Sussex. Providers that contributed to the data set are outlined in table 1. Data cleaning and standardisation took place prior to analysis. This is the first time that such a data analysis exercise has taken place for this cohort, where data is linked in a pseudonymised way to provide a more accurate description of need.

Table 2: Local providers which contributed pseudonymised data to the bespoke linked dataset

Provider	Primary Need Type
Changing Futures	All five needs
Rough Sleeper Initiative	Homelessness
Lewes and Eastbourne Housing Authority	Homelessness
Wealden District Housing Authority	Homelessness
Rother District Housing Authority	Homelessness
Hastings Borough Housing Authority	Homelessness
HM KSS Prison and Probation Service	Criminal Justice
Change Grow Live	Substance Misuse
Clarion Housing Group	Domestic violence, Homelessness
Sussex Partnership NHS Foundation Trust	Mental Health
ESCC Adult Social Care	Various

Analysis was undertaken by a second member of the Public Health Intelligence team who was part of the steering group. Data were analysed to answer specific questions raised by the MCN board.

Limitations of the data were missing data, as noted above only 11 providers contributed to the data set, and in some cases, data were only a limited subset of their clients. Additionally, within each data set there were missing data fields, and inconsistent coding despite data cleaning.

Engagement methodology

Engagement work was undertaken on three main groups: professionals at a strategic level, frontline staff and people with lived experience. Where possible topic guides were co designed with local staff working in with people with MCN.

Data collection was undertaken between June and September 2024, via ten semi structured interviews of strategic stakeholders, and four focus groups with people with lived experiences and frontline staff. Interviews were conducted via MS Teams, one to one with a member of the steering group and consent was gained to record and transcribe. Focus groups were attended by 2-4 members of the steering group and facilitated by one team member and transcription and note taking completed by other team members. Therefore, quotes from the focus groups are paraphrased. This was due to data protection restrictions on recording the voices of frontline staff of those with lived experience.

Data were then analysed using framework analyses. The framework was created by all members of the steering group who had undertaken qualitative data collection who identified codes throughout the data. Data were coded against the transcripts and notes by two members of the steering group, with a cross check of conformity after one transcript was complete. Codes were then grouped into themes for synthesis and write up.

Literature search results

Prevalence and demography

Prevalence

Multiple national level reports have attempted to estimate the number of people living in England with MCN. The most recent national estimate of people with multiple compound needs was published in Hard Edges, however the data used in the report was from 2010 to 2011 (2). For this report, Lankelly Chase used the term 'severe and multiple disadvantage' (SMD) to describe the cohort of people in England who experience of two or more of homelessness, substance misuse, and offending; with people experiencing all three to be grouped as SMD3. They 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.

Sosenko *et al*. estimated that a minimum of 336,000 people in the UK were experiencing compound disadvantage, utilising the definition of four disadvantages: poor mental health, experience of interpersonal violence and abuse, substance misuse, and homelessness (3). They observed an even gender split within this group, and that women experience multiple and severe disadvantage differently to men (3).

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

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 as we are to include five components (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.

Brighton and Hove completed a needs assessment for this population in 2020, this is the most up to date data to estimate the prevalence of people with MCN locally (24). The assessment of people with MCN via service providers and found that each provider had between <100 to >1900 of their clients experiencing MCN. However, data were not individually linked as such there may be duplication of clients across services.

Prevalence of the five disadvantages that contribute to MCNs

The national Changing Futures evaluation report found that, by April 2023, of 1,250 of their participants who's data were analysed 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.

They additionally found that 83% of their total participants (2,567) had experienced three or more of the disadvantages, and 62% had experienced four or more of the disadvantages (30).

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.

Geographical distribution

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).

East Sussex has seaside towns 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).

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.

Evidence suggests that individuals with multiple compound needs are likely to experience poor mental health as one of their needs; with estimates ranging from 55% to 90% (3, 2, 30), with a higher prevalence of poor mental health among women than men.

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 also 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.

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). 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 Adult Psychiatric Morbidity Survey (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); where a significant proportion of drug and alcohol users report a concurrent need for mental health support.

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). Drug misuse can result from, and perpetuate, social challenges such as deprivation, creating a complex web of interrelated issues.

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).

Similarly to substance abuse, homelessness is rarely a single isolated experience. Sosenko *et al.*, estimated that only 0.5% of the general population experience homelessness without any other disadvantage (3).

Friel *et al.* and Harland *et al.*, highlighted the detrimental impact of homelessness on mental and physical health. Through direct, but also indirect harms such as exposure to alcohol and substances (36 ,33). They also described mental health support was the intervention which could have prevented homelessness and issues related to MCN.

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 (35). Additionally, they are more than nine times as likely to complete suicide compared to their housed counterparts.

Sosenko *et al.* observed that substance abuse problems and homelessness rarely exist as isolated problems, suggesting that both 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). 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).

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. 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 individuals who have spent time in prison are at a higher risk of experiencing homelessness (92% Vs 70%), and individuals with a history of incarceration are more likely to struggle with substance abuse issues (94% Vs 79%) (30). 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).

Alongside other studies (3), these findings suggest that being in prison is connected to other experiences such as homelessness and substance abuse.

Domestic abuse

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 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). 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, supported by other evidence (3,30), male clients were nearly twice as likely to require support for substance misuse, with 48% compared to 25% for females.

Demographics

The evidence base describing the demography of individuals living with MCNs shows that this population is a 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).

The national Changing Futures evaluation found that 62% were male; 86% were White, and 60% were aged between 30 and 49 years (30). While the evaluation of the previous national initiative, Fulfilling Lives, revealed a congruent demographic profile; 63% were

male; 84% White; and 57% aged between 30 and 49 years (44). This demographic profile is consistent across multiple studies (2,30,44), other than those focussed on specific populations who aren't representative of the England's demography (3 ,36).

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 (45).

However, it is noted that 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".

This theory is in line with the 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). Suggesting the currently represented MCN demographic may only be those who are most able to access services.

Gender

The Hard edges report, Fulfilling lives and Changing Futures evaluations suggest that between 60%-70% of people with MCN are male (2, 30,44).

However, when Sosenko *et al*. looked into different levels of complexity of MCN; 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.

The Changing Futures Evaluation Report found notable differences in individual needs among service recipients along the axis of gender (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 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 (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.

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

Evidence suggests that people with MCN are predominantly white; however, 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 (57).

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 suggested that mental health problems often go

unrecognised in this group (58). 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.

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). 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).

This suggests that Black and Asian individuals with multiple needs may be a hidden population requiring more tailored and targeted approaches to engage with support services, particularly Asian women.

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, other major reports suggest that around two-thirds of MCN service users are 30-49 years old (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).

Younger age

The age profile of those accessing homelessness services is notably younger than the general population. *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, 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).

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. Older age is generally linked to poor mental health, while homelessness is more prevalent among younger individuals (3).

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.

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. However, other needs assessments suggest a strong link between these characteristics and disadvantage (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). 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).

Table 2: Key barriers to effective engagement with people with MCN

Service barriers	
Communication	Literacy issues or language barriers contribute to a poor experience and isolation (33, 34, 44).
Scheduling	Set appointment times that cant adapt to complex and chaotic lives (34,61), and held in settings that may be triggering or indiscreet (61). Services opening times may not correlated to times of vulnerability for this complex group (62).
Strict requirements	Criteria around missed appointments opposed to a "treatment first" model have been found to marginalise people with MCN as well as lead to discharge from support (6, 29,33, 61, 62, 63). Failure of services to recognise the relapsing-remitting nature of progress, and the time required, in this group (64). People with MCN seen as being too complex, and failing to comply with behaviour standards without recognising underlying trauma (17,34,61,64,65).
Staff training	Lack of understanding of multiple complex issues, or psychologically informed work (17,33). This may lead to stigma and negative service interactions (33). However, this is heavily linked to resource to complete training (30)
Siloed services	Services are designed to support one specialist issue (30), which acts as a barrier not only to MCN (6,63) but staff working in services who aren't aware of the full offer available to clients (66). Those with co occurring conditions and MCN can fail to meet criteria across multiple agencies which still experiencing complex disadvantage, this is particularly problematic for concurrent substance misuse and mental health needs (6,17,33,63,64,67), or those with substance misuse and homelessness (33)

Structural barriers	
Mental Health	Complex to navigate and utilised GPs as a gatekeeper (34) High thresholds for support (17,62,63) Diagnosis driven, which leaves social issues without support (61)
Substance misuse	Wait times not inline with times of crisis or motivation (61) Lack of staff training on co occurring conditions or compound disadvantage Lack of resource to dedicate time to complex clients
Homelessness	Poor quality housing (33) Low tolerance policy on for substance misuse (52)
Criminal justice	Not focussed around preparation and risk assessment prior to discharge (17).

What works for people with MCN?

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.

Recommendations applicable to all services

Service access and engagement recommendations for working with people with MCN (63) (72)

- 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.
- Building a positive sense of community for people with MCN, fostered by peer support workers.
- Services should aim to be available outside of 9-5 hours for particular populations such as women with MCN
- Services should ensure that they ask about domestic abuse
- 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.

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 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 (71).

Differing service access needs for women with MCN

Many reports focussed their recommendation on women due to the specific barrier they face when accessing services (73, 52).

- Women-only resources and physical spaces should be designed to encourage disclosure and attendance, and Female peer support workers and navigators with lived experience, with outreach services developed to engage with this more hidden group of women
- 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 use services should not limit access to those who are experiencing substance misuse as part of their MCN.
- For housing and accommodation: Sofa surfing and other forms of homelessness that are not rough sleeping should be recognised as potentially abusive situations; Smaller women-only supported accommodation, which is trauma-informed and includes

options for women with children and accommodation options close to amenities (schools, shops, etc.) to help embed women in the community.

- 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.

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 recommendations which are general to all services rather than specific to domestic abuse providers.

Service recommendations for supporting people which MCN which includes homelessness

Other recommendations across the system include (76, 77, 79):

- Longer appointment times, relaxing missed appointment rules
- Shared decision making and co designed interventions
- Continuity of care
- Lower thresholds of attendance and assertive outreach
- For staff at all levels training on trauma informed approaches should be offered
- Support during critical life events

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.

Description of Services in East Sussex

Providers which submitted data to contribute to the bespoke linked dataset were also asked to complete forms describing their service offer. This information can be used with and by clients. It also provides a summary overview of what kind of support people with MCN in East Sussex might have access to, when, and via what routes.

Duration of support

Most services supporting people with MCN in East Sussex (Changing Futures, RSI, housing, SPFT, CGL substance misuse, CGL domestic abuse, and probation) are available to clients for as long as required. Clarion Housing Group provides accommodation to clients for up to nine months with a further six months' resettlement support provided as required.[1] Some services, however, are funded by short-term grants and therefore the duration of support they provide may be curtailed for financial reasons.

Hours of support

Most services operate from 9am to 5pm, Monday to Friday, though some services have an out-of-hours offer: ESCC Adult Social Care services offer an Emergency Duty Service which can be accessed out of hours, and Changing Futures staff will also occasionally work flexibly outside of core hours to respond to individual client needs; housing authorities have out-of-hours phone lines; and Clarion Housing Group provides an out-of-hours support service from 5pm to 9am Monday to Friday and across the weekends; the probation service has late office hours once or twice a week, and some interventions are offered at weekends or in the evenings. As part of the RSI, outreach begins at 5am on weekdays.

Access routes

Many services supporting people with MCN in East Sussex accept self-referrals, including RSI; CGL's substance misuse and domestic abuse services; housing authorities; Clarion Housing Group; and some mental health services like learning disability services, the veterans' mental health and wellbeing service, the specialist perinatal mental health service, and NHS talking therapies. Most secondary care mental health services are accessed via professional referral only, and Changing Futures does not accept self-referrals.

[1] Please note the service reports that it aims to support clients for 6 months but will house them for up to nine, see the service description in **Error! Reference source not found.** for more information

Waiting times

Most services in East Sussex reported no or short waiting times. People presenting at homelessness services are triaged; those with an urgent need will be seen on the same day, and otherwise clients are seen within two to three weeks, varying by authority and over time. When accepting nominations, Changing Futures clients are normally allocated a worker within two weeks, and then contacted by that worker after three working days. It is worth noting, however, that the service's capacity is capped by the number of staff and where capacity is reached, the service stops accepting nominations entirely. Clarion Housing Group accommodates approximately 80% of new referrals within 48 hours, and otherwise within four to five days. Probation, the RSI, and CGL's domestic abuse service have no waiting times.

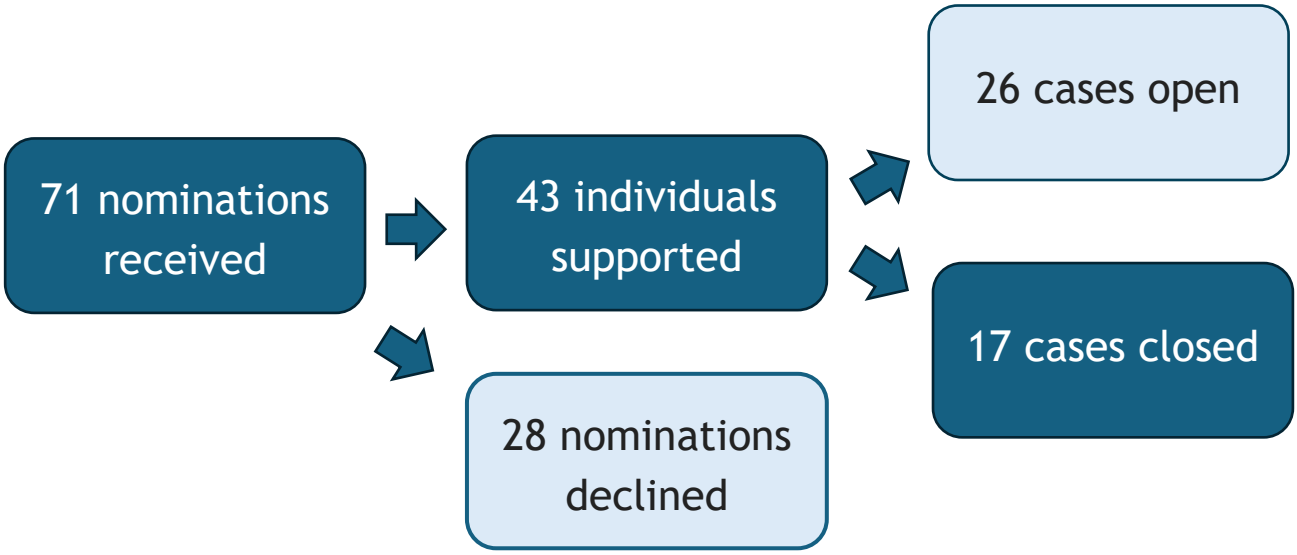
SPFT reported that the services work to the national waiting time directives, and did not provide any other information about waiting times.

Performance of grant-funded services supporting people with MCN

Changing Futures

Over a one-year period between 2023 and 2024, Changing Futures East Sussex received 71 nominations for help and supported 43 clients (Figure 1). Seventeen of those clients had their cases closed to the service in that period.

Figure 1: Nominations received, clients supported, and clients closed by Changing Futures East Sussex, between 24/09/2023 and 24/09/2024



Twelve of the declined nominations were due to team capacity, and seven did not have a reason for declining recorded. Other reasons have been suppressed due to small numbers (<5).

Five of the client closures were related to client goals being met and support no longer being required or desired, and five clients did not have a reason for closure recorded. Other reasons have been suppressed due to small numbers (<5).

Rough Sleepers Initiative

Between July and September 2024, there were 336 cases open to the RSI, with 215 (64%) identified as having MCN (141 individuals were identified as having three needs and 74 as having four needs). Data about experiences of violence were not, at this time, coded.

The individual needs of the total RSI caseload (including those with one or two needs) during this quarter were as follows:

- 336 (100%) had a homelessness need
- 136 (40%) had a mental health need
- 90 (27%) had a substance misuse need
- 41 (12%) had a history of offending or had received a custodial sentence

Out of the 336 individuals on the caseload, 183 (54%) were considered to have meaningfully engaged in the service. Of those 183 who meaningfully engaged, 137 (75%) were people with MCN (87 of those who meaningfully engaged were identified as having three needs and 50 as having four needs).

This suggests that the rate of engagement with the service is higher in people with MCN (64%, 137 out of 215, of those on the caseload with MCN engaged with the service) compared to people on the caseload with one or two needs (38%, 46 out of 121, engaged with the service).

The multi-disciplinary team (MDT) had a caseload of 103 people in this quarter, of whom 88 (85%) had MCN (51 of those on the MDT caseload were identified as having three needs and 37 as having four needs). This suggests that the MDT is prioritising support for people with MCN, as is the intention of the service.

Between July and September 2024, there were 39 RSI clients with MCN (24 with three needs and 15 with four needs) who achieved the outcome of no longer rough sleeping, out of 73 total clients where rough sleeping ended. There were 18 clients with MCN (13 with three needs and 5 with four needs) who achieved the outcome of no longer being homeless, out of 32 total clients where homelessness ended.

Epidemiology

Objectives

The epidemiological needs assessment seeks to understand, in East Sussex:

1. How many people meet the criteria for MCN and what are their characteristics?
2. What are the most common patterns of need in this population?
3. What are the characteristics associated with having multiple compound needs?
4. How do the population's needs differ from demand and appetite for services?
5. How are existing services meeting the population's needs and/or demands?

Findings

The number of people with Multiple Compound Needs

Several estimates of the number of people with MCN in East Sussex have been calculated from the bespoke linked dataset.

The number of people identified as having MCN within the entire time period of the data request was **1,360** (Table 3). If data were unlinked, the estimate would be 1,124, meaning that 236 additional individuals were identified by linking data to determine whether individuals had additional needs known to other providers.

Table 3: People with three or more needs in East Sussex in the a) full data set, b) 2023 only, and c) new to providers in 2023.

a) 2022-2023

	Total people	Multiple	Compound	Needs	
All Providers		3+	3	4	5
Unlinked data	12,346	1,124	929	189	6
Additional found by linking		236	53	133	50
Total	12,346	1,360	982	322	56

b) 2023 only

	Total people	Multiple	Compound	Needs	
		3+	3	4	5
Unlinked data	9687	923	765	153	5
Additional found by linking		268	72	146	50
Total	9687	1191	837	299	55

c) New to providers in 2023 Total people

	Total people	Multiple	Compound	Needs	
		3+	3	4	5
Unlinked data	4426	318	279	38	1
Additional found by linking		60	27	28	5
Total		378	306	66	6

The number of people identified as having MCN in 2023 was 1,191. If data were unlinked, the estimate would be 923, meaning that 268 additional individuals were identified by linking data to determine whether individuals had additional needs known to other providers.

The number of people identified as newly having MCN in 2023 was 378. If data were unlinked, the estimate would be 318, meaning that 60 additional individuals were identified by linking data to determine whether individuals had additional needs known to other providers. The number of people newly identified as MCN in 2023 shows the fast-moving nature of working with the group, as this represents over 30% of the total cohort in 2023.

These estimates are based on a combination of verified and self-reported needs, and it is worth noting that some of the needs reflected in these data might not require service input.

Figure 2: People with three or more needs in East Sussex in 2022 and 2023, identified using unlinked and linked data

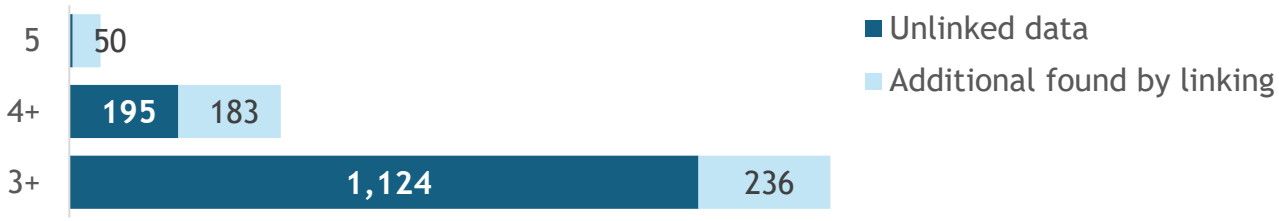
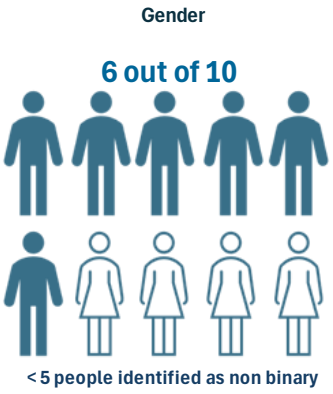


Figure 2 highlights the importance of data linkage in the assessment of the numbers of people with MCN. It shoes the number of additional people identified using this unique data set, including the majority of high-risk people with 5 compound needs. Overall highlighting the need to data cooperation across the system supporting people with MCN.

The characteristics of people with Multiple Compound Need

Gender



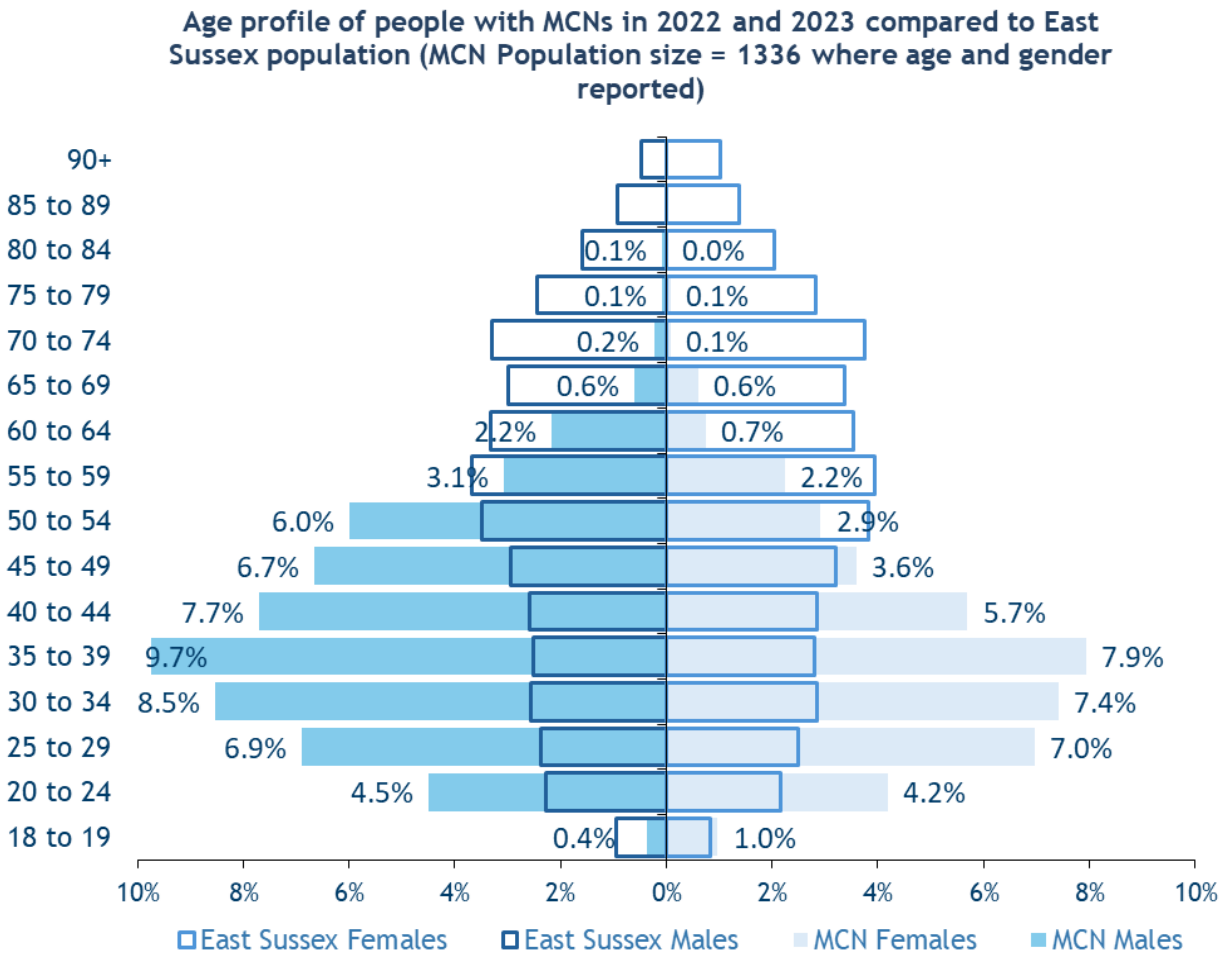
There are more men with MCN in East Sussex than women; 56.6% of the identified cohort was male.

Age

Error! Reference source not found. shows the age p rofile of the general population in East Sussex, and the proportion of people with MCN in East Sussex in each age band, split by sex. There are few people with MCN in the county older than sixty, though a small but not insignificant number of men with MCN in the 60-64 age band. The most common age band across both men and women is 35-39, with 9.7% of men with MCN being this age and 7.9% of women. Women with MCN are younger than men with MCN in East Sussex, with approximately proportionate representation of women with MCN in the 45-49 age band and proportionally lower representation in all older age bands; and men over-represented proportionately until ages 55-59.

The age distribution of the MCN population by comparing the proportion of men with MCN in each age band, and the equivalent for women. Please note that the age bands are presented as 5 year age bands, other than 18-19 to include those 18+.

Age Profile



Ethnicity

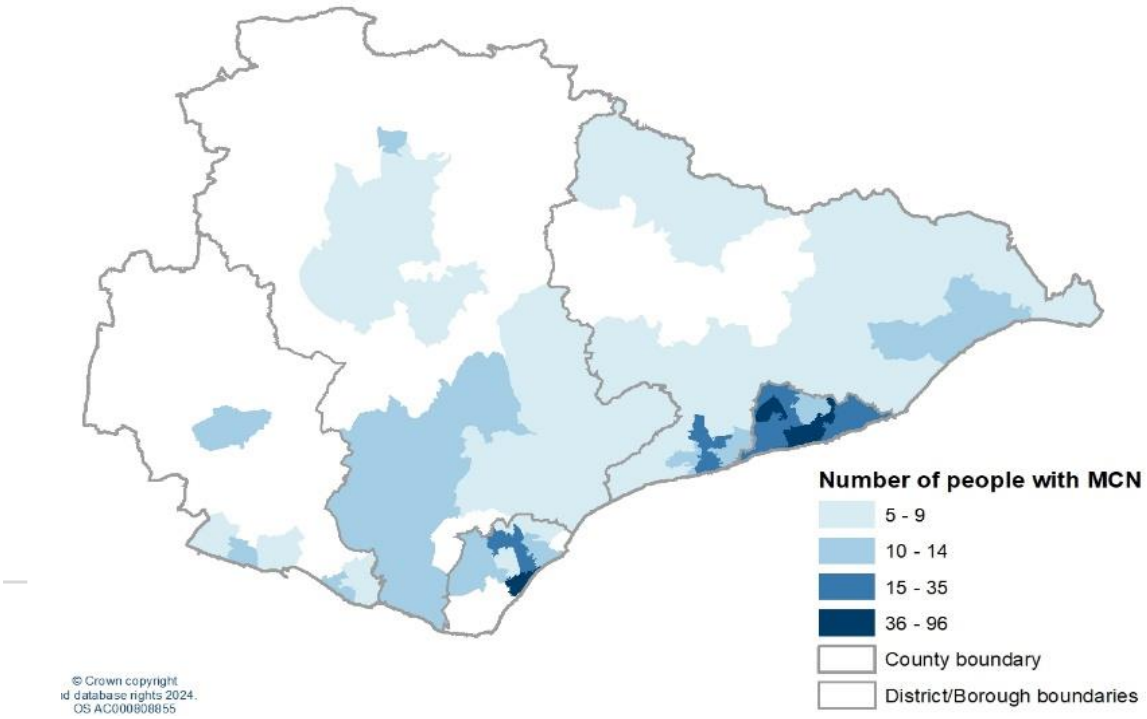
In East Sussex, people with MCN are overwhelmingly (91%) White.

Geography

In East Sussex, there are higher concentrations of people with MCN in Hastings and Eastbourne. These towns, however, are also the location of some of the most deprived areas in the county; the relationship between deprivation and specific challenges facing coastal communities, which might affect MCN status, are difficult to unpick. Areas of high concentration are observed in East Sussex towns and in the more deprived coastal communities. Lewes and Eastbourne housing authorities submitted only partial data, meaning that people with MCN in that area are likely under-represented in analysis; and locations may be skewed towards large accommodation settings and hostels.

Excluding those with no address recorded, 1158 (85%) people with MCN served by East Sussex services had an East Sussex postcode; 14 with a Kent postcode; 9 with an outer London postcode; 6 with an inner London postcode; and fewer than 5 in each of West Sussex, Brighton and Hove, Surrey, Berkshire, and Hampshire. This highlights both the transient nature of this group during their support, or recovery, and the need for cross county collaboration when managing people with MCN.

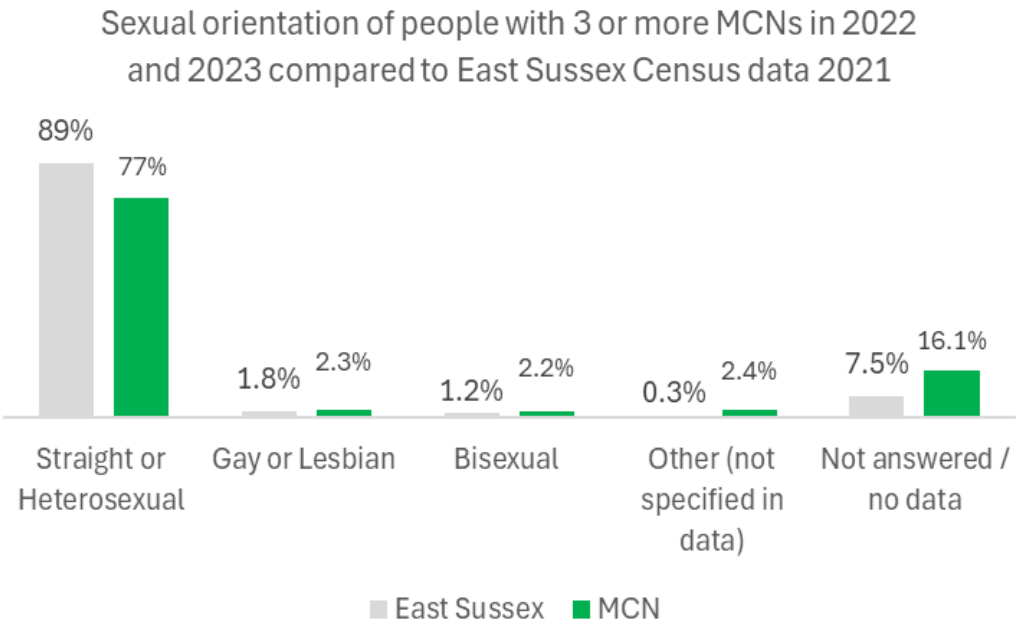
Geography



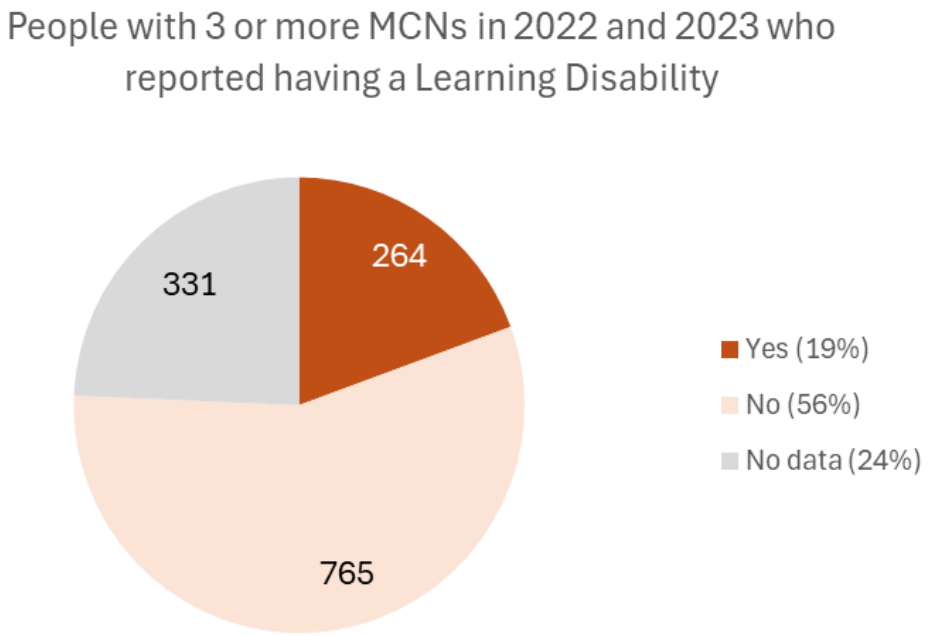
Learning Disability

Local evidence estimated that 26% of the MCN population had a learning disability (LD), which is higher than in the general East Sussex population. However, this is of those who provided data, a quarter of the sample had no data provided against LD, and some data were excluded due to inconsistent definitions of LD (e.g which included neurodiversity or mental health). Therefore, although suggestive of high rates of LD amongst MCN in East Sussex, in line with the literature, missing data and differences in coding mean this estimate requires further review.

Sexual Orientation



Learning Disability



Sexuality

The estimated proportion of people with MCN who are LGBTQ+, in data provided, was 8.2%; with 16% of data missing information on sexual orientation, hindering robust analysis.

Employment

Most people with MCN in East Sussex were found to be unemployed, with a large proportion of the cohort additionally unable to work due to illness or disability. 13% of the population are recorded as being employed.

Other characteristics

Data on carers status or experience, and armed forces status were missing in a large proportion of documentation as such no clear conclusions can be made about these characteristics and further review should be considered.

Most common demographic groups by need type

Analysis of the most common demographic groups in the 1,360 people found to have MCN in 2022 and 2023, split by type of need, shows some notable differences between need types.[2] Table 4 shows the number of people with MCN who have each type of need (not mutually exclusive) and describes the most common:

- age group: 35-39 across all need types,
- gender: male for all needs except domestic violence,
- ethnicity: White, between 90 and 94%, in all groups,
- employment status: unemployment is lowest in those with a domestic violence need (53%), highest in those on probation (62%),
- learning disability status: prevalence is lowest in those with a domestic violence need (19%), highest in those on probation (34%).

[2] The term “probation” is used to describe the need of people with criminal justice experience who are subject to probation.

Table 4: The most common group by need type in people with MCN in East Sussex in 2022 and 2023

Need	Number with need	Age Group	Gender	Ethnicity	Employment	LGBTQ+	Care Experienced	Veteran	Learning Disability
Homelessness	1095	35 to 39	Males (54%)	White (91%)	Unemployed (56%)	Yes (9%)	Yes (3%)	Yes (4%)	Yes (25%)
Substance Misuse	991	35 to 39	Males (67%)	White (94%)	Unemployed (58%)	Yes (8%)	Yes (3%)	Yes (4%)	Yes (24%)
Domestic Violence	656	35 to 39	Females (78%)	White (90%)	Unemployed (53%)	Yes (11%)	Yes (3%)	Yes (2%)	Yes (19%)
Mental Health	1147	35 to 39	Males (55%)	White (91%)	Unemployed (54%)	Yes (9%)	Yes (3%)	Yes (4%)	Yes (31%)
Probation	625	35 to 39	Males (81%)	White (94%)	Unemployed (62%)	Yes (5%)	Yes (4%)	Yes (2%)	Yes (34%)

Most common demographic groups by complexity

Analysis was also conducted to understand the different demographic profiles of people with three needs only, compared to those with four needs or five needs, among those with MCN in East Sussex in 2022-23. Table 5 shows that rates of both unemployment and learning disability increase as the number of needs increase, and similarly that the population becomes proportionally more ethnically White as needs increase. The group with four needs has a slightly younger age, and those with five needs are more likely to be female. Once again, analysis excludes those with missing data, which for learning disability is around a quarter of the cohort, for armed forces experience is around a fifth, and for care experience is nearly two thirds of everyone identified as having MCN.

Table 5: Most common group by number of needs in people with MCN in East Sussex in 2022 and 2023

	Number with MCNs	Age Group	Gender	Ethnicity	Employment	LGBTQ+	Care Experienced	Veteran	Learning Disability
3 needs only	982	35 to 39 (17.6%)	Males (57%)	White (89%)	Unemployed (53%)	Yes (8%)	Yes (2%)	Yes (4%)	Yes (23%)
4 needs only	322	30 to 34 (16.9%)	Males (57%)	White (96%)	Unemployed (62%)	Yes (9%)	Yes (4%)	Yes (2%)	Yes (31%)
5 needs	56	35 to 39 (25.4%)	Females (56%)	White (97%)	Unemployed (65%)	Yes (10%)	Yes (7%)	Yes (4%)	Yes (41%)

The profile of needs relating to Multiple Compound Needs

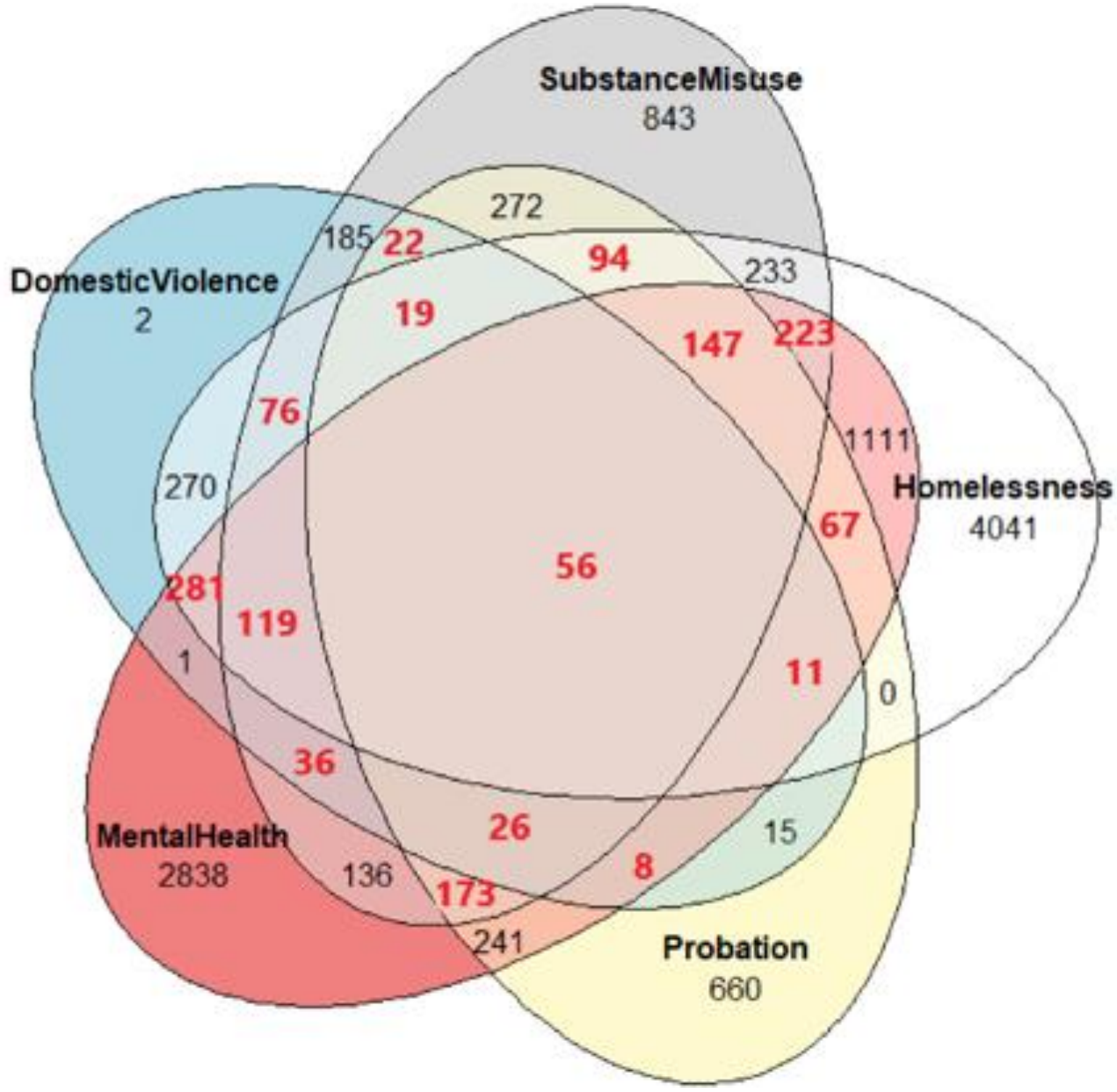
Figure 3 shows the number of people across the entire dataset, regardless of whether they have MCN, who have every possible combination of needs. This shows, for example, that only two people were identified as having a domestic violence need alone, with no other overlapping needs.

Some of the most populous combinations include:

- people experiencing homelessness and mental health problems, but no other problems (1,111);
- people experiencing homelessness, mental health, and domestic violence[3] (281);
- people on probation with substance misuse needs (272).

[3] Domestic violence figures here reflect survivors and not perpetrators.

Figure 3: Intersections of needs amongst people with any need which might contribute to MCN in East Sussex in 2022 and 2023



The profile of Multiple Compound Needs

Individual needs

For people with MCN in East Sussex, the most common need is mental health (bold), followed by homelessness, then substance misuse, penultimately domestic violence, and finally probation (Table 6). The same rank order pattern is found when narrowing the group only to those with three MCNs, likely because the majority of the group experienced three needs. When the group is limited only to those with four MCNs, substance misuse

(bold) is the most frequent need, followed by (in order) mental health, homelessness, probation, and domestic violence. This suggests that substance misuse is a relatively more common need and domestic violence a relatively less common need as people have more complex needs.

Table 6: The ranking of individual needs by frequency among people with MCN in East Sussex in 2022 and 2023 * People with MCN = MCN

MCN type	**MCN**		**3 MCNs**		**4 MCNs**	
	Count	As a %	Count	As a %	Count	As a %
Mental Health	1147	84%	788	80%	303	94%
Homelessness	1095	81%	743	76%	296	92%
Substance Misuse	991	73%	624	64%	311	97%
Domestic Violence	656	48%	425	43%	175	54%
Probation	625	46%	366	37%	203	63%

There are variations in the relative prevalence of the needs among service users with MCN known to different providers. As expected, the most common need among clients of each provider is the need which the provider supports. The exception is Clarion Housing Group, the refuge provider, whose clients all have a housing need, but also have mental health needs. The relative prevalence of each need among each provider's client group is reflected in Figure 4, which describes the number of people with MCN per provider and the rank order of individual needs, with the most common need in the top position. The people with MCN associated with each provider are not mutually exclusive, and the same individuals appear in multiple providers' data, as inherent to the nature of MCN.

Notably, mental health is the only need type which ranks third or higher for clients across every provider. There are also some conspicuous differences between comparable providers, for example domestic violence ranks as a more common need than substance misuse among people with MCN in Rother and Wealden.

The complexity of case mix was also assessed using the linked and unlinked data sets. Figure 5 shows that, other than Clarion Housing Group, all services have a more complex case mix than each services data alone reflects. This highlights the hidden complexity of this cohort even from services they are involved with, but also the need for services to communicate, or data share, across sectors to identify and support people with compounding needs.

Figure 4: The number of people with MCN reported in providers data and the needs ranked as the most common for that provider, in East Sussex in 2022 and 2023

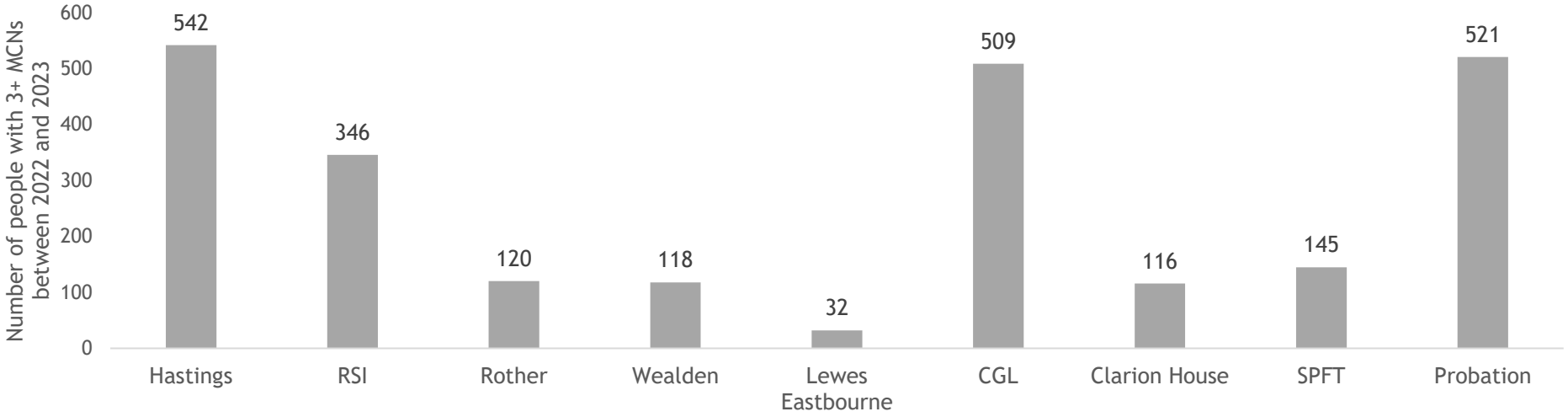
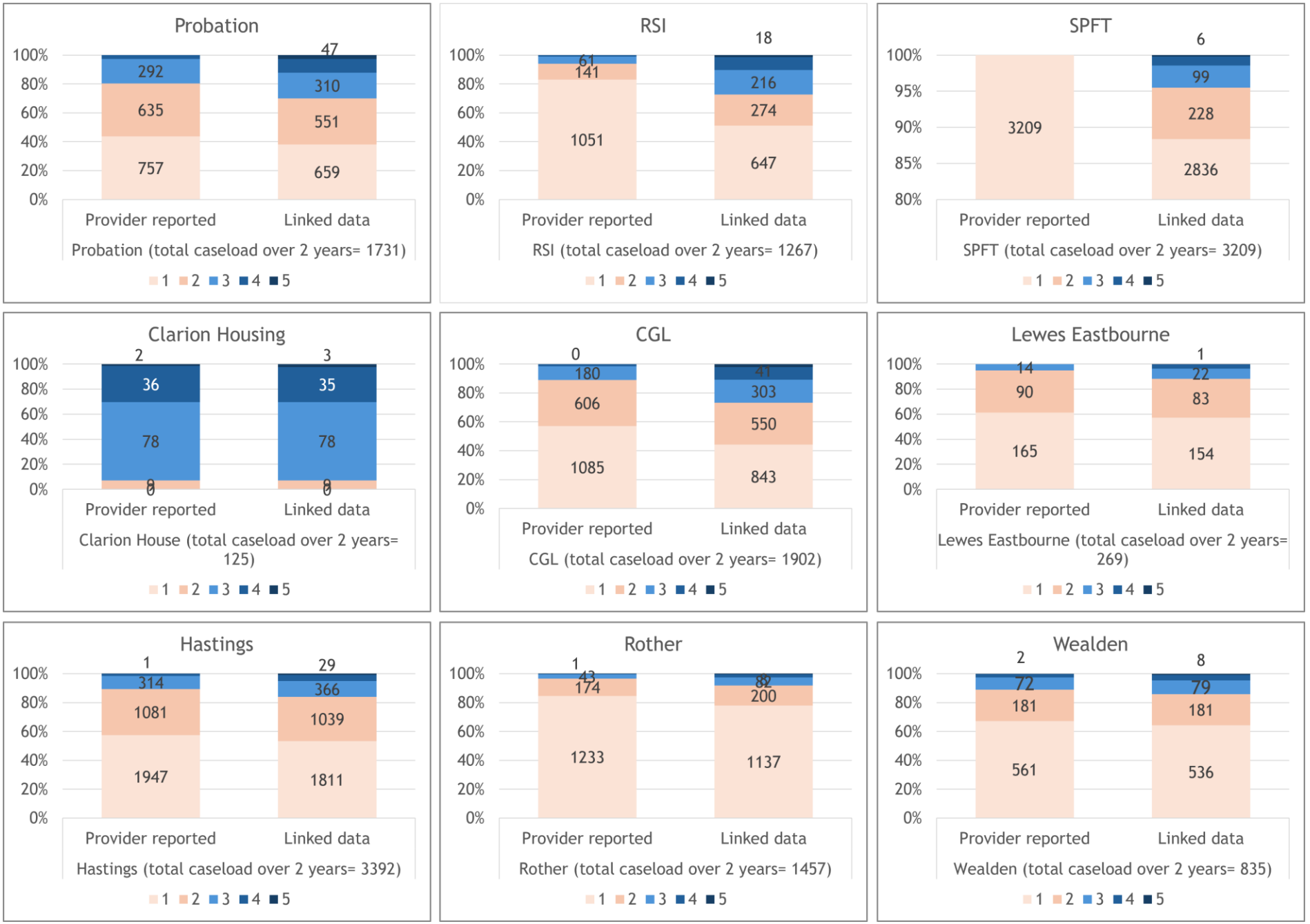


Figure 5: Providers' case load mix by each individual's number of needs in East Sussex in 2022 and 2023 using linked and unlinked data



Combination needs

For people with three needs in East Sussex, the most common combination of needs is housing (H), mental health (MH), and Domestic violence (DV) (Table 7). The second most common combination is housing, mental health, and substance misuse (SM). The third most common combination is mental health, substance misuse, and probation (Pr).

Table 7: The ranking of combinations of needs by frequency among people with 3 MCNs only in East Sussex in 2022 and 2023 (H- Homelessness, MH- Mental Health, DV- Domestic Violence, SM- Substance misuse, Pr- Probation)

Combinations of Need	Number of people	As a %
H+MH+DV	281	29
H+MH+SM	223	22
MH+SM+Pr	173	18
H+SM+Pr	94	10
H+DV+SM	76	8
H+MH+Pr	67	7
MH+DV+SM	36	4
DV+SM+Pr	22	2
MH+DV+Pr	8	0.8
H+DV+Pr	2	0.2

When the group is limited only to those with four needs, the most common combinations by some considerable way are housing, mental health substance misuse and probation; followed by housing, mental health, substance misuse and domestic violence (Table 8). This suggest that housing, mental health, and substance misuse needs are almost always involved in people with four combined needs. Furthermore, these data suggest that people with four or more needs are relatively more likely to have substance misuse and mental health together than other pairs of individual needs; conversely, it is relatively uncommon to experience domestic violence and probation together.

Table 8: The ranking of combinations of needs by frequency among people with 4 MCNs only in East Sussex in 2022 and 2023

Combinations of Need	Number of people	%
H+MH+SM+Pr	147	46
H+MH+DV+SM	119	37
MH+DV+SM+Pr	26	9
H+DV+SM+Pr	19	6
H+MH+DV+Pr	11	3

Finally, table 9 shows the whole cohort, looking at the most common combinations of 3 needs. The combination of housing and mental health are the most common, with substance misuse or domestic violence, making up almost 40% of the cohort. This increases to almost half of the cohort when including 5th ranked mental health, homelessness and probation.

Table 9: The ranking of combinations of needs by frequency among people with 3+MCNs in East Sussex in 2022 and 2023

Combinations of Need	Number of people	As a %
H+MH+SM	545	19
H+MH+DV	467	17
MH+SM+Pr	402	14
H+SM+Pr	316	11
H+MH+Pr	281	10
H+DV+SM	270	10
MH+DV+SM	237	8
DV+SM+Pr	123	4
MH+DV+Pr	101	4
H+DV+Pr	88	3

The relationship between need and contact with services

Analysis of the locally-collected linked dataset shows that there is a gap in all services, of varying degrees, between the residents with MCN reported to have a need and the residents with MCN in touch with the relevant service. Table 10 shows the number of people who have the need reported by any provider, compared to the number of people found within that's providers data.

These data do not describe unique individuals, meaning that there is crossover of individuals between need types due to the nature of MCN.

Table 10: Of the people with MCN, the number and proportion in touch with services for each of their different needs, in East Sussex in 2022 and 2023

Need	People found to have this need (reported across all service providers)	People found within service providers' data	% in touch with a service provider
Homelessness	1095	923	84%
Substance Misuse	991	509	51%
Domestic Violence	656	116	18%
Mental Health	1147	145	13%
Probation	625	521	83%

The proportion of people with MCN with a reported need who were also found to be in touch with the relevant service (as determined by whether those individuals were present in the relevant providers' returns) ranged from 84% of the cohort (homelessness) to 13% (mental health). This initially suggests that for homelessness 84% of those who have the need described are in touch with homelessness services. However, where proportions of people in touch with services is low, for example domestic violence and mental health, this could be due to data issues or a genuine estimation. Reasons for lower rates are:

- Missing data
    - Missing data- Many providers could only provide parts of the data they hold due to data sharing restrictions. Specifically for domestic violence data. Therefore, low proportions of people in touch with services likely reflects missing data.
    - Other services not involved in data collection provide a service. For Mental health many services and support are provided by community or primary care organisations and therefore won't be reflected in this data set.
- Data coding issues

    - Specific referral criteria. Data provided for mental health was from tertiary services which will only provide data on their patients, which as a tertiary service may be a specific subset of those who suffer with mental health issues.
    - Self reporting. Many data points were self reported and so although the need was identified it may not reach eligibility criteria for that service.
- Genuine estimation of differences in access
    - Lack of capacity. Where proportions of people seen within the service where a need has been identified was low, this may represent lack of capacity within services.
    - Differences in eligibility to services, qualitative engagement found that statutory housing duties meant many people have to be taken on by housing, whereas mental health services have specific diagnostic thresholds to reach.
    - Differences in access to services. Mental health services require referral from another medical professional which can act as a barrier to access as GPs have limited appointments, and often require an address to register patients.

While the proportions of people with MCN reported to be in contact with a service for which they have a need change with consideration of reported contact, the patterns and the gaps between reported need and reported support remain. Despite the limitations of this exercise, this comparison suggests that there may be unmet need in some service areas.

Local engagement

Analysis of the engagement work identified seven overarching themes from 41 codes. These can be reviewed in table 16; and included understanding the characteristics people with MCN, the prioritisation process of their needs, the service offer, and broader contextual factors that influence care.

Table 11: Themes and codes identified from the analysis of engagement material.

Theme	Description of Theme	Sub-theme codes
Understanding people with MCN	The characteristics and experiences of people with MCN	Trauma, stigma, complexity and risk, fluctuating needs and motivation, Skills, Autonomy, choice and control, personal relationships, Gaming, Outcomes.
Prioritisation of need	How people with MCN prioritise their competing, and the role of service in this process.	NA
Service Principles	The overarching principles services could adhere to to optimise support for people with MCN.	Trauma informed approach, Relational approach, co production.
Service design to meet intersectionality within the system	The more specific aspects of services that were discussed in relation to people with MCN.	Flexibility, door never closes, Professional to professional collaboration, Supported transitions and aftercare, Named staff, co location, lead worker, MDT, administration, small case loads and assertive outreach, peer to peer support, practical support.

Broader contextual factors	The wider factors that influence the system and affect how we best support people with MCN.	Funding, targets, Differences in organisational structures, housing regulation, guidance and strategy, research, partnership structures, responsibility and ownership, co occurring conditions, shared objectives, governance
Workforce development	Any discussion of the workforce and areas for development.	Training, Supervision, Role clarity, Staff skills,
Met or unmet need	Whether the needs of people with MCN in East Sussex are met, and to what extent.	NA

Understanding people with MCN

Professionals and individuals with lived experience described a range of characteristics and behaviours associated with experiencing MCN, and highlighted how awareness and understanding of these factors were pertinent to the effective design, development and delivery of services and support for individuals with MCN.

Trauma, stigma and autonomy.

> Throughout the engagement work it was clear that childhood or adult trauma was a significant factor in the lives of people with MCN. Trauma was often described as the root cause of compounding need and an ongoing driver of for example substance use, which then impacts all parts of their lives and may create more situations of trauma. Trauma was often found to be an ongoing process, either due to negative coping mechanisms, self-medication, influence from others or due to ongoing negative experiences within services which fail to meet their needs. One professional also commented how individuals with MCN may make up their own back-story as the vulnerability of having to repeatedly tell their personal history could often be too painful.
>
> Someone described it to me as “I made up a story because the vulnerability of having to tell my story over and over again was too painful, so I just made up a story to tell people that I thought would get what I needed” (Strategic professional).

It was highlighted that this trauma will influence ongoing personal and professional relationships. Either manifesting in mistrust of services, negative behaviours when feeling rejected or unsafe, challenges engaging with support, or insecure attachment styles. This may cause difficulties in recognising when situations or relationships were unsafe, or gravitating towards building relationships with people who have similar experiences which subsequently might mean being exposed to negative influences.

It was also felt to impact the need for individuals with MCN to attempt to regain some autonomy or control on their lives while accessing services. At times this was represented as negative behaviour, such as smoking in non-smoking properties, but overwhelmingly people with MCN want to be involved in the conversation around their support in order to feel that sense of control that's often been taken form them. For example, the ability to access housing was often viewed by MCN individuals as something outside of their control; however other behaviours, such as using drugs, could be viewed as within their control and able to help them manage the lack of a stable home. A lack of suitable accommodation was also described as having the potential to negatively impact on other needs experienced by MCN clients. This was seen to pose a risk as times for staff, as several professionals described the challenges associated with enabling client autonomy, particularly when the choices clients make are regarded as unwise, such as refusing accommodation. Frontline professionals also described needing to consider how their actions may be reviewed professionally, particularly if a client had a poor outcome.

> "If someone wants to get their washing done and it's not, it's not life and death. And then that's what's important now, accountability-wise for local authority, for an organization, they might say, "OK, when Miss Bloggs passed away, you were folding her washing. What was that about?" You know, in the worst-case example, but for that individual that's what they wanted to do and it's weighing that up and it's really tricky. But for that short period of time, maybe they felt control. When a world is very threatening and not understood by them, and if those small wins people have capacity and that's where it comes in about letting people make their unwise decisions." (Frontline professional)

This interplay between trauma, autonomy and control was regularly discussed in relation to stigma. Individuals with lived experience described feeling stigmatised by professionals for their needs, beliefs, or past experiences (such as being treated like addicts when they were in recovery); and highlighted how experiencing shame had negative consequences, such as lying about their needs, often to loved ones. This also manifested in access to services which in some circumstances the negative behaviours exhibited (born from a trauma response) meant people with MCN weren't welcome in some services, or the location of services was considered more around the optics of people with MCN in a particular area rather than maximising access.

Finally, those who have experienced trauma such as care leavers and people who are homeless where also found to lack the necessary skills to succeed in mainstream services. Participants described how individuals with MCN often lack practical life skills around living independently, managing a home and organising their life, including gaining employment. Several professionals highlighted the cyclical relationship between housing and skills, in that it was difficult for MCN individuals to organise themselves whilst homeless, yet it was also difficult for them to be able to maintain a tenancy without a range of skills which they may not sufficiently have.

> "There is still this sort of wide comprehension that somebody turns 18, and suddenly they're capable to live independently as an adult when they've never, ever experienced stable household… "My God this person has been through so much trauma. No, they didn't know how to be a tenant because nobody's ever shown them." (Strategic professional)

Many professionals felt that there should be work across adult and children's services in order to understand and manage trauma that often stems from childhood, to reduce its impacts in later life and to equip people with the necessary skills to succeed.

Motivation and engagement

It was found that needs fluctuated rapidly for people with MCN, and as such services needed to be ready to respond in a timely way. Some professionals also described how individual needs could fluctuate depending on the services they were in receipt of, for example a need starting to emerge more prominently due to another need being supported by a specific service.

> "I think the presenting need could fluctuate at different times as well… we certainly see that mental health might be the cause of their homelessness, but that might, you know, stabilise once they're in accommodation. But then drug use might go up- or vice versa…" (Strategic professional)

This was also found in relation to motivation, where participants discussed that the window of motivation to engage with services is often brief before another competing need may take priority. This was particularly problematic when services expected people with MCN to self-refer for treatment, as the intrinsic motivation is low and failure to make a referral when in contact with people with MCN was a missed opportunity to build trust. Additionally, that motivation was negatively impacted by MCN clients being repeatedly told that there is not a service to meet their needs.

> "Someone had been into A&E with alcohol-related issues five times, and five times they were told to self- refer and they didn't. So, there's five potential missed opportunities

there, over the course of like a two-year period, to get someone involved in services" (Strategic professional)

Individuals with lived experience commented that prompt access to services was highly valued, as well as flexible opening times, as then services were ready when the motivation to engage was present in the individual. This was felt to have been impacted by the pandemic; where now opening hours are more and more restricted, wait times for appointments longer and services are only offered at certain times (e.g night shelters only open during the winter).

Finally, this led to people with MCN gaming the system. Whereby some clients may lie to gain access to services or support as a means to respond to unmet need and the eligibility criteria of some services at a time of motivation.

If services were efficient enough people wouldn't have to lie or be deceitful to get the help they need. Because clearly if someone's doing that, they clearly need the help. (Focus group with people with lived experience, paraphrased).

Complexity and outcomes

As previously noted people with MCN experience need in constant flux, which professionals noted that results in affected individuals having combinations of needs which conferred complexity, raised levels of risk, and resulted in individuals with MCN being in crisis. For example, if substance use is prioritised (perhaps due to a mental health need), this then in turn affects housing, which may consequently lead to criminal activity. This snowballing effect was viewed as being compounded by insufficient or inadequate service provision, relapse, and clients being filtered out of services on the grounds of their complexity. For example, people with co-occurring mental health and substance misuse needs often struggle to access mental health support and that individuals' complexity (for example in those assessed as high risk to themselves or others) could make it near impossible to house them using currently available stock.

"Yeah, sorry, that sounds awful. I don't mean they would do that meaningfully, but what they might do is go "we've got so many people who need us. Why would we focus our attention on a couple of people who were very highly likely to make a mess and might be horrible to all staff in the process? When we can focus on all these other people?" Will make no difference to their service and terms of funding or things like that. But I think that's when you get those sort of critical few who are just so complicated and so very, very damaged who have got to the point where it's almost like no one wants to touch them." (Strategic professional)

There was also felt to be a knock-on effect on physical health, and significant undiagnosed needs around learning disability, and neurodivergence which all add to the complexity of people with MCN but have not been classified into the compound disadvantage of our definition.

Despite this complexity it was felt that people with MCN can and do achieve positive outcomes with the right support. With many services expressing positive outcomes or targets achieved within this group. However, it was clear that positive outcomes in this group are likely to look different from those who have one or two needs. Examples of positive outcomes described by professionals included keeping clients alive, clients regularly taking required medication, and clients attending appointments and engaging with services. It was also noted that the time it takes to achieve positive outcomes for this group was generally greater than those with less complex needs.

> "You know, we're talking about somebody who's actually making the appointments and turning up and, you know, getting on the housing register, it's things like that… It's the little wins for these times because there's a lot to get your teeth into with these clients" (Frontline professional)

Service principles

During the engagement there were three key principles of working with people with MCN; trauma informed approaches, relational based approaches and adopting co production. These core principles were felt to be key to a service designed for people with MCN.

Trauma informed approaches were in answer to the theme of trauma described above. Professionals described trauma as the root cause of MCN and highlighted how, if services could understand the impact of trauma on an individual (namely behaviour as a response to experiences rather than an active choice), their ability to support clients to progress would be enhanced. This was seen more and more in East Sussex, from provider to strategic levels, and a number of services where working in this way and offering training to staff.

However, professionals reflected how individuals with MCN were still repeatedly being asked to tell their personal story by multiple providers suggesting that despite services moving towards trauma informed working many aspects were not successful. In particular the trauma informed principal didn't extend to some service environments which were described as unfriendly or unsuitable for families in some cases. Service users highlighted how service venues did not cater for individuals at different stages of recovery and as a result could sometimes be triggering. This extended to accommodation offerings, where accommodation didn't match with the clients stage of recovery they felt triggered and their progress set back. A lack of suitable and affordable accommodation was commonly described by professionals. Insufficient social housing was also highlighted, with people on

the highest banding within Hastings having to wait between three and five years, placing pressure on the rest of the system. Despite achieving better outcomes when clients can live in stable, secure accommodation, such as through RSAP/NSAP, it was noted that the provision of accommodation via these initiatives was not sufficient to meet demand and that tenancies were only up to 24 months. Positively, 'getting housing right' was highlighted as an agreed priority of the East Sussex MCN Board, with actions underway to increase housing supply; within Hastings, for example, the council is trying to increase supply of one-bed properties and has commissioned some self-contained accommodation to better meet those with higher needs.

Overall, participants with lived experience felt the environment of service delivery, or accommodation offerings if not trauma informed could hinder their engagement and success.

Many participants felt this could be achieved through co production of services, as well as co production within a clients care plan. Professionals described several advantages of utilising a 'co-production' approach when supporting individuals with MCN: this included enabling staff to better understand a client's needs so that their support plan reflects their aspirations; and supporting the creation of more realistic actions, namely not setting the client up to fail. Importantly, co-production was viewed as enabling staff to demonstrate trust in clients, providing them with autonomy in their own next steps, and helping to address power dynamics by reducing feelings of 'being done to'.

> "So, a service, or a worker from a service, will look at someone's risk assessment or look at someone's presenting needs and be like, right you need, we need to get you onto a treatment programme and you need to do this, whereas the person might have a completely different perspective on what's important. So, I think that's why it's really important to listen to what each individual wants and there's not a standard approach at all. I think it is very much all the individual" (Strategic professional)

Finally, being able to co produce care plans depends on utilising a relational approach. Where key workers build an effective relationship with the clients which is key to a trauma informed environment, and listening to clients to treat them with compassion, honesty, dignity, empathy, and balance. Feedback from individuals with lived experience also highlighted the importance of not feeling judged by staff, feeling respected, and having someone to advocate for them. This relationship helped to build trust, allowed clients to be honest and open and also allowed workers to more effectively challenge a client gently, or call out their behaviour, and being able to better manage client expectations through honest and transparent conversations.

> But she was the only one I really, really trusted. It was almost like I could trust her with my life. She just knew me. She just got me. She understood me. I didn't have to explain

> myself. She was just amazing (Focus group with people with lived experience, paraphrased).

Many of the services in East Sussex are working towards all these principles, with positive feedback from participants throughout the engagement work on a number of services. However, professionals described how a lack of time and competing priorities could prevent staff from fully adopting a relationship-based approach, and that whether needs are effectively supported may depend on the worker the client receives. This view was echoed by the experiences of individuals with lived experience; several described being unable to trust professionals, with trust often lost when services did not commit to what they said they would do.

Service design to meet intersectionality within the system

Alongside key principles the engagement work identified different aspects of service design that could be used to optimise working with people with MCN.

Flexibility

> In response to the fluctuating needs of people with MCN it was noted that the system needs to be flexible. Professionals commented that services for MCN individuals should be made up of people willing to work flexibly and that services could not necessarily expect individuals with MCN to respond in the same way as the general population, with MCN clients likely to need support from services on multiple occasions, and for longer. Flexibility was described as enabling clients to focus on the needs they would like to meet, meeting in different locations, and staff working flexibly to meet specific parts of a care plan, sometimes using personalised funding for the client. Services were also described as being able to work flexibly when they worked with some individuals over a longer timeframe, or working across different teams to bypass conventional bureaucracy to focus on urgent client needs.
>
> "I'm pretty much allowed to do whatever the client needs me to do in way to support these guys so that the care plans get actioned. And yes, a lot of hand holding it's, it's beyond flexible" (Frontline professional)

Despite flexibility being highlighted within many different services in East Sussex, participants also described several limitations and challenges associated with adopting a flexible approach. For example, professionals described how flexibility varied across different services (such as in the toleration of behaviours), leading to MCN individuals often being at increased risk of losing support somewhere within the system. Some professionals also highlighted how some services were still quite traditional in their support offer, for example using fixed appointment times, and discharging clients who

don’t respond appropriately, where in fact a “door never closes” approach was seen to be more appropriate for this group. Finally, some professionals stressed a need to have the flexibility to step outside of legislative restrictions, for example around homelessness, as these contributed to MCN individuals not being able to access services or to affected people displaying negative cycles of behaviour.

"So sometimes they won't want to engage with support, and that's fair enough. But obviously- and then you know, they might change their minds. So, we need to try and keep an open-door policy, an open-door approach to when they're ready to engage. I think it's all about being present, being there, be- you know, continue building that rapport and just offering the services when they're ready." (Strategic professional)

This flexible approach could also be reflected in an assertive outreach approach. This approach, originally designed to fit within mental health services, is a proactive and persistent method of continuing engagement with complex clients in the community. This involves going out to clients at a location that suits them, and attempting contact many times to continue engagement. It also hopes to develop trust and leans into relational approaches discussed above. Despite the adoption of outreach approaches across the system, professionals highlighted how assertive outreach was resource intensive to deliver and that it was not a typical feature of mainstream services (including mental health, adult social care, physical health services and housing teams), which has a negative impact on how MCN individuals access and engage with mainstream support. This may impede outreach being utilised equally across areas resulting in an inequitable service offer for clients.

> “That's one thing, being there at the right moment and that involves going back time and time again, even when they say they're not interested. So if they're rough sleeping, it's like saying good morning every morning, coming up with a coffee every morning it’s that, you know, “I'm still here. I'm still, whenever you're ready for it” because you never know what moment they might just say “I've had enough of being here”.” (Strategic professional)

Collaboration, and shared responsibility

Throught the engagement work the theme of professional collaboration was highlighted, with particular emphasis on multiple organisations taking shared responsibility for clients. Strategic partnerships in East Sussex were reported to be particularly strong, compared to other types of structures, especially in terms of facilitating the development of joint working protocols and joint funding bids. Collaboration was seen to allow staff to share the inherent risk of managing complex clients, and as a means to discuss and problem solve clients who may be in need but fail to meet statutory and eligibility criteria. At a strategic level, several professionals also emphasised the need for future commissioning to be undertaken in a more co-ordinated and collaborative way to ensure the effective use of

resources and to encourage equal accountability (and that as part of this, commissioners needed to engage with operational teams to further develop understanding of MCN).

> "I think it's how we as a service stop seeing people as one person and which service they're engaged with, rather they are society's responsibility. They're all of our responsibility. Everyone with multiple compound needs is equally the responsibility of everybody in that partnership. And no one can therefore say "no", people can say "not right now"." (Strategic professional)

Professionals described how an MDT approach can help facilitate holistic support and collective responsibility for clients, with outreach provision considered an important aspect of an MDT. A range of services that support individuals with MCN were described by professionals as using an MDT approach. For example, as part of the RSI, clients regarded as higher-risk are supported under an MDT, with this MDT made up of professionals with specialisms who meet weekly to discuss a small caseload of clients. A few professionals also commented that having dedicated time was crucial to implementing an effective MDT but that staff within services did not necessarily have the time to discuss multiple cases that may not involve them at every stage. It was also highlighted that a specialist MDT should only support clients for a brief time, but without ongoing support from mainstream services the utility of specialist MDTs was limited, or their capacity was strained through holding clients who need dedicated support for longer. Whilst the original intention of the MDT had been to highlight what could be done differently within mainstream services, in effect, the MDT had become an alternative route for MCN individuals to access support, away from mainstream services.

Professional collaboration was not restricted to the providers included in this report; participants highlighted the importance of supporting individuals with MCN during transitions and providing after-care support, extending the collaboration through time as well as across organisations. Transitions, such as from youth to adult services, or from institutions, such as prison and hospital, were regarded by professionals as representing an important opportunity to identify needs; and given that individuals with MCN may often be hidden to services, such transitions could enable an individual's needs to be more 'visible'. Professionals described how supported transitions helped to ensure continuity of care, build capability and confidence in clients to engage in other services or support, and maximise client independence and integration or reintegration. Individuals with lived experience specifically highlighted the importance of aftercare, such as peer support groups, following experiences like rehab.

Good examples of this work occurring in East Sussex were within services who could continue their support for a client long term, or without a time bound restriction, as they could step down their support as a client progresses towards their goals.

> "I'm now preparing her to get computer skills towards a job because she'll you lose her PIP sometime next year because she's now sober. She's been clean a year this August, so I'm already forward thinking before discharge. What else does she need?" (Frontline professional)

Although progress is being made some gaps in well supported transitions were noted; a need to strengthen links with hospitals, for example around discharge planning, and the criminal justice system. This was emphasised to help disrupt cycles of behaviour, such as being released from prison without housing, leading to reoffending. As with MDT support participants also reflected that whilst the transition of MCN clients from specialist, grant-funded services to mainstream services, as well as transitions out of services (aftercare), were key points in an individual's care; a transition from one-to-one, intensive support to long waiting times and group interventions, or minimal support could negatively impact ongoing engagement and progress.

As well as collaborating chronologically, the engagement work highlighted the need for physical or geographical collaboration through co location. For example, within one borough, mental health and housing services were highlighted as being physically located next to one another, yet clients accessed support in siloed and separate ways. Participants described a range of benefits associated with the co-location of services and staff when supporting individuals with MCN. Professionals reflected how the co-location of services can take away the need for MCN clients to have to plan and prioritise their needs, and can enable services to better understand each other and facilitate more effective joint working and onward referral. There were many good examples of services within East Sussex who co locate highlighted in the engagement work; there was a positive effect noted for both staff facilitating complex clients, but also clients finding it easier to navigate the system.

> "Since having the co-located link workers, it's really beneficial. So, we've got one from SPFT and one housing substance misuse. So, for instance, like we've got very chaotic person that was presented today, I've been able to go directly to our SPFT link worker, find out exactly what's happening with her, and that can then inform the next step." (Strategic professional)

Finally, the ability to take shared responsibility for clients was optimised by having named contacts across organisations. Professionals described how losing a named contact within a specific service made it more challenging to maintain connections between services; including within substance misuse, adult social care and mental health services. Several professionals also described how they would like to have stronger collaboration with those services. This finding was echoed by individuals with lived experience who reported poor communication between services involved in their care.

> "Half of the time I didn't know who I was talking to. Maybe that's part of my condition. But I don't find there's communication between the services." (Focus group with people with lived experience, paraphrased).

Ways to achieve this

The overarching principles of trauma informed and relational care, co production, flexibility and collaboration were clear throughout the engagement process; how these where to be achieved were also proffered thought the work with multiple examples of good practice.

In an answer to the need for relational approaches, many participants highlighted the importance of adopting a lead worker approach and discussed how this facilitated continuity and meaningful relationships between clients and staff. Professionals described how having a lead worker encouraged responsibility for the co-ordination of a client's support (including onward referral to appropriate services), facilitated advocacy, and could enhance client engagement with services by making the process less overwhelming. It was noted that the East Sussex MCN Board had chosen a 'lead worker approach' as one of its agreed strategic priorities, thus demonstrating a high-level commitment to achieving delivery of this across the system. This was reinforced by other organisations looking to adopt similar models such as "team around the person" approaches.

One limitation of this approach (described by frontline professionals) was that their expertise was potentially being diluted due to time spent undertaking broader case management work. Other difficulties included; the approach being resource heavy, as such hard to maintain when staff are on short term contracts, it being difficult to determine who a client's lead worker should be when MCN individuals were accessing multiple services, and a lack of specific training for staff to work in this role. It was also found that services needed to demonstrate more trust in other providers (such as VCSE) to adopt the lead worker role, and facilitate staff to work across organisations where they may not traditionally have access.

> "Someone needs to lead because otherwise there's that assumption that everyone's doing something. So, it needs to be led and the lead ought to be responsible for sequencing the support that everyone else chucks in or tries not to chuck in." (Strategic professional)

In order to support this "lead person" approach many participants felt there was a need for smaller case loads. Professionals highlighted the importance of services having the necessary time to effectively work with individuals with MCN. It was recognised that due to the characteristics, behaviours and experiences of the cohort, MCN individuals were often more challenging to engage with. However, resource challenges, such as requiring

more staff, as well as negative impacts on service demand and wait times were also highlighted.

> We've been able to deliver a quality support service, but I think once you go more than 8 or 10 on a caseload, you lose the opportunity to really give the amount of time that's needed to build relationships." (Strategic professional)

Alternative ways to meet this need was to utilise peer support networks. This was felt to be the most trauma informed method to offer support as peer support reduced stigma, and were described by participants as less judgemental, as well as being able to empathise and instil hope better than other staff. MCN individuals were regarded as more likely to be open with their peer support worker as they were not viewed as an authority figure, and more likely to listen to what they had to say as they were deemed a credible source.

> ''Experience makes all that difference. Lived experience. We pay more attention to someone with past experiences than someone who's just done a few courses online'' (Focus group with people with lived experience, paraphrased).

Peer support workers were also able to reflect on their own experiences, providing practical support that those without lived experience may not have identified as a need. For example, individuals with lived experience reflected how clients may need to rebuild their lives, having often lost their job, savings, and relationships; and how services could play a role in helping regenerate within society. As mentioned above in understanding people with MCN, many people lack the skills to maintain housing, or other practical skills to succeed with services. Providing practical support was also viewed by some frontline professionals as working outside of their remit and having the potential to put staff at risk of harm; but peer support was seen as a means to role model skills in a non-judgemental way.

A small number of services which support individuals with MCN were described as using peer to peer support or offering practical support. Several professionals described how the 'lived experience' aspect of the Changing Futures programme worked well and that it could be a lesson for how mainstream services could operate. Despite being regarded by some as an affordable component, several professionals reflected how peer support did not often feature within services for individuals with MCN.

> "Idle hands are the devil's friends. It's something to keep you engaged, you come out and you're like "now what do I do?" I had that life, now I need a new life." (Focus group with people with lived experience, paraphrased).

As noted in the Trauma informed approach theme, clients repeating their story to multiple different services could be triggering, and lead to clients "editing" the details to avoid this trauma. The loss of information throughout the system or between services was also

highlighted, resulting in information having to be unnecessarily collected and recorded again. For example, probation described how they often knew much of an individual's story through court proceedings, and that with a client's permission this information could be shared with other agencies to avoid repeated assessments. Access to data, different data systems, and issues relating to GDPR and information governance were all described by professionals as challenges that needed to be overcome to enable safe information sharing, with these issues requiring dedicated service time to be worked through. The structure of some services, such as ten-minute GP appointments, was also regarded by one professional as not conducive to holistic data collection, resulting in some professionals not having a full understanding of MCN individuals' needs.

A response to this was offered during the engagement work in the form of a single assessment that could be shared across organisations to in identifying risk in a timely way, but in being able to pull in the right support for a client, and in ensuring that all services involved are aware of a client's care plan. This work was already being worked on as part of the RSI, the MDT uses a locally-developed shared assessment tool to collect information about clients across 12 areas of need. However, some participants described negative instances of information-sharing without consent, and personal health information being leaked to the community; as such any shared documents should be carefully co-produced with the client and consent for sharing gained.

Broader contextual factors

The desire for many participants was to optimise cross sector collaboration, however this was felt that there were many wider factors that impeded this.

Funding

Throughout the research many different approaches were identified to optimise support for clients with MCN. These were regularly described as resource heavy and participants described how funding for services had been routinely cut over the years, for example in mental health, often despite calls for enhanced service provision, particularly when austerity might increase the numbers of people experiencing MCN. It was also noted that in a resource limited setting, with targets focussing on numbers of clients seen, services may focus their time on supporting less complex or challenging clients, to the detriment of individuals with MCN. Another way that funding limitations were impacting services was that a lack of funding inhibited the use of more qualitative evaluation methods that could provide greater insight into service impact.

A particular focus was placed on the short term nature of funding, which was misaligned with the long term need of this particular client group. For example, if the Changing Futures programme had received more long-term funding this could been used to better understand the impact of data-sharing in case management; or the lack of funding

certainty impacting on current provision due to staff leaving fixed term posts. Where best practice approaches, such as small caseloads, were being adopted by services including the Changing Futures programme, RSI, and Eastbourne Hub, professionals reflected that current staffing capacity was often insufficient. For example, there are not enough staff for every rough sleeper to have a caseworker as part of RSI MDT. For those services able to implement a 'Team around the Person' approach, professionals reflected that these were often missing key staff that were crucial to their effectiveness; three different services highlight specialist staff they were unable to recruit to the team.

> "We got the co-located mental health link worker. That role has just [been] made permanent, which is great. That's sort of a real recognition that the need is there and is, you know, quite substantial. But it's one person, and frankly we could do with ten and they'd still be bogged down with all of our inquiries" (Strategic professional)

Several professionals described that the ideal service for individuals with MCN was currently unaffordable, yet there was recognition that the MCN population represented a significant cost to society and that an invest to save approach is required. Several professionals emphasised the importance of commissioning and the pooling of resources; with commissioning approaches also taking a collaborative approach to optimise sustainability. For example, one professional commented that had the RSI been delivered through mainstream services, the MDT be less likely to be facing funding uncertainty.

> "you know we're reliant on fixed term funding and so on for the MDT, like we don't have the confirmation that funding will continue beyond March next year whereas if, and I know there's pressure right across the budget even for mainstream services, but if it was mainstreamed, you wouldn't be in the same you know cliff edge situation next March, which we are in with the MDT" (Strategic professional)

Misaligned organisational structures

Although there was lived experience desire, and professional progress towards shared objectives, for example through the MCN board, it was found that many organisational structures were hindering true alignment of services for people with MCN.

> "Theres a great bunch of people in East Sussex, it's one of the things I've really loved about working here. There are just brilliant people everywhere that are very similar in thought, and drive, and wanting to do the best for clients, albeit you know some differences" (Strategic professional)

These challenges included differences in the legal and regulatory frameworks within which services operate. For example, one professional highlighted that the RSI had an overall ambition to end rough sleeping, but that this conflicted with housing authorities which are

limited by the housing legislation to be able to support only those to whom they legally owe a duty.

> So we're kind of at conflicting priorities where in the RSI we're trying to house everyone, whereas in in the local authority, it's only certain types of people." (Strategic professional)

This was also reflected in eligibility misalignment, professionals reflected that due to increasing thresholds in some services, and the lowering of thresholds within housing due to national policy, the default position for many individuals with MCN was to access housing support despite often also requiring other services to meet their needs. This mismatch in eligibility also involved whether people could access support whilst using substances as different organisations had different approaches to this issue.

> "The thresholds in housing decreased, they were never increased in line with the others, they were decreased with the HRA in 2018, so we then we suddenly had assessment duties, and support duties for people that we otherwise would have just said no to… They come to us, and because our thresholds are so low, we end up sweeping them up. And then we're stuck because we can give them housing, but we can't give them the support that they need" (Strategic professional).

In housing, and other areas, participants reflected that national influences caused differences in the ways organisations worked. Professionals suggested that the homelessness legislation should be reviewed by national government, and that the private rented sector needed to be better regulated to address homelessness. In other areas, national policy change resulting in police officers no longer attending emergency calls for mental health-related incidents left services unsure about what to do when clients were experiencing a mental health crisis, while feeling unsupported by the national agenda.

Funding was also an area of national influence that impacted local delivery. One stakeholder commented that the ending of the funding associated with the national drugs strategy, and the establishment of a new government, meant that future funding in this specific area of need was currently uncertain. Commissioning and research were also noted to not align; with timelines for research to understand impact resulting in services often being recommissioned (and based on a different model) by the time national research on current approaches has been published. Finally, it was highlighted that services were working under NICE guidance that, in some instances, was almost 8 years old, for example the guidance for coexisting severe mental illness and substance misuse; therefore, at a national level, there is a notable lack of robust guidance on how to support individuals with MCN.

> "For example, if somebody is a care leaver, but maybe they had a tenancy and it failed, and it failed because of all the obvious reasons, but it failed and it was ultimately their

> fault, we just say “well you’re intentionally homeless, and therefore we've got no duty to you”… it's just very frustrating sometimes because it's not the wrong decision, it's the right decision in terms of the legislation… But it's wrong” (Strategic professional)

There were some positive national influences noted, professionals spoke positively about the Dame Carol Black review and the 2021 national reform of the probation service which both allowed for clear direction of services towards the same goal. The national early prisoner release scheme was also reported as having had a positive impact on bringing partners together several professionals. Others described examples of funding attached to national initiatives and how this was being accessed locally to support individuals with MCN, such as ‘Target Priority Group’ funding which has enabled local areas to be able to work with a small number of entrenched rough sleepers in a more intensive way.

Differences in performance indicators and targets between services were also mentioned by professionals, who described that those services without a target number of clients to support each quarter were able to achieve more meaningful support to individuals with MCN.

Even time was described as a factor that is not aligned across services. For example, the refuge service described advocating for clients, however if the client might benefit from support to access their GP and they needed to call their practice at 8am, Refuge workers were not employed to start work at that time. Additionally, the typical duration that some services can provide support for clients was also reported to not align well with the waiting lists for other services. For example, the Refuge service described how they were commissioned to provide support to individuals for up to six months; therefore, it was challenging to support clients when waiting lists for some services were two months or more.

There were also other services that were out with this report; these included dental services, detox, physical health services such as GPs, adult and children’s social care services, the police, family courts, and counselling and therapeutic services to help address or resolve trauma. Which were all felt to be an important part of the system of support around people with MCN but not readily connected to the major services discussed here. This was particularly in relation to physical health; it was described that there are higher rates of premature death in people with co-occurring conditions highlighting a need for greater physical health collaboration for this cohort.

Overall, we found that different organisations can have a different ethos and value base and that, as part of a multi-agency approach, there is a risk that individuals might experience varying approaches which have the potential to undermine each other.

> “But I think when you get some of the more complex it gets, the more people that are involved also, the more people you get doing slightly deviated models of rehabilitation and

> things like that and you start ending up with things potentially undermining other things because they are different. Yeah, different models and different ways of working." (Strategic professional)

At times these differences were seen as complimentary; the differences between mainstream or statutory and non-statutory or voluntary sector organisations were a common theme described by several professionals. Compared with statutory services who provide a the majority of services, the voluntary sector was regarded by some as able to be more agile, flexible, and responsive which allowed them to fill in gaps where statutory services weren't able to support a client.

Finally, professionals highlighted that it was important to scrutinise services which support individuals with MCN, with strong governance having the ability to facilitate improvements like joint working.

Workforce development

Professionals described a range of key attributes integral to enabling individuals with MCN to access support and services, and for staff to successfully reduce levels of need. This included being open, flexible, relational, persistent, supportive, competent, and committed. There were some services that were highlighted to lack the ability to build relationships with clients, which was seen as detrimental to a trauma informed approach to people with MCN.

However, good training offers were described across the system, including; trauma-informed training, dual diagnosis training, substance misuse training, behaviour change training. Despite this, not all providers interviewed seemed to be aware of current training on offer, professionals reporting that there was no clear training related to mental health despite the existence of dual diagnosis training. Professionals often commented that it would be good to have training specifically on people with MCN, to have a better understanding of MCN, what works in supporting the cohort and the support available to partners across the system, as well as agreeing trauma informed training would be integral to working well with this group.

Some professionals reported that there was a general lack of knowledge amongst staff as to how to support specific needs which sit outside of the direct remit of individual services, and that this could lead to staff working outside of their qualification area.

Some professionals also reflected that services lacked understanding of other services, with the frequent changing of contracts and providers compounding this issue. Specifically, understanding of the mental health system, to include different access routes, mental health teams, and levels of need, was regarded as poor, resulting in staff sometimes

lacking the knowledge to navigate this form of support for clients (also see Navigating the system).

For wider workforce development, professionals outlined the importance of staff receiving strong supervision and support due to the complexity and risk they are required to manage daily in supporting individuals with MCN.

> "If we took the risk assessments to the max, we probably wouldn't meet most of our clients on our own. That's the reality... We have to do a lot of dynamic risk assessing on the day, what's in front of us. If you looked at it on paper, we wouldn't be out working on our own" (Focus group with frontline professionals, paraphrased)

Several professionals reported strong models for supervision and described positive examples of support being provided to staff, such as dual diagnosis practitioners providing advice to other staff in mental health services and to staff in other organisations via the Co-occurring Conditions Forum. However, other staff felt that there was a lack of psychological support for staff who work with complex, risky, and behaviourally challenging clients on a daily basis. Administrative support was viewed favourably in facilitating communication and organising meetings between services

Participants highlighted how role clarity was important for both staff and clients, enabling staff to feel empowered and able to carry out their functions, and enabling clients to understand their own care and which professional to approach for different aspects of support. The importance of staff being able to operate within their expertise and competence, for the safety and wellbeing of both clients and professionals, was also emphasised.

> "Our roles become so diluted, they become almost less effective. We are massively effective as who we are, as people where we wear multiple hats. There's no way that you can take on five hats and wear them all properly." (Frontline professional)

Some individuals with lived experience also reported positive experiences, with the roles and responsibilities of staff at the mental health trust being made clear to clients. Despite these positive experiences, some individuals with lived experience described being in contact with several services simultaneously and struggling to understand the different responsibilities of all the professionals involved and who to contact when there was a problem.

> "We've done this for a few clients to sit around and say… "I'm responsible for this, He's responsible for that, She's responsible for that, This is who you go to for this, This is who you go to for that" and it just gave him a more clearer picture of who is going to support him with what, because I think there was a lot of confusion, a lot of overlap, or a lot of different professionals involved, which can become overwhelming" (Strategic professional)

Prioritisation of needs

Unique to people with MCN is the daily need to prioritise their needs. We explored this with both lived experience participants and professionals. Their observations on the prioritisation process were different and at times at odds.

Generally, participants reported that the process of prioritising needs was difficult and did depend on the known fluctuations between competing needs, making the process ever changing; it was clear that this process was unique to each individual. Some felt that mental health and substances often was the priority for people as these are needs which could be acutely 'felt', whereas others felt that housing was most likely to be prioritised by MCN clients, as it was seen as a conduit to addressing other needs. Professionals commented that sometimes MCN individuals prioritise their needs based on with whom or which service they have the best rapport, which was echoed by clients who talked about working around services and gaming.

It was also found that regularly services will prioritise needs for clients based on the level of risk, or availability of services. This was found to create tensions, both between services who do not always work in partnership with one another to consider how to prioritise support for MCN, or the order in which needs are addressed is at odds with the client, which can lead to mis-prioritisation and disengagement. Professionals recognised that enabling MCN individuals to prioritise their needs could facilitate a sense of control. This misalignment may come from a lack of trauma informed care, or co production such that services label a client's decisions as unwise. For example, for those who rough sleep, professionals described that services often think accommodation is a priority, but it was important to note that the streets sometimes provide a sense of community to this cohort. Frontline professionals furthermore highlighted that it could be difficult for staff to balance protective responsibilities whilst facilitating client autonomy, especially when service users prioritised needs differently from services providers, such as by not addressing a serious physical health need. Differences in prioritisation between services and MCN individuals could also lead to challenges in early worker relationships and trust-building.

> "I work with a client who really struggles to prioritise things.. She'll have cellulitis in her arm or her leg and she needs to go to hospital. But in her head… she needs to go and wash her clothes… [what we're] saying is you need to go to hospital now and she's thinking, I need to go get my washing. You have to help them get there themselves, but it's really hard to do when there is a very obvious pressing issue that could affect their physical well[being]." (Frontline professional)

Population level met or unmet need

Finally, we aimed to assess need and asked participants to offer their observations on the situation within East Sussex. Professionals reflected that alongside positive progress locally, the needs of individuals with MCN remained largely unmet.

Some professionals reflected that services were getting better at identifying needs, many felt that more work needed to be done to address and reduce the level of need experienced by the MCN cohort.

Particular groups were identified as needing more support, including those with the most complex needs. Those MCN individuals who were regarded as less likely to have their needs met, and to experience additional barriers to accessing and engaging with support included: individuals with learning difficulties, neurodiverse conditions, or those without English as a first language. Finally, a needs assessment (and recent refresh) for victims of domestic abuse found the leading gap in provision to be support for MCN individuals.

Unmet need was also described across particular needs. Almost all professionals described a significant unmet mental health need amongst the MCN population, with services supporting many individuals with undiagnosed and untreated mental health problems. Professionals reflected that due to the lack of appropriate housing and the ability of MCN individuals to successfully maintain accommodation, homelessness remained also remained a significant unmet need.

> "One of the biggest things that I struggle with is undiagnosed mental health with my clients, massive, and then with that goes no medication. It's huge. A large percentage of substance misuse clients will have ADHD, undiagnosed" (Frontline professional)

Several professionals described that the needs of individuals with MCN were not met by current services due to a lack of resources and appropriate services. This often meant that needs remained unresolved or were being perpetuated by the system. Inequality in service provision across geographical areas within the county was also described, alongside a lack of specialist provision to support some needs such as a counselling services specialising in domestic abuse. Other systemwide failure where highlighted, with professionals acknowledging that, due to limitations in the current system, services may provide support to clients knowing that they are likely to have limited success. Finally, some services were described as having rules, such as around behaviour, which often resulted in individuals with MCN inevitably losing support, and hence their needs remaining unmet.

Finally, taking a different perspective, some respondents felt that the goal of all needs being met was unrealistic; and that some the best outcomes they might ever achieve with a client would concern basic needs, such as keeping clients alive. This perspective took into account the complex trauma of many MCN clients, and reframes unmet need away from a deficit perspective.

> “ there are some people who would never be green. [They] will never live completely independently, but if we can lower the level of chaos, if we can reduce the level of need to a slightly more manageable level then they have a greater chance of going a longer time without having a crisis and we can help plan for that. I think that's a very realistic aim rather than just saying ‘we'll just eliminate, there won't be people with multiple complex needs they'll have all their needs met’. That's just not feasible. People are human. Trauma happens” (Strategic professional)

Conclusion

This needs assessment represents the first comprehensive attempt to quantify the number and nature of people with MCN in East Sussex. These findings, triangulated with learning from published literature and local evidence about the characteristics and experiences of the local population, the factors which make services work well for people with MCN, and the barriers and facilitators of such provision, have shown that there is significant unmet need amongst a population of socially-excluded residents which is much larger than may have been expected. The evidence base generated as a result of this process has informed a series of recommendations for local service commissioners and providers intended to improve delivery, and consequently experiences and outcomes of the local population with MCN. These recommendations hinge on mainstreaming specialist MCN support and fostering true shared responsibility for these clients’ outcomes across all relevant providers.

Recommendations

New service model

1. Review the current service delivery model, considering key issues and ideas identified though this report.
    a. Key concepts include: Team around the person and assertive outreach approaches, client collaboration into their care plan, mainstream services supporting specialist MCN services, consideration of continuity and aftercare for this group.

Developing a trauma informed system

2. Systemwide staff training should focus on implementing a trauma informed approach at all levels and strengthening relational- approaches for frontline workers.
    a. Including during staff recruitment, assessing for interpersonal skills and ability to connect well with others alongside role specific skills.
    b. Those who supervise frontline staff should also receive training in how to support those working with complex clients, and could include specific clinical psychologist support, and ensuring staff work within their competence either through training, supervision or specialist support.
    c. Trauma informed approaches should extend to accommodation that understand the different stages of a client's journey.
    d. When taking a trauma informed approach, the adult system should collaborate closely with children's services to support a prevention approach.
    e. Where staff regularly work with people with MCN with the same cross sector issues (e.g. Mental health, ASC and substance misuse, police and domestic violence) specific training should be offered to improve the holistic support package delivered by that service.

Collaborative commissioning and funding

3. Utilising collaborative commissioning and funding applications the system wide approach should be to secure long term, or sustainable funding which meets the larger population identified in this report.
    a. Services currently support a fraction of the number of people identified as having MCN in East Sussex, and funding should reflect that unmet need.
    b. Funding should be based on sustainable models to ensure ongoing development and positive outcomes
    c. In many areas collaborative approaches to commissioning would support a system wide approach to this group.

A flexible system

4. The system should be prepared to be flexible to the changing and unique needs of these client group.
    a. Where accommodation settings can be flexible, within legal limits, they should take an equitable approach to this particular group. This could include placing clients who are recovering from addiction in housing that supports their stage of recovery, relaxing thresholds around timely rent payments, or taking a trauma informed approach to behaviour.
    b. Offering a “personal budget” to help address acutely presenting needs and offer money management skills.
    c. Mainstream services adapting their approach to this client group including taking on a smaller caseload to offer a more assertive approach to these clients and not offering services on a “time bound” basis.
    d. Specialist and mainstream services should be able to respond to clients rapidly changing situation and risks by being ready to mobilise services when a client is ready to engage, and quickly convening an MDT as a client journey shifts.

Recognising compounding characteristics

5. Services should take into account how different aspects of MCN may overlap with other protected characteristics or vulnerabilities.
    e. Recognising the high prevalence of learning difficulties in this group and supporting through prioritised assessments, and additional input as required.
    f. Noting the unmet need within mental health services for this group, as such considering lower thresholds to offer support, and increased provision.
    g. Ongoing review and improvement of support for those with both mental health needs and substance misuse issues, including increasing staff training and capacity, and considering joint commissioning together, and across the system.
    h. Offering specific support for those undergoing court proceedings, and navigating the legal system.

System collaboration

6. The system should continue to develop its approach to taking shared responsibility for this population through sector collaboration, data sharing and shared assessment tools.
    i. Continue work started via the MCN board to collaborate though joint appointments, cross sector roles, co-location, and strategy alignment, including broadening membership.
    j. Review data sharing agreements to allow for robust but open sharing of data between sectors for this cohort.

k. Consider the development of a pan East Sussex MCN assessment tool, that meets cross sector requirements but means each client shares their story once.

Practical actions

7. Aim to quickly review and initiate some practical actions including:
    l. Developing a risk assessment tool and referral pathway for those who may develop MCN.
    m. Offer practical life skills as part of all support packages
    n. Identify clear communication and navigation pathways between sectors e.g named MCN champions within each sector.

Research and Evaluation

8. Strengthened evaluation practices specific for this cohort and ongoing research will improve systemwide knowledge to allow for ongoing positive development.
    a. Evaluations for individuals should include ongoing assessment of the clients needs to understand how to successfully reduce support when appropriate, and if outcomes are poor in depth reviews of the case would offer richer insights into service delivery gaps.
    b. Wider strategic evaluations should be co-produced, and targets for services should reflect the complexity of working with people with MCN.
    c. Research should build on work started within the needs assessment, specifically looking into people who might be at risk of MCN, exploring better terminology to understand this groups experiences, and into sub groups within this population e.g sexual orientation, employment status, armed forces, carers and disabilities.

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