Appendix 3 : Qualitative MCN HNA

Qualitative methods

Materials

The nature of people with MCN is that many services are relevant to their care and the individuals themselves are far from a homogenous group. This context presented some limitations for the design of qualitative materials, particularly that the questions were designed to be broad, and speak to the entire system, meaning that respondents were often commenting on services about whom they might know limited detail; and that the responses themselves were broad and wide-ranging, making analysis challenging.

Interviews

Interviews were conducted with strategic stakeholders. The interview format enabled participants to be candid, but provided no opportunity for challenge from other services mentioned. VCSE organisations were not engaged, meaning that a large part of the provision for people with MCN was not reflected by those services themselves, though other participants did mention VCSE provision. Partners from physical health services and social care services were also not engaged.

Focus groups

The focus groups with people with lived experience had several limitations. In an attempt to minimise the data collected and avoid risk for this group, specific focus group events were arranged via professionals in key organisations so that the opportunity could be advertised to relevant people who could then opt in to focus groups anonymously, without the research team being required to collect any personal identifiable information from them. This decision limited the organisations through which engagement could be conducted; informal, drop-in settings were ruled out on the basis that participants could not opt-in, but would need to be approached; that attendees coming at different times would pose challenges for the focus group format and the need to consent participants; and that screening for MCN would conflict with data minimisation efforts. As such, people with lived experience were engaged through Changing Futures and CGL, which both biased participants towards those who were engaged with services, biased discussion towards substance misuse needs as most participants were recruited via CGL. This approach still risked the inclusion of participants with single or double needs, as the responsibility for screening was devolved to partners and the methodology used was not shared. The qualitative arm of the needs assessment would have benefited from additional engagement with people with lived experience, and from engaging participants with a more diverse range of experiences including more participants who were earlier on in their recovery journeys.

It was anticipated that uptake would be limited, so vouchers were offered to incentivise attendance, which may have created a bias in respondents and appeared to encourage

some degree of gaming as some participants attended the session but did not engage in discussion, despite the efforts of facilitators. Uptake of focus groups was still limited despite the incentives; three out of the four focus groups with clients from Changing Futures were cancelled due to non-attendance.

It is also worth noting that some of the people with lived experience who contributed their experiences and perspectives may have had MCN for a long time, and some of the feedback may not be contemporary.

The focus group with frontline operational staff was limited to staff at Changing Futures.

During multiple focus groups, some participants left during the session. While this presents challenges for analysis, as the findings cannot be attributed to all participants, it was considered that it was important for participants to be able to withdraw in order to create a trauma-informed environment. Thus, the instability of the focus groups is considered a limitation rather than a methodological error.

Analysis

Data collected during interviews and focus groups reflect the thoughts, experiences, and opinions of participants. Some experiences and opinions conflict with one another, and this was reflected in analysis as far as possible. The contents of responses, however, have not been checked for factual accuracy.

Analysis was undertaken by staff with experience of qualitative research, one of whom had previously undertaken framework analysis. These staff do not specialise in MCN or any of the constituent needs, so while offering a certain degree of objectivity as far as that is possible to achieve in the context of qualitative research, this lack of expertise posed some challenges for interpreting the data. This was mitigated by consulting colleagues when questions arose, and taking the findings to the MCN board for comment.

Results

As described within Methods, the qualitative arm of the needs assessment sought to describe the experiences and perspectives of stakeholders in East Sussex with either lived or professional experience of MCN.

Qualitative data collected from all strands of engagement was subsequently analysed using the Framework method (see Methods section for further detail). Through this approach, 13 overarching thematic areas were identified, with these comprising 61 distinct yet interrelated sub-themes. Where appropriate, some of these sub-themes have been combined, with all final themes presented within Figure 1. Figure 1 illustrates how emerging themes group together, the relationships between themes, and how

these are associated with access to and engagement with services and support for individuals with MCN. In summary, thematic areas describe:

- The characteristics, behaviours and experiences of MCN individuals (Light Pink Boxes and Dark Pink Box) which would be pertinent to the design, development and delivery of services and support for individuals with MCN (Yellow Boxes).

- The key components of service design and delivery approaches (Yellow Boxes) which would maximise access to and engagement with (Light Green Boxes) services and support for individuals with MCN, and which would ultimately influence outcomes and whether needs are met for this cohort at a population level (Purple Boxes).

- Those components of service design or delivery approaches which would positively impact on the ability of both professionals and individuals with MCN to navigate services and support within the local system (Grey Box/Yellow Boxes within Orange Border).

- The workforce development and support needs (Teal Boxes) of frontline professionals which would help facilitate the effective delivery of one or more components of an ideal service for MCN individuals (Yellow Boxes).

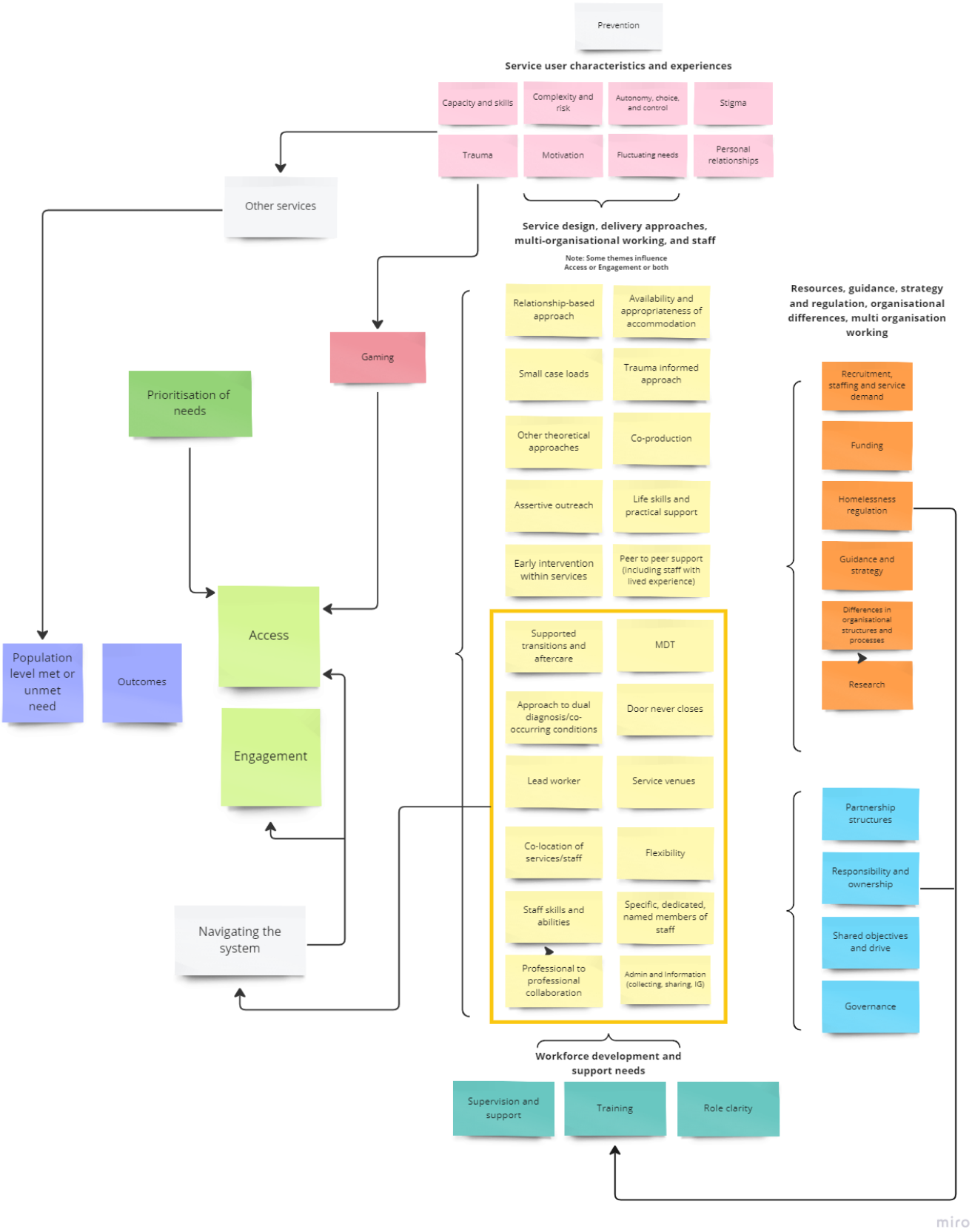
- The broader contextual factors (Orange and Blue Boxes) which may enable or inhibit either the delivery of one or more components of an ideal service for MCN individuals (Yellow Boxes) or opportunities for staff workforce development and support (Teal Boxes).

- Other services which play an important role in determining whether the needs of MCN individuals are met at a population level (Grey Box); and

- the differences in how professionals and individuals with MCN may prioritise their needs (Dark Green Box) and how these differences might impact on access to and engagement with services and support (Light Green Boxes).

The remainder of this section describes each thematic area in more detail, highlighting how sub-themes are often interlinked, and outlines commonalities and differences between the different audiences interviewed. Please note where the term ‘participants’ is used, this refers to both professionals and individuals with lived experience.

Figure 1: Identified themes from qualitative engagement with strategic professionals, frontline professionals, and individuals with lived experience of MCN



Characteristics, behaviours and experiences of MCN individuals (Pink Boxes)

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. These characteristics and behaviours have been summarised under eight sub-themes:

Trauma

Individuals with MCN will almost always have a significant history of trauma: Whilst in many situations, trauma was viewed to stem from experiences during childhood; other examples described by participants included abusive relationships (including coercive control and psychological abuse), being trapped in unsafe living conditions, having significant personal items stolen, being lied to, and experiencing suicidal thoughts. Participants described how the experience of accessing services could be traumatic for individuals with MCN, with this being as a direct result of stigma, bullying, or individuals having to repeatedly tell their story. Specific examples of traumatic service use highlighted by individuals with lived experience included engaging with children's social care as well as the family court system. Participants described how trauma can often lead to distrust in services, negative behaviours (such as displaying anger or abuse towards staff), and challenges in accessing and engaging with support (for example MCN individuals often expect to be rejected by services). It was highlighted by one professional how individuals experiencing trauma can often self-medicate with substances, and alongside other needs, this could increase risk of re-offending. As a result of trauma experienced, participants described how MCN individuals could sometimes 'put on a front' or persona, play down their needs and experiences, or lie to protect themselves and their loved ones. Given the trauma experienced by this cohort, professionals reflected that it may take time for individuals with MCN to feel comfortable talking about their past and that service performance measures often did not recognise or reflect this. Participants emphasised how services which support the MCN population should be mindful of trauma, including how it can manifest, and provide a more human response.

"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". I just think that's a horrible place we've got to that people can't bring themselves to be honest because they know next week they're going to have to tell somebody new and every system we refer into asks the same questions" (Strategic professional).

*"I keep thinking I'm a problem person."(*Focus group with people with lived experience, paraphrased*)*

Stigma

Individuals with MCN face stigma and discrimination across services, which subsequently inhibits access to, and engagement with, support: Individuals with lived experience described feeling the effects of prejudice by organisations within East Sussex, including NHS services (such as clinical and administrative staff reportedly inappropriately attributing physical health issues to drug use), voluntary services (such as CGL's service for people with substance misuse needs in hospital), the police, supported accommodation providers, and social services. Some individuals with lived experience also fed back that CGL could be doing more to destigmatise addiction by making service venues more publicly visible to minimise any shame associated with attending. 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. Some professionals reflected how certain settings, for example GP practices, could be stigmatising by preferring not to offer support to people with MCN within their premises (specifically people with substance misuse needs), or welcome services for people with substance misuse issues in town centre venues. It was also described by some professionals how antisocial behaviour in Hastings town centre was often unfairly attributed to CGL service users, making this a politically sensitive issue. Finally, stigma was regarded by some professionals to result in services withdrawing support or choosing to focus on less complex clients. This was regarded to affect the highest risk MCN individuals the most.

"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)

Complexity and risk

There is a negative cyclical relationship between the number and interaction of people's needs, and the capacity for services to successfully support people with MCN: Professionals described how the nature of MCN often resulted in affected individuals having combinations of needs which conferred complexity, raised levels of risk, and resulted in individuals with MCN being in crisis. It was also noted however, that personal risk was not always well-understood or respected MCN clients. Professionals reflected how MCN was rooted in trauma and that coping mechanisms for trauma could be destructive, such as self-medicating with substances. Care leavers and women with

MCN were regarded as particularly complex groups. Professionals described how, inherently, needs snowball, and can have a compounding effect. 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. Participants reported that amongst the MCN population there were significant undiagnosed needs around mental health, learning disability, and neurodivergence; given that the cohort is comparatively transient, this could place additional obstacles between individuals and services. Complexity and risk were also described by professionals as having knock-on effects on physical health, for example via increased risk of blood-borne viruses or the adverse effects of smoking.

Complexity was also regarded by professionals to affect access and engagement and act as a "ceiling" for might be what is realistically achievable. For example, individuals with MCN may simultaneously not have the skills to maintain a tenancy, be more likely to lose mobile phones (and be difficult to contact), display antisocial behaviour (resulting in them being barred from services), and demonstrate difficulty in complying with processes or managing on waiting lists. Furthermore, it was reported by multiple professionals that 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. The cross-organisational nature of supporting individuals with MCN was also described as uniquely challenging. For example, professionals reflected that individuals accessing one or two services were generally much better supported, with services often reluctant to take on responsibility for individuals with MCN who may need additional services concurrently. Complexity was also regarded as sometimes less visible to mainstream services, especially when an MCN individual was being managed by an additional support service, which could subsequently lead to inaccurate assessments within mainstream support. Finally, individuals with lived experience described how those experiencing addiction issues could receive large sums of money through their universal credit or housing benefit, which could trigger substance misuse behaviours, leading to relapse or overdose.

"I've seen so many people die through a relapse when their PIP is sorted out."(Focus group with people with lived experience, paraphrased)

"So, the first thing is to deal with their housing because it won't be touched by a County Council. There's no private rented out there, there's no options for them, so I'll have to look at what the combination options I could find before you even deal with the substance misuse. You could say to someone, 'You got to become abstinent', but they're

not going to do it all the time they are sleeping on the beach, it's just not going to happen." (Frontline professional)

Fluctuating needs

The needs of individuals with MCN change rapidly and often unpredictably:
Professionals reflected how the needs of individuals with MCN can often change rapidly from a stable to high risk or crisis position, and hence require staff to be ready to respond in a timely way. Given the fluctuating nature of needs, professionals reported that achieving long-term progress with MCN clients could be challenging. 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, you know, as to what's most pressing, we certainly see that whilst people are in temporary accommodation, you know, they might have - mental health - might be the cause of their homelessness, but that might, you know, stabilise once they're in accommodation. But then you know, drug use might go up- or vice versa... Once you're in accommodation, the drinking or drug use goes down because it was a way of coping living on the street, but then the mental health then goes up, so the support from substance misuse services needs to back down but not disappear completely" (Strategic professional)

Motivation

Low motivation, often a result of MCN, is an avoidable barrier to service access:
Professionals highlighted how, due to poor mental health, and other characteristics and experiences (such as complexity and risk, capacity and skills, and trauma), individuals with MCN often only experience brief windows of motivation to initiate contact with services or willingness to engage with support. Motivation was also regarded by one professional to be negatively impacted by MCN clients being repeatedly told that there is not a service to meet their needs, with a lack of mental health services (or specialist mental health knowledge within non-mental health services) being provided as a specific example.

Low motivation was also highlighted by participants as extending to self-advocacy and motivation to take care of oneself. Individuals with lived experience described how the experience of making initial contact with services was difficult when the onus was placed on them to do so, and this was further echoed in comments made by professionals. For example, one professional described how it was unhelpful and outdated to rely on individuals with MCN to have the intrinsic motivation to pro-actively access support (for example, relying on people receiving support for mental health problems to self-refer to substance misuse services) and how professionals should

make consensual referrals (where possible) and use evidence-based approaches to support clients to be ready to engage.

"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)

Capacity and skills

People with MCN have skills gaps: Participants described how individuals with MCN often lack practical life skills around living independently, managing a home and organising their life, including gaining employment. This was regarded by professionals as particularly acute in care leavers and people who are homeless. Due to a lack of organisational and life skills, professionals described how this resulted in individuals with MCN often not attending appointments or engaging with services more broadly, and that this could lead to a substantial use of time and capacity within services to address. 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 (for example maintaining a property's condition, paying rent, or not causing antisocial behaviour). Professionals reflected how, increasingly, the MCN clients they engaged with did not have the capabilities to manage a tenancy safely (for example being at risk of cuckooing) or independently, yet they were not eligible for care and support from adult social care. Participants described how MCN individuals can sometimes lack the skills to prioritise their needs and make safe decisions (also see Prioritisation). Finally, it was highlighted by an individual with lived experience how people with MCN need specific and high-level skills to navigate services (such as representing oneself in court) and that it was unrealistic for people with MCN to have or gain these skills (placing them at a disadvantage).

"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… "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)

Autonomy, choice, and control

Autonomy is important for people with MCN but may manifest in challenging ways: Individuals with lived experience reflected how it was important to be able to maintain autonomy and choice whilst accessing services, particularly as their past experiences or current situations often threatened their individual sense of control. One professional also reflected how MCN individuals' efforts to exercise control may sometimes manifest as unacceptable behaviours (e.g. continuing to smoke in non-smoking properties) and

serve as an act of defiance. Several professionals described the challenges associated with enabling client autonomy, particularly when the choices clients make are regarded as unwise, such as refusing accommodation. Such decisions can also result in difficulties for staff who have a responsibility to support clients to make safe decisions, and therefore required them to weigh up the value of enabling client autonomy against any risk a client's decision might pose.

Personal relationships

Individuals with MCN often lack support networks and safe personal relationships:
Participants reflected how individuals with MCN often have different attitudes towards their personal relationships, depending on the dimensions of their needs. For example, individuals with substance misuse needs emphasised the importance of prioritising recovery over their personal relationships and described how some people in recovery will seek new relationships to avoid being triggered. Whereas for individuals with lived experience of domestic abuse, the importance of reviving old relationships (from which they were isolated by their abuser) was specifically highlighted. Professionals reflected that individuals with MCN tended to have less support from loved ones than people with single needs, and therefore might be more likely to seek support from the MCN community or gravitate towards support networks on the streets. Professionals also reflected how individuals with MCN often have insecure attachment styles, which may cause difficulties in recognising when situations or relationships were unsafe. Finally, participants reflected that individuals with MCN can struggle to build trust with professionals due to repeated negative experiences, often with high-stakes services such as children's social care, for example having children removed.

> *"I am someone that will get up continuously, dust myself off, and keep going because I have another child that needs me to be OK and I do have an amazing family and supportive friends. But some people don't have that. Some people have nobody because they've been isolated for so long. I was just lucky that yes, I was isolated for some time, but my friends were there waiting for me when I was ready to reach out"*
> (Focus group with people with lived experience, paraphrased)

Gaming (Dark Pink Box)

Current systems of support may encourage MCN individuals to lie to gain access to services or support: A theme around 'Gaming' the system was highlighted by a small number of professionals and individuals with lived experience; with this being linked to the characteristics, behaviours and experiences of MCN individuals (Pink Boxes) and service design and delivery approaches (Yellow Boxes). For example, there was acknowledgement amongst individuals with lived experience that some clients may lie to gain access to services or support, but that this scenario only highlighted unmet need and the inappropriate eligibility criteria of some services. 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.

"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. Clearly most of them will actually be in need and in dire circumstances. It doesn't condone lying" (Focus group with people with lived experience, paraphrased).

Prevention (Grey Box)

Given the significant history of trauma experienced by people with MCN, a few professionals highlighted the need for the broader system to intervene earlier and have the right services in place for children and young people to prevent individuals experiencing severe and multiple disadvantage. One professional described how a potential way of achieving this would be for MCN services to work more regularly with children's services (as per the early ambition of the Changing Futures programme) to help identify those children who were most likely to go on to become adults with MCN. MCN services could then intervene to prevent exacerbation of harm/ complexity for such young people. Finally, CGL service users described how they were keen to raise awareness of addiction to support prevention efforts.

"I just see that kind of bad end of it, the working backwards, and I would love if we were doing more work with Children's Services, for example. This was one of the earlier ambitions of Changing Futures. I bet if you spoke to specialist children's services, "Who do you think are going to be our multiple compound needs adults of the future?" They could point to the kids. We ought to be getting in there now with them because they will be bouncing around for years to come and some of them are already very complex. So, yeah, our kind of projections of who will be our multiple compound population. You could probably go into the school and they'll tell you, they'll point at the two kids in the class" (Strategic professional)

Service design and delivery approaches (Yellow Boxes)

Professionals and individuals with lived experience highlighted a range of components associated with service design, delivery approaches, staff, and multi-organisational working, which they regarded as key to maximising access to and engagement with services and support for individuals with MCN. These components were also commonly described in relation to the characteristics, behaviours, and experiences of the MCN population (Pink Boxes). These components have been summarised under twenty-two distinct, but interrelated, sub themes:

Lead worker

Participants highlighted the importance of adopting a lead worker approach and 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. A few professionals also reflected how the adoption of a lead worker approach was optimised when the client was actively involved in the decision as to who their lead worker should be.

Several specialist, grant-funded services which support individuals with MCN were described by professionals as seeking to implement a lead worker approach. For example, within the RSI MDT, a client's lead worker is typically the professional who has the best working relationship with the client, responsible for co-ordinating a shared assessment, working with partners to identify needs and risk, and to develop a client's support plan. However, it was acknowledged that not every client within the RSI MDT had a lead worker due to capacity. As part of the Changing Futures programme, each client also has an allocated caseworker; however, it was noted that whilst caseworkers had certain specialisms, they were often working in a generalist way to support clients. 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. Finally, one professional reflected how 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 commitment was reinforced by other professionals who described a desire to adopt a lead worker approach as part of their service (for example participants described an intention for the Eastbourne Hub to include a lead worker role as part of a 'Team around the Person' approach).

Professionals, however, also outlined several challenges associated with implementing a lead worker approach. For example, one professional commented that, despite some services having a lead worker, these staff sometimes worked within boundaries that did not always best meet the needs of MCN clients (for example only being able to co-ordinate support to a certain point in a client's recovery or lead on a specific aspect of their support). One professional described how it was sometimes difficult to determine who a client's lead worker should be when MCN individuals were accessing multiple services (and particularly when services were not communicating with one another), and that services needed to demonstrate more trust in other providers (such as VCSE) to adopt the lead worker role. Multi-agency initiatives were also described as resulting in MCN individuals having multiple staff working with them concurrently and it was felt that this could negatively impact client engagement. Finally, one professional reflected that the concept of the lead worker role was challenging as services were not necessarily trained to be aware of, or understand, the wider partnership of services.

"That's another thing that I think is essential criteria for anyone with these conditions, experiencing life in this way, is that they do need a lead professional. 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)

MDT

Professionals highlighted the importance of working as a multi-disciplinary team when supporting individuals with MCN. Specifically, an MDT approach was viewed as providing high-risk MCN individuals with an access point to services which mainstream services were less able to offer, as well as a mechanism to more easily identify and agree a lead worker and co-produce a client's support plan. 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 (or less able to access mainstream services) are supported under an MDT, with this MDT made up of professionals with specialisms who meet weekly to discuss a small caseload of clients. The MDT functions as a 'one stop shop' at venues, building rapport with rough sleepers, undertaking assessments, and providing access to key services (either directly via the MDT or as a bridge into mainstream services). As part of the Changing Futures programme, staff also come together as an MDT, with frontline professionals positively describing working together as team to support client's needs. Additionally, within CGL, weekly clinical meetings are held to discuss specific cases, with relevant partners invited to participate. Finally, the Multi-Agency Risk Management (MARM) model was described as an example of a well-functioning MDT.

"I think that's where that MARM kind of model comes in, where you all sit down and discuss these kind of really complex multiple compound need cases and come up with a partnership approach where no one just goes "not my problem" and opts out or says that person doesn't engage with me, so I'm no longer involved in the conversation. It's like, no, actually you need to be involved in the conversation. You need to help guide us for how we can work with this person so they stop being society's problem if that makes any sense" (Strategic professional)

Professionals however also described several challenges associated with the delivery of an MDT approach. For example, some frontline professionals reflected that, despite implementing an MDT model, they often worked alone and could feel isolated. 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. Finally, the impact of having bespoke MDTs within specialist, grant-funded MCN services was questioned. One professional described how the RSI MDT was able to provide initial support to clients, but that at some stage ongoing support would need to be picked up by

mainstream services. However, the MDT had subsequently experienced challenges in accessing support for clients within mainstream services, resulting in them either having to walk away from clients or try to hold them within the MDT, impacting capacity. 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.

Small case loads

Professionals highlighted the importance of services having the necessary time to effectively work with individuals with MCN, with smaller caseloads providing a mechanism for achieving this. It was recognised that due to the characteristics, behaviours and experiences (Pink Boxes) of the cohort, MCN individuals were often more challenging to engage with. Smaller caseloads were therefore described by professionals as enabling staff to dedicate more time to build rapport and develop effective relationships, as well as deliver high-quality, intensive support.

A small range of services which support individuals with MCN were described by professionals as utilising small caseloads; these included the Changing Futures programme (which accepts maximum ten clients per worker) and the RSI MDT (which was described as typically having smaller caseloads than the standard caseloads for their respective mainstream services). Project workers within the Off the Street Offer (OTSO), were additionally highlighted as being able to hold smaller caseloads. Participants however described several key challenges in enabling the delivery of smaller caseloads; this included resource challenges, such as requiring more staff, as well as negative impacts on service demand and wait times. Variation in caseload size across different services was also highlighted, with an individual with lived experience specifically describing how social services did not have enough time for each client due to large caseloads.

"I think that caseloads need to be low. I think that's something that's come out quite strongly in our delivery is there's a real, it's a really tricky one, because you know you've got to balance and be able to meet the need. 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)

Peer to peer support (including staff with lived experience)

Participants described the beneficial impacts of utilising peer-to-peer support (including staff with lived experience) when supporting individuals with MCN. For example, professionals reflected how such support is valued by clients as peer support workers have been in a similar position to clients and so are better able to empathise, understand, instil hope, and relate in a way that other staff cannot. This was echoed by individuals with lived experience who described having peer-to-peer support as

comforting, especially during recovery. Participants also described the beneficial impact of peer-to-peer support on relationships. For example, 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. Peer support workers were also considered as being more able to challenge a client's behaviour without coming across as judgemental. Professionals reflected how the inclusion of peer support was often welcomed by other staff as it could help put clients at ease and enable dedicated focus on supporting a client into meaningful activity, rather than on performance measures. Finally, becoming a peer support worker was highlighted by individuals with lived experience as being particularly rewarding for the lived experience peer and helpful to their own recovery by keeping them occupied and in touch with services.

A small number of services which support individuals with MCN were described as using peer to peer support. For example, peer navigators within the Changing Futures programme work in a holistic way to support clients to engage and ensure that the team working with the client are kept up to date. 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. CGL was also highlighted as an example of offering peer support, such as through its recovery groups which are staffed and attended by people with lived experience.

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. For example, the RSI was described as not having a peer support component and thus lacking dedicated staff to focus purely on building relationships, providing emotional support and encouraging engagement with services. Individuals with lived experience also reflected how peer to peer support could sometimes be upsetting, for example hearing how others have experienced similar negative situations. Finally, where services did not have peer support provision, it was strongly felt by one lived experience individual that staff (specifically social workers and the police) would benefit from training delivered by individuals with lived experience to help improve their understanding of trauma, and how such situations and behaviours manifest in real life.

''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).

Life skills and practical support

Participants routinely highlighted the importance of offering practical support to individuals with MCN, enabling them to develop life skills crucial to achieving their goals and reducing relapse. For example, individuals with lived experience reflected how clients may need to rebuild their lives, having often lost their job, savings, and

relationships. Services were viewed as playing a key role in supporting clients to positively reintegrate within society and to take up opportunities. Participants also stressed the importance of MCN individuals avoiding boredom and staying occupied during treatment (especially at weekends), and that hobbies were important in rebuilding lives and developing a sense of self. Finally, professionals reflected that individuals with MCN often have limited experience of managing or maintaining a home. Providing practical support to clients in self-contained accommodation was therefore regarded as important in enabling clients to be able to maintain their accommodation and could help to facilitate engagement with other services and support.

A range of services which support individuals with MCN were described as offering practical and life skills support. For example, within the East Sussex Floating Support Service, support includes practical assistance to enable people to maintain their current accommodation, such as providing adaptations, and offering benefits and legal advice. CGL was also described as providing practical and psychosocial support in the community through activities such as low-level employment support, volunteering, cooking, and days out; whilst the refuge service was described as providing support with basic life skills, such as ensuring that clients have washed and eaten. Finally, one professional reflected how Changing Futures' clients often appreciated the practical help they received, such as support to obtain a housing or mental health appointment, or support with completing paperwork.

However, the provision of practical and life skills support for individuals with MCN is not without its challenges. Professionals questioned whether helping clients with practical tasks was really enabling clients to be able to live independently and whether this was inevitably creating dependency and unrealistic expectations. 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. Individuals with lived experience suggested that services could helpfully provide more support with life skills, such as how to successfully obtain education and employment, with one professional describing how providing MCN clients with access to a personal budget could help enable them to take up hobbies, as well as develop money management skills.

> *"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).

Assertive outreach

Participants highlighted the importance of adopting outreach approaches when supporting individuals with MCN. For example, assertive outreach was viewed as improving access and engagement with services by directly going to, or being where, individuals with MCN are and not expecting them to come to services. Specifically, individuals with lived experience described how it was beneficial to be able to access

other services (primary care, podiatry, dentistry) at VCSE organisations. Outreach approaches were regarded by professionals as not only helping to identify individuals with MCN, but also useful in building relationships and supporting individuals to be ready to engage with services (as they may not be ready to engage upon initial invitation). Finally, professionals reflected that the benefits of assertive outreach were not only experienced by the service providing the outreach, but also by partner organisations as outreach could support individuals to engage in broader services and support.

A wide range of services which support individuals with MCN were described by professionals as adopting outreach approaches. For example, assertive outreach is embedded within the Changing Futures programme, with this regarded by staff as essential to helping individuals with MCN. An outreach service (provided by Southdown Housing Association) also forms a key part of the RSI, with outreach seeking to identify rough sleepers and connect high-risk clients into support (either within the RSI MDT or via mainstream services). Staff with an RSI caseload work together to identify which relevant professionals are required to outreach to clients and they encourage services to engage with clients, rather than the other way around. Staff with an RSI caseload adopt outreach approaches via engagement on the streets, at partner organisations such as VCSE providers, or in informal venues, such as cafés. CGL was also described as adopting an outreach approach by taking services to places where MCN individuals may already reside, such as Seaview, as well as working from venues such as community centres and static hubs which are deemed to optimise access due to their location and accessibility. Finally, within the East Sussex Floating Support Service, staff can meet with clients within their own accommodation or out in the community.

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. One professional described experiencing variation in the outreach support received across different geographical areas, resulting in an inequitable service offer for their clients, with another highlighting how the COVID-19 pandemic provided a good barometer for how assertive outreach could look. Finally, individuals with lived experience reflected the need for staged outreach to support people through different parts of their recovery.

“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)

"The doctor at the Sally Army is great, he's been marvellous for so many people." (Focus group with people with lived experience, paraphrased).

Door never closes

Participants highlighted the importance of a 'door never closes' approach when supporting individuals with MCN, which helps to ensure that support is available to clients when they are ready to engage. Professionals recognised that the needs of MCN individuals were likely to fluctuate, and hence enabling clients to be able to re-access support in a timely way was key.

A wide range of services (including Changing Futures, RSI, CGL, East Sussex Recovery Alliance) which support individuals with MCN were described by participants as having a 'door never closes' approach whereby clients can access services when ready, despite rejecting initial service invitations, and can easily re-access services as required, for example following dis-engagement. Open-access facilities such as the CGL recovery café and drop-in sessions were also regarded as making it easier for clients who have previously accessed support to access support again. However, one professional reflected that some services could benefit from being more flexible with regards to this specific approach. Finally, the challenges of implementing a 'door never closes' approach were described; these included how it could be difficult for services to 'hold' individuals on their caseload whilst not actively working with them, and pressure to close cases so that staff can address waiting lists.

"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)

Supported transitions and aftercare

Participants highlighted the importance of supporting individuals with MCN during transitions and providing after-care support. 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.

A range of services which support individuals with MCN were described by professionals as offering support during key transitions. One specific example of this was the Changing Futures programme, which was viewed as able to effectively provide support during transitions due to the length of time staff can work with clients. Other examples included the RSI, where clients are specifically supported to move into more stable accommodation units progressively, for example from rough sleeping into temporary accommodation and then into the Rough Sleeper Accommodation Program. As needs stabilise and clients progress through the pathway, support is stepped down and the client is transitioned into mainstream support. Some RSI clients were also described as being supported to transition into the Changing Futures programme to receive broader support. In addition, CGL were described as having a range of specific roles, such as hospital liaison nurses and criminal justice workers, and pathways to support transitions between services and ensure continuity of care. This included supported transitions related to employment, volunteering and peer mentoring. One professional also highlighted how there was an increasing level of wrap-around support available to probation clients, with the Early Discharge Scheme described as performing well by another.

"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)

Despite the positive examples described, participants also outlined a range of challenges and current limitations associated with supporting transitions and providing aftercare support. For example, professionals described how MCN individuals often fell through the gap of 'needing services but not being able to access them' and felt that more work was needed to support individuals with MCN to be ready to engage and transition to services. A need to strengthen links with hospitals, for example around discharge planning, and the criminal justice system (probation) was also emphasised to help disrupt cycles of behaviour, such as being released from prison without housing, reoffending whilst on the streets, and then being sent back to prison. Participants also reflected that whilst the transition of MCN clients from specialist, grant-funded services to mainstream services was a key point in an individual's care, current approaches were viewed as a cliff edge, namely a transition from one-to-one, timely, intensive support to more sporadic appointments, long waiting times and group interventions that could negatively impact ongoing engagement. Difficulty in transitioning clients into mainstream services was also highlighted by the RSI, who found that mainstream services often wrongly assumed that they could support clients within the RSI MDT on a long-term basis. With regards to housing, the importance of supporting client's to successfully transition to 'unsupported accommodation', such as the private rented sector was noted.

Whilst it was acknowledged by individuals with lived experience that not all service users will take advantage of peer support groups, they described a current gap in provision around formal post-recovery support to help individuals integrate or reintegrate into society, with re-entering education, employment or volunteering described as challenging transitions. Individuals with lived experience also described needing more help with planning to move on from supported accommodation, with one participant describing the sudden cessation of housing benefit when they entered work, and being charged with backdated rent, as disincentivising their progression. Finally, one individual with lived experience reported that they had not received aftercare after their engagement with services (the police, family courts, and social workers) and strongly felt this was a significant gap, with family relationships suffering as a result.

Relationship-based approach

Participants highlighted the importance of adopting a relationship-based approach when seeking to support individuals with MCN. For example, 'effective relationships' were described by professionals as key to providing a psychologically-informed environment, and this included listening to clients and treating 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.

Adopting a relationship-based approach was described by professionals as helping clients to feel more comfortable in sharing their personal experiences, namely telling the truth, which supported staff to better understand them and how best to support them. It was also described as helping to build trust, which may have a positive impact on a client's subsequent behaviours, for example building trust so that when a client receives accommodation, it is a trust they do not want to break intentionally. Additional benefits of developing a positive relationship with clients, described by professionals, included it being easier to challenge a client gently, or call out their behaviour, and being able to better manage client expectations through honest and transparent conversations. Building positive relationships with clients was importantly seen as key to reducing disengagement in services, for example via listening to what clients want before determining support, and was deemed particularly helpful in supporting initial engagement with services and preparing individuals to be ready to access wider support.

A range of services which support individuals with MCN were described as using a relationship-based approach. For example, as part of the Changing Futures programme, staff have frequent touch points with clients, with the use of an 'equals card' within the service (namely a card used to spend on small purchases for clients) regarded by frontline professionals as a good leveller between staff and clients, helping to develop trusting relationships. The refuge service was also described as adopting an honest

approach to working with clients which was viewed as positively impacting on staff-client relationships. Within the RSI, intensive case-working is used to build a rapport with clients, with outreach staff building relationships with clients to support them to be ready to access support. Finally, individuals with lived experience described positive experiences of relationship-building with staff and services. For example, one individual described how their Independent Domestic Violence Advocate (IDVA) listened to them and showed they cared, helping them to feel understood and to trust their worker.

[re: IDVA] "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).

Despite the benefits, professionals highlighted a range of challenges associated with adopting a relationship-based approach. For example, continuity of worker was viewed as key to enabling positive relationships, however one professional suggested that Changing Futures had struggled to provide continuity due to recruitment issues. It was also acknowledged that building relationships can take time, and that therefore some services may be more conducive to relationship-building than others. For example, the Changing Futures support offer was described as longer than the RSI support offer and hence allowed for the development of more long-term relationships with clients. Frontline professionals also highlighted how a relationship-based approach could create a risk of co-dependency (also see Life skills and practical help), which needed to be managed given that support was not ongoing. Finally, 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. For example, several described being unable to trust professionals, with trust often lost when services did not commit to what they said they would do. Some reported that they had been lied to or about by police and social services, had had their trust abused (for example children's social care involvement after asking for support with addiction), or had experienced bullying and harassment by staff (for example within supported accommodation). Individuals with lived experience also reflected how social care services tended to adopt a 'tick-box' approach rather than one focused on developing relationships. One individual with lived experience also described negative experiences of engaging with the police, social services and family courts, commenting how their social worker had lacked empathy, compassion, and understanding about domestic abuse, and that they broke trust by not attending arranged meetings and basing a report solely on the client's abuser's testimony.

"It's like I was continuously silenced and continuously just not listened to, not believed that that was a huge thing for me when all I did was tell the truth and it just. I just felt like

there wasn't a justice system, that it was just they… they didn't like what I was saying."
(Focus group with people with lived experience, paraphrased).

Trauma-informed approach

Several professionals highlighted the significance of using a trauma-informed approach when seeking to support individuals with MCN and in understanding patterns of service engagement. For example, 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. Several professionals reflected how services were becoming increasingly more trauma- informed and that there had been improvements in understanding at both a strategic (commissioning) and provider (frontline staff) level. Some professionals commented how staff were accessing trauma informed training, with some speaking positively about the training being delivered. A wide range of services which support individuals with MCN, including BHT Sussex, CGL, and ESTAR, were described as using a trauma-informed approach or working in a psychologically-informed way. For example, frontline professionals within the Changing Futures programme described providing corrective emotional experiences for clients. Furthermore, within the Eastbourne Hub, the co-location of staff was also positively viewed to support the adoption of a trauma-informed approach by ensuring that individuals only had to tell their story once. Finally, individuals with lived experience highlighted a range of services, including women's groups, and described how these had recognised the trauma experienced by women.

Despite the adoption of trauma-informed approaches, many professionals reported that the approach was not universally adopted, with some describing staff as resistant to change. Professionals reflected how individuals with MCN were still repeatedly being asked to tell their personal story by multiple providers and how, in their opinion, some service environments were not psychologically informed, for example the booths and screens at the Eastbourne Hub were described by one professional as like a prison visiting centre. A need to better acknowledge the trauma that individuals have experienced when considering legislative frameworks, such as whether someone has made themselves intentionally homeless, was also highlighted. Individuals with lived experience described how some accommodation and service venues, or staff behaviours at such settings, were triggering or made clients feel unsafe or misunderstood. Specifically, there was a common theme of people dealing drugs in supported accommodation and triggering other residents, leading for calls by individuals with lived experience for services to provide 'sober housing'. Individuals with lived experience also reflected that some services could do more to remove stigma and not attribute blame to service users for developing their substance misuse needs, with one individual specifically describing how social workers and the police should take a

more trauma-informed approach which acknowledges the effects of abuse, particularly psychological abuse, on victims and family members.

Finally, frontline professionals reflected that although services helped clients to manage the impact of trauma they have experienced on their day-to-day life by soothing trauma at a surface level and not triggering it, they were often not designed or appropriately staffed to remove or address underlying trauma. This meant that clients' needs inevitably fluctuated, and it could therefore be hard to engage them in services.

"Yes, we're trauma-informed, and we come from a trauma-informed place and we're dealing with clients with a massive amount of trauma but it does feel sometimes that we're just simply putting a band aid on that. So you've got, you know, traumatic and the client have a real traumatic past. Our role isn't to trigger that. But actually, who's dealing with that?Because that is just going to keep resurfacing, resurfacing and resurfacing and so I personally feel that it's, you know, fundamentally everyone just kind of like just skirts around, you know, the core wounds of these clients" (Frontline professional)

Co-production

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 wants 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'.

The adoption of co-production approaches was described by a small number of participants. For example, within the East Sussex Floating Support Service, staff utilise client knowledge and experience to develop a support plan that is meaningful and achievable. The Eastbourne Hub enables clients, where appropriate, to particate in casework meetings. CGL service users also described being supported by staff to achieve outcomes that were specific to them, such as rehab, detox, sobriety, and accessing support for health issues. The need to ensure that clients are provided with enough information to make informed choices, if they have capacity, was highlighted by one professional, whilst another reflected how co-production may require negotiation to ensure that what is regarded as important to the service is also incorporated within a client's support plan, for example to manage risks. Finally, the need for services to undertake co-production with other services around a client's support plan was mentioned.

"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)

Co-location of services and staff

Participants described a range of benefits associated with the co-location of services and staff when supporting individuals with MCN. For example, 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.

A range of services which support individuals with MCN were described as using a co-location approach. For example, the co-location of staff at the Eastbourne Hub provided opportunity for staff to undertake their respective roles, but within a designated shared space which facilitates joint working. CGL was also described by several professionals as being co-located with other services and delivering support from other service locations, such as the hepatology teams in hospital, GPs, Seaview drop-in, probation, refuge service, and housing options teams. This was echoed by CGL service users who highlighted how CGL hospital liaison staff visiting patients at the Conquest hospital with drug and alcohol problems had facilitated a better understanding of addiction within physical health services. One professional highlighted how staff within the RSI sometimes based themselves out of other organisations such as VCSE providers, acting as a one-stop-shop to provide services opportunistically. Individuals with lived experience also spoke positively about clinical services being co-located within VCSE organisations, such as the Salvation Army, and how they valued such accessibility. As part of the Changing Futures programme, frontline professionals highlighted the benefits of their registered nurse being employed by the mental health trust and how this could support referrals for mainstream mental health support. The location of the Changing Futures programme within adult social care was also specifically regarded by one professional as providing a strong foundation for any statutory work needed for clients, enabling risk and safeguarding to be managed effectively. However, it was the view of another that the programme had been slow to get off the ground because of its location within adult social care, and because the management infrastructure had not been ready.

"The hub is equally about the opportunity for these agencies to co-locate, as it is for clients to come and see somebody face-to-face. Because we just whole heartedly believe that the opportunity to actually sit next to members of staff from other agencies just to do your regular job, nobody doing a different job, just do regular job, but have somewhere to sit co-located cuts out the middle man, builds on those working relationships, makes for better practice, better joint working, leads to joint assessment." (Strategic professional)

"Since having the co-located link workers, it's really beneficial. So, we've got one from SPFT and one from 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)

Whilst many professionals described how MCN clients benefit from accessing the support they need from multiple services via a single location, it was also noted that not all services provided co-located support.

Approach to dual diagnosis and co-occurring conditions

A small number of services were described as having a specific approach to supporting individuals with co-occurring conditions, with some professionals highlighting that there was strategic will across the system to improve this area of support specifically. For example, acrossthe SPFT, there a dual diagnosis Practitioner and a Strategic Lead who support staff within mental health services and partner organisations to feel better equipped to care for people with co-occurring substance misuse and mental health needs. As part of a dual diagnosis strategy and protocol, staff model best practice, deliver training, undertake joint reviews and assessments, offer advice and improve joint work between services, including via a Co-occurring Conditions Forum. CGL also have a named co-occurring conditions worker, with weekly meetings between SPFT and CGL taking place to share information and discuss cases. Frontline professionals commented how staff can use locally developed protocols as leverage to support clients to access care.

Some CGL service users reflected how mental health services had supported clients well and that they had demonstrated a good understanding of the association between addiction and mental health; however, others reported exclusion from mental health services until addiction issues had been addressed and highlighted a lack of an interim service to support individuals with co-occurring conditions during recovery.

A few professionals commented that, whilst improving, the system was not yet effectively established to support people with co-occurring conditions consistently, and that local protocols were not always working well in practice. It was also considered by one professional that operationally it would take time for mental health staff to be willing to work with people with substance misuse issues. Professionals reflected how those with co-occurring mental health and substance misuse needs often experienced a 'chicken and egg scenario' whereby they were unable to access support from one service without addressing the other need. As a result, many individuals were routinely turned down for mental health support due to their substance misuse and remained 'stuck' within the system. One professional also described how some clients would never be stable enough for mental health assessment, yet accessing mental health support in a timely way was critical. Overall, professionals highlighted a need for mental

health and substance misuse services to work more collaboratively together to tackle both needs co-currently and to adopt a more holistic approach.

"I also had that where my mental health wasn't dealt with until I'm sober. They say you can't make an accurate diagnosis until you're sober, maybe there should be a halfway in between… I wanted talking therapy; the talking therapy would have been good." (Focus group with people with lived experience, paraphrased).

Availability and appropriateness of accommodation

Several professionals highlighted the importance of individuals with MCN needing stable accommodation to effectively engage in services and support, with a lack of suitable, affordable accommodation regarded by some as the main reason why the needs of individuals with MCN remained largely unmet (also see Prioritisation of needs). A lack of suitable accommodation was also described as having the potential to negatively impact on other needs experienced by MCN clients. 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 small number of professionals described how they currently support individuals with MCN to access accommodation. For example, as part of the RSI, there are a range of accommodation options for different stages in a clients' journey out of rough sleeping, with the best results experienced when clients can live in stable, secure accommodation through the Rough Sleeper or Next Steps Accommodation programme (RSAP/NSAP). There is also specialist accommodation in the county for higher risk clients, for example with 24-hour staffing, night security, and daytime on-site coordination. Finally, within the RSI, funds may be used to support clients to access housing from the private rented sector, for example by funding deposits, providing rent in advance, or incentivising landlords. The probation service was also described as having access to Community Accommodation Service (CAS) accommodation and Accommodation for Ex-Offenders (AfEO) funding to help provide accommodation to ex-offenders. Finally, '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.

A lack of suitable and affordable accommodation was commonly described by professionals. For example, one professional reflected that there was insufficient statutory accommodation to meet the homelessness need, with this being the result of an unregulated private rented sector and those on low incomes being unable to access private rented accommodation. 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. The immediate relief off-the-street accommodation for those who have not yet had a housing options assessment was also described as insufficient, comprising 13 beds across the county. Given that MCN individuals who are more likely to benefit from supported housing are also likely to require this accommodation longer term, a specific need for additional supported accommodation was highlighted by some professionals. Certain categories of individuals with MCN were also described as particularly challenging to accommodate safely. For example, sex offenders, those with arson offences, and those who misuse substances which are not managed routinely in statutory pathways. This was because accommodation facilities are often shared and hence placing high risk clients within these settings could put other residents at risk. Whilst the availability of housing was described as a universal challenge and not specific to individuals with MCN, professionals reflected how MCN clients could be disproportionately affected, for example as social housing and housing associations may be less likely to take on individuals with MCN due to perceptions that this cohort can be problematic and less likely to pay their rent (also see Stigma). The provision of housing for MCN individuals on a Housing First basis (also see Other theoretical approaches) was particularly advocated for by a few professionals.

Finally, participants highlighted how certain types of accommodation, such as communal accommodation, like hostels, may not be the best environment for MCN individuals, especially when individuals are in different or competing stages of recovery. For example, CGL service users reported how living in supported accommodation alongside dealers and people using drugs had triggered their substance misuse and that there was a need for 'sober' accommodation (also see Trauma-informed approach). Others reported feeling unsafe in their accommodation and that elements of quality such as homes being furnished, of a decent standard, and sufficient in size could be an issue.

> *"Some of the conversations we've had at the multiple compound needs board have been about making that clear, not trying to force county's or health's hand or whatever, but just being really clear, we can't operate a rough sleeper service that doesn't have enough access to housing, that doesn't work, so we're gonna have to prioritize that"*
> (Strategic professional)

Admin and Information (collecting, sharing and information governance)

Given their experience of trauma, the way in which MCN clients' information is collected, shared, and used was regarded by professionals as extremely important in preventing individuals from becoming re-traumatised. The appropriate collection and

sharing of MCN client information was reported as not only important 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. The collection of lived experience perspectives was also described as key to better understanding need and the effectiveness of current services, enabling the system to be more strategic in its response. Professionals from a small range of services described how MCN client information was collected and shared. For example, as part of the RSI, the MDT uses a locally-developed shared assessment tool to collect information about clients across 12 areas of need. Clients are holistically assessed for both needs and risk level, with client information used to identify whether clients have MCN, for planning future service input, and for reporting and governance. The RSI outreach team also seeks consent from clients for information sharing with other services. Within the Changing Futures programme, the development of a shared support plan helps to ensure that workers involved with a particular individual know what each service is doing, and the wider support being accessed. The plan also provides an opportunity to document any other statutory activities that clients might be involved in, such as safeguarding enquiries or mental health act assessments. Peer navigators also play a key role in sharing information between staff, given that situations with clients can constantly change.

Whilst some individuals with lived experience (CGL service users) described positive examples of professionals using information already collected to better understand their history and situation, others described negative instances of information-sharing without consent, and personal health information being leaked to the community. Others also reflected that information was not sufficiently shared within health services and believed that it was often only shared in the interests of the organisation, rather than the client. CGL service users outlined how information could be used better, such as linking information to support people into employment, and highlighted a need for improved data collection about homelessness to ensure that only truly homeless people were using services.

Professionals described several key challenges associated with the collection and sharing of MCN client information. For example, professionals commented how it could be particularly challenging to maintain effective information sharing when multiple workers were involved in a client's case, resulting in different workers having different levels of awareness, clients being asked the same questions multiple times, and clients not receiving the most effective support. Specifically, one specialist MCN service reported challenges in receiving communication back from mainstream services they had contacted. The sharing of information was also described as easier to achieve at a strategic level, with it being challenging to ensure that information is filtered down to frontline staff. 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.

"My colleagues in the prison service tell me that they have recorded at least 25% of the prison population are care experienced, and yet in Probation we have recorded only 3% in my area. So we know that almost all those people get released on licence to us, so the big question for me is why didn't that information translate across systems? So that means we have to ask again and then record it again." (Strategic professional)

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. New initiatives were described by one professional as resulting in more paperwork for MCN individuals and staff to complete, and it was recognised that the information collected by services was often self-reported and therefore had some limitations. A few professionals described how it would be beneficial if all services could collect and hold the same datasets. For example, an ideal service would involve whichever service an individual engages with first undertaking the same assessment that they would receive from any other service, with information only being requested once. The client could then be provided with something in writing that they could share with any other service, or their consent gained to share information with other services. Finally, one professional highlighted the importance of ensuring that the sharing of information between services also included information about services, so that staff were aware of eligibility criteria and how to refer.

Staff skills and abilities

Participants highlighted the importance of staff having sufficient knowledge, skills and abilities to effectively support MCN clients. 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. Administrative support was also viewed favourably by one stakeholder in facilitating communication and organising meetings between services.

The skills and abilities of staff working within services which support individuals with MCN were highlighted by participants. For example, housing staff working within Hastings Borough Council were described as flexible, persistent, and committed to not automatically evicting MCN clients into homelessness, with probation staff also described as persistent when trying to access housing for their clients. The skills of CGL

staff were also highlighted by professionals, namely that they are experienced in assessment, recognising risk, prioritising, triage, leadership, and managing challenges. This was echoed by CGL service users who commented that staff were knowledgeable about treatment options. One individual with lived experience also reported how various staff, including an IDVA and NHS talking therapy staff, were well-trained and knowledgeable. Finally, the commissioning team within East Sussex Public Health were regarded as forward-thinking and inquisitive.

Whilst some staff were described as very good at understanding and responding to individuals with MCN; this was not regarded as universal, with participants describing a range of current limitations associated with the skills and abilities of staff. For example, 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. Specifically, frontline professionals within the Changing Futures programme described working to support clients to access housing as the team did not have a housing officer. They also reported a gap in mental health expertise, as the nurse within team is a Registered General Nurse without specific mental health training. Frontline professionals reported that, whilst staff supported clients awaiting mental health support emotionally, there was recognition of the need to not overstep professional competence. Having named, contactable individuals within services, who were experts in their field, was subsequently described as crucial given that individual staff could not be expected to be experts in everything. How services are currently structured was also regarded as preventing staff from utilising their skills and expertise, with frontline professionals from the Changing Futures programme outlining that they did not always feel enabled to make best use of their specialist skills due to being generalist workers.

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). Finally, whilst individuals with lived experience highlighted some of the positive attributes of staff they had encountered, they also described negative experiences. For example, some individuals with lived experience felt that police had limited understanding around addiction, with others reporting that staff in some services (specifically social services, council, police, and family court) were discriminatory, judgemental, held old fashioned views, and displayed a lack empathy and understanding for example around trauma and mental health, and psychological and post-separation abuse. This resulted in service users feeling mistrusted by these services. Others also described how receptionists in services could also be judgemental.

"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)

Specific, dedicated, named members of staff

The inclusion of specific, named individuals within services was described by participants as having the potential to enhance the support provided to individuals with MCN. This included having a named individual within services that other services could directly contact to discuss a client or to seek advice, or the provision of dedicated roles within services that were able to focus on individuals with specific needs. Furthermore, professionals described how the co-location of such staff provided additional benefits, such as enabling multi-agency case work to start quicker due to not needing to navigate pathways or services.

Several services which support individuals with MCN were described by professionals as having specific, dedicated, named members of staff. For example, within CGL, there are dedicated roles (such as hospital liaison nurses, criminal justice workers, hepatology workers and dual diagnosis workers) providing direct liaison with other services and offering support to specific individuals (such prison leavers) or within specific places (such as hospital). CGL also works in partnership with similar roles within other services, for example via a mental health link worker. Within the RSI, the MDT is made up of specialist staff including mental health workers, substance misuse workers, social workers, housing specialists, and health specialists, each with established links to their own mainstream services. Furthermore, as part of the Changing Futures programme, named peer navigators and caseworkers play a pivotal role in ensuring that services are up to date regarding a client's care. Finally, within SPFT, specific dual diagnosis practitioners offer support to the mental health trust and partner organisations to better equip staff to care for people with co-occurring substance misuse and mental health needs.

"Yeah, I think it would be everyone joint working, and everyone kind of knowing a point of contact in each service that they're able to follow up with." (Strategic professional)

"And I think I've kind of touched on as well, like having named people in the organisations that we can go to follow up if... for example, we've had like referrals go in, for one client for example, we had a MARAC and the point was to get the mental health support through ATS, and then we never heard anything, and then it was really hard to try and find someone in that organization that could help us, let us know like where is this referral at. And then we found out, oh, she'd been declined for both levels of support. So, I think it's really useful when you have someone you can just go to, and that knows your agency..." (Strategic professional)

Professionals, however, also described several challenges associated with having dedicated, named members of staff or link workers within services, including resource requirements that could impact sustainability. Some professionals highlighted that, despite having named specialist link workers, there were still gaps, for example a lack of housing specialists dedicated to RSI clients within the MDT. Adult social care was also reported to have a specific post working with MCN individuals adopting assertive outreach; however, one professional expressed concern that this role was due to end. The importance of having a specific triage role to support MCN individuals was highlighted by one professional, with this role being viewed as crucial in ensuring an appropriate level of staffing is involved at each stage of a client's support. CGL service users also reflected that some services , such as health, did not have specific, dedicated staff to support MCN individuals. This resulted in staff sometimes automatically blaming wider issues on a client's substance misuse, as well as services looking to address single issues and discharge clients quickly. The need for courtrooms to have a domestic abuse specialist to be able to help look at cases more holistically was also suggested by one lived experience participant.

Finally, despite an MCN client having a lead worker or named link workers between services, it was also highlighted by some professionals that communication between services could still go awry, and whilst CGL service users viewed the inclusion of dedicated hospital liaison staff for people with addiction as a positive approach, they described some staff as judgemental.

Professional-to-professional collaboration

Collaboration between services and positive working relationships between professionals were described by those interviewed as playing a crucial role in enabling individuals with MCN to access and effectively engage in services and support. Enabling professional collaboration within and between services was viewed as helping to ensure that clients receive appropriate support or treatment, reduce siloed working and duplication of efforts, enable effective problem solving, and to build a collective understanding of service provision. Professionals described numerous examples of collaboration with and between services to support individuals with MCN. These are summarised below, and are associated with several other subthemes.

Changing Futures: As part of the programme, professionals described the development and delivery of a shared support plan, with multiple workers involved at any one time in supporting an individual. The programme also implements a wider multi-agency group which is updated on the progress of a case; namely, all workers involved with an individual have sight of each other and know what everyone is doing.

RSI: As part of the RSI, professionals described collaboration within and beyond the MDT, with the service aiming to create a team around the client which can serve all their identified needs. For target clients, the RSI seeks to engage with all other services a

client might be using, including those not formally partnered with as part of the initiative. Within the RSI, collaboration was viewed as particularly important when a priority risk is identified which required involvement from partners. RSI operates on a basis of inviting professionals onto a case, rather than referring a client out into another service. Professional collaboration was described as working particularly well by the RSI with SPFT and CGL.

CGL: Professionals described CGL as having several roles and pathways which facilitate professional-to-professional collaboration with other services, such as hospital liaison nurses, workers attached to the hepatology team, and dedicated respiratory and criminal justice pathways. Having good links with local providers like Seaview is regarded a strength of the service, with improvements in collaboration with probation and police also achieved over recent years.

SPFT: SPFT described how the dual diagnosis practitioner in Hastings works with staff, including those outside of SPFT, to better equip them to support individuals with co-occurring substance misuse and mental health needs. This included joint assessments and reviews, and improving joint work between services. Regular meetings between SPFT and CGL to discuss cases and share information were provided as an example of strong collaboration, alongside the Co-occurring Conditions Forum, where the dual diagnosis practitioner offer advice.

Eastbourne Hub: The Hub model was described as facilitating professional-to-professional collaboration, relationship-building, and joint working assessments; and reducing duplication. As per the RSI model, services are invited to join a case rather than a referral being made to a partner agency. The service has regular meetings with the RSI to identify rough sleepers who may benefit from Hub support, as well as weekly meetings as part of the OTSO. The Hub has also been involved in setting up a task and finish group to discuss Target Priority Group cases to ensure that services are all in one place to discuss a case.

Refuge Service: The refuge service described how, when receiving referrals, they will always seek to work with those professionals already supporting the client. The service also meets monthly with housing colleagues to discuss cases, and highlighted how professional collaboration works well with housing, probation, children's social care, and CGL.

Multi-Agency Risk Management Group (MARM): The MARM was described as a mechanism to review cases once all local safeguarding processes like the Multi-Agency Risk Assessment Conference (MARAC) had been exhausted. Professionals positively described the coming together of senior professionals and how collective problem solving helped to unlock resource and innovation in support for individuals with MCN.

However, professionals also outlined a range of challenges associated with services working in a collaborative way. For example, whilst there is good commitment at a senior level to work in partnership to support individuals with MCN, professionals reflected how this didn't always filter down to work at the operational level (and that joint working between delivery teams and lines of communication needed to be improved). 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. 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).

A few professionals also described how losing a named contact within a specific service made it more challenging to maintain connections between services. Examples included named contacts for substance misuse, adult social care and mental health services. Several professionals also described how they would like to have stronger collaboration with specific services, namely adult social care, housing and mental health services. The need for greater collaboration and communication between services was also highlighted by some professionals to facilitate better decision making as to which clients would benefit from a more enhanced multi-agency approach, and to help secure housing for people. This finding was echoed by an individual with lived experience who reported poor communication between services involved in their care. Finally, it was noted that professional relationships can sometimes be challenging due to the behaviours of MCN individuals, real and perceived, which can impact on constructive ways of working.

"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).

"I think it's around that proactive approach that, you know, being communicative with wider partners, recognizing risk quickly and sharing that between partners involved in the case, not doing referrals on but inviting people onto the case" (Strategic professional).

Service venues

Participants fed back that the venues or locations from which services operate play a key role in how individuals with MCN might access or engage with support. This not only includes the geographical location of services and the venue environment, such as whether it is psychologically informed, but also the perceptions, beliefs, and views that individuals with MCN might have regarding certain organisations or venues.

Key features of service venues were highlighted by professionals, including the welcoming and relaxing environment of certain service locations. For example, professionals described how those accessing Warming up the Homeless were able to receive a cup of tea and something to eat, which was something that council offices could not easily replicate. The Recovery Café provided by CGL was also described as a more inspirational environment for clients. The importance of neutral venues was also noted by some professionals. For example, within the RSI, the MDT adopts an outreach approach to enable individuals to access support away from local authority service locations that might be viewed negatively. Finally, co-location was also mentioned as an important factor in the accessibility of service venues. For example, several professionals highlighted how the co-location of services as part of the Eastbourne Hub facilitated access to support for individuals with MCN.

[Re: Warming up the Homeless] "It's a nicer place and you know a friendlier place for people to come into than, say, the council offices which, you know, serve a purpose, but you know it's not the same as, you know, somewhere you get a cup of tea and something to eat and more relaxed space, so a lot of the, um, engagement work has taken place in there, and that's been successful." (Strategic professional)

The limitations of some existing service locations were described by participants. For example, the environment of some service venues, like the Eastbourne Hub, were described by some professionals as unsuitable for families or not being psychologically informed (also see Trauma informed). Furthermore, CGL service users highlighted how service venues did not cater for individuals at different stages of recovery and as a result could sometimes be triggering (also see Trauma informed). CGL service users also reflected how several service venues had strict rules regarding access, such as abstinence, or specific or changing opening hours, which resulted in individuals at times having nowhere to go. Access was additionally described as being further compounded by some services shortening their opening hours or closing on additional days. Participants also reflected that night shelters were needed all year round, and not just during the winter.

Professionals described several challenges associated with accessing and using specific service venues, with several professionals describing how the views and perceptions of individuals with MCN could act as a barrier to being able to deliver services from preferred locations (also see Stigma). For example, one professional commented how they wanted to provide their service from within a GP practice; however, the practice had not been supportive of individuals with substance misuse needs accessing their practice. Furthermore, whilst the location of service venues within town centres, like the CGL Recovery café and Warming up the Homeless, were regarded as positive in terms of accessibility, several professionals reflected how this was also a contentious issue, due to the characteristics and behaviours (actual and

perceived) associated with the MCN cohort (also see Stigma). Finally, the costs associated with hiring venues such as Station Plaza surgery was cited as an additional barrier to delivering services from venues that were perceived as more accessible for clients.

Other theoretical approaches

Participants described a range of additional theoretical approaches or principles that were considered important in the provision of support for individuals with MCN. The most reported approaches are summarised below:

Holistic approach: Professionals highlighted the need for services to be holistic in their approach and recognised that the issues and needs of individuals with MCN were not likely to be resolved unless services were able to consider the client as a whole and be able to address needs concurrently. The RSI was described as adopting a holistic, wrap-around approach, considering the person's needs in combination and how they interact, and with the Changing Futures programme also adopting a holistic approach whereby staff seek to address whatever need the client presents with.

'Team around the Person' approach: Like an MDT approach, professionals described the need for individuals with MCN to receive support from a multi-disciplinary team given that no single organisation can provide all elements of support and that a Team around the Person approach is what is often needed to enable individuals with MCN to achieve more independence from services. The RSI was described as operating a 'Team Around the Person' approach within its MDT, with a lead worker co-ordinating other staff to support each client. Changing Futures also supports clients through a multi-disciplinary team, which includes a shared support plan which can have multiple workers involved at one time. The Multi-agency Risk Management group (MARM) was reported by one stakeholder as a good example of utilising a 'Team around the Person' approach, enabling partnership working and facilitating shared responsibility.

Housing First approach: A few professionals described the importance of a Housing First approach for individuals with MCN and outlined how the approach centres on the principle of moving people experiencing homelessness into independent and permanent housing with intensive wrap-around support to help people to sustain their accommodation. Professionals described how this intensive support should be free from conditions, apart from an individual's willingness to sustain a tenancy, with the RSI commenting that they were keen to implement a Housing First approach based on evidence that this promotes engagement with other services.

Other approaches mentioned by professionals included strengths-based, person-centred and solution-focused approaches, behaviour change (including 'Making Every Contact Count', Nudge theory and motivational interviewing), and empowerment. One

professional also referenced Maslow's Hierarchy of Needs and how this related to MCN service provision.

However, professionals also outlined a range of limitations associated with the adoption of these approaches by services supporting individuals with MCN. For example, some professionals reflected than mainstream services were less likely to adopt a holistic approach, instead adopting a deficit-based approach and focussing only on one presenting need at a time. This was regarded as ineffective for individuals with MCN as their needs may need to be addressed in combination to order to enable an individual to progress. Several services were specifically referenced as not set up to work in a holistic way. These included health services, mental health services, probation and adult social care; professionals described how they often worked to treat symptoms, but not cause, and therefore did not look at things in a holistic way or with a long-term solution in mind. It was also suggested that working in a holistic way required services to work with a client over a longer timeframe, for example to work with a client to support them to be stable in their accommodation, as opposed to just accessing accommodation.

"So, people are not seen in the entirety of their experience, they're seen on their kind of one presentation, and the bit that we can do, which is this bit. Even though there's no point doing a mental health intervention, if the person hasn't got anywhere to sleep."
(Strategic professional)

Furthermore, whilst a 'Team around the Person' approach was described as a best practice approach, professionals reflected that for it to be effective, it required all key specialisms and staff to be involved; and for services to work together with genuine shared responsibility for clients. Some professionals reflected that there was limited capacity within the broader system to adopt a 'Team around the Person' approach and that where such approaches were already in existence, capacity issues sometimes limited their effectiveness.

Whilst professionals highlighted the importance of being able to provide housing to MCN clients on a Housing First basis, and being relatively tolerant of tenants violating conditions, they also recognised the legal considerations associated with doing this. It was additionally suggested that the current Housing First contract was perhaps not fulfilling a 'Housing First' approach and that there may be benefits to hold this contract elsewhere within the system, for example as part of Changing Futures programme. Finally, it was described by one professional how the adoption of a 'hierarchy of needs' approach saw services previously focus on addressing physiological and safety needs first, but that now services tended to start from a rehabilitative approach as the ability for services to meet physiological and safety needs was not always an option, for example by providing safe accommodation. It was therefore suggested that any future

focus on commissioning should be on support for the bottom tiers of need, namely physiological and safety needs.

Early Intervention within services

Some professionals described how services which support individuals with MCN often include early intervention approaches to prevent clients from reaching crisis or their risks escalating. For example, through the East Sussex Floating Support Service, staff support people to maintain their current accommodation, via support with benefits or practical support, to help prevent homelessness. Lower-level support around domestic violence, such as healthy relationships work, is provided as part of the refuge service to empower clients not to re-enter abusive relationships. The need to identify and address needs in a timely way was also highlighted by a few professionals, with one commenting that it was important to address physical health needs, such as prescribing thiamine to alcohol-dependent clients at the earliest opportunity. Some professionals commented how certain service models were more conducive to facilitating an early intervention approach; for example, the co-location of staff at the Eastbourne Hub was described as enabling the better identification of needs and ability to intervene at an earlier stage. Finally, one professional described how diminishing investment in early intervention provision across public health and adult social care had, in their opinion, exacerbated the housing crisis.

"So if we're able to kind of catch things an earlier stage and also there's the masking effect of substances as well, people might not notice things at an early stage. So I think that there's a really big need for more physical health screening for this group. And prevention in terms of alcohol related brain damage as well, things like prescribing of a thiamine at the earliest opportunity" (Strategic professional)

Flexibility

Participants highlighted the importance of adopting a flexible approach when supporting individuals with MCN, and that flexibility within services was central to access, engagement and outcomes for the MCN population. 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. Flexibility was described as enabling clients to focus on the needs they would like to meet, with individuals with lived experience commenting that they valued lots of options as part of peer support.

A wide range of services which support individuals with MCN were described by professionals as adopting a flexible approach. For example, as part of the Changing Futures programme, staff described working flexibly by being reactive to clients' fluctuating needs, providing support to clients with needs beyond their specialist area, and using 'equals cards', enabling flexible spending to meet clients' needs. Peer

navigators were also described as working flexibly with clients and supporting specialists to action care plans. The MDT within the RSI was described as operating flexibly through an assertive outreach approach and the flexible use of funding to support people into the private rented sector. Professionals also highlighted how CGL provided flexible access routes and approaches to support, such as via established pathways and an open access offer, namely the Recovery Café. Within the East Sussex Floating Support Service, flexible support was described as providing support to clients within their own accommodation or the community, and via a range of delivery methods. The service was also described as being able to work flexibly with some individuals over a longer timeframe. The flexibility of staff working within the Hastings Housing Team and the refuge service was also highlighted, with the Eastbourne Hub described as operating outside of the restrictions of existing systems and hence being able to be more flexible in its approach.

[Re: being a peer navigator] "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 services, 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 that support could feel a bit 'all or nothing' and not flexible enough to be dialled up or down. Some of these findings were echoed by individuals with lived experience who described the inflexibility of one VCSE venue, with people arriving a few minutes late not able to receive food, and reporting that some services required abstinence or sobriety to enable access in contrast to other services where clients were asked to maintain a substance misuse habit so their dependency could be assessed.

Whilst professionals reflected that flexibility within some sectors was improving, for example within VCSE, they also highlighted a need for mainstream services (especially mental health services, physical health services, and adult social care) to deliver a more flexible navigation model, including for example assertive outreach. Specifically, mental health services were described as inflexible and rigid. Frontline professionals also commented how it could be challenging for services to be sufficiently flexible, as client's needs often fluctuated rapidly. 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 (see Other theoretical approaches).

Navigating the system (Grey Box and Yellow Boxes within Orange Border)

The ability of both professionals and individuals with MCN to navigate support was described as a leading factor in enabling access to services and maximising client engagement, with several components of service design or delivery approaches (Yellow Boxes within Orange Border) regarded as positively impacting on navigational efforts. These included flexibility; the inclusion of specific, named link workers/liaison roles; having a lead worker; the co-location of services and staff; and adopting a 'no wrong door' approach.

A range of services which support individuals with MCN were described by professionals as helping to navigate support for MCN clients. For example, as part of the RSI, the MDT acts as navigator for a client by communicating directly with the services the client is using, acting as a bridge between the RSI and mainstream provision, and as a single point of contact for the client. As part of the Changing Futures programme, staff similarly have the knowledge and skills to act as a navigator for the client, supporting them to access and attend other services. Staff support clients by identifying what they need support with and helping them to engage with relevant services, advocating for them. The multi-agency and co-location approach of the Eastbourne Hub was also described as making it quicker to navigate support for clients, with named link workers making it easier to navigate through the complexity of large organisations, such as SPFT, rather than staff having to utilise standard referral routes which may result inappropriate referrals, not getting a timely response, or long waiting times. Finally, some service pathway and access routes were positively described as easy to navigate. For example, the access route for CGL was described as clear, and participants said the service was good at maintaining communication. Participants however also outlined several challenges associated with the navigation of support for individuals with MCN, which are summarised below:

<u>Individuals with MCN can find it difficult to navigate support for themselves</u>: Several participants described how individuals with MCN can find it particularly difficult to make initial contact with or refer themselves to services and to advocate for themselves; hence this acts as a barrier to navigating support. Even once 'receiving support', one individual with lived experience described not knowing who to speak to about bullying concerns and drug dealing within their supported accommodation.

"I got referred to here from Southdown mental health then I was referred to ESRA and emerging futures, and rehab. So, most of my referrals came from here. That was good that everything came from here because I'm not good at first contacts, so that fact that it all came from here was helpful" (Focus group with people with lived experience, paraphrased).

The existing system of support for individuals with MCN is not designed in a way that they can easily navigate: The need to attend multiple services and appointments was cited as adding to the complexity experienced by MCN individuals trying to navigate support for their needs. Furthermore, professionals described how MCN individuals were often repeatedly asked questions about their history which may be triggering and therefore, for many, navigating the system of support may be a negative experience. Finally, individuals with MCN reported that it was difficult to navigate more holistic support when services were only concerned with or focused on their own subject area.

The existing system of support and service models for individuals with MCN also make it challenging for stakeholders to easily navigate support for MCN clients: Most professionals described how when there were multiple services involved, and no lead worker, it could be more difficult to co-ordinate support and harder for services to maintain communication, and track what is happening and who is doing what. A lack of named link workers within services was also described by some as a barrier to navigating effective support, and that due to staff capacity some services had experienced difficulties in hearing back from organisations they had contacted. Differences in services' own processes were also described as something which made navigating support for MCN clients challenging (see Differences in organisational structures and processes). The impact of service thresholds was noted, with the lowering of thresholds in housing meaning that it was often the default starting point for individuals, as it was easier to navigate access to housing support than other services. Finally, as mainstream services which support individuals with MCN are often in distinct, separate places, professionals noted that it was not easy to know which service clients would benefit from first.

Lack of knowledge or awareness of the broader system of support can make it difficult for services to navigate support for clients' other needs: Some professionals described that a lack of knowledge regarding existing services and how different parts of the system worked, for example housing and what people are entitled to, could make it difficult for professionals to navigate the broader support that their clients needed. This could result in them being bounced between services or not accessing the most appropriate service.

Navigating mental health support is often the most challenging: As highlighted within other sub-themes (see Population level met or unmet need), navigating and accessing mental health treatment (including support for co-occurring conditions) was described as particularly challenging by several professionals, with the current mental health support offer described as always changing and varying across geographical areas. The short-term funding of initiatives was reported by professionals as meaning that services often had to spend time looking for new or alternative agencies to refer onto.

The ability of staff to navigate clients from specialist to mainstream services has the potential to impact client engagement and outcomes: It was noted by one professional that, as part of the RSI MDT, once a client has been assessed and received initial intervention, ongoing support needs should then be picked up within mainstream services. The RSI reported that navigating and accessing mainstream support for clients was difficult as such services often declined referrals due to eligibility criteria, or had the incorrect understanding that the client could continue to be supported by the RSI.

> *"A lot of our clients, they just, it's almost like every service sector they go to, it's like a launchpad into another. Navigating our way through, you know that process with [UNCLEAR] and then what have you, it's just mind numbing and if I can't do it, how the hell are the clients going to do it... And I know what I'm doing."* (Frontline professional).

Broader contextual factors (Orange and Blue Boxes)

Professionals and individuals with lived experience described a range of broader contextual factors (Orange and Blue Boxes) which were highlighted as either enabling or inhibiting the delivery of one or more components of an ideal service for MCN individuals (Yellow Boxes) or the opportunity for staff development and support (Teal Boxes). These factors have been summarised below under ten distinct, but interrelated, sub themes:

Funding

Participants described several challenges in providing support for individuals with MCN which were directly associated with access to and use of funding. For example, participants described how funding for services had been routinely cut over the years, often despite calls for enhanced service provision, for example in mental health. Individuals with lived experience reflected how health services were being privatised and professionals commented that a reduction in funding was resulting in fewer staff and increasing thresholds to access support. One professional described how increasing demand for services (within the context of limited resource) also meant that services could, in effect, choose to focus their time and support on less complex or challenging clients, to the detriment of individuals with MCN.

Several professionals highlighted that best practice approaches for supporting individuals with MCN were likely to be more expensive and hence limited funding was a barrier to being able to deliver the most effective support, such as sufficient staffing to deliver assertive outreach and enable small caseloads. Specifically, SPFT described that they had sought to introduce peer support roles within their service, but that a lack of funding had prevented implementation. One professional also commented that a lack of funding further inhibited the use of more qualitative evaluation methods that could provide greater insight into service impact.

The short-term nature of funding and subsequent ability to achieve meaningful long-term outcomes was also frequently mentioned by professionals. For example, one professional reflected that 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. However, another commented that it was difficult to justify sustaining the Changing Futures programme as it was not yet delivering intended outcomes, in part due to the nature of government funding also requiring a focus on systems change. Variation in funding across geographical areas was also highlighted. For example, the refuge service described differences in how GPs and Primary Care Networks invested in additional interventions which resulted in inequality of service provision across geographical areas. This included differences in the existence of services between areas, service venues or the type of support than could be offered, such as outreach. The uncertainty around ongoing government funding for specific MCN services post March 2025, namely Changing Futures and RSI, was also a key issue raised by some professionals, with the lack of certainty impacting on current provision due to staff leaving fixed term posts. Other sources of national funding, such as those specifically focused on substance misuse, were also regarded as uncertain.

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. One professional suggested that an 'invest to save' approach was required, but that historically MCN had not been prioritised by services such as ESCC Adult Social Care or Public Health. Given that resources are limited, professionals reflected that there was a need to prioritise those with greatest needs; however, it was difficult to estimate the affordability of any future service for MCN clients given a lack of understanding regarding the potential number of individuals with MCN across East Sussex. Several professionals emphasised the importance of commissioning and the pooling of resources. For example, it was recommended that future commissioning be undertaken in a more co-ordinated and collaborative way to ensure resources are used effectively and to encourage equal accountability. Commissioning should also be based on robust evaluation of services, ideally with long-term funding or in a way that maximises sustainability. For example, one professional commented that had the RSI been delivered through mainstream services, the MDT would probably not be in the cliff edge situation it currently found itself.

Despite the challenges described, several professional referred to external pots of national funding that they had been successful in applying for to support homelessness work. One professional also commented that national investment into specific aspects of multiple disadvantage, such as substance misuse, had positively helped to bring status, profile and scrutiny to work at a local level.

"I think the MDT - and this is not in any way criticism because they do fantastic job - but I think it's a solution to a problem that I think has a different solution, you know, it was there to fix the problems with accessing mainstream services. I think the original intention was to kind of highlight what could be different in mainstream services, but what's actually happened is they've become, uh, a different route for people to access that means they don't then need to come near mainstream services which kind of wasn't the original intention, and then 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)

Recruitment, staffing, and service demand

Professionals highlighted how issues such as recruitment, staffing resource and capacity, and current demand on services were impacting on the ability of services to deliver timely and effective support for individuals with MCN. For example, several professionals described challenges in recruiting and maintaining staff, which had a negative impact on capacity within services and continuity of care. Specifically, this included challenges in recruiting to certain roles within the Changing Futures programme, with both Changing Futures and the RSI having experienced difficulties in retaining staff, in part due to the fixed term nature of posts. It was also highlighted that fewer individuals were coming out of education or training and wanting to work within the mental health and substance misuse sectors, and yet it would be useful to have more people with mental health qualifications within substance misuse services.

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, with individuals sometimes being triaged before their needs have been fully assessed. Professionals also reflected that the implementation of best practice approaches, such as relationship-based approaches, could also conversely increase waiting lists, with it being challenging to balance demand for services against being able to support individuals in the most effective way. 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. For example, Changing Futures reported that they were currently missing a dedicated housing specialist and mental health worker. The MDT within the RSI also reported that it was currently missing a housing specialist and needed to have mitigation in place. Finally, the Hub at Eastbourne reported that it lacked representation from adult social care and children's services, due in part to staffing changes and a lack of staffing capacity (also see Specific, dedicated, named members of staff). It was highlighted that best practice

approaches, such as small caseloads, assertive outreach and a 'Team around the Person' approach all required significant staffing resource due to these approaches being more labour intensive. Consequently, some services were only routinely able to provide group-based interventions as a primary support offer, which risks disincentivising engagement, and with much of an individual's support subsequently reliant on one worker. Furthermore, whilst individuals with MCN are likely to benefit from timely support, services (particularly mental health services) were described as often unable to provide a quick or flexible response due to service demand.

"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)

There was a recognition that national strategies and broader societal issues, such as austerity and cost of living, could have a significant impact on demand for services which support individuals with MCN. Several professionals described long waiting lists to access mainstream services, particularly mental health services, and that these were increasing the thresholds for individuals to meet to access support. Conversely, one professional outlined that the thresholds for providing support within housing services had lowered, and hence demand on housing services was significant by virtue of this discrepancy. Demand on mainstream services was also reported by one professional to result in some services choosing to focus their support on less complex clients (also see Stigma). Individuals with lived experience described how they had experienced very long waiting times for some services, such as nine to twelve months for support from local domestic violence charity, and from their experience felt that social services and housing staff did not have enough capacity to dedicate time with individuals.

"What we're saying is there are multiple complex needs individuals who any normal person would look at and go, you know, they got high needs, they've got mental health needs, they've got XYZ needs, but the thresholds for some of those other services are now higher than they used to be because of budget cuts. 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. So what happens with that is that anything that no longer hits thresholds for the other services they actually really need, the default position is housing. 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).

Given limited resource, professionals described a need for future commissioning to be more co-ordinated and collaborative (see Professional to professional collaboration

and Funding) to help reduce the risk of duplication and to prevent gaps in provision, as well as a need for services to consider how existing staff could be utilised in a more effective way.

Despite these significant challenges, professionals also spoke positively about the impact of initiatives on service demand. For example, the Changing Futures programme was highlighted as an example of a service which seeks to reduce demand on other services by reducing revolving door service use. Several professionals spoke positively of how Changing Futures were able to do some of the 'legwork' which other services simply did not have the resources or capacity to do. A few professionals also reported that multi-agency approaches helped to reduce wait times for interventions and support. For example, the recruitment of RSI social workers was described as particularly valuable in supporting ASC involvement and helping to shorten long wait times for ASC assessments. Finally, whilst CGL service users reflected that mental health waiting lists were long, they welcomed how they had been kept up to date regarding their place on the waiting list following triage.

Differences in organisational structures and processes

Differences in organisational structures and processes were described as having an impact on the ability of individuals with MCN to access and engage with services and support, with many of the findings below relevant to other themes identified. For example, the differences between mainstream or statutory and non-statutory or voluntary sector organisations were a common theme described by several professionals, with the non-engagement of MCN individuals within mainstream services described as a prominent issue. Compared with statutory services, the voluntary sector was regarded by some as able to be more agile, flexible, and responsive; and less likely to work in a deficit-based way. Mainstream services were described as having formal access routes and standard ways of working which made it difficult for individuals with MCN to access them. Finally, despite improvements like training, one professional commented that there was still work to do to enable statutory agencies to have the same level of understanding to supporting MCN clients as those seen within the voluntary sector.

"You know, it's not particularly criticism of those sort of formal access routes to health and social care, but they are set up for the majority of people and they have a fairly standard way of working. We need to have flexibility, the nurse who's within the multidisciplinary team within the RSI will come out on outreach and go and see someone where they're bedded down, you know, you can't say to Conquest Hospital, "Can you go out and see that", you know it's not gonna happen" (Strategic professional)

Differences in specific processes and approaches were also described as having a negative impact on the support and services provided to individuals with MCN. This included differences in processes related to eligibility, such as whether people can

access support whilst using substances; data sharing and information governance; how individuals are encouraged to access support, for example via signposting or pro-active referral; and operating hours of 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. One professional reflected that some services were more psychologically-informed and relationship-based in their approach than others, and that these differences could impact on whether an MCN individual's needs could be met. Other services were also regarded as less holistic in their approach. Finally, it was noted 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.

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. Differences in performance indicators and targets between services were also mentioned by one professional 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.

Frontline professionals reflected that, as part of the Changing Futures programme, staff exclusively worked with people with complex needs, whereas in mainstream services staff would work with individuals with varying levels of need. This difference impacted ways of working, with Changing Futures staff often working with limited respite, under heightened awareness, and with risk management being an ongoing priority.

Homelessness regulation

Several professionals highlighted that, under the Homelessness Reduction Act, services and staff had a duty to refer clients if they had concern that someone was homeless, or at risk of homelessness. Where individuals were owed a housing duty, professionals described how housing teams were good at ensuring that MCN individuals received this entitlement. Housing professionals reflected however 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. Several professionals also commented how current homelessness regulation was outdated, with it not being effective in identifying or including those at highest risk and hence MCN individuals often did not meet the threshold for priority need; for example, someone with MCN with severe mental health issues or alcohol dependency might not be considered significantly more vulnerable than the ordinarily vulnerable

person if they were to be made homeless, with many authorities looking primarily at whether an individual has high physical medical needs. Furthermore, the homelessness regulation was cited as offering limited acknowledgment of the characteristics and behaviours of individuals with MCN which may result in them losing accommodation; in accordance with the regulation, such individuals would be regarded as intentionally homeless in these instances and not entitled to housing support.

Several professionals emphasised that it would be valuable to suspend the homelessness legislation for the MCN cohort and to be able to work outside of the legislative restrictions, namely using professional discretion to support individuals with MCN to better access housing when they do not meet eligibility requirements and to maintain their accommodation (See Other theoretical approaches). Another professional also 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.

"If the government, for example, wants us to end rough sleeping, they really need to think about the legislation in and of itself because we feel the legislation rationalises homelessness rather than trying to actually reduce it altogether. 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)

"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)

Guidance and strategy

Several professionals spoke of the significance of national strategy and guidance in shaping the provision of support for individuals with MCN at a local level and how both national and local guidance and strategy influenced partnership working.

For example, one professional spoke positively about the Dame Carol Black review and how it had had a positive impact in terms of services accessing trauma-informed training and in establishing workforce competencies around substance misuse. Another also spoke of the positive impact of the 2021 national reform of the probation service. The police were also described as an example of how national guidance had positively increased engagement with and accountability towards individuals with MCN as part of a multi-agency approach. The national early prisoner release scheme was also reported as having had a positive impact on bringing partners together. For example, a pan-Sussex drop-in meeting set up as part of the scheme has 50 to 60 stakeholders regularly attending, including services of which probation were not aware, and resulted in

services offering support. Finally, several professionals 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.

However, many professionals also expressed concern about the impact of national guidance and strategy on local services and support for individuals with MCN. For example, one professional described that a national policy change resulting in police officers no longer attending emergency calls for mental health-related incidents had raised queries as to what services should do when clients were experiencing a mental health crisis. Government funding of national initiatives was also raised by several professionals. For example, one described that the duration of funding for the Changing Futures programme was not long enough to be able to focus sufficiently on achieving systems change; another commented that increasing societal issues such as rough sleeping were not being adequately addressed or funded by national government, making it increasingly challenging for services to be able to support individuals with MCN effectively. Furthermore, 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.

"...I guess you've got the other kind of part of things which is about rough sleeping, and people hitting the streets and you know that's gone up by 130 percent. Those things are really, really worrying. These are societal issues and they're not being resolved from the top in the right way, and they're not being funded properly. So, as that filters down, we've got less and less chance maybe of helping people in the right way." (Strategic professional)

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.

Research

A lack of current research, specifically a lack of evidence regarding those with co-occurring mental health and substance misuse conditions, was highlighted by one professional. It was also noted by another how timelines for commissioning often did 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, one professional highlighted the need to research and better understand the wider impacts of investing in effective approaches to support individuals with MCN, to include potential savings to the NHS.

"I think that the timelines for commissioning don't necessarily fit with the timelines for research. So, I don't think we often find out what's the most effective model until after we've changed it." (Strategic professional).

Partnership Structures

Professionals highlighted that partnership structures allowed organisations with different expertise and experiences of supporting people with MCN to pool their knowledge to enable strategic planning and problem solving. Professionals referenced several strategic partnership structures, like the Combatting Drugs Partnership, Target Priority Group, the RSI and East Sussex MCN Board, which convene stakeholders to focus on high-needs residents. 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. Recent progress to better integrate housing and health was also described as generating helpful strategic objectives and supporting planning for future service design.

Whilst professionals generally reported strong partnership working, underpinned by robust partnership structures in East Sussex, many of the structures described as most effective were only operating across a small number of services. Mainstream services were also described as having structures in place to enable them to support clients whose needs required them to use multiple services, for example CGL has several established pathways with criminal justice and secondary healthcare, and collaborates with specific partner organisations such as VCSE organisations. Similarly, a strong joint working protocol between the refuge and housing services was described. Professionals also mentioned operational and clinical structures in place, such as the Co-occurring Conditions Forum and the MARM.

Whilst joint working practices, shared pathways, and partnership groups were spoken about positively where in place, several professionals highlighted that there were not strong links between all services. It was also noted that the partnership structures within Changing Futures and the RSI operated on short-term funding, and it was the view of one professional that more focus and funding should be directed into strengthening partnership working between existing organisations and systems, rather than creating new initiatives. Partnership initiatives like Changing Futures and RSI were described as requiring a considerable amount of work to operationalise, and very clear structures which could sometimes take a long time to set up, particularly in view of the timeframe for national funding. It was also highlighted that it could sometimes be challenging to bring partners on board with strategic decisions, with difficulty involving adult social care in the work on the Housing Hub model provided as an example of this. Finally, a few professionals commented that some strategic partnerships had narrow memberships which might exclude valuable voices, or which operated with narrow

functions, leading to one professional suggesting that the East Sussex MCN board could beneficially have offshoots focussed on workstreams, such as commissioning.

"Mechanisms like the Multi-Agency Risk Management are really helpful if they can bring in either additional resource or encourage the providers around the table to take a more flexible approach than they would usually.... Like for example, having housing there, who will say we're not going to issue an eviction notice if the other providers around the room make sure that the person does this then this... So, they're taking a more kind of multi-agency plan approach and I think that's [a] really helpful mechanism as well." (Strategic professional)

Responsibility and ownership

Individuals with MCN often experience being passed between services, with no single provider taking responsibility for a client's overarching needs, wellbeing or outcomes. This often leads to poor assessment, quality of care, and inadequate services and support plans. Individuals with MCN routinely require input from several services, with the interaction of their needs meaning that no single agency is positioned to support clients without collaborating with partners. True collaboration is underpinned by trust and mutual ownership of responsibilities and risks.

Professionals described positive examples of shared responsibility being taken for people with MCN in East Sussex. For example, SPFT's established dual diagnosis workstream and funded posts were described as helping to embed joint working protocols which facilitated shared responsibility. It was also described that CGL had been working with the police to enable certain staff to carry nasal naloxone to support in instances of suspected overdose, thereby sharing responsibility for substance misuse issues. Some initiatives, like the government's Target Priority Group, were also highlighted as effective in creating shared system responsibility for the most entrenched rough sleepers, with the MARM also fostering collective ownership.

Professionals also described the importance of shared responsibility within more specialist and bespoke services for individuals with MCN. For example, within the RSI, a client case is shared across the MDT and beyond by inviting relevant professionals onto a case instead of referring a case onwards. This supports multiple partners to own risks for clients. Changing Futures staff also work closely enough together to provide a shared narrative about care, however frontline professionals acknowledged that at present they did not truly share responsibility for clients as a team, or with other partners. Some professionals also reported that the Housing Hub model (namely co-location of services, inviting stakeholders to join a case, and joint working) helped to foster joint responsibility for clients. Finally, national strategy was regarded as facilitating shared responsibility (also see Guidance and strategy).

Despite the positive examples provided, professionals stressed that individuals with MCN still often fell through the gaps due to no single service taking the lead on supporting a client, or services not adopting collective responsibility. Some professionals also highlighted that there was some residual expectation for housing services to lead, and that just providing housing was insufficient. Some services were also described as adopting a single-issue approach by participants, with such services only engaging clients relative to their own service domain, rather than taking a holistic approach. Such services included the police, children's social services, family courts, and mental health services.

> *"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)

Shared objectives and drive

Professionals highlighted that partnership working to support individuals with MCN required, to a certain degree, shared objectives; though it was acknowledged that in some cases true alignment was in fact inhibited by statutory frameworks. Having shared objectives or approaches was considered to facilitate the pooling of resources, and indirect access to additional resources, as well as supporting staff resilience.

Professionals described that, whilst there was shared agreement at a strategic level that more needed to be done to support individuals with MCN, a wide range of partners were engaged in partnership working to develop support and were working well together to use learning to plan services and prioritise resources. Professionals commented that the development of shared objectives was facilitated well by partnership structures such as the East Sussex MCN board.

Professionals also reflected that some services also had shared ambitions on core topics, such as working differently with people with co-occurring substance misuse and mental health needs to improve their access to support; and addressing the issues related to housing.

However, several challenges to having shared goals between services were also described, including 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. A few professionals also described how shared goals between strategic partners around partnership working did not always trickle down to frontline staff who were the ones required to operationalise, though there were good practice

examples of shared goals for clients between partners. Finally, one professional commented that not all partners buy into, or support, shared goals such as the proposal to ensure that individuals with MCN are a priority cohort.

"There's 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)

Governance

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. East Sussex governance structures, such as the East Sussex MCN board, the RSI board, and the East Sussex Homelessness Forum, were described by professionals as working well to help achieve and maintain quality standards within some services, namely the RSI and Changing Futures, by reviewing regular performance reports. National guidance was also regarded by one professional as supporting increased scrutiny of other systems in the county, such as the links between substance misuse and prison services (See Guidance and strategy). However, it was highlighted by one professional that scrutiny of other relevant commissioned services could be improved, and that the East Sussex MCN board should have a stronger role in ensuring mainstream services are commissioned appropriately to support MCN individuals.

"I don't think we hold people to account that strongly necessarily about what they deliver. So I think for me it's like if you know there needs to be a much more robust partnership view of commissioning services as well. So again, if we had that multiple compound needs kind of board service type affair that could run at various levels, part of the strategic look would be you know about that sort of bid and tendering process." (Strategic professional)

Workforce development and support needs (Teal Boxes)

Professionals and individuals with lived experience described that opportunities for staff workforce development and support (Teal Boxes) could either enable or inhibit the effective delivery of one or more components of an ideal service for MCN individuals (Yellow Boxes). These have been summarised below under three distinct, but interrelated, sub themes:

Training

Participants highlighted the importance of staff, especially those in client facing roles, having a strong understanding of MCN and what works to support people experiencing MCN, with training being a key element in facilitating this. Specific examples of relevant training included trauma-informed training and training about psychologically-informed

environments. Several professionals provided examples of partners providing relevant training, such as the dual diagnosis training on offer from SPFT or substance misuse training for partners offered by CGL. The Wellbeing Team working alongside the Eastbourne Housing Hub had also received behaviour change training which was regarded as useful in supporting work with MCN clients.

Despite this, not all providers interviewed seemed to be aware of current training on offer, with one strategic professional reporting that there was no clear training related to mental health despite the existence of dual diagnosis training. Furthermore, professionals reported that training could be improved in several ways, including a need for professionals 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 a near-universal need for training about trauma-informed practice, psychologically-informed environments, and addressing attitudes to stigma. Staff in SPFT were specifically identified as requiring additional training in holistic approaches, improving referring practices, and around supporting co-occurring substance misuse needs in people with poor mental health. One professional also commented that staff in substance misuse services would benefit from more training or qualifications in mental health, beyond the dual diagnosis training available. It was also reflected that staff in some services, such as Probation, would require additional training to be able to adopt a lead worker approach.

Finally, individuals with lived experience reported that staff from several services, specifically adult and children's social care services, police, and family courts, lacked understanding and training about the experiences of people with MCN. Specific topic areas mentioned were health and addiction; and domestic abuse, specifically psychological abuse, post-separation abuse, coercive controlling behaviour, and how these behaviours manifest.

Supervision and support

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.

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. It was also highlighted that adopting psychologically-informed practices not only benefited clients but also the staff working within such services.

However, whilst strong models for supervision were reported by some professionals, there was mixed feedback about the extent to which this happens in services. Frontline

professionals at Changing Futures, for example, reported that they would benefit from more psychological support as part of their supervision to help them process their responses to clients. Some frontline professionals also reported working in situations which could be considered unsafe, but that the service was making positive efforts to have more team check-ins. Finally, some individuals with lived experience described professionals behaving in ways to protect themselves psychologically and that these behaviours were possibly a self-preservation mechanism in lieu of insufficient supervision and support.

> *"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)

Role clarity

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.

A few professionals highlighted that, in some services, staff routinely supported clients to access support for needs which fall outside of their service's remit. Participants also reported that where there had been confusion amongst clients about staff roles, some services had invited clients to join an MDT to help them better understand different professionals' remits. 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, namely which professionals would be involved in which element of the pathway.

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. The issue of unclear delineations between professional roles was also echoed by strategic professionals as challenging, with clients feeling unclear about who can support with what and staff becoming unsure about their own role in a client's care when there are a lot of professionals involved. Frontline professionals also described how staff roles and responsibilities could sometimes become eroded and blurred because of the complexity of presentation amongst MCN clients, with staff sometimes responding to what the client needed, whether it is technically part of their role or not. This was particularly apparent amongst Changing Futures staff, some of whom were still shaping their roles, or wrestling with how flexible their roles should be.

It was also recognised that differences in opinion about the tension between flexible and 'boundaried' working had the potential to confuse clients. Finally, whilst some members of staff reflected that they were operating too far beyond their role, other professionals were regarded as not taking on responsibilities which should be within their remit, such as (with consent) mental health professionals referring people with co-occurring substance misuse and mental health needs to substance misuse services rather than relying on patients to self-refer.

"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)

"I think that some of the stuff I do probably is well out of my remit, as such, are they boundaries or are they working with the client where they're at?" (Focus group with frontline professionals)

Prioritisation of needs (Dark Green Box)

Differences in how services and individuals with MCN prioritise their needs (Dark Green Box) and how such differences may impact on access to and engagement with services/ support (Light Green Boxes) were described by participants. These differences are summarised below:

<u>MCN individuals find it difficult to prioritise their multiple and complex needs:</u> Professionals commented that having multiple needs could be overwhelming for MCN clients, with prioritising needs often being challenging due to poor mental health or substance misuse, and having to tell their personal story being potentially triggering. Professionals recognised that enabling MCN individuals to prioritise their needs could facilitate a sense of control, but that when clients prioritised their needs inappropriately, this could mean that immediate risks were not always addressed. Individuals with lived experience also described challenges in prioritising their needs and in adapting to learn to make use of available support. However, the co-location of services was regarded by one professional as making it easier for MCN individuals, meaning that they did not need to plan or prioritise as much.

<u>The prioritisation of needs by MCN clients varies and is unique to each individual:</u> Given the fluctuating nature of their needs, professionals described that individuals with MCN will often prioritise their needs based on necessity. Despite this, some felt that housing was most likely to be prioritised by MCN clients, as it was seen as a conduit to addressing other needs. Others described how mental ill health, particularly where admission was required, may also be a prioritised need as this was a need which could

be acutely 'felt'. Another professional noted that individuals with MCN will often prioritise what makes them feel better in the short term, such as alcohol or drugs as a means of escape; and that prioritisation can also be influenced by addiction, namely being preoccupied with accessing or using substances, which impacts on engagement with services. For individuals who have experience of domestic abuse, professionals highlighted that re-establishing relationships with family members or loved ones was often prioritised; however substance misuse clients reported prioritising recovery over some personal relationships. Finally, one professional commented that sometimes MCN individuals prioritise their needs based on with whom or which service they have the best rapport.

Services consider a range of factors when considering how to prioritise support for MCN individuals: Professionals described that they will often prioritise support or input based on level of risk, however one professional acknowledged that sometimes prioritisation decisions were made before full assessment and so high-risk clients could be missed. One professional also noted that needs may be prioritised based on the availability of services, for example when weighing up rehabilitative work versus housing, and that services needed to feel comfortable in prioritising those experiencing the greatest needs due to limited resources. It was also acknowledged that services can sometimes wrongly assume that MCN clients will want to address mental health and substance misuse needs *after* being housed. Finally, it was noted that services do not always work in partnership with one another to consider how to prioritise or order support for MCN individuals, which may ultimately lead to mis-prioritisation or a lack of engagement.

Differences in prioritisation between MCN individuals and services can lead to dis-engagement and impact on client outcomes: Professionals reflected that individuals with MCN often do not prioritise needs in the same way as services, and that what services often think are priorities for clients are not always what the client regards as important. 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. Furthermore, one professional noted that MCN individuals will often seek to prioritise what makes them feel better, but supportive interventions such as seeing a counsellor may lead them to feeling vulnerable. 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 inappropriately, 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. Finally, the MARM protocol was described by one professional as helping to develop a common language around MCN, however, they reflected that there was not yet consensus as to who should be prioritised as part of the MCN cohort.

"I work with a client who really struggles to prioritise things and gets confused about what to prioritise. She'll have cellulitis in her arm or her leg and she needs to go to hospital. But in her head, she needs to speak with citizens advice about something or she needs to go and wash her clothes or go to the food bank or something like that, she's got this health issue and she's thinking, I need to go get my washing. (Frontline professional)

Other services (Grey Box)

Participants highlighted a range of key services, external to those specifically involved in the needs assessment, which were seen as playing a contributory role in meeting the needs of individuals with MCN at a population level (Purple Box); 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.

For example, it was described that higher rates of premature death in people with co-occurring conditions highlighted a need for greater physical health screening in this group. A few professionals also reflected that a large proportion of substance misuse clients also smoked cigarettes, therefore it was important to be able to provide accessible stop smoking support to MCN individuals, should they wish to quit. The importance of encouraging clients to access a full medication review via their GP was also noted, especially given the length of time MCN individuals may require medication. Finally, individuals with lived experience specifically described that they valued access to dentistry within VCSE organisations.

As highlighted within other sub themes, adult and children's social care services were mentioned on numerous occasions by individuals with lived experience, with negative experiences described of social workers being judgemental, narrowminded, unsupportive of people going through recovery, treating substance misuse clients with suspicion, and having a poor understanding of addiction and mental health. It was also noted by one professional that social services and social care workers were often associated with the trauma experienced by individuals with MCN, for example if clients had been looked after children or had children removed, and that employing staff with lived experience within social care services could help to offset the historic hostility many clients feel towards social workers.

The importance of social care services being able to support MCN clients to help improve their situation, especially in terms of accessing safe and appropriate accommodation, was described by professionals. One professional also highlighted that when specialist services were needed, such as social work interventions or community care act assessments, these interventions should be brought alongside other support in a timely manner; however, thresholds for adult social care were

considered very high, with support often based on how much the client is willing to engage.

Finally, one individual with lived experience described their negative experience of the family court system, with their legal aid being removed (and previous payments asked to be paid back).

Access and Engagement (Light Green Boxes)

Individuals with lived experience commented that prompt access to services was highly valued. For example, one individual positively described only having to wait two weeks to be connected with workers within the Emerging Futures programme, but it was acknowledged that, for other services, two to three weeks could feel like too long to wait.

Whilst some individuals with lived experience positively described gaining access to certain services (IDVA, GP, counselling at the women's centre, and mental health services such as Health in Mind), others highlighted difficulties accessing mental health support, either feeling required to jump through hoops or being turned away because of their addiction. Lived experience participants also noted difficulties in getting seen by housing officers in times of need, or people only being able to use night shelters during the winter despite needing shelter at other times. Other homelessness services were regarded to offer very restricted hours, with access becoming increasingly more limited since the pandemic.

> *"I had to turn up at xxx council with my duvet and all day the bods in the office were saying they were going to help me. And I was sat there all day and then they gave me the out of hours number."* (Focus group with people with lived experience, paraphrased)

As outlined throughout this section of the report, a wide range of service design and delivery approaches were regarded by participants as optimising MCN individuals' access to services and support; these included the co-location of services and staff, the use of assertive outreach, a 'no wrong door' approach, flexibility, proactive professional referral, accessible service venues and locations, a Team around the Person or MDT approach, simplicity, effective approaches to dual diagnosis, timely referral and short wait lists, access not being contingent on active support-seeking behaviour from clients, and the right infrastructure to be able to provide access to support safely out of hours.

> "I think the other elements are that you need providers who have enough of a local infrastructure to be able to deliver out of hours support without worrying about their staff being unsafe". (Strategic professional)

In addition to the factors supportive of service access and engagement already described above, individuals with lived experience highlighted that first impressions of

services played an important role in determining whether they were likely to stay engaged, with online options like Zoom and WhatsApp described as positively supporting clients to stay engaged in peer support activities. CGL service users also commented on the importance of people in recovery being provided with emotional support to enable them to stay engaged, as emotions and senses are often heightened during sobriety. Conversely being instructed to maintain a habit so that it could be understood by the service was off-putting, leading clients to disengage.

"We had a really, really complex young man who came out with 19 different people involved and you just say you can't give a young vulnerable man with autism 19 different people he can potentially connect him with when he can barely connect him with one and expect him not to fail" (Strategic professional)

Outcomes (Purple Box)

Participants described a wide range of service design and delivery approaches (Yellow Boxes) which were regarded as key in maximising access to and engagement with (Light Green Boxes) services and support for individuals with MCN, and impacting on client outcomes (Purple Box). Alongside these, several additional themes related to outcomes were described by professionals, as summarised below:

Individuals with MCN can, and do, achieve positive outcomes with the right support: Several professionals highlighted that they had been able to successfully support MCN individuals to achieve positive outcomes. For example, the refuge service described a client who was able to achieve successful outcomes despite the complexity of their needs and history of trauma. The response of services was regarded as very positive, specifically CGL, from which staff came to the refuge weekly to engage with the client. Furthermore, CGL was described as successfully meeting (or almost meeting) drug strategy targets, with an increasing number of individuals accessing structured treatment and leaving treatment in a planned way. However, one professional did express some concern regarding the risk of services over-celebrating projects or initiatives, especially in view of limited evaluation, and felt that it was challenging to establish if some initiatives had made any meaningful difference to MCN individuals.

What is considered a successful or positive outcome for individuals with MCN may look different compared to individuals with single needs: Several professionals described how positive outcomes for individuals with MCN were likely to look different compared to other parts of society and be more nuanced and specific to the individual. 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's the little things you get, you know, they are so important for the clients, the things that don't sometimes carry a lot of weight. We're talking about somebody who's actually

making the appointments and turning up and getting on the housing register, it's things like that, the little wins because there's a lot to get your teeth into with these clients" (Frontline professional)

The commissioning and contract management of services has the potential to influence achievement of outcomes for individuals with MCN**:** Professionals described how commissioned services which provide support to MCN individuals were often contracted to work with a certain number of clients each year or only make a certain number of contacts before having to close a case. However, some services were positively described as being commissioned in a way which enabled a more flexible approach to maximise outcomes. One professional also reflected that commissioners did not always hold providers to account in terms of what they have been commissioned to deliver. There was also recognition that, as many services had their own niche outcomes and metrics, this could impact on the way services engage with each one another other, for example services wanting other services to prioritise clients accessing support to achieve performance requirements.

"So, where the typical [REDACTED] services, they have quotas, numbers that they need to get through, so therefore they will only see X many people, or only X many attempts to contact. If that fails, it's case closed and …, we just don't have that." (Strategic professional)

There is a need to better understand the impacts of MCN services on wider services and society, and any cost benefits: A few professionals described that certain approaches (such as the co-location of staff, joint working, no wrong door, and early intervention) could have a positive impact on multiple agencies and reduce the amount of time spent by services supporting MCN clients. However, others highlighted the need to better understand the wider impact of investing in such approaches to support MCN clients, to include potential savings to the NHS.

Population level met or unmet need (Purple Box)

Finally, as part of the interviews and focus groups, participants were directly asked about the extent to which they felt the needs of individuals with MCN were being met across East Sussex. Whilst a few professionals provided examples of how they were supporting individuals with MCN to address their needs, professionals largely reflected that overall the needs of individuals with MCN remained largely unmet, with responses summarised under the main key headings below:

Overall, the needs of individuals with MCN remain largely unmet: Whilst some professionals reflected that services were getting better at identifying needs, and that there were examples of success, many felt that more work needed to be done to address and reduce the level of need experienced by the MCN cohort, particularly those with the highest needs. Some professionals described that it was difficult to help clients

achieve basic needs, such as taking essential medication, and that unmet need was a contributory factor in the escalation of risks and individuals disengaging from support. Certain MCN individuals were regarded as less likely to have their needs met, and to experience additional barriers to accessing and engaging with support. This 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.

Mental health and housing represent the most significant unmet needs for MCN population: 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. A lack of capacity within mental health services, alongside the volume of mental health referrals which are declined, were particularly highlighted. Individuals with co-occurring mental health and substance misuse issues were identified as a particularly vulnerable cohort, and that whilst dual diagnosis protocols were in place, they did not seem to be working in practice. 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. This was also echoed by an individual with lived experience who reflected that street homelessness was getting worse. The current homelessness legislation was seen as a barrier to providing support with homelessness as rough sleepers often did not meet thresholds for support.

"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)

The needs of individuals with MCN are often not met due to limited or lack of service provision: 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. For example, due to their delivery model, specifically small caseloads, professionals described that demand for support via the Changing Futures programme had outstripped the number of people they were able to work with. Increasing thresholds within social care and mental health services were also described as preventing some individuals from accessing support, with a lack of that specialist knowledge within other services to support individuals. Specifically, a lack of support and services for individuals who pose a high risk to themselves or others and require specific accommodation to mitigate was highlighted. 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.

The system could potentially be setting individuals with MCN up to fail: A few professionals acknowledged that, due to limitations in the current system, services may provide support to clients knowing that they are likely to have limited success. For example, it was noted that clients were much less likely to get clean whilst remaining homeless, and that clients being placed in private rented accommodation without support to maintain this were less likely to have their needs met. 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.

There is some consensus amongst professionals that meeting the needs of individuals with MCN is unrealistic: A small number of professionals described that it was unrealistic to think that the needs of all individuals with MCN could be effectively met, and that for some the best outcomes they might ever achieve with a client would concern basic needs, such as keeping clients alive. One professional highlighted that some MCN clients would never be RAG-rated as 'Green' and that a more realistic aim would be to reduce need to a more manageable level.

> *"...one of the recognitions within that level of need measure and within the hub was exactly that: 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. And 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, and they'll all be dealt with, they'll have all their needs met. That's just not feasible. People are human. Trauma happens"* (Strategic professional)

Several professionals suggested that, to address unmet need, services should explore opportunities for joint commissioning and that all services should be involved in an individual's care and support plan regardless of the client's engagement in services. Some professionals also emphasised a need to improve understanding of MCN amongst commissioners and services, as a lack of understanding was also contributing to unmet need. Finally, one professional suggested that any future specialist service for MCN individuals should be for those with the most complex, intractable, chronic needs.

Experiences and characteristics of local people

Local stakeholders, both professionals and those with lived experience, emphasised that trauma is the root cause of almost all cases of MCN. The lasting effects of trauma consequently affect behaviours, like self-medication, which hinder those affected from recovering and progressing through support. The experiences and needs of people with MCN have a compounding and multiplicative effect, making it difficult to navigate services designed for single support needs, particularly as the combined effect of MCN is often volatility and fluctuating risk. People with MCN may lack true capacity to live independently and self-advocate for support, or may choose to prioritise needs in a way which is harmful or detrimental to the case they are making to services for assistance. People with MCN may also experience low motivation to continue trying to access support due to their needs themselves or fatigue from repeated poor experiences. These manifestations of MCN contribute to stigma surrounding this population, which itself creates both direct obstacles if support is withheld as a result, and indirect obstacles as affected individuals seek to avoid prejudicial interactions.

The relationships between these factors are often bidirectional or cyclical, creating complex webs of exclusion and disenfranchisement.

Limitations

Materials

The nature of people with MCN is that many services are relevant to their care and the individuals themselves are far from a homogenous group. This context presented some limitations for the design of qualitative materials, particularly that the questions were designed to be broad, and speak to the entire system, meaning that respondents were often commenting on services about whom they might know limited detail; and that the responses themselves were broad and wide-ranging, making analysis challenging.

Interviews

Interviews were conducted with strategic stakeholders. The interview format enabled participants to be candid, but provided no opportunity for challenge from other services mentioned. VCSE organisations were not engaged, meaning that a large part of the provision for people with MCN was not reflected by those services themselves, though other participants did mention VCSE provision. Partners from physical health services and social care services were also not engaged.

Focus groups

The focus groups with people with lived experience had several limitations. In an attempt to minimise the data collected and avoid risk for this group, specific focus group events were arranged via professionals in key organisations so that the opportunity could be advertised to relevant people who could then opt in to focus groups anonymously, without the research team being required to collect any personal

identifiable information from them. This decision limited the organisations through which engagement could be conducted; informal, drop-in settings were ruled out on the basis that participants could not opt-in, but would need to be approached; that attendees coming at different times would pose challenges for the focus group format and the need to consent participants; and that screening for MCN would conflict with data minimisation efforts. As such, people with lived experience were engaged through Changing Futures and CGL, which both biased participants towards those who were engaged with services, biased discussion towards substance misuse needs as most participants were recruited via CGL. This approach still risked the inclusion of participants with single or double needs, as the responsibility for screening was devolved to partners and the methodology used was not shared. The qualitative arm of the needs assessment would have benefited from additional engagement with people with lived experience, and from engaging participants with a more diverse range of experiences including more participants who were earlier on in their recovery journeys.

It was anticipated that uptake would be limited, so vouchers were offered to incentivise attendance, which may have created a bias in respondents and appeared to encourage some degree of gaming as some participants attended the session but did not engage in discussion, despite the efforts of facilitators. Uptake of focus groups was still limited despite the incentives; three out of the four focus groups with clients from Changing Futures were cancelled due to non-attendance.

It is also worth noting that some of the people with lived experience who contributed their experiences and perspectives may have had MCN for a long time, and some of the feedback may not be contemporary.

The focus group with frontline operational staff was limited to staff at Changing Futures.

During multiple focus groups, some participants left during the session. While this presents challenges for analysis, as the findings cannot be attributed to all participants, it was considered that it was important for participants to be able to withdraw in order to create a trauma-informed environment. Thus, the instability of the focus groups is considered a limitation rather than a methodological error.

Analysis

Data collected during interviews and focus groups reflect the thoughts, experiences, and opinions of participants. Some experiences and opinions conflict with one another, and this was reflected in analysis as far as possible. The contents of responses, however, have not been checked for factual accuracy.

Analysis was undertaken by staff with experience of qualitative research, one of whom had previously undertaken framework analysis. These staff do not specialise in MCN or any of the constituent needs, so while offering a certain degree of objectivity as far as that is possible to achieve in the context of qualitative research, this lack of expertise

posed some challenges for interpreting the data. This was mitigated by consulting colleagues when questions arose, and taking the findings to the MCN board for comment.

Qualitative materials

Please note that topic guides were accompanied by notes for facilitators with guidance for briefing and consenting participants, including to be recorded where relevant, and co-creating ground rules for focus groups

Professional participant topic guide

Theme: Service mapping

Tell us about your service, how it supports those with *multiple compound needs*, and which areas you cover.

Prompt: Your service, and partner services

Prompt: How do people access your service?

Prompt: What are the main client groups that use your service?

Theme: What works well

Considering services users with multiple compound needs …

In your experience, what if anything, is working well to provide support for people with *multiple compound needs* in your service, and your partners?

Prompt: Are there any particular groups who you think benefit more from your service?

Prompt: What, if anything, works well in how you provide your service?

From your experience, are there particular aspects of the service that you most value? In your experience what, if anything, is most valued by those who access your service?

From your experience, what does an ideal service for people with *multiple compound needs* look like?

Theme: Areas for improvement

Considering services users with multiple compound needs …

In your opinion, is there anything that could be done differently within your service, or by your service partners, to improve support for people with *multiple compound needs*?

Prompt: This could be something from another service, or area that you have heard of, or worked in a previous role.

Prompt: Are there any particular groups within people with *multiple compound needs* that you feel could be better supported within the service?

Are you aware of any particular barriers to people with *multiple compound needs* accessing, or staying engaged with, support?

Theme: Exploring known themes; people with MCN, Partnership working, current working climate

We understand there are differences in working with this client group compared to people with 1 or 2 needs, in your experience, what are the main differences in supporting people with complex needs compared to single needs?

Prompt: Is there anything you find/think is particularly useful in engaging or building relationships with this group?

Theres an element of collaboration/partnership working required to support people with *multiple compound needs*. How does your service work in partnership with others for people with *multiple compound needs*?

Prompt: Which services do you collaborate with most effectively?

Prompt: Are there other ways of working collaboratively that might improve support?

Given the current social, political and economic climate, have you noticed any effect on the way you provide support now, or how it will offer support over the coming years?

What would you say are the key priorities for future provision which commissioners need to be aware of going forward?

Theme: Multiple needs

In your experience, how do people with *multiple compound needs* prioritise their multiple needs?

Prompt: Are there some types of need for which people are more likely to present than others?

Prompt: Are there certain needs which people tend to seek support for first, or prioritise as more urgent/important?

If time : Do you feel there are enough guidelines, evidence or training to support your work?

Closing comments

Considering everything we've discussed today...

From your experience, to what extent do you feel the "*multiple compound needs"* population's needs are met or unmet?

Is there anything we haven't talked about that you feel affects how we support people with *multiple compound needs* in East Sussex? **OR** Do you have any further comments or reflections?

Thank you for your time...

Lived experience participant topic guide

<u>Open questioning</u> Tell us about services you've used and what you think of them. How well do you feel the **needs and goals of people facing the issues you face** are understood by those services?	Prompts: Can you tell us more about that? Why… e.g (do you feel needs are met/unmet) Can you explain that? What do you mean by that?
<u>Service mapping</u> Do people in your position get everything they need from services in East Sussex? Are people in your position able to access services they need? Do you feel services are there for you at a time when they are most needed?	Prompts: Can you tell us more about that? Why… e.g (is the access bad?) Can you explain that? What do you mean by that?
<u>Best practice</u> Talk us through what, if anything, works well for you. **OR** If positives already mentioned, summarise them and ask if there's anything anyone has to add. <u>Areas for improvement</u> Explain what, if anything, needs to be done better for people in your position and why.	Prompts: How did you feel about that? Can you tell us more about that? How… e.g (did that help? Not help) Why… e.g (was that good/bad) Can you explain that? What do you mean by that?
<u>Exploring known themes</u> 1. *Services are set up to be experts on one of the many issues people in your position face.* How does it feel for someone in your position to need to access multiple services. Do all the different services that East Sussex offers work well together? From your experience, what, if anything, could we do improve how services work together? 2. *We understand that the relationship between people facing multiple issues and their case workers is important.* For people in your position, what, if anything, do you feel makes a good or bad relationship with a case worker?	Prompts: How did you feel about that? Can you tell us more about that? How… e.g (did that help? Not help) Why… e.g (was that good/bad) Can you explain that? What do you mean by that?

3. *We know from other research that its really difficult for people facing multiple issues to stay connected with services.* What, if anything, makes it difficult to stay connected with services? And so what, if anything, would help people facing the same issues as yourselves to stay connected with services?	
<u>Hierarchy of needs</u> Of the issues people in a similar position to yourselves experience, which would you want dealt with first? Do you feel involved in decisions about which issues are dealt with first?	Prompts: Can you tell us more about that? Why… e.g (was that good/bad) Can you explain that? What do you mean by that?
<u>Closing comments</u> Is there anything else you want to share?	

Lived experience participant invitation poster