



I·SPHERE

*Adverse Childhood
Experiences and Complex
Needs: An Agenda for
Action*

A Tale of Three Research Projects

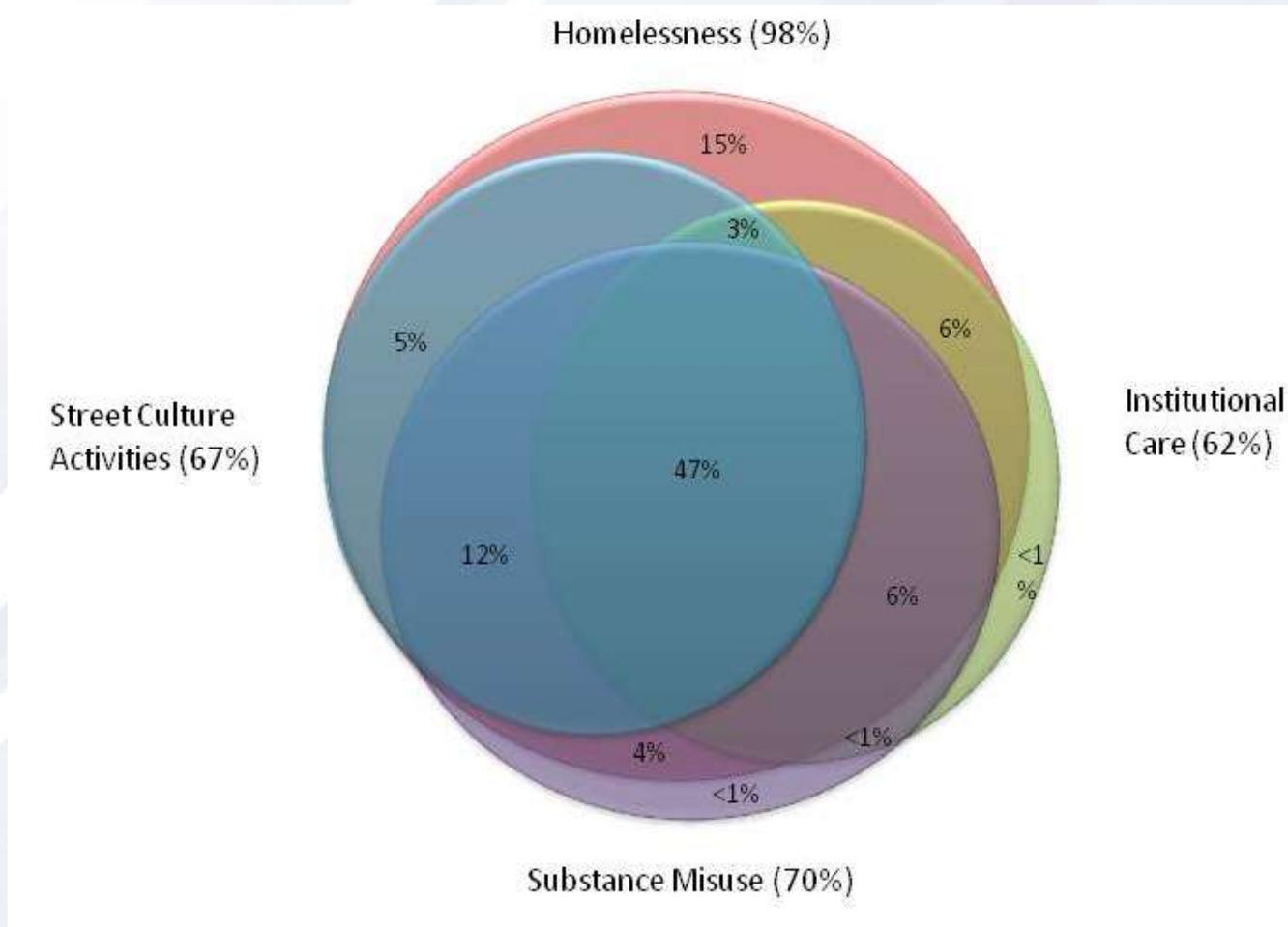
- *Multiple Exclusion Homelessness* (ESRC, 2010-2012)
- *Hard Edges: Mapping Severe and Multiple Disadvantage* (LankellyChase Foundation 2011-2015)
- *Solve UK Poverty: Complex Needs* (Joseph Rowntree Foundation, 2012-2016)

Multiple Exclusion Homelessness

- Nature and patterns of MEH in the UK
- Multi-stage quantitative survey of people experiencing MEH in seven UK cities
- MEH = 'homelessness' + 'institutional care' (prison, care, mental health hospitals) and/or 'substance misuse' and/or 'street culture activities' (begging, street drinking, 'survival' shoplifting, sex work)

Methods

- Identified all relevant ‘low threshold services’ – randomly selected 6 services in each location (= 39 in total)
- ‘Census questionnaire’ survey of all service users over a 2 week ‘time window’ = 1,286 short questionnaires returned
- ‘Extended interview’ survey with service users who had experienced MEH = 452 interviews completed



Clusters of Experience

1. 'Mainly homelessness' (24%) = least complex (5 experiences); male + over 35; migrants; Westminster
2. 'Homelessness + MH' (28%) = moderate complexity (9 experiences); disproportionately female
3. 'Homelessness, MH + victimisation' (9%) = much more complex (15 experiences); suicide attempts, self-harm; victim of violence; LA care and prison; younger than average
4. 'Homelessness + street drinking' (14%) = moderate complexity (11 experiences); high levels of rough sleeping + street culture; male + over 35; Glasgow
5. 'Homelessness + hard drugs' (25%) = most complex (16 experiences); very high across all domains, especially substance misuse and street culture; most in their 30s

Routes In

- **Phase 1** - Substance misuse + leaving home or care
- **Phase 2** – Transition to street lifestyles: anxiety/depression; survival shoplifting; survival sex work; sofa-surfing; prison
- **Phase 3** – Confirmed street lifestyle: sleeping rough; begging; injecting drug use; admitted to hospital with a mental health issue
- **Phase 4** – ‘Official’ homelessness: applying as homeless, and staying in hostels or other temporary accommodation
- Consistent across all five clusters

Adverse Childhood Experiences

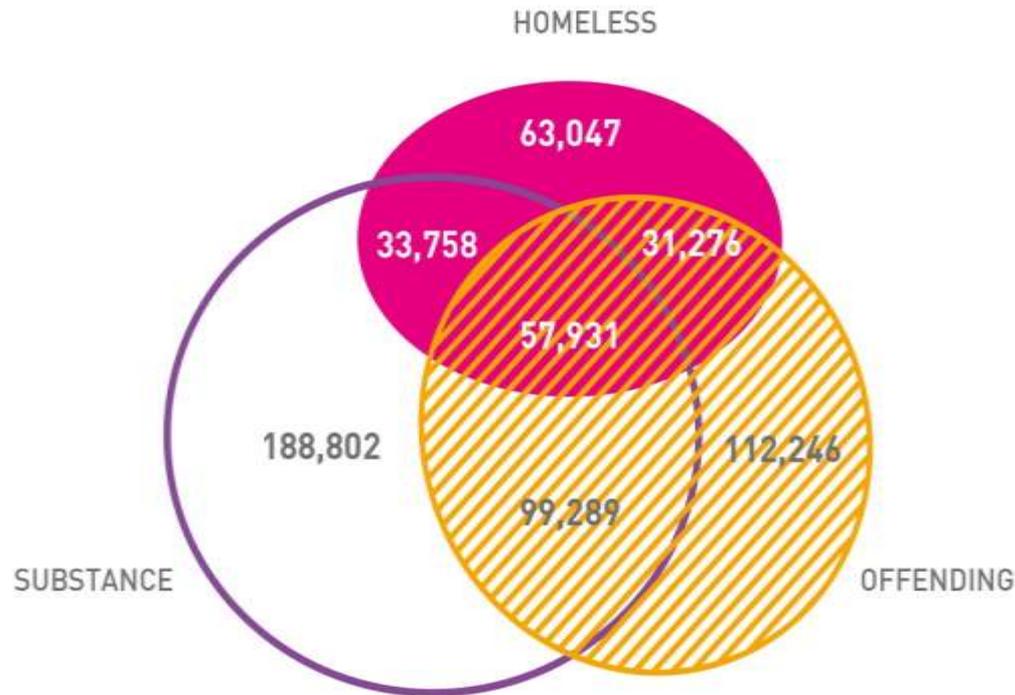
At least one adverse childhood experience	85%
Truanted regularly	54%
Suspended/ excluded	39%
Ran away	38%
Didn't get on with parent(s)/step-parent	30%
Domestic violence	29%
Parental drug/ alcohol problem	26%
Bulied	25%
Sexually abused	24%
Physically abused	23%
Local authority care	18%
Family was homeless	16%
Neglected	16%
Not enough to eat	15%
Parental mental health problem	15%

Hard Edges

- Followed on from MEH study
- National scale and distribution of ‘severe and multiple disadvantage’ = combination of ***homelessness, substance dependency*** and/or ***offending behaviour***
- ‘Triangulated’ analysis of 2 survey data sets (MEH and ‘Poverty and Social Exclusion’ survey) and 3 ‘administrative’ (ie service use) data sets (OASys, NDTMS, and Supporting People) ***which contain information about relevant 'disadvantage domains'***

Scale and Overlap

Overlap of SMD disadvantage domains, England, 2010/11



- 58,000 in core SMD3 group
- 164,000 in SMD2
- 364,000 in SMD1
- 586,000 in total
- Confirms interviews in finding majority (2/3) of (single) homeless and offenders have SMD; also true of about half of substance misusers, especially drugs

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Demographics

- **Gender:** a largely male phenomenon (8 out of 10 are men) (*a parallel research project is exploring more female-orientated forms of SMD*)
- **Age:** predominant age group is 25-44; very few older people; young people more common in 'homeless only' category
- **Ethnicity:** predominantly white, like working age population of England; Black & Mixed ethnicities somewhat over-represented; Asians under-represented

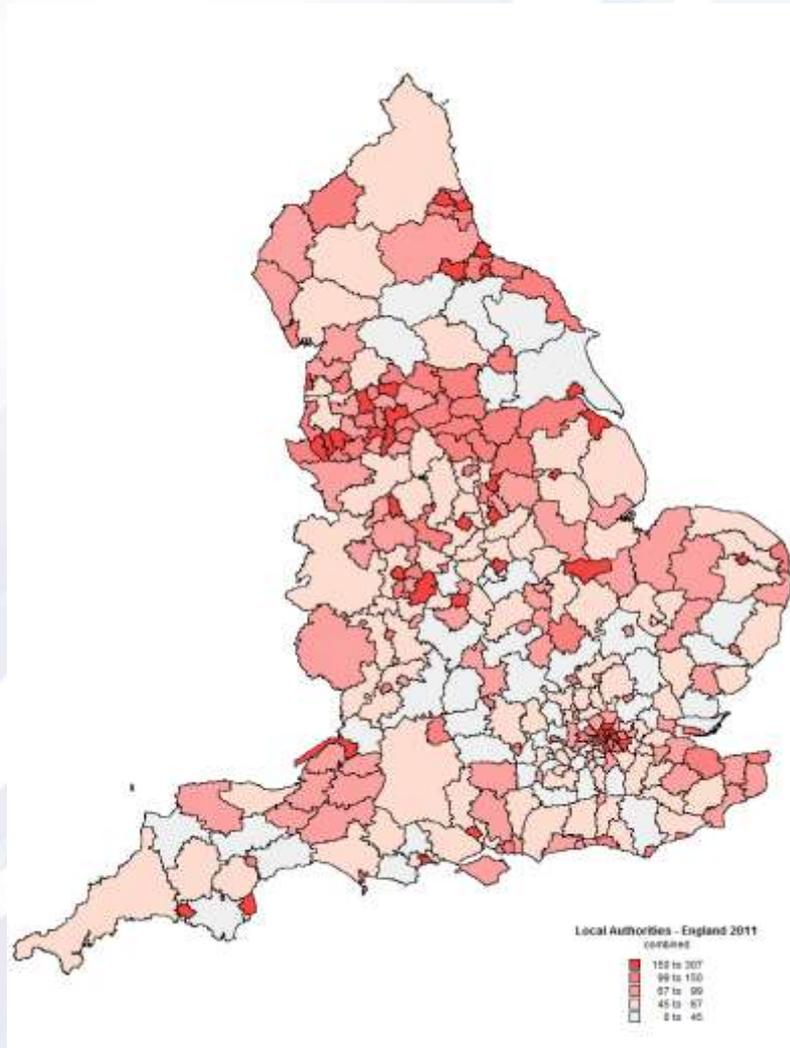
Families/Children

Parental and Child Contact Status by SMD Category for Substance Treatment population



- 85-90% of SMD are 'single homeless'
- However, *a majority* of SMD cases have links with children
 - as parent, living with own children
 - as parent, not living with own children but in contact with them
 - having other child contact, i.e. living with partner's children

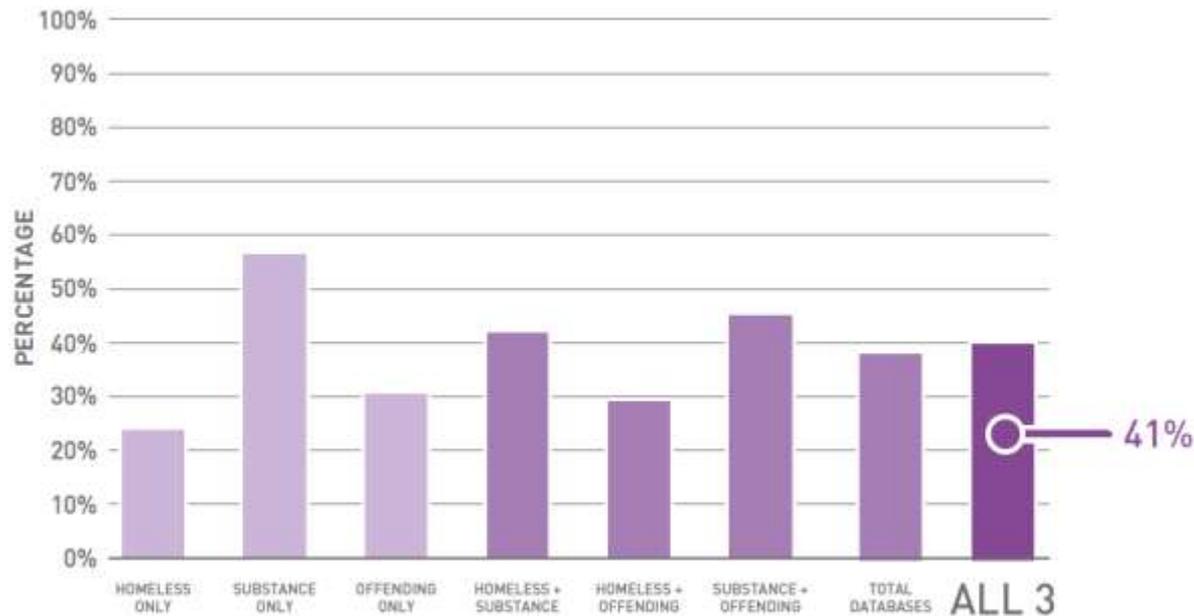
Geography



- All three main administrative sources tell a very similar story.
- SMD is concentrated in
 - core northern cities
 - declining industrial towns and ports
 - seaside resorts
 - some central London boroughs
- It is low in affluent rural and suburban areas
- Difference of 10x from lowest to highest (in prevalence)

Mental Health

Figure 10: Prevalence of mental health problems by SMD Category – composite of four data sources

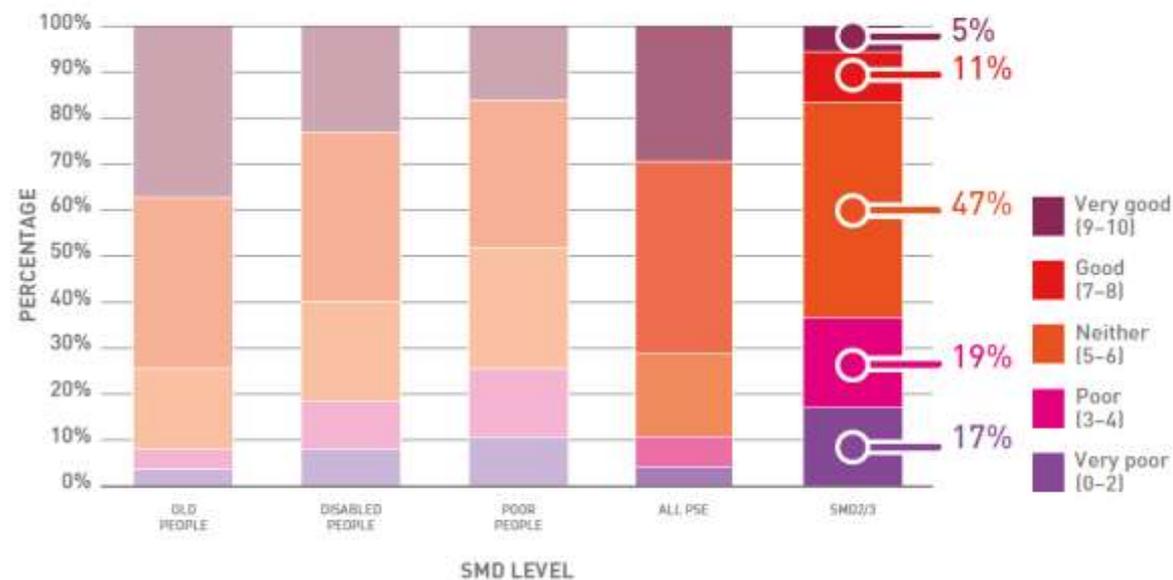


Sources: Authors' analysis of Inform data from seven homelessness providers, SP, OASys and MEH Survey (current status)

- Data is a mixture of self-reported, referral/file data, professional judgements etc.
- It likely understates severity profile

Quality of Life

Figure 12: Current overall quality of life rating comparing SMD group [MEH] with General population groups [PSE]



- Overall quality of life, based on standard questions, is rated very low (using MEH)
- Much worse than all benchmarks (drawn from PSE):
 - all adults
 - older people
 - disabled people
 - people living in poverty

Poverty and Complex Needs

- Poverty is almost universal in the SMD/complex needs population
- It is also a critical ingredient in all of the key ACEs:
 - » Child maltreatment
 - » Domestic violence and abuse
 - » Homelessness
 - » Parental substance misuse
 - » Parental mental ill-health

Five core principles

Personalisation: open-ended, persistent, flexible and co-ordinated support. ‘Whole-person’ ‘whole-family’ approaches which take into account underlying causes of complex needs and challenging behaviours

Deinstitutionalisation: as far as possible, people should have the option of staying in mainstream housing, rather than separate institutions

Reintegration: enabling people to go to work and other ordinary social settings

Asset-based: interventions focusing on an individual’s strengths

Poverty-informed: dealing with the financial and material hardship that people face, not just their social or personal needs or behavioural issues

Applying the principles

- **1. Children and families**
 - Sanctuary schemes
 - Family Intervention Projects
- **2. Young people**
 - Family mediation
 - Night stop/Supported Lodgings
 - Job coaching
- **3. Adults**
 - Housing First
 - Individual Placement schemes

Conclusions

- Adults with 'complex needs' have long-term histories of economic and social marginalisation
- Childhood trauma is core – 85% report adverse childhood experiences
- Early roots of adult complex needs found in:
 - poverty
 - very difficult family relationships
 - very poor educational experiences
- We have well evidenced core principles for 'systemic' action that cut across life stages, and some models that have been shown to work
- But must not lose sight of the overriding importance of 'structural' inequalities and poverty in driving people to the extreme margins of society, with catastrophic impacts on their health and well-being

Weblinks

- *Multiple Exclusion Homelessness* (ESRC, 2010-2012)

<https://www.hw.ac.uk/schools/energy-geoscience-infrastructure-society/research/i-sphere/homelessness-social-exclusion/multiple-exclusion-homelessness.htm>

- *Hard Edges: Mapping Severe and Multiple Disadvantage* (LankellyChase Foundation 2011-2015)

<http://lankellychase.org.uk/multiple-disadvantage/publications/hard-edges/>

- *Solve UK Poverty: Complex Needs* (Joseph Rowntree Foundation, 2012-2016)

<https://www.jrf.org.uk/solve-uk-poverty>

If you have any questions to the speaker,
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