Lankelly Chase Foundation

Hard Edges

Mapping severe and multiple disadvantage

England

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LankellyChase Foundation is an independent charitable trust that works to bring about change that will transform the quality of life of people who face severe and multiple disadvantage.

It focuses particularly on the clustering of serious social harms, such as homelessness, substance misuse, mental illness, violence and abuse and chronic poverty. Its work combines grant making, commissioned research and policy analysis, and special initiatives.

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Foreword

Most of us understand that people who are homeless, or offenders or drug misusers must also face a wider set of challenges. It is hard to imagine a person who has fallen into a hard drug problem, for example, who isn't dealing with early problems stemming from childhood or who isn't facing a new set of problems as a result of their drug taking.

Despite the common sense of this, we still categorise people in separate boxes defined by single issues. So a person who takes drugs to deal with childhood trauma, who falls into offending as a consequence, and loses their home when entering prison acquires three quite distinct labels. Each of these labels triggers a different response from statutory and voluntary systems, different attitudes from the public and media, different theoretical approaches from universities, different prescriptions from policy makers.

One structure that keeps these labels separate is the way we collect data. Each public system corresponding to a label maintains its own database in which the needs of individuals are separately analysed. The drug system analyses a person's homelessness problems, and the homelessness system analyses the person's drug problems. This data is rarely joined up, so we've had no way of establishing the degree to which those systems are all dealing with the same people.

LankellyChase Foundation focuses on the multiplicity of disadvantage that individuals and families can face. Our purpose in commissioning this report has been to address the fragmentation of data and so create the clearest quantitative picture possible of the reality of people's lives. By establishing the extent to which different systems overlap,

we hope to stimulate thought and action on whether single issue systems and services are any longer the most effective response.

The challenges of creating this profile have been considerable. For example, people on the extreme margins of society are often absent from authoritative household survey data precisely because they may be in prisons or hostels. The research has therefore had to rely heavily on administrative data from public services. In meeting this challenge, we have been fortunate to work with colleagues at Heriot-Watt University who were previously responsible for landmark research on 'multiple exclusion homelessness'.

The data contained in this report is the first step we are taking towards building a more comprehensive picture of severe and multiple disadvantage. The next stage of the research will include and analyse other datasets, such as from violence against women and girls services, which will reveal a different profile again. In helping to build this picture, we hope to contribute to a new discipline in quantitative research, less driven by the needs of systems, more grounded in the lives of people.

Julian Corner
Chief Executive, LankellyChase Foundation
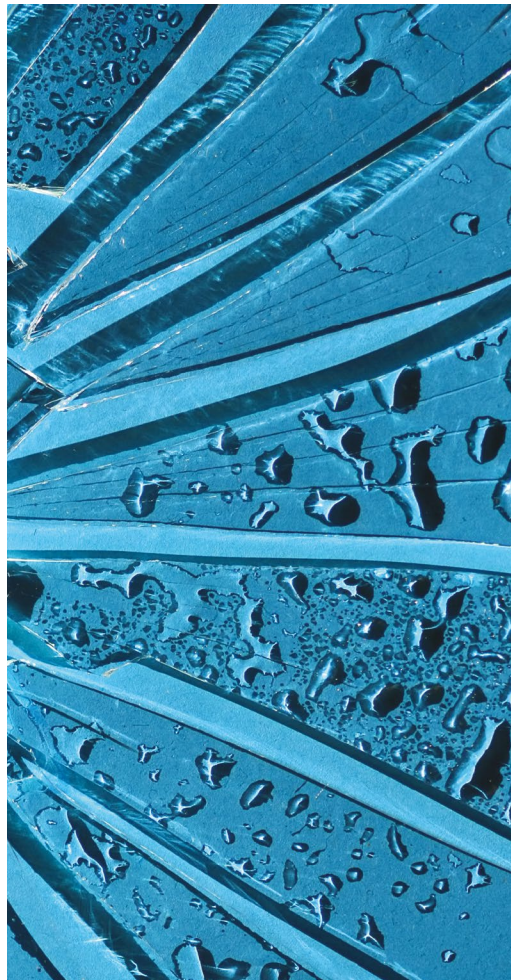
Acknowledgements

Summary

This study sought to provide a statistical profile of a key manifestation of 'severe and multiple disadvantage' (SMD) in England. In this report, SMD is a shorthand term used to signify the problems faced by adults involved in the *homelessness*, *substance misuse* and *criminal justice systems* in England, with *poverty* an almost universal, and *mental ill-health* a common, complicating factor. The study also included an initial qualitative scoping phase.

The main findings were as follows:

- each year, over a quarter of a million people in England have contact with at least two out of three of the homelessness, substance misuse and/or criminal justice systems, and at least 58,000 people have contact with all three;

- SMD, as defined in this report, is distinguishable from other forms of social disadvantage because of the degree of stigma and dislocation from societal norms that these intersecting experiences represent;

- people affected by this form of SMD are predominantly white men, aged 25–44, with long-term histories of economic and social marginalisation and, in most cases, childhood trauma of various kinds;

- in addition to general background poverty, it seems to be in the realms of (very difficult) family relationships and (very poor) educational experience that we can find the most important early roots of SMD;

- the 'average' local authority might expect to have about 1,470 SMD cases over the course of a year (as defined by involvement in two out of the three relevant service systems);

- in practice the distribution of SMD cases varies widely across the country, and is heavily concentrated in Northern cities and some seaside towns and central London boroughs. However, all local authorities contain some people facing SMD;

- the quality of life reported by people facing SMD is much worse than that reported by many other low income and vulnerable people, especially with regard to their mental health and sense of social isolation;

- SMD creates a significant cost for the rest of society, particularly with respect to disproportionate use of certain public services;

- there are also significant social costs associated with SMD, not least the potentially negative impacts on the children with whom many people facing SMD live, have contact, or are estranged from;

- there are some encouraging short-term improvements reported by services working with people who face SMD, but progress is weaker amongst those with the most complex problems.

Glossary of terms

Disadvantage domains: the three realms of negative experience focussed upon in this study, i.e. homelessness, offending, and substance misuse

Homelessness: a broad definition of homelessness is adopted, including not only rough sleeping, but also other forms of highly insecure and inappropriate accommodation, insofar as this is recorded in the key datasets

Index of Multiple Deprivation (IMD): the official suite of measures of deprivation for local and small areas across England

Indices: measures of the local prevalence of severe and multiple disadvantage derived from different sources expressed as an index number with an average value of 100

'In-Form': a dataset that monitors client journeys through selected homelessness services in England, and maintained by Homeless Link

Multiple Exclusion Homelessness (MEH): a quantitative survey of people using 'low threshold' homelessness, drugs and other services in seven UK cities conducted in 2010

Multiple regression analysis: a statistical process for investigating which variables have an independent effect on a particular outcome, when a range of other factors are held constant

National Drug Treatment Monitoring System (NDTMS): a national dataset that monitors client journeys through substance misuse services; a subset of this dataset covers alcohol services

Offender Assessment System (OASys): This dataset covers a substantial part of the prison population and also of those undertaking community service punishments

Offending: Involved with criminal justice system, whether in custody or under supervision, as a result of multiple and/or non-trivial criminal convictions

Severe and multiple disadvantage (SMD): experiencing one or more of the relevant disadvantage domains

SMD categories: specific combinations of the three disadvantage domains

SMD1: experiencing *one* only of these three specified disadvantage domains (i.e. 'homelessness only', 'offending only', or 'substance misuse only')

SMD2: experiencing *two out of three* disadvantage domains (i.e. 'homelessness + offending'; 'substance misuse + offending'; 'substance misuse + homelessness')

SMD3: experiencing *all three* relevant disadvantage domains. (i.e. 'homelessness + offending + substance misuse')

Substance misuse: participating in publicly-funded treatment for dependence on drugs (particularly opiates and crack cocaine) or alcohol

Supporting People (Client Record and Outcomes for Short-Term Services) (SP): a housing-related support services dataset that includes most publicly-funded single homelessness services and covers most higher tier (social services) authorities in England

Acronyms

DWP	Department for Work and Pensions
ESRC	Economic and Social Research Council
HNA	Homeless Link's Health Needs Audit
HSCIC	Health and Social Care Information Centre
IMD	Index of Multiple Deprivation
MEAM	Making Every Adult Matter
MEH	Multiple Exclusion Homelessness
MoJ	Ministry of Justice
NDTMS	National Drug Treatment Monitoring System
NOMS	National Offender Management Service
NTA	National Treatment Agency
OASys	Offender Assessment System
OPCS	Office of Population Censuses and Surveys
PHE	Office of Population Censuses and Surveys
SMD	Severe and multiple disadvantage
SP	Supporting People

Introduction

There is growing awareness that populations experiencing the sharp end of problems such as homelessness, drug and alcohol misuse, poor mental health, and offending behaviours overlap considerably (Fitzpatrick *et al.*, 2011; Department for Work and Pensions (DWP), 2012). There is also concern that these vulnerable individuals may 'fall between the gaps' in policy and services altogether, or be viewed through a succession of separate and uncoordinated *'professional lenses'* (Cornes *et al.*, 2011). People with multiple needs should be supported by effective, coordinated services (MEAM, 2008, 2009; Revolving Doors Agency and MEAM, 2011). However, making the case for this requires a robust evidence base, and data underpinning social policy for those on the extreme margins remains largely patchy and fragmented (Duncan & Corner, 2012; DWP, 2012).

The central aim of this study was to establish a statistical profile of the extent and nature of this form of severe and multiple disadvantage (SMD) in England, and to ascertain the characteristics and experiences of those affected, insofar as possible. A helpful precursor for this exercise can be found in MEAM's (2009) indicative snapshot estimate of the number of individuals in England with 'multiple needs and exclusions' (56,000), which drew on Schneider's (2007) psychologically- and medically-orientated study of 'chaotic lives' and 'multiple needs'. Schneider in turn based some of her estimations on data generated back in the 1990s, by major surveys of psychiatric morbidity amongst homeless people (Office of Population Censuses and Surveys (OPCS), 1997) and prisoners (Singleton *et al.*, 1998).

The purpose of this current profile was therefore to bring these estimates up to date, place them on as reliable a statistical footing as possible, and provide a more detailed and socially-orientated picture of relevant overlaps, trends, geographical distribution, background factors and causation, quality of life and service outcomes, and social and economic costs. It is premised on making the best possible use of existing administrative and survey data, including 'triangulating' (cross-checking) findings from independent sources. It is limited, by definition, to the information and evidence that can be gleaned from interrogating these datasets. While in many respects exploratory rather than definitive, it offers the most robust account to date of the overlap between groups subject to these specific multiple and extreme forms of disadvantage.

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Methodology

Methods

The initial phase of the study was a qualitative scoping exercise, involving a wide-ranging literature and policy review, complemented by interviews with people with direct relevant experience and senior stakeholders in the fields of homelessness, substance misuse, criminal justice and mental health (see Appendix A for details).

The main phase of the study focused on developing a statistical profile of SMD via an integrated analysis of the following 'administrative' (i.e. service use) datasets which, crucially, contained data about service users' experiences and needs across a range of relevant 'disadvantage domains':

1. Offender services – Offender Assessment System (OASys). This dataset covers most of the prison population, and also those on parole and undertaking community service punishments.[1]

2. Substance misuse services – National Drug Treatment Monitoring System (NDTMS); a subset of this dataset covers alcohol services.

3. Homelessness services – Supporting People (Client Record and Outcomes for Short-Term Services) (SP), augmented by 'In-Form' datasets maintained by selected major homelessness service providers in England accessed with the help of Homeless Link.

These administrative dataset analyses were complemented with interrogation of two recent survey-based statistical sources: the 'Multiple Exclusion Homeless' (MEH) survey (Fitzpatrick *et al.*, 2013), and the ESRC 'Poverty and Social Exclusion' (PSE) survey 2012.[2]

The key potential concern in such an administrative data-led approach is omitting individuals who are not in touch with relevant services. However, it was established in the scoping phase of the study that, while people with facing multiple disadvantage may not be in touch with *'each and every service they need'* (Clinks *et al.*, 2009, p.8), the configuration of these services is such that that the chances of

them being in touch with *none* of them is much slimmer. This is important because, so long as relevant individuals are in touch with *at least one* of the services discussed above, they are captured in the 'population universe' for our integrated service data-led analysis.

Nonetheless, in the estimates provided we include an evidence-based national total figure for the main potential missing group: substance misusers not in treatment. While we considered the possibility of providing a similar national estimate for homeless people[25] not in touch with SP services, a reconciliation exercise involving all of the available survey and administrative datasets found that there was no strong evidence case for an upward adjustment in our total homelessness numbers (see Appendix C for details).

A secondary concern with this approach is that, while we may capture most relevant individuals in one or another of the datasets, any one dataset will probably not have all of them, and there may be some difference in the profile of each 'sub-group' or 'segment' in the population, when viewed through the lens of one dataset rather than another. There is some evidence of such differences in demographics, for example gender (more females in SP than in OASys). Such differences may suggest that our overall totals are too low. However, consistent with the overall approach in this study, which is conservatively built on administrative datasets relating to people using or in contact with services, we do not attempt to adjust reported numbers to allow for this.

This synthesis report integrates the key findings from both the qualitative (see Appendix A) and the quantitative stages of the study (see Appendices B-I for methodological and technical details). It is worth noting that where possible we combine evidence from three or four sources to generate composite profiles of the relevant populations, we weight these average profiles to reflect the extent to which particular sub-groups/segments are represented in particular datasets. Where one dataset has markedly more informative evidence on a particular issue, we focus simply on that dataset.

[1] OASys is completed for most of those in the community at Tier 2 and above, and for all 18–20 year olds in prison and all older prisoners on sentences of 12 months or greater. See further discussion in Appendix D.

[2] www.poverty.ac.uk

[3] The definition of 'homelessness' used in this study had to be necessarily wide and somewhat variable, given our dependence on what was available in the relevant datasets. Thus with regard to SP, we defined as 'homeless' all individuals classified by client group as 'single homeless', 'rough sleeper', and 'family homeless', together with anyone else using relevant types of service (e.g. refuge, foyer) or types of accommodation (e.g. temporary accommodation, B&B, with friends), and assessed prior statutory/other homelessness status, In OASys homelessness was identified by cases with 'no fixed abode' plus those with 'significant' problems with the suitability, permanence or location of their current home. In NDTMS we defined homelessness using the 'Accommodation Status' categories of 'NFA- urgent housing problems' or 'housing problems'; although potentially broader, we were advised that NDTMS tended to under-record housing problems and this helps to balance coverage.

Defining severe and multiple disadvantage

Defining SMD in this study

There are of course a great many forms of societal disadvantage, and the Coalition Government has used the term 'multiple disadvantage' to refer to a wide-ranging set of concerns in the realms of education, health, employment, income, social support, housing and local, calculating that as many as 5.3 million people (11% of the adult population) are disadvantaged in three or more of these areas at any one time (HM Government, 2010).

Our current profiling exercise was far more tightly focused on a particular conceptualisation of the *extreme margins* of social disadvantage, as this is where there was felt to be the most profound evidence gap. Our initial proposal was that this SMD profile should focus on people who had experienced some combination of homelessness, substance misuse, mental health problems, and offending behaviours, as this particular set of experiences is strongly resonant with what is often termed 'multiple needs', 'complex needs' or 'chronic exclusion'(Rankin & Regan, 2004; Rosengard *et al.*, 2007; Clinks *et al.*, 2009; Hampson, 2010; Revolving Doors and MEAM, 2011; DWP, 2012; Duncan & Corner, 2012), and people with this profile of need might not be captured in statistical exercises that rely on household surveys.[4] There are also evidence-based reasons for thinking that this specific nexus of issues not only overlaps in practice for many individuals (Fitzpatrick *et al.*, 2013), but also comprises a set of mutually reinforcing causal inter-relationships (Fitzpatrick, 2005) that serve to push people to the edge of mainstream society (McNaughton, 2009).

In the scoping phase of the study we found that these four 'disadvantage domains' commanded broad consensus amongst our stakeholder interviewees, and the service user interviewees likewise identified this set of experiences as the crucial set of (negative) interactions in their lives.

"Usually people have got more than one... it's never really down to one thing. You usually have the addiction which will then highlight other problems, which are mental health, situation, background, stuff like that. How they grew up socially, in certain situations where they came from. Not always, and criminality... Say homelessness you might see as a problem but that might tie into other things like addiction and mental health..."

Service user

"For my point of view, they seem to be the right sort of groups... if you pick one group, say offenders, they have various sort of dimensions of disadvantage, don't they? So, for example, a lot of them are homeless, substance misuse problems and mental health is a big issue. So, I think they are the key ones from my perspective."

Academic expert

The extreme nature of SMD, as defined in this report, was often said to lie in the multiplicity and interlocking nature of these issues (Duncan & Corner, 2012), and their cumulative impact, rather than necessarily in the severity of any one of them. For example, the argument was made that this form of SMD tends not to be associated with the most serious forms of offending, but rather with persistent, low-level offenders serving short prison sentences ('churn prisoners') or community sentences, who generally have a much more 'disrupted lifestyle' than those serving longer prison sentences, of whom some will be 'high functioning' (see also Revolving Doors Agency, 2012).

» **The extreme nature of SMD, as defined in this report, was often said to lie in the multiplicity and interlocking nature of these issues, and their cumulative impact** «

[4] Household surveys will by definition exclude people with no fixed abode or living in 'institutional accommodation' such as hostels, shelters, B&Bs, prisons or hospitals; they are likely to record limited or no information in respect of people who are staying on a temporary and informal basis; and they are known to have generally low response rates in areas of relatively high deprivation and transient populations.

Another key point to emerge was that this form of SMD was felt to be distinct from other types of social disadvantage because of the degree of dislocation from societal norms that these intersecting experiences represent. The association with perceived behavioural 'deviance' or 'transgression' (McNaughton, 2009; Fitzpatrick & Stephens, 2013), means that a particularly high degree of stigma is thought to attach to people caught up in the homelessness, substance misuse or criminal justice systems (MEAM, 2008; Shelton *et al.*, 2010):

> *"… clearly these are potentially groups that are disadvantaged by also being heavily stigmatised and therefore perhaps that's a reason for focussing on these particular ones."*
>
> Academic expert

The service users interviewed certainly felt the issue of stigma keenly:

> *"Being judged and labelled: I think that helps you get to the point because you get to a stage, if you've heard it all your life then you just think, well, if I'm being judged and labelled as this kind of person then…"*
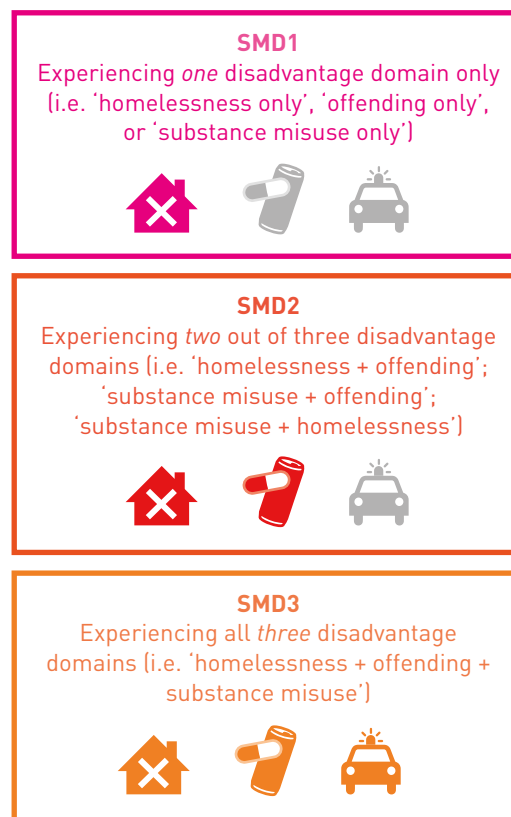>
> Service user

» SMD was felt to be distinct from other types of social disadvantage because of the degree of dislocation from societal norms «

Drawing on remarks made across all of the interviews, there appeared to be two key factors contributing to stigma in this context: the degree of *social harm* thought to be brought about by the activity or issue in question, and the extent to which it was perceived to be within the affected person's *locus of control*. Broadly speaking, the following 'stigma hierarchy' could be identified:

1. Offending (considered most harmful/ in personal control)

2. Substance misuse

3. Homelessness

4. Mental health problems (considered least harmful/in personal control)

Also relevant here is the fact that mental ill-health is a much more widespread experience in the general population than these other three domains of societal disadvantage (see below). However, significant methodological problems were posed by the absence of a unified national dataset on the delivery of mental health services which, crucially, included data on the other domains of interest. The focus of these services on people with the most acute mental health conditions rather than those with multiple needs was another methodological barrier. Mental ill-health was therefore treated not as a definitional parameter within this research, but rather as a primary aspect of the 'quality of life' profiling of people experiencing the remaining three core SMD domains.

We differentiate between the various categories of SMD experiences reported on in the remainder of this report as follows:

SMD1
Experiencing *one* disadvantage domain only (i.e. 'homelessness only', 'offending only', or 'substance misuse only')

SMD2
Experiencing *two* out of three disadvantage domains (i.e. 'homelessness + offending'; 'substance misuse + offending'; 'substance misuse + homelessness')

SMD3
Experiencing all *three* disadvantage domains (i.e. 'homelessness + offending + substance misuse')

Scale, overlap and trends

We estimated the annual scale of this form of SMD in England by combining data from our three service-based data sources (OASys, NDTMS, and SP), with 2010/11 selected as the optimal year for analysis for reasons of data coverage and quality.

Figure 1 presents our composite 'best estimate' of the annual number of people affected by the combination of issues in each SMD category, with the data source for each segment chosen by judgement as the most appropriate for measuring that particular group or overlap. This reliance on one (most appropriate) dataset per segment means that the figures below should be treated as probable minimums given that, as discussed above, we know that people do not access all of the services relevant to their needs.

Our annual estimate for the core **SMD3** category, who experience all three disadvantage domains, is **58,000**.[5]

When we look at the **SMD2** 'overlap' category, we find that about 99,000 people have a combination of substance + offending issues; about 31,000 people have a combination of homelessness + offending issues; and about 34,000 homelessness + substance issues, totalling **164,000**.

Finally, we estimate that around **364,000** people are in the **SMD1** category, comprising around
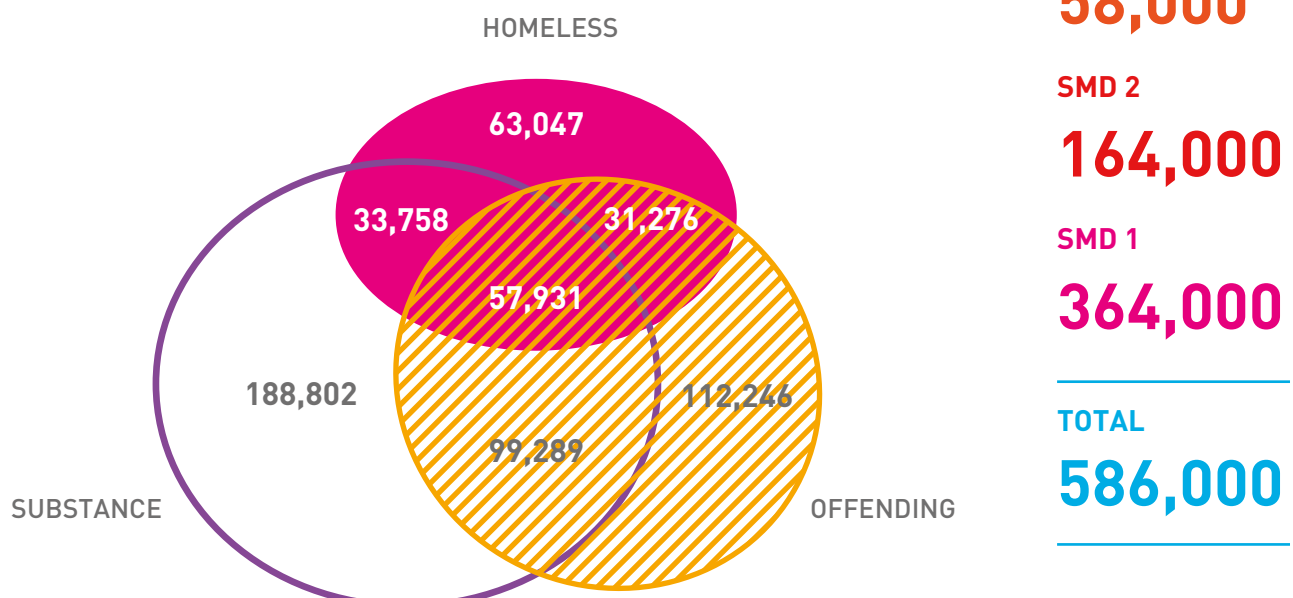
112,000 people receiving services relating to offending only, 189,000 to substance misuse only, and 63,000 receiving services relating to homelessness only.

In total, around **586,000** individuals received services across the three domains over the course of 2010/11. These data suggests a national prevalence rate of SMD1 of 9.3 people per thousand, SMD2 of 4.2 people per thousand, and SMD3 of 1.5 people per thousand, making 15 per thousand in all, based on the adult working age population of England. An 'average' social services local authority might therefore expect to have about 1,470 active cases over a year (using SMD2/3 as the threshold), including 385 with disadvantages in all three domains. In practice, as we show below, this rate varies widely across the country.

>> Key informants argued that in these three domains (but not in mental health) it was likely to be the **majority** not minority of service users who faced SMD «

[5] Note that this is very close to the 56,000 estimate made by MEAM (2009), but they differ in a number of respects, including that our estimate is an annual prevalence, whereas MEAM's is a 'point-in-time' snapshot estimate.

Figure 1: Overlap of SMD disadvantage domains, England, 2010/11

HOMELESS

63,047

33,758   31,276

57,931

188,802   112,246

99,289

SUBSTANCE   OFFENDING

SMD 3
58,000

SMD 2
164,000

SMD 1
364,000

TOTAL
586,000

Most key informants argued that in these three domains (but not in mental health) it was likely to be the *majority* not minority of service users who faced SMD (see also Schneider, 2007; MEAM, 2009; Ministry of Justice, 2010; Revolving Doors Agency, 2012; Fitzpatrick *et al.*, 2013).

"I think it would be very rare for someone just to have an issue. So, if it's an offender where it's just their offending record that's an issue they're unlikely to need significant help from us generally. And the same on the homeless side, there will be very few people who are sleeping rough on the streets tonight who their only issue is they haven't got a house over their head. So, I would normally expect to see a multiple degree of barriers."
Statutory sector key informant

"One of the things people say in our sector… their problem with the multiple need agenda is they're not quite sure who it would exclude rather than who it would include."
Voluntary sector key informant

Our statistical analysis enabled us to confirm this to be the case. Within the homelessness data, only 34% of people were classed as 'homeless-only', and with the offenders data 37% were 'offender-only'. The case of substance misuse appears less clear-cut, insofar as 'substance-only' appears to account for around 60% of cases. However, it should be noted that this is taking drug and alcohol misuse together; for drug misuse service users, the overlap with other issues is higher (48% overlap for drugs, 24% for alcohol).[6]

» **Within the homelessness data, only 34% of people were classed as 'homeless-only', and with the offenders data 37% were 'offender-only'** «

The above analysis is still based on conservative estimates, in that they include only those people who are receiving services in at least

one of the domains. It is known that this does not capture the whole population with problems in the substance misuse domain in particular. We have therefore made an alternative calculation based on adjusted total populations for drugs (Hay *et al.*, 2011) and alcohol (NTA, 2013) misuse as statistical bases for this 'upwards adjustment' exercise were available from the existing literature. This raises the 'SMD1' total estimate to 552,000, 'SMD2' total estimate to 209,000, but leaves SMD3 at 58,000, and the combined SMD1/2/3 to 819,000. We think that this is closer to a true estimate of the prevalence of SMD, although further upward adjustment might be warranted from evidence of different demographic profiles. But because our general approach rests on working with databases for people in touch with services, in what follows we continue to work with numbers relating to the more conservative totals above.

Although all of the main sources of data cover the time period 2006–2012, changes in coverage, classifications used, and in some cases the unavailability of date information, placed limitations on the extent to which we can offer a picture of trends over time.[7] Moreover, caution is required when using primarily administrative data to derive trends, as fluctuations in the number of service users will in some cases be significantly influenced by changes in the supply of services.

All that said, the data available is indicative of broad stability in the annual numbers affected by SMD. Within the SP dataset, for example, the annual number of SMD2/3 cases has remained static at around 85,000 since 2009, though there has been a slight decline in SMD1 cases, which may indicate a reduced capacity on the part of SP services to support those with less complex needs as a result of funding cuts[8] (see Homeless Link, 2014).

The most interesting trends 'story' to emerge from our analysis relates to the drug treatment data from NDTMS (see Figure 2 on page 15). This suggests an increase in the total number of people using drugs services up to 2008, mainly accounted for by an increase in those with homelessness/ housing issues or with problems across all three SMD domains (although this may also be an artefact of improved recording of housing problems). There is then a gentle decline to 2010, and a slightly sharper decline in 2011. The numbers

6   It is also highly likely that the drug/homelessness overlap is under-recorded in NDTMS.

7   SP client data can provide reasonably consistent timelines for 2009–2012, and NDTMS similarly for 2008–11; date information was omitted from OASys dataset provided, although published MOJ statistics give timelines for main offender populations.

8   Supporting People overall spending budgeted by local government in England reduced by 48.8% in real terms between 2010/11 (original budget) and 2014/15, based on analysis of CIPFA *Financial and General Statistics* carried out as part of Annette Hastings *et al* study for Joseph Rowntree Foundation on *Counting the Cost of the Cuts* (report forthcoming).

with only drug issues declines throughout the period. This pattern may be related to the apparent recent decline in illicit drug use amongst younger age cohorts (Health and Social Care Information Centre (HSCIC), 2013; Home Office, 2013). However, there were also potentially relevant changes affecting the treatment system over this period, with a significant policy move in 2008 in favour of promoting recovery as opposed to numbers in treatment (Roberts, 2009). In 2010 drug treatment responsibility moved to Public Health England, with new outcomes for commissioners that were wider in scope. Thus, changes to incentive structures around treatment could also explain part of the pattern indicated in Figure 2.

In addition to considering how the net total of people affected by SMD changes over time, it is also instructive to look at how 'dynamic' this population is, i.e. the extent to which it is the same individuals affected by SMD year on year, or if there is a substantial 'inflow' and 'outflow', so that there is significant turnover in the actual individuals involved. Our analysis,

taking SMD2/3 as the threshold, suggests that the extent to which the SMD population is 'static' or 'dynamic' in this sense differs between the datasets reviewed. In other words, the proportion of the total number ('stock') receiving services in a year comprised of new cases ('inflow') in any given year (i.e. people who were not in this population in any previous year for which we have data) differs markedly between them. For example, in the case of the offending dataset we estimate that the inflow of new cases is only one-quarter of the stock (45,000 vs 184,000), underlining the high level of re-offending for this group. In the homelessness-services based SP data, the inflow of cases in 2010/11 was much higher at 85,000 compared with the stock estimate of 109,000, but in this case the inflow includes cases who may have been in SMD category in previous years. For drug and alcohol treatment data, the inflow of cases was somewhere in between relative to the stock (59,000 vs 124,000). Thus, as things stand, it is difficult to come to a clear view on the extent to which this population can be characterised as dynamic or static.

Figure 2: Drug treatment new client-journeys by SMD categories 2006–11
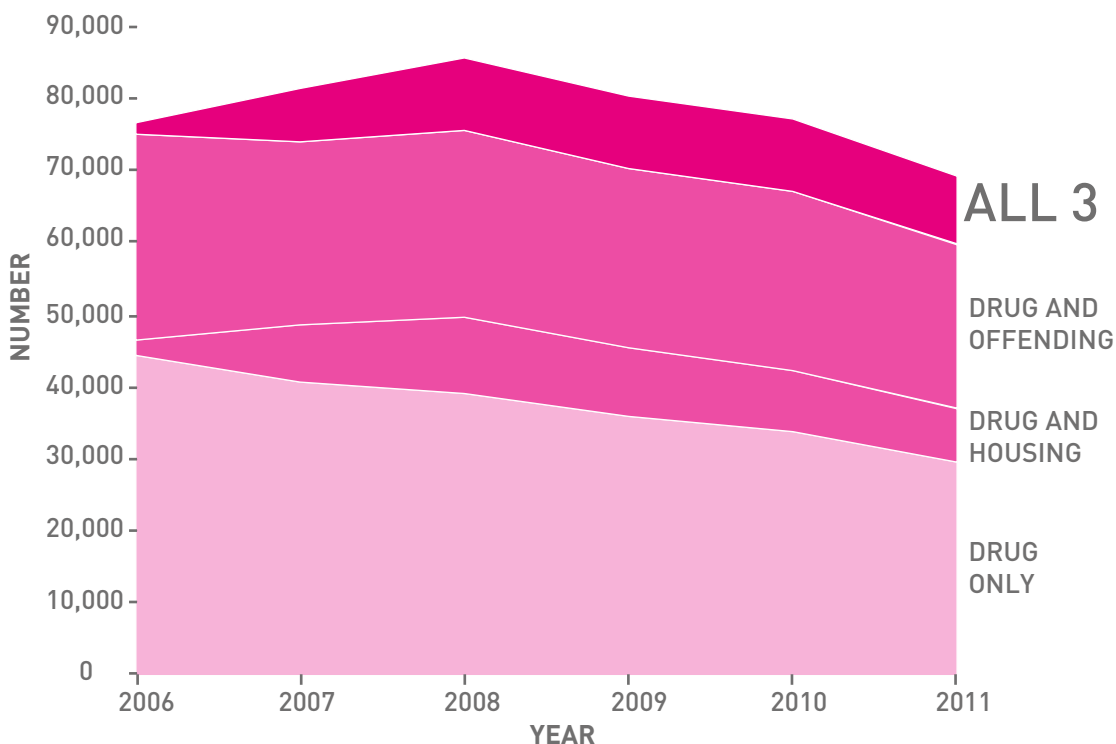
Source: NDTMS

Profile (gender, age, ethnicity, family status)

Gender

Previous research had suggested that SMD, as seen through the lens of offending, substance abuse and homelessness, was likely to be a predominantly male phenomenon (e.g. Fitzpatrick *et al.*, 2013),[9] and our composite analysis of the three main administrative data sources confirms this. As indicated in Figure 3 below, while women represent a small majority of those who experience homelessness only, males predominate in the substance and, especially, offending domains, and hence also in the combinations of two or more domains (ranging from 71% of homeless + substance, to 78% of SMD3, and 85% of homeless + offending).
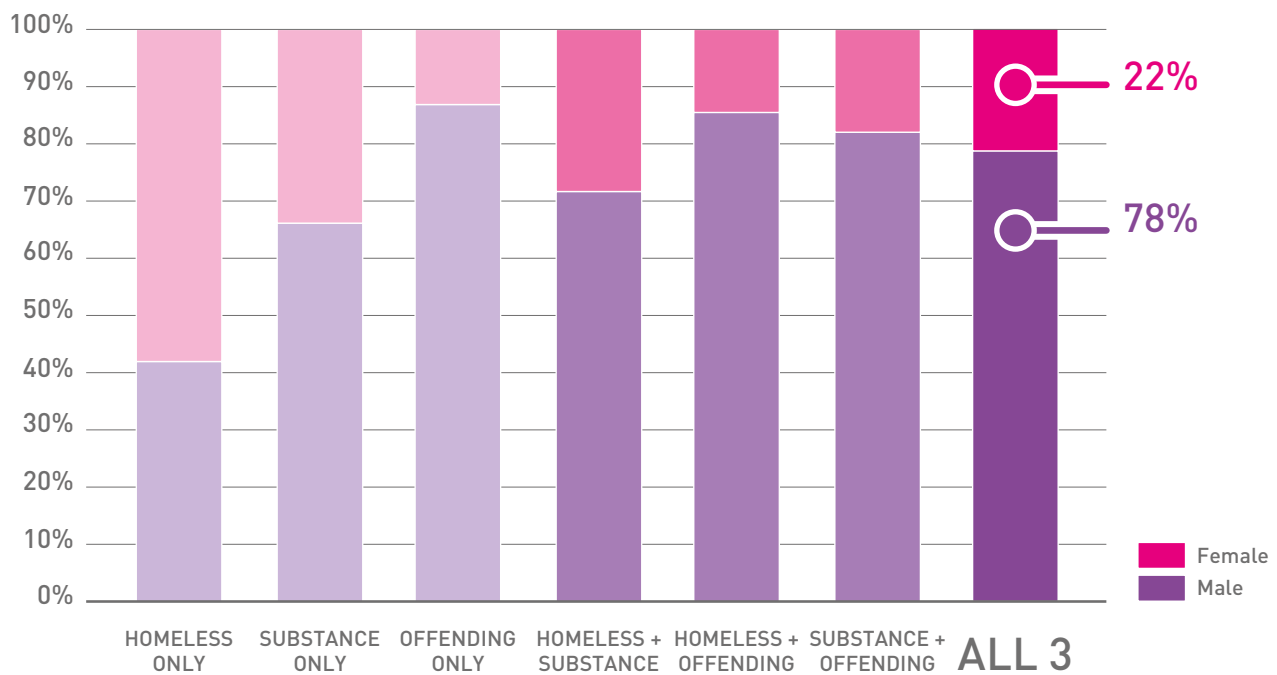
[9] Though note that street sex work, closely interrelated with some of these more extreme manifestations of SMD, is dominated by women (Fitzpatrick *et al.*, 2013).

8 out of 10
people facing SMD are men

Figure 3: Gender composition of SMD categories based on composite of main sources

Source: Composite of SP, OASys and NDTMS

Age

For all SMD categories apart from homeless-
only, the most common age group is 25–34
years old, and in most instances the next most
common category is 35–44 years old (Figure 4).
The dominance of the 25–44 year old age band
is most marked for those SMD categories that
include substance misuse and/or offending.
It is notable that the homeless-only category
is the youngest, with over 40% aged under 25[10]
(see also Homeless Link, 2014), whereas the
substance-only category is the oldest, with one
quarter aged 45–64. There are very few over
65s in any SMD group. This age breakdown,
as with the gender profile above, is very similar
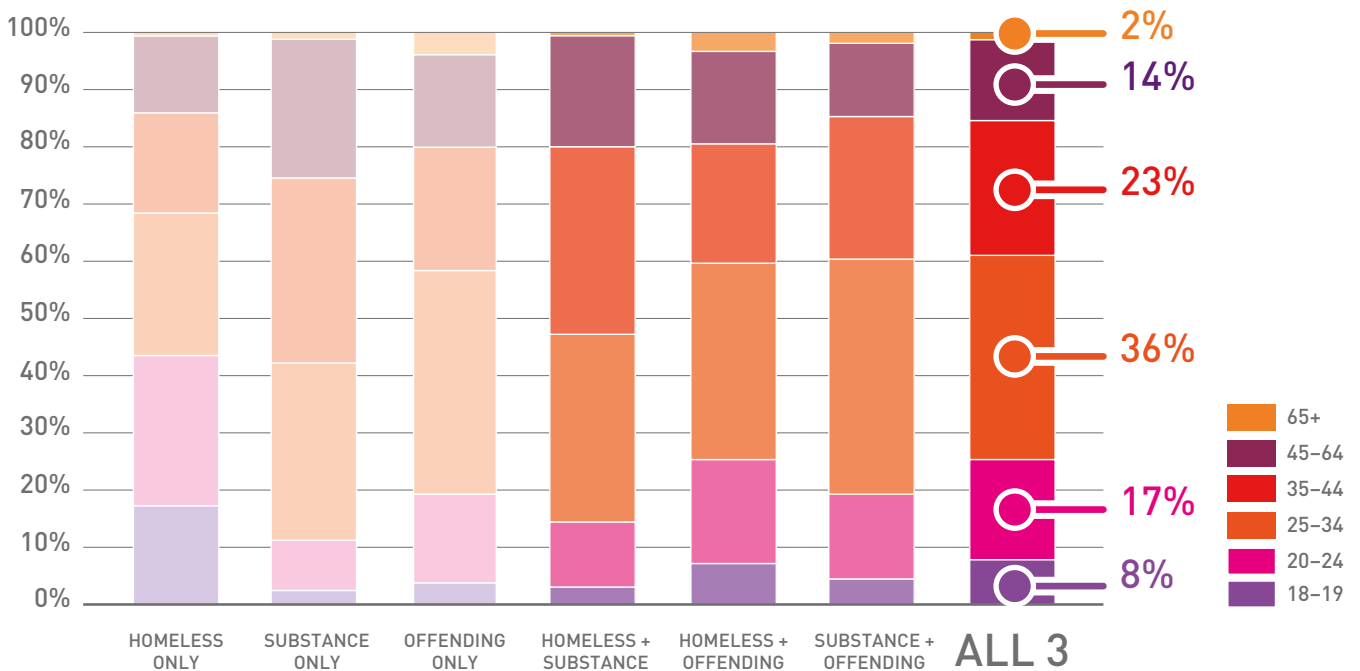to that found in the MEH survey (Fitzpatrick
et al., 2013).

**This form of SMD
predominantly affects
men aged**

25–44

Figure 4: Age profile of each SMD category in 2010 based on composite of three
main sources

Source: Composite of SP, OASys and NDTMS

Interestingly, however, these age profiles appear to be changing over time, which is most apparent in the drug treatment SMD population (see Figure 5 below). This suggests that there is a cohort ageing process at work here – a group of people who were younger adults in the early 2000s, and were then dominant in the drug misuse scene, are moving up the age categories while still remaining active drug users (see also National Treatment Agency, 2012; Morgan, 2014).

At the same time, there may be fewer young people entering the drugs treatment system as a result of the changing nature of drug cultures (HSCIC, 2013; Home Office, 2013), though the evidence on this point is somewhat inconclusive (e.g. see King *et al.*, 2013.)

Figure 5: Age profile of drug treatment intake over time
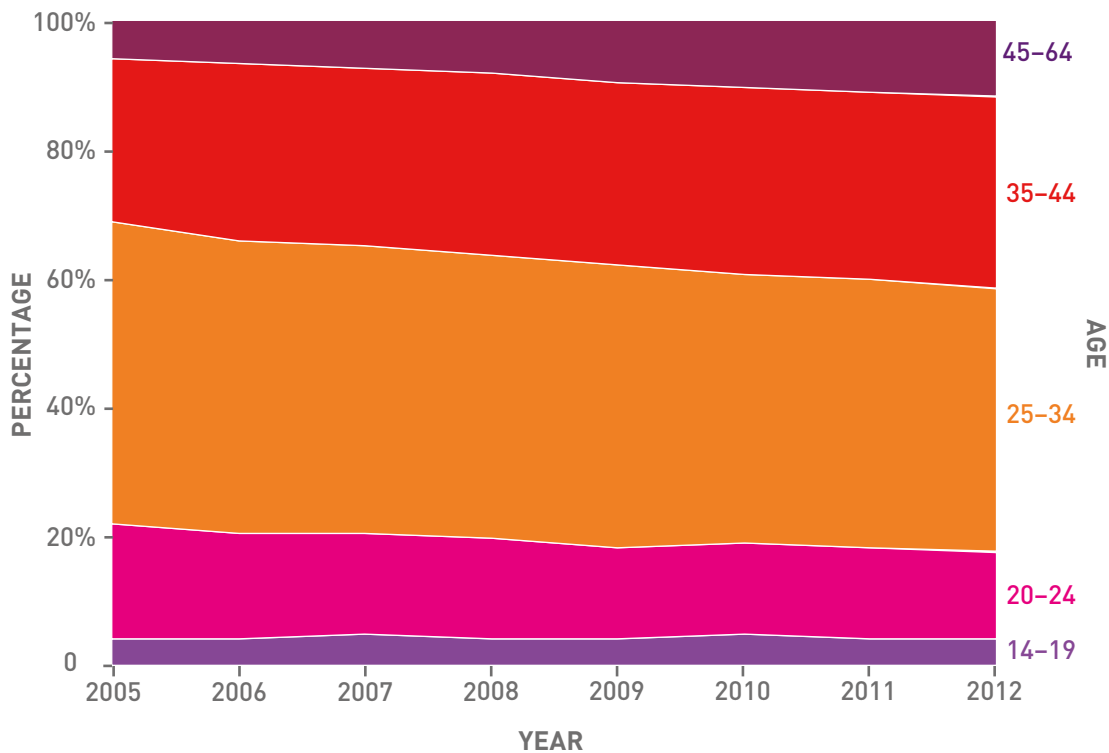
Source: NDTMS Drug treatment cases – flow of treatment journey starts

Race and ethnicity

As can be seen from Figure 6 below, the SMD population as defined here is predominantly white, in line with the working age population of England as a whole, but this is most strongly the case in the substance-only group (89%), and least so with respect to the homeless-only group (74%). There is the reverse story for black and mixed race clients of the relevant agencies: these groups are strongly over-represented in the homeless-only category, and also to some extent in the homeless-offender and offender-only groups. Asians are generally underrepresented in all of these SMD populations, except homeless-only. Again, this pattern of ethnicity mix echoes closely that found in previous research (McNaughton Nicholls & Quilgars, 2009; Fitzpatrick *et al.,* 2012).

Figure 6: Broad ethnic group composition of SMD categories (percent of each SMD category)
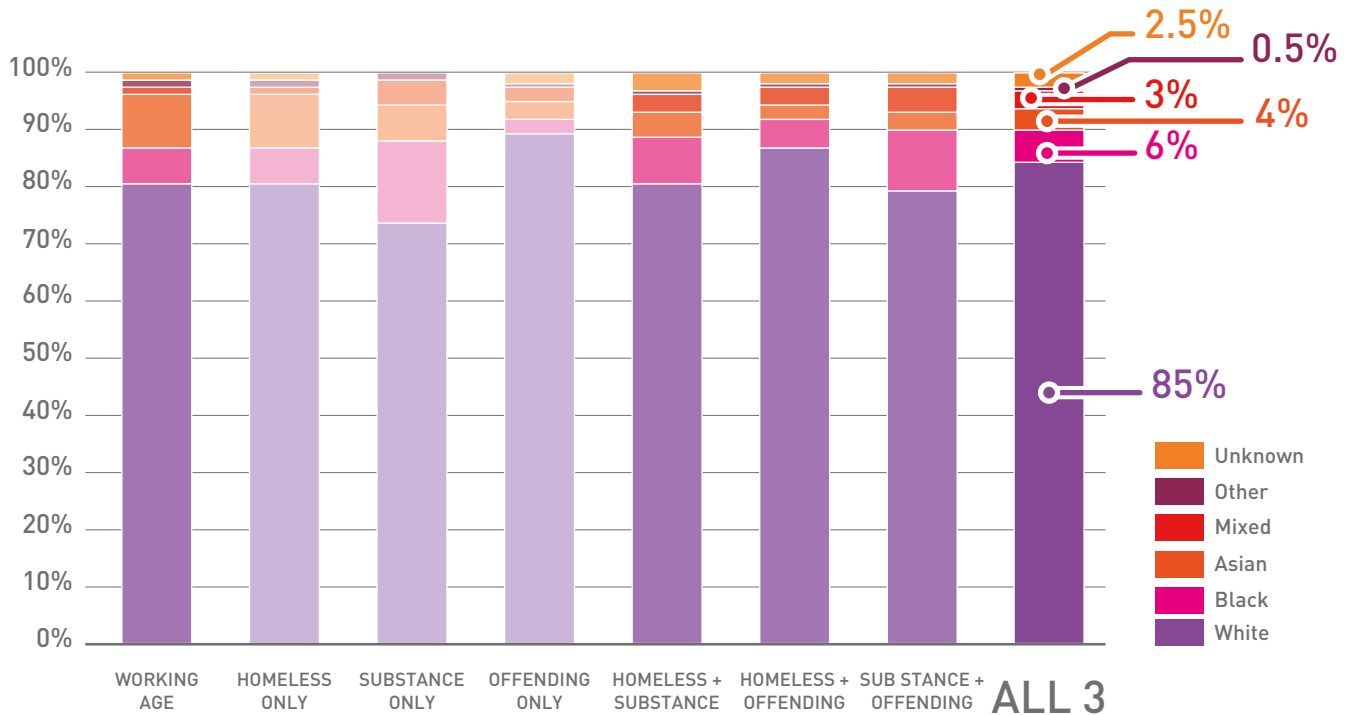
Source: Composite of SP, OASys and NDTMS with PSE benchmark for working age population

Migrants

Using the MEH survey we are able to provide rather more of a picture of SMD groups in terms of migrant status, although it should be stressed this is based on a moderate sized sample of adults in only seven cities, one of which (Westminster) is rather exceptional. Excluding Westminster, less than 10% of the overall SMD group in MEH had migrated to the UK as adults (including current and former asylum seekers, as well as A10 migrants, undocumented migrants, and other migrants), but that this proportion was higher in SMD1 (mainly homeless-only cases). Including Westminster, the overall proportion of migrants rises to 21%, with a particularly high rate (around 50%) in SMD1, but a lower level in SMD3 (only 13%) (see Fitzpatrick *et al.* (2012) for more details).

Household and family status

Our analysis confirms the preponderance of single person rather than family households in the service systems focussed upon in this study (see also Fitzpatrick *et al.*, 2013). Thus, the SP database indicates that, while nearly a third of 'homeless only' clients are living as part of families with children, this group forms only a small minority of those in the various SMD combinations – one-in-seven (14%) of homeless-offender group, and one-in-ten of the homeless-substance and SMD3 groups (Figure 7). Analysis of OASys seems to suggest a somewhat similar story, with only one quarter (27%) of SMD2/3 offenders reporting that they have 'parenting responsibilities'.

Figure 7: Proportion of homeless families vs single homeless in SP population by SMD category
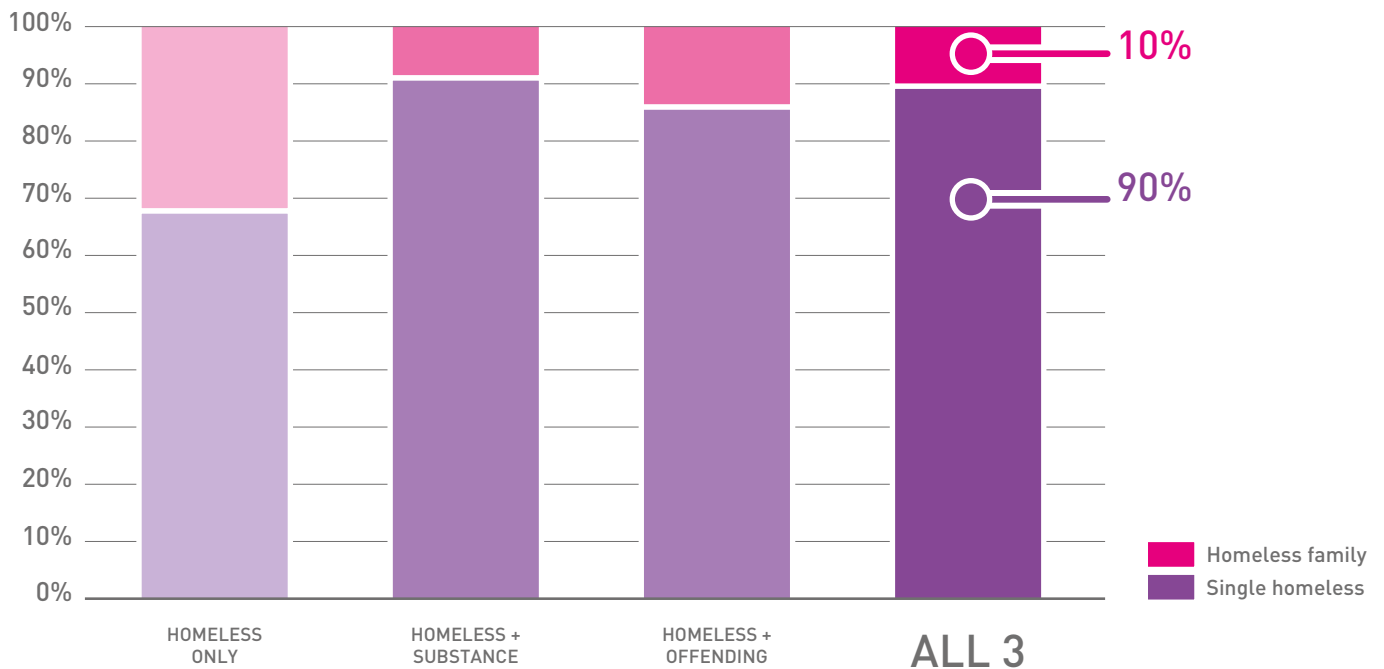
Source: SP client records with ID

However, data from the substance treatment database presents a fuller and very interesting picture with regard to child contact amongst the SMD population (Figure 8). While only one fifth (21%) of the substance treatment adult population are parents living with their own children, another 14% are living with other people's children (presumably mainly their partner's children), or have contact with their own children while not living with them (20%) – the last of these being more predominant for SMD3 cases.[11]

The implications of Figure 8 are highly significant in several respects. First, they undercut the idea that SMD is about single adults living lives entirely disconnected from families with children. That is evidently not true

of a majority of the SMD population in one of our main data sources. Even amongst those with the most complex needs, in the SMD3 group, almost 60% either live with children or have ongoing contact with their children while not living with them. Second, they underline the potential indirect social cost which can stem from the impact of adult substance misuse on children, with children in these families potentially affected by chaotic lives, economic and housing insecurity, and social stigma, not to mention heightened risks of neglect, abuse and domestic violence (see below). Third, and correspondingly, they point to the greater value of the prize, in terms of saved social and financial cost, which may be secured by successful coordinated interventions with this group.

[11] See also a recent analysis of drug-related deaths in Scotland which established that around one third of the deceased were 'a parent or parental figure' (Hecht et al., 2014).

Even amongst those with the most complex needs, in the SMD3 group, almost

60%

either live with children or have ongoing contact with their children

Figure 8: Parental and child contact status by SMD category for substance treatment population

SUBSTANCE ONLY

SUBSTANCE + HOUSING

SUBSTANCE + OFFENDING

SMD3

Legend:
- Parent living with own children
- Other child contact – living with children
- Other child contact – parent not living with children
- Not a parent / no child contact
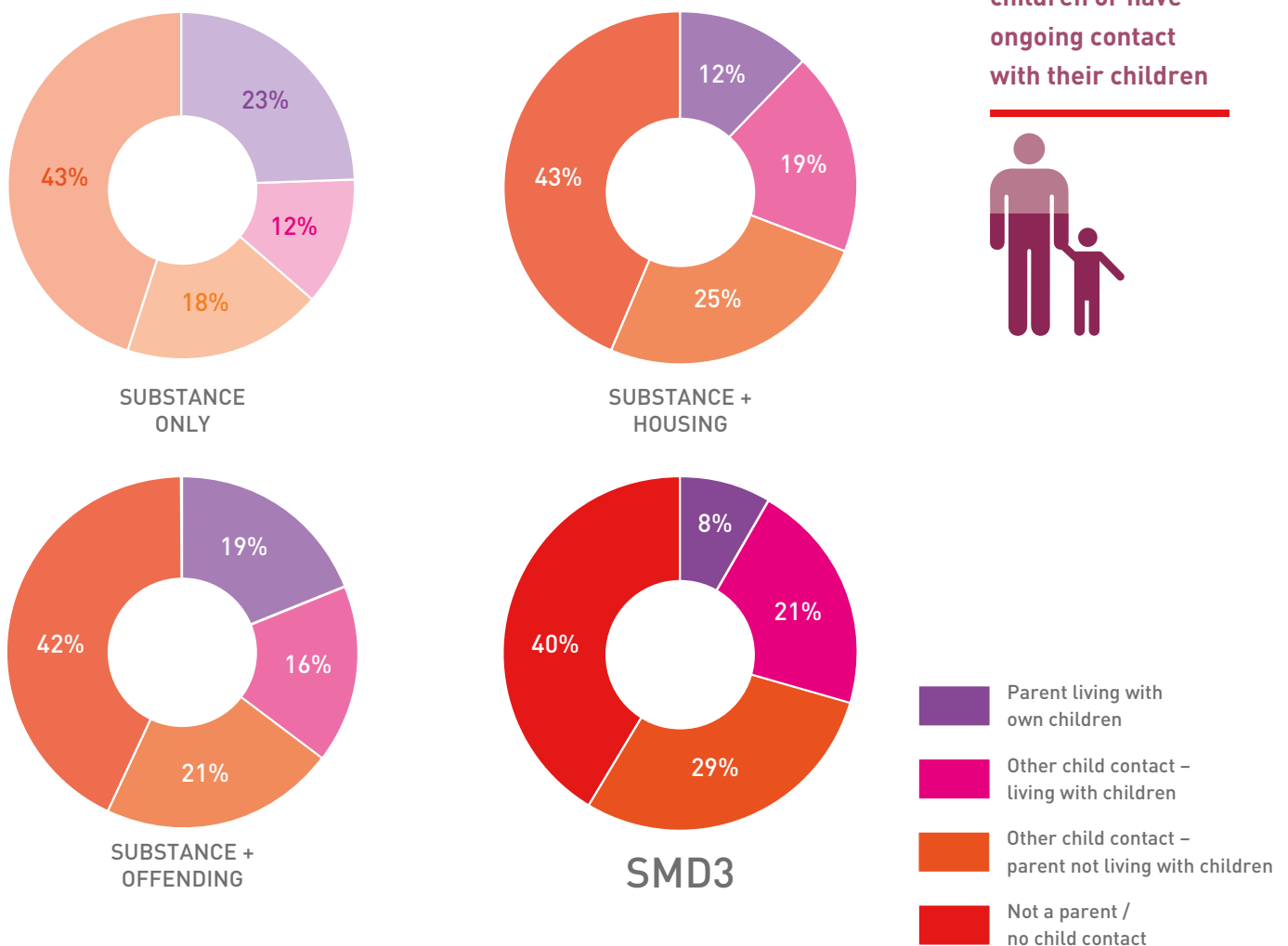
Source: NDTMS drug and alcohol cases combined

Geographic spread

Geography

We noted above that an 'average' local authority might expect to have about 1,470 active SMD cases over the course of a year (using SMD2/3 as the threshold), but also that this rate would vary across the country. All of the main data sources used in this study enable geographical location of service users to a local authority level. We have therefore calculated local 'prevalence rates' per 1,000 working age population for each of these data sources, again using SMD2/3 as the threshold. For presentational purposes we express each prevalence rate here as an index, where 100 is the national average. Table 1 shows the top (part (a)) and the bottom (part (b)) of the list of upper tier (social services) local authorities[12] on an overall combined index score, presenting also the score for each component index.

Appendix J sets out the prevalence estimates for all Local Authorities in much more detail, using a slightly more refined methodology based on selecting data for each of the Venn diagram segments (e.g. offending only, offending + homeless, offending + homeless + substance), using the best available data set for each segment. As this is a more complicated and involved methodology, we have used the simpler index data for the main report. It is worth noting that the alternative prevalence methodology produces a slightly different ordering of areas.

Turning to the index, several points are immediately apparent. First, authorities at the top of the list typically have prevalence rates between two-three times the average, indicating very substantial variation in SMD rates across the country.

[12] Upper tier or 'social services' local authorities in England comprise London Boroughs, Metropolitan Districts, Unitary Authorities and Shire Counties

The 'average' local authority might expect to have about

1,470

active SMD cases over the course of a year

Table 1: Index of Local Authorities with the highest and lowest prevalence of SMD based on three national data sources for England, 2010/11 (where 100 is the national average) (a) 24 authorities with highest prevalence

Local Authority (SS)	SP	OASys	NDTMS	Combined
1. Blackpool	378	298	244	306
2. Middlesbrough	152	306	387	281
3. Liverpool	265	200	249	238
4. Rochdale	310	183	184	226
5. Manchester	245	212	217	225
6. Kingston upon Hull	251	191	232	224
7. Bournemouth	266	177	218	220
8. Nottingham	260	199	181	213
9. Stoke-on-Trent	193	215	224	210
10. Newcastle upon Tyne	271	186	167	208
11. Leicester	219	196	187	200
12. Knowsley	179	143	271	197
13. Derby	323	159	110	197
14. North East Lincolnshire	227	140	208	191
15. Blackburn with Darwe	122	235	216	191
16. Camden	239	125	199	188
17. Islington	174	175	205	185
18. Birmingham	171	162	217	183
19. Coventry	216	165	161	181
20. Tower Hamlets	188	140	210	179
21. Westminster	193	96	236	175
22. Plymouth	262	101	162	174
23. South Tyneside	123	157	238	173
24. Bristol	187	159	162	169

Source: Authors' analysis of SP, OASys and NDTMS data and 2011 census

» Local authorities at the top of the list have prevalence rates of **two to three times the average** «

Second, there is substantial agreement between the different component indices, with nearly all relevant local authorities substantially higher than average on all three. Third, this pattern points to SMD concentrations in specific types of locales: northern urban areas, both 'core' cities and former manufacturing towns; some coastal areas, including major seaside resorts and former port cities; and certain London authorities, namely the 'central' boroughs of Islington, Camden, Tower Hamlets and Westminster.

Local authorities near the bottom of the list (Table 1 (b)) have prevalence rates between a quarter and a half of the national average, and may be characterized broadly as affluent suburbs or commuter areas accessible to major cities. Six London boroughs appear in this Table. While these data confirm the great variation in SMD prevalence (more than ten times between topmost and bottommost authorities), they also make clear that people facing SMD are to be found in every part of England, implying that all authorities have responsibility to consider this issue and the responses they offer.

This striking coincidence of high prevalence rates across three independent data sources provides persuasive 'triangulation' evidence to support the veracity of the geographical patterns indicated. Note also that the OASys (offender) data in particular cannot be considered primarily 'supply-driven' (in the sense of influenced by political decisions about levels of investment in support services). Rather, the most plausible interpretation is that these patterns are driven by higher 'real' levels of need in particular parts of England.
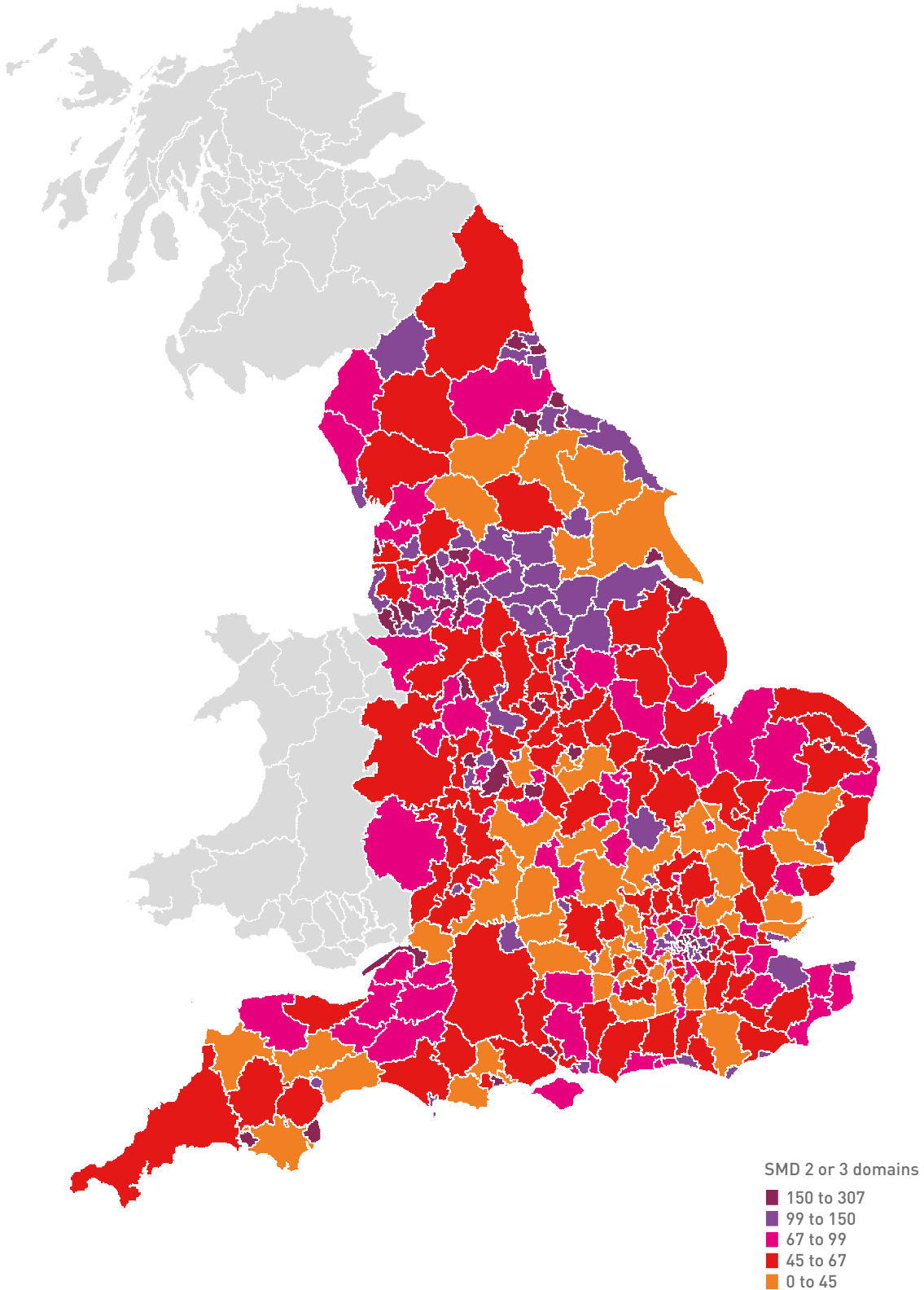
A representation of this geography is presented in Map 1 below, based on the combined index scores. This underlines the general north-south difference, the concentration on core Northern cities and some parts of central London and certain coastal areas, as well as the solid belt of higher values across the urbanised regions of Yorkshire and Lancashire (see also Schneider, 2007).

» People facing SMD are found in **every part of England.** All authorities have a responsibility to consider and respond to this issue «

Table 1 (b) 20 local authorities with lowest prevalence

Local Authority (SS)	SP	OASys	NDTMS	Combined
1. Bracknell Forest	43	65	58	55
2. Redbridge	27	84	54	55
3. Shropshire	37	58	67	54
4. North Yorkshire	47	63	47	52
5. Wiltshire	48	46	57	50
6. Havering	17	63	70	50
7. Greenwich	30		113	48
8. Rutland	14	95	33	47
9. Leicestershire	32	60	49	47
10. Bexley	26	62	51	46
11. Newbury	57	47	31	45
12. Surrey	38	46	49	45
13. Richmond upon Thames	18	51	65	44
14. Harrow	19	46	59	41
15. Buckinghamshire	23	44	43	37
16. East Riding	34	38	38	37
17. Windsor and Maidenhe	3	49	58	36
18. South Gloucestershir	25	38	44	36
19. Central Bedfordshire	20	36		28
20. Wokingham	10	31	23	21

Source: Authors' analysis of SP, OASys and NDTMS data and 2011 census

Map 1: Combined SMD prevalence index by Local Authority district

SMD 2 or 3 domains

- 150 to 307
- 99 to 150
- 67 to 99
- 45 to 67
- 0 to 45

Source: Authors' analysis of SP, OASys and NDTMS data and 2011 census

The mapping exercise above is suggestive of an association between SMD prevalence rates and areas of the country where poverty tends to be concentrated, and this was confirmed by an analysis of these SMD indices by levels of low income deprivation at local authority level (see Figure 9 below). The combined SMD prevalence index falls from 168 in the poorest fifth of local authorities, to 50 in the richest fifth. The pattern is strikingly similar across the three component indices, though with the NDTMS index showing the sharpest variation, and OASys almost as sharp a pattern, which is then somewhat less pronounced with regard to SP.[13]

Finally, we were able to use multiple regression analysis to explore the relationships at local authority level between SMD prevalence (using all three component indices and the composite index) and a range of demographic, social, economic, health and institutional factors. We found that, other things being equal,[14] the factors associated with higher levels of SMD included:

- **Demographic factors:** having a high proportion of the population aged 16–24 and/or large numbers of single person households.

- **Economic factors:** high rates of unemployment and/or poverty.

- **Housing factors:** housing markets with concentrations of smaller properties (e.g. bedsits and small flats). However, indicators of housing pressure (overcrowding) or low quality (lack of central heating) were not associated with areas of high SMD.

- **Health factors:** a poor health profile amongst the local population.

- **Institutional factors:** concentrations of institutional populations, especially those living in mental health hospitals or units, or in homeless hostels, as we might expect. There was also an association with local concentrations of holiday accommodation, tying in with the overrepresentation of seaside towns noted above.

[13] The flatter pattern for the SP index partly reflects the fact that this is averaged across shire county areas.

[14] In addition to the factors listed, other variables tested and discarded as non-significant included older age groups, employment rates, students, occupational class, housing tenure, non-white ethnicities, density/sparsity of population, migrant groups (e.g. new EU), and defence establishments.

Figure 9: SMD prevalence measures by IMD low income quintiles of Local Authorities
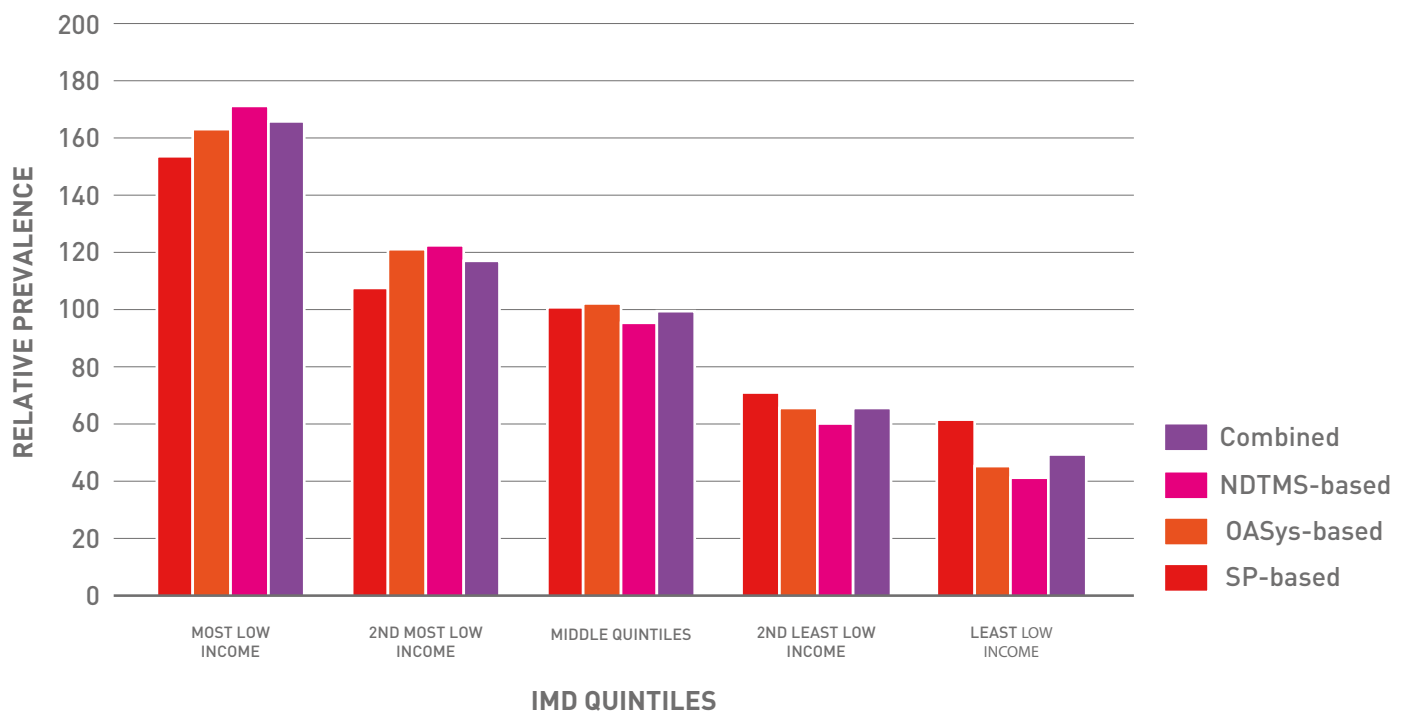
Source: Authors' analysis of SP, OASys and NDTMS data and 2011 census

Local Examples: Manchester and Lambeth

For the purposes of comparison, two examples are presented below alongside each other – Manchester (a northern city with high prevalence of SMD) and Lambeth (an inner London borough with fairly high prevalence) (for more details on these cases see Appendix J).

We present for each authority a prevalence rate (per 1,000 working age population) and an estimated actual number for each SMD category. We follow the same approach as with our presentation of the national total numbers in Figure 1, by estimating the number in each category (or segment) of SMD from the best available source for that number.

We also present an estimate of the number within any of these SMD categories who *also* have mental health problems. As discussed elsewhere in this report, there are grounds for believing that the incidence of mental health problems may be significantly greater than recorded here. Thus these initial estimates give a feel for a conservative estimate of the overlap between mental health problems and our SMD groups.

As can be seen in Table 2, Manchester generally has higher prevalence rates than Lambeth, although both are well above the national average (using the combined index referred to in the main text and shown in tables 1 and 2, Manchester scores 225 and Lambeth 169 against a national norm of 100).

In addition to this difference in prevalence rates, Manchester has a larger population, so the overall numbers are bigger again for that reason.

For both authorities, the multiple regression analysis referred to in the main text predicts a markedly higher than average prevalence of SMD. This is therefore borne out in this local data on rates and numbers, although in both cases the actual level is higher than the prediction. Considering these regression results in detail (see Appendix J), it becomes apparent that SMD in Manchester is particularly prevalent because of its large young adult population, while both authorities are high because of their high unemployment and large share of one-person households. Manchester, to a greater extent than Lambeth, is also pushed up by its poor health conditions. Variables associated with local institutional accommodation do not appear to make much difference.
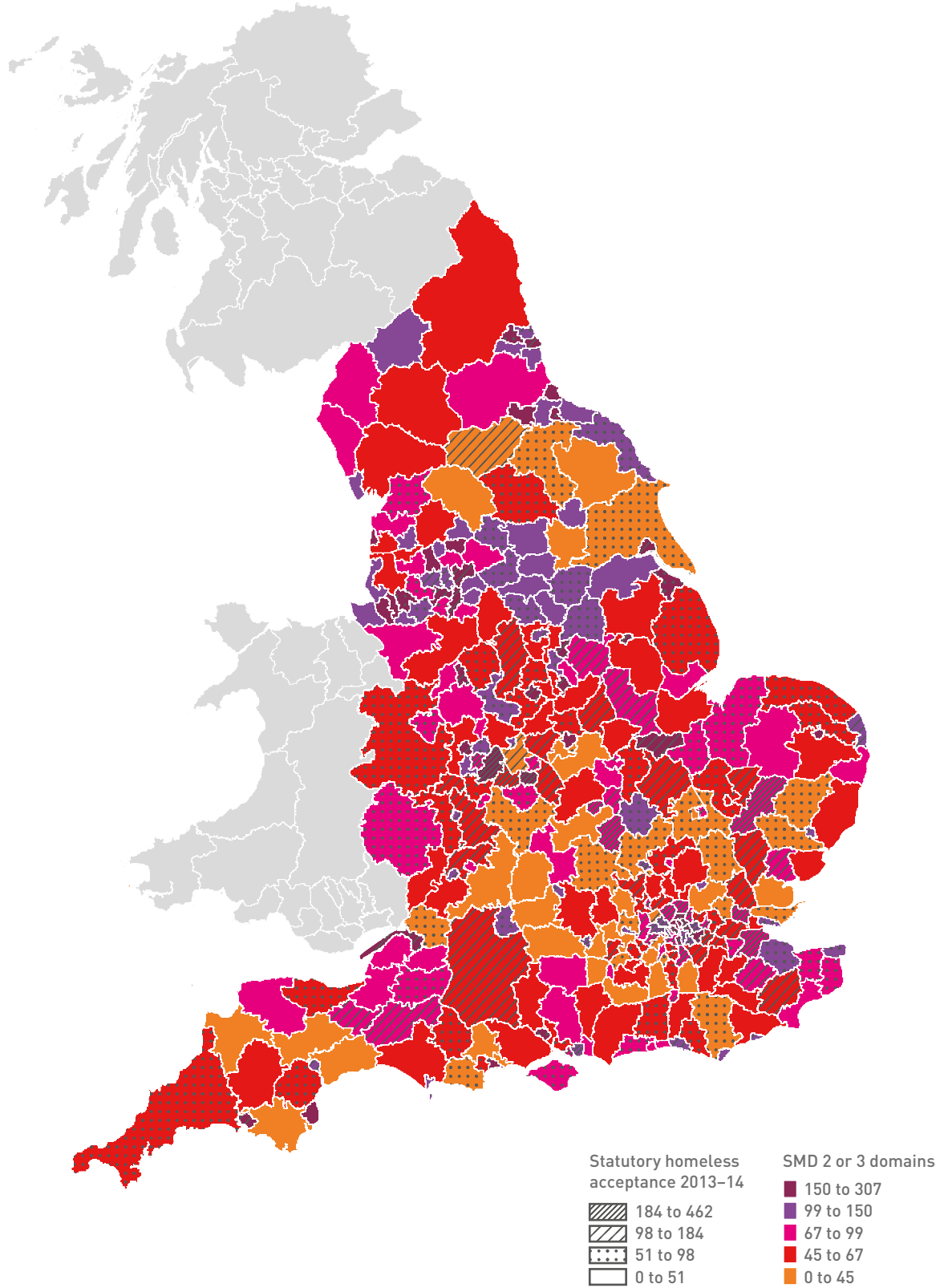
Comparison with statutory homelessness

If you look at the spatial distribution of SMD compared to the distribution of statutory homelessness the picture is not the same across the country. As Map 2 below shows, statutory homeless pressures are in some cases high in areas which also have high SMD, but also in many instances they are high in different kinds of areas. And not all of the areas which have a high prevalence of SMD have high levels of statutory homelessness.

Table 2: SMD comparison between Manchester and Lambeth

SMD Category	Manchester		Lambeth	
	Rate per 1,000 working age population	Total number (rounded)	Rate per 1,000 working age population	Total number (rounded)
SMD1	17.77	6,790	11.18	2,640
SMD2	10.07	3,850	8.01	1,890
SMD3	3.34	1,275	1.68	395
Total	31.18	11,915	20.87	4,925
Total of SMD 1/2/3 who also have Mental Health problems	**5,240**		**1,985**	

Map 2: Spatial distribution of SMD compared to statutory homelessness figures

Statutory homeless acceptance 2013–14

▨	184 to 462
▨	98 to 184
▨	51 to 98
☐	0 to 51

SMD 2 or 3 domains

■	150 to 307
■	99 to 150
■	67 to 99
■	45 to 67
■	0 to 45

Causes of severe & multiple disadvantage

Causes and antecedents

These geographical patterns provide strong evidence to support the 'poverty plus' causal argument favoured by most of our key informants. In other words, these key informants mainly took the view that poverty was a 'necessary' but not 'sufficient' condition to generate the extremely negative outcomes associated with SMD (see also Fitzpatrick, 2005; Johnsen & Watts, 2014). In most cases, it was argued, there were additional social or family factors present which compounded the negative effects of poverty on particular people.

Thus, chiming with the results of our statistical analysis, most key informants insisted that impoverished communities constituted the broader population from which this particular sub-population was drawn. This was a view that was particularly strongly expressed by a range of experts in criminal justice, who made the point that 'churn' prisoners were *'predominantly poor'* and that the causation of persistent offending was *'overwhelmingly about poverty'* (see also Webster & Kingston, 2014).

The social as well as economic disadvantage associated with sustained poverty was often alighted upon in explaining its relationship with SMD:

> *"... yes, lack of support. [But] it's worse, it's harsher than that. It's lack of support, but it's also a poverty of environment, or of social networks or inputs."*
> Voluntary sector key informant

At the same time, the importance of 'complex trauma' associated with childhood abuse (sexual, physical, emotional) or neglect (physical, emotional) was widely identified as increasing the likelihood of poorer children facing SMD later in life (see also Macguire *et al.*, unpublished (a)(b); McDonagh, 2011; Fitzpatrick *et al.*, 2013). Key informants expert in mental health cited longitudinal evidence of exceptionally strong links between 'childhood conduct problems'[15] – often associated with undiagnosed mental health problems – and subsequent involvement in criminal activity in particular (Richards & Abbott, 2009; Sainsbury Centre for Mental Health, 2009):

> *"Conduct disorder is very interesting. Eighty per cent of people that commit a crime as an adult have a conduct disorder as a child, largely untreated."*[16]
> Voluntary sector key informant

A combination of structural poverty and family stress was focussed upon by those with direct relevant experience:

> *"It's like my mum, when I was at home, no money, mouth to mouth, and then my mum started working as a prostitute, going to work at brothels, so yes, poverty, definitely causes, you know, your life."*
> Service user

> *"….I think a part of it is down to drinking, your family life, how you're treated in your family. Like me, personally, my mum give me my drink at nine; both my parents were alcoholic. I went through crime and everything because I didn't want to be at home, so I was in and out of jail…"*
> Service user

Two of our key datasets – the MEH survey and OASys – furnished us with evidence on the background circumstances of people facing SMD. This provides some important pointers to the underlying causes and pathways through which people may have come to face SMD, and supports the 'poverty plus' argument outlined above. As will be seen, these data demonstrate a very strong association between SMD category and childhood trauma and other difficult background experiences, particularly in the realms of education, employment and family relationships.

As we can see from Table 3 on page 29, the proportion of MEH respondents reporting adverse childhood experiences markedly rise as you move from the SMD1 up to SMD3 categories, with the experiences most often reported including: 'ran away', left home before or shortly after the age of 16; violent or addicted parents; and not getting on with family. Abuse and neglect are also quite commonly reported. Only a small minority of SMD3 cases (15%) had experienced none of these traumatic experiences in childhood.

[15] According to the Sainsbury Centre for Mental Health (2009, p.1), childhood conduct problems is used to describe *'…a range of oppositional or anti-social behaviour in childhood such as disobedience, lying, fighting and stealing. In some cases the severity and persistence of these problems is sufficient to justify a psychiatric diagnosis of 'conduct disorder', in which the scale of problems is such as to impair a child's functioning as well as causing significant distress to others.'*

[16] To be more precise, the statistical evidence indicates that around 80% of all criminal activity is attributable to people who had 'conduct disorder' or 'other conduct problems' in childhood or adolescence (Sainsbury Centre for Mental Health, 2009).

85%

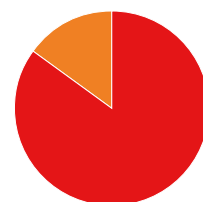### had experienced traumatic experiences in childhood

Table 3: Background experiences by SMD Category in MEH sample (SMD category based on 'ever experienced')

Background Experiences	SMD1	SMD2	SMD3
Childhood			
In care	6.5%	17.4%	**17.8%**
Homeless family	3.7%	9.7%	**13.7%**
Left home < 16	4.5%	12.9%	**16.3%**
Left home > 16–17	18.6%	28.2%	**30.7%**
Ran away	10.3%	28.3%	**41.9%**
Starved	12.7%	9.5%	**17.3%**
Abused	9.5%	22.4%	**24.3%**
Neglected	4.8%	15.1%	**17.9%**
Parent(s) violent	13.1%	27.9%	**29.3%**
Parent(s) drug/alcohol	9.1%	19.9%	**29.0%**
Parent mentally ill	5.0%	16.6%	**16.9%**
Not get on with family	19.4%	31.7%	**29.5%**
None of the above	43.3%	24.4%	**15.2%**
Education			
No qualifications	26.5%	34.5%	**45.2%**
Dyslexic	6.9%	11.6%	**16.4%**
Other learning difficulty	6.8%	14.0%	**14.6%**
Truanted	16.6%	47.3%	**59.1%**
Suspended	10.3%	25.7%	**46.8%**
Bullied	13.3%	21.6%	**24.5%**
Employment			
Mostly casual emp	22.0%	18.5%	**24.8%**
Mostly unemployed	16.2%	22.7%	**26.0%**
Ever long term sick	12.8%	35.7%	**33.4%**
Long Term Limiting Illness	20.4%	41.9%	**45.4%**
Mostly on benefits	15.5%	32.8%	**44.7%**

In the sphere of education, high proportions, especially in the SMD2 and the SMD3 categories, have obtained no qualifications at all. Learning difficulties including dyslexia are cited by significant numbers of people affected by SMD2 and SMD3, but more striking are the high incidence of truanting and suspension, and to a lesser extent bullying. These are critical early warning signals for school age children and indicates a clear need for early intervention.

In the sphere of employment, many people in the MEH sample, especially in the SMD2 and SMD3 categories, report having been mostly in casual employment or unemployed, and a third have been long-term sick, with nearly half of SMD3 people reporting a limiting long term illness or disability. Nearly half of people experiencing SMD3 have been reliant on welfare benefits for most of their adult lives. These findings are strongly indicative of lives dominated by sustained experiences of poverty.

42%
of people facing SMD3 had run away as children

45%
of people facing SMD3 have no qualifications

» **Critical early warning signs for early intervention include: high incidence of truanting and suspension from school** «

OASys collects ratings on a large array of background problem indicators, mainly based on evidence that these factors can help to predict re-offending. Table 4 looks at proportions of cases in each SMD category where 'significant' or 'any' problems of the relevant type are reported.[17] There is a remarkable consistency in terms of the way these indicators rise as you move from people experiencing SMD1 to the SMD3 category. There is a high level of consistency with the MEH findings on many indicators, such as a low level of qualifications and severely disrupted schooling.

The background issues and characteristics associated with the most sharply differentiated incidence between SMD3 and SMD1 related to family relationship problems, problematic relationships with partners, poor work skills, significant learning difficulties and, most significantly, childhood psychological problems (see also Sainsbury Centre for Mental Health, 2009).

These findings suggest that, in addition to general background poverty, it is in the realms of family relationships and of educational experience that we can find the most important roots of SMD experiences involving offending for adults.

[17] We are selective here, focusing on those indicators with the most striking patterns.

Table 4: Background factors in Offender Assessment by SMD Category

Background indicator	SMD1	SMD2	SMD3
First convicted < 14	14.7%	16.9%	**18.9%**
First police contact >14	21.8%	25.1%	**27.4%**
Work skills (significant problem)	18.1%	29.6%	**38.7%**
School attendance (significant problem)	30.4%	39.7%	**46.8%**
Literacy (significant problem)	7.3%	9.5%	**11.4%**
Numeracy	11.1%	13.8%	**16.1%**
Learning difficulty (significant problem)	4.4%	6.3%	**8.0%**
No qualifications	35.5%	43.9%	**48.6%**
Family relationship problems	10.3%	17.8%	**32.4%**
Childhood experience (significant problem)	25.9%	33.3%	**43.0%**
Partner relationship (significant problem)	9.1%	15.1%	**23.6%**
Relationships experience (significant problem)	31.4%	35.4%	**44.0%**
Domestic violence	44.1%	49.0%	**54.8%**
Domestic violence perpetrator	38.5%	42.1%	**47.9%**
Domestic violence victim	12.7%	15.4%	**18.3%**
Childhood psychological problems	18.4%	27.1%	**33.9%**

Source: Authors analysis of OASys data

Quality of life

As well as the background factors and experiences in the lives of people who face SMD discussed above, we were also able to examine a range of aspects of their current quality of life, with the MEH survey tending to provide the most detailed account.

Mental health

In Figure 10 below we provide a composite picture of the prevalence of mental health problems recorded across the SMD spectrum derived from four of our core data sources.[18]

What this shows is that across these databases covering potential SMD populations, on average around 40% of people are identified as having mental health problems. The proportion is markedly lower for those who are only homeless (25%) and rather lower for those who are in the offender-only or homeless-offending categories (30%). The highest prevalence is for those who are in the substance-only category (58%), with a fairly high incidence among the substance-offender category (46%), and moderately high for the SMD3 group (41%). These findings confirm the perceptions of key informants about the pervasive extent of mental health problems across the SMD population, but with a particular association with substance misuse.

[18] The databases varied widely with respect to the basis they used for recording a mental health condition. See Appendices C–G.

Figure 10: Prevalence of mental health problems by SMD category – composite of four data sources
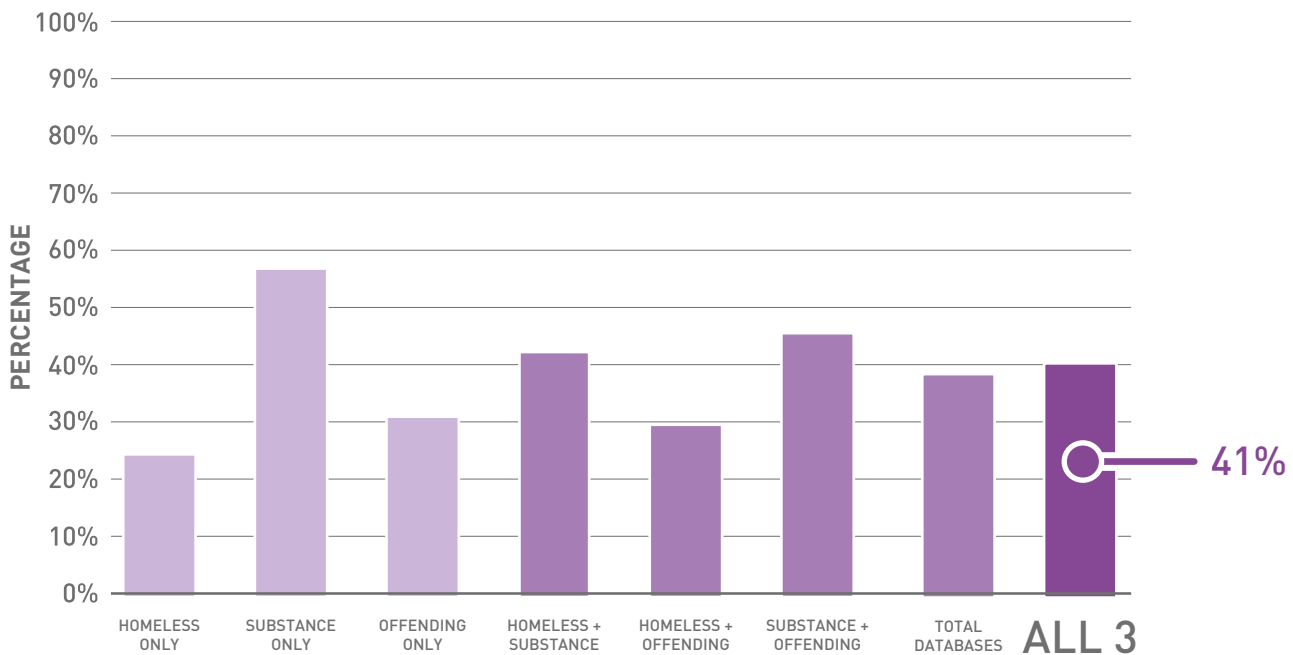
Sources: Authors' analysis of Inform data from seven homelessness providers, SP, OASys and MEH Survey (current status)

What this shows is that across these databases covering potential SMD populations, on average around 40% of people are identified as having mental health problems. The proportion is markedly lower for those who are only homeless (25%) and rather lower for those who are in the offender-only or homeless-offending categories (30%). The highest prevalence is for those who are in the substance-only category (58%), with a fairly high incidence among the substance-offender category (46%), and moderately high for the SMD3 group (41%). These findings confirm the perceptions of key informants about the pervasive extent of mental health problems across the SMD population, but with a particular association with substance misuse.

However, it seems likely that this data represents a significant under-recording of the extent of at least some specific mental health problems amongst the SMD population. There is earlier survey evidence that a range of mental illnesses (including some psychotic conditions) are found at high levels within the hostel population (OPCS, 1997), and also within the prison population (Singleton *et al.*, 1998), with evidence of a range of 'personality disorders' (often now referred to as 'complex trauma') being quite prevalent amongst this latter population too.[19]

55% of people facing SMD3 have a mental health condition that has been diagnosed by a professional
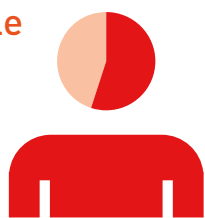
A newly available dataset, based on a Health Needs Audit (HNA) conducted with 2,590 clients of homelessness support provider agencies in 19 localities across England, gives picture of a higher overall level of mental ill-health within the homeless/SMD populations. This appears to show that 42% of this group have a mental health condition *diagnosed by a professional* (rising to 55% in SMD3), while 80% have a *self-reported* mental health problem (rising to 92% in SMD3). This appears to contradict the above evidence from the administrative datasets, but we can achieve a degree of reconciliation. The most comparable dataset is probably MEH, for which we report a core estimate of mental health problems of 51%. This includes people who report feeling anxious and depressed *and regard this as a serious problem*; if you take all those who feel anxious and depressed, whether they regard it as a serious problem or not, you see the headline figure rise to 72% (range 51–78%). Alternatively, if you add in anyone who has in the past attempted suicide or self-harm, then you also get 72%. The remaining difference between 72% and 80% is probably accounted for by the fact that the HNA dataset appears to be quite strongly skewed towards clients with substance issues, and all datasets concur in showing that SMD combinations involving substance misuse have higher incidence of mental health problems.

In considering the intersection between mental health problems and SMD it is important to consider this relationship from both directions – not only the extent to which mental health problems are present in the SMD population, but also the extent to which people with mental health problems have experienced the core domains of SMD considered in this profile.

Here the UK PSE Survey 2012 is particularly helpful, as a data source which is representative of the whole UK adult population living in private households (albeit that it therefore excludes those currently in institutional accommodation with no fixed abode). The PSE survey asked questions about experiences of mental health problems, offending and homelessness, but unfortunately not substance misuse so is not a complete match with SMD in this regard.[20]

[19] See also www.gov.uk/government/publications/estimating-the-prevalence-of-disability-amongst-prisoners

[20] It also differs from our SMD analysis in that it relates to experiences over people's entire life histories, rather than whether they have relevant experiences 'simultaneously' (i.e. for our purposes in the same year).

» There seems to be a **significant under-recording** of some mental health problems among the SMD population «

Table 5: Retrospective experiences of homelessness, offending and mental ill-health, in the working age adult household population, England, 2012

Combinations	Percent	Number
None	72.3	23,534,436
Mental health only	12.9	4,205,339
Homeless only	4.8	1,566,383
Offending only	3.0	960,317
Mental health + homeless	3.5	1,134,555
Mental health + offending	1.2	398,261
Homeless + offending	.9	295,501
All 3	1.4	451,592
Total	100.0	32,546,383
All mental health	19.0	6,189,746
All homeless	10.6	3,448,031
All offending	6.5	2,105,670
All 'SMD'	7.0	2,279,908

Source: Authors' analysis of UK Poverty and Social Exclusion Survey, 2012[21]

[21] 'Offending' includes having been in prison or having a criminal record. 'Homeless' includes ever lost home or stayed in temporary accommodation or slept rough. 'Mental health' includes those who report a long-standing mental health condition or have a General Health Questionnaire (GHQ) score greater than 32.

Several points arise from the data summarised in Table 5 above. First, mental ill-health is, as we would have expected, the most common of these three disadvantages, reported by 19% of working age adults, as compared with 10.6% who report having been homeless and 6.5% who report having been involved with the criminal justice system. Second, those adults who have experienced either homelessness or the criminal justice system are at a far higher risk of reporting mental ill-health (40–46%) than the general population (19%). Third, however, most (68%) of those with some experience of mental health problems have *not* also experienced homelessness and/or criminalisation. This suggests that the degree of overlap between mental ill-health and our core SMD domains is not as high as is the overlap between these domains (albeit that we cannot take substance misuse into account in this PSE-based analysis). That said, the fact that 32% of those with mental health problems had experienced these other core domains is in itself a remarkable finding.

Physical health

The most detailed picture of the physical health conditions of people facing SMD is provided by the MEH survey (see Table 6). This demonstrates that a range of physical health problems are more often found amongst SMD groups than in the general working age population. By far the most striking difference is in relation to alcohol or drug related problems, where the incidence among the SMD population captured in the MEH sample is 85 times higher than in the general working age population. Other conditions where the MEH sample have a markedly higher incidence include epilepsy (five times), difficulty in seeing (3.4 times), stomach/liver/digestive (3 times), chest/breathing, cancer and stroke (2 times). Only in the case of diabetes do MEH respondents have slightly lower incidence than the general working age population.

Table 6: Health problems reported (prompted) by MEH sample, by SMD category

Do you have any of the health problems or disabilities listed on this card?

Illness/Health Problem	SMD1	SMD2	SMD3	All MEH	Wkg Age
Alcohol or drug related problems	30%	60%	**78%**	43%	0.5%
Problems/disability with: arms, legs, hands, feet, back, or neck	27%	23%	**30%**	27%	20%
Chest/breathing, asthma, bronchitis	24%	26%	**25%**	24%	12%
Stomach/ liver/ kidneys/ digestive	14%	19%	**32%**	19%	6%
Heart / high blood pressure or circulation	21%	10%	**13%**	16%	12%
Skin conditions / allergies	15%	12%	**13%**	14%	14%
Migraine or frequent headaches	10%	10%	**18%**	12%	7%
Difficulty in seeing (excl normal glasses)	11%	13%	**17%**	12%	3.5%
Difficulty in hearing	7%	7%	**17%**	8%	5.2%
Epilepsy	6%	7%	**0%**	5%	1.0%
Diabetes	4%	0%	**1%**	2%	3.2%
Other health problems	4%	0%	**3%**	2%	5.0%
Cancer	1.6%	2.5%	**0.0%**	1.6%	0.8%
Hepatitis	1.7%	0.7%	**2.2%**	1.2%	
Stroke	1.6%	0.9%	**1.9%**	1.2%	0.5%
ADHD	1.4%	0.0%	**3.8%**	1.0%	
HIV positive	1.7%	0.0%	**0.0%**	0.8%	
Chronic fatigue/tiredness	1.0%	0.4%	**0.0%**	0.6%	
OCD	0.4%	0.0%	**1.9%**	0.4%	
Autism	0.0%	0.0%	**0.6%**	0.1%	
None					

Source: Authors' analysis of MEH survey and British Household Panel Survey (BHPS) 2008/09

### Employment, income and benefits

We noted above the extent to which people facing SMD are characterised by long-term marginalisation from the labour market. Figure 11 below confirms that only a minority of this population is currently in employment, ranging from 6.4% of SMD3 to 34% of offender only cases. Very few people facing SMD are in education or training across the piece. The dominant category is unemployed (seeking work) or related sub-categories, like being on a Work Programme. This accounts for between 37% of homeless-only cases to 60% of SMD3 cases. The proportion unavailable for or unable to work ranges between one fifth (offender-only and homeless-offender) to almost half (homeless only). Health and disability issues are reported as a major reason for not being in employment or available for work amongst people facing SMD.

It was clear from the findings of the MEH survey reported above that many people facing SMD had experienced lives dominated by sustained low income. The overwhelming majority of respondents to the MEH survey (86%)[22] reported that they were currently receiving UK benefits. There were also other indications of current financial difficulties, with one third (32%) overall reporting having a problem with managing money/debt, rising to half (51%) of SMD3.

OASys also contains data on financial problems (as assessed by probation staff) which confirms this picture. Almost two thirds (63%) of all offenders had some financial problems, with 21% recording these as significant; these proportions rise to 82% and 43% for SMD3 offenders. And almost two thirds (64%) have financial management problems, with 22% categorised as significant; again these rise to 83% and 43% for SMD3 offenders.

[22] This rose to 93% when one excluded migrants to the UK, who were far less likely to have received benefits in the last month than UK nationals.

Figure 11: Economic activity of SMD categories based on composite of main sources
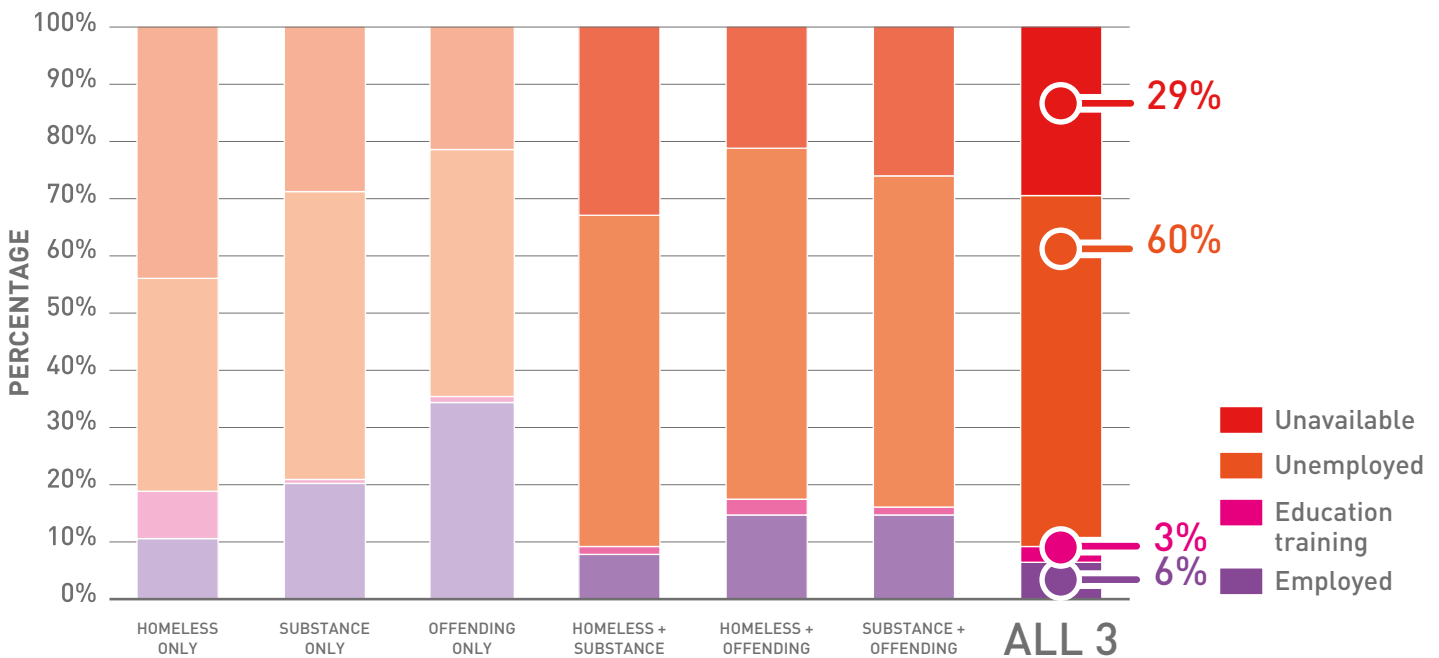
Sources: Authors' analysis of SP client records, OASys data (grossed) and NDTMS drug and alcohol treatment cases

Social support

There are a number of questions in the MEH survey which allowed us to explore the extent to which people facing SMD are socially isolated. For example, 60% of MEH respondents reported problems with boredom (86% of SMD3), and 51% reported problems with loneliness (75% of SMD3).

In answer to the question 'Who can you really count on to listen to you?', the most striking finding is the extent to which the MEH sample rely on professional support workers, and to some extent friends, rather than family members or partners (see Table 7). The rankings change when the question is 'Whose help can you really count on in a crisis?', with friend(s) top, and parent(s) and other family rather more prominent. However, it is particularly noteworthy that parents and children are hardly ever mentioned by people in the SMD3 category in response to either question, indicative of the degree of breakdown in these relationships.

» **75%** of people facing SMD3 report problems with **loneliness** «

Table 7: Sources of social support for MEH sample by SMD category

Who can you really count on to listen to you?

	SMD1	SMD2	SMD3	Total
Social worker/other prof suppt worker	47%	37%	**34%**	41%
Friend(s)	39%	40%	**28%**	37%
Other family	13%	16%	**17%**	15%
Partner	9%	9%	**12%**	12%
People from local community/voluntary groups	11%	10%	**12%**	11%
Parent(s)	12%	11%	**0%**	11%
Child(ren)	4%	1%	**0%**	3%
Medical profession	2%	1%	**11%**	2%
Church (member)	1%	1%	**0%**	1%
Other	2%	0%	**0%**	1%
Don't Know	0%	0%	**0%**	0%

1/3 rely

on social worker/support worker to listen to them but 42% rely on friends in time of crisis

Whose help can you really count on in a crisis?

	SMD1	SMD2	SMD3	Total
Friend(s)	37%	34%	**42%**	35%
Parent(s)	17%	40%	**1%**	25%
Social worker/other prof suppt worker	30%	19%	**14%**	23%
Other family	20%	15%	**30%**	21%
Partner	10%	7%	**12%**	10%
People from local community/voluntary groups	6%	7%	**5%**	7%
Other	2%	2%	**6%**	3%
Child(ren)	4%	1%	**0%**	2%
Church (member)	1%	0%	**4%**	1%
Don't Know	0%	1%	**0%**	0%
Medical profession	0%	0%	**0%**	0%

Source: Authors' analysis of MEH survey data

Overall quality of life

The overall satisfaction of people with their current quality of life can be compared between the respondents in the MEH survey who were in the SMD2/3 categories, and broader UK population benchmarks from the PSE 2012 Survey, as shown in Figure 12. We have selected for comparison the overall adult population and three sections of the population who might be expected to suffer the effects of various general disadvantages as a result of old age, disability or a long term illness, or poverty (i.e. 3+ material deprivations and below median income).

As can be seen, the SMD2/3 group in the MEH survey have a much lower quality of life than all of these comparator groups, particularly the general population and the older group, but also the disabled and poor groups, although it is clear that poverty is associated with substantially lower satisfaction than reported by the general population.

Only 16%

of people facing SMD2/3 consider their quality of life to be good or very good, compared to over 70% of the general population
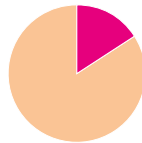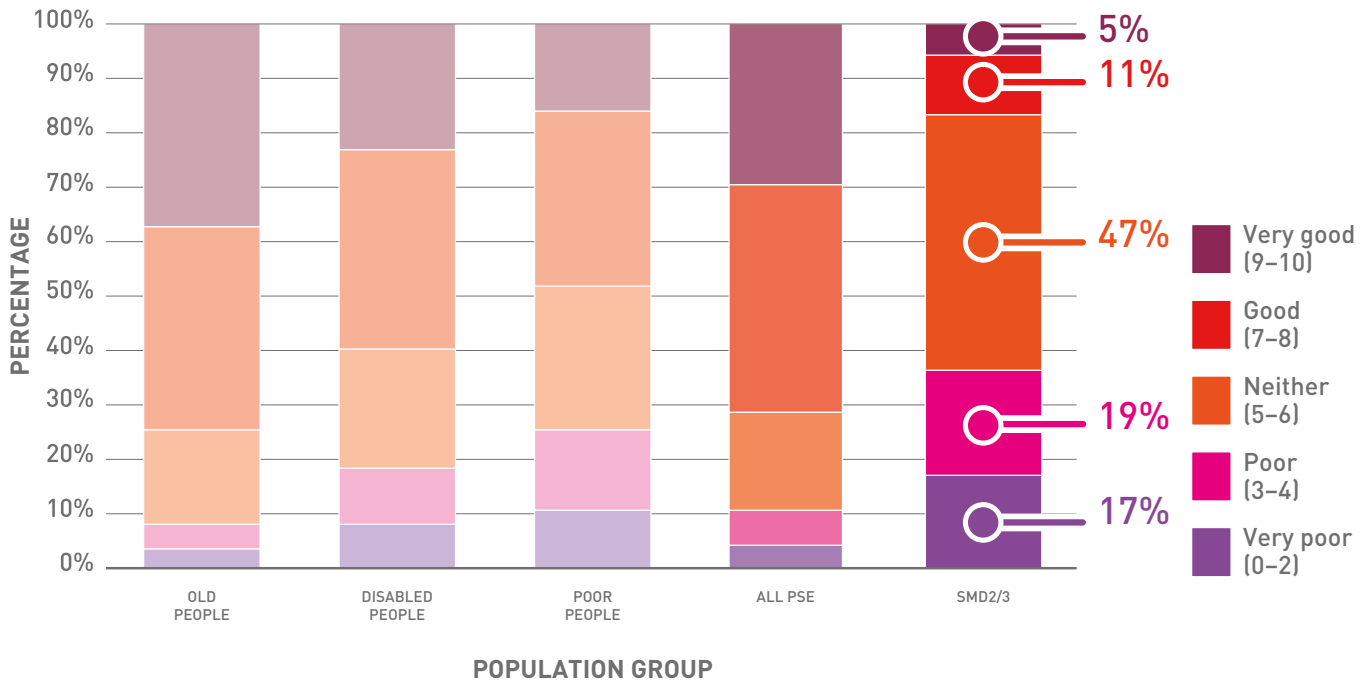
Figure 12: Current overall quality of life rating comparing SMD group (MEH) with general population groups (PSE)

System and service response

In this section we focus on the question of outcomes, particularly the outcomes which agencies working with people experiencing SMD are seeking to achieve from their interventions. However, it must be stressed that this current study was not designed to evaluate specific services or systems performance. For one thing, the kinds of data analysed for our profiling work, limited mainly to snapshots or relatively short records on episodes, falls far short of the longer-term tracking data which would ideally be looked at in detailed evaluation studies. That said, there are indications provided below of some encouraging short-term outcomes from these services, but with much poorer results reported for people experiencing SMD2 and SMD3.

Homelessness service outcomes

The SP dataset contains a lot of detailed data on needs and short-term outcomes across a wide range of domains, such as health, debt, work, housing, substance misuse, and harm to others. Figure 13 summarises the pattern of outcomes in relation to five of the 17 categories of need covered by SP outcomes, by broad SMD level.

Figure 13 shows two findings clearly. Firstly, there is considerable variation in the achievement of target outcomes between different types of need. Thus a large majority of clients with needs in the mental health, offending (avoid harm to others) and housing (avoid eviction) fields achieved some short-term positive goals, whereas for substance misuse the level of positive achievement was somewhat lower and, for 'paid work' only a minority achieved a positive outcome (though given their enduring labour market barriers even this last result may be more promising than could perhaps have reasonably been expected, see also Johnsen & Watts, 2014).

Secondly, it shows clearly that the pattern of lower positive outcome achievement with higher SMD level applies more or less across the range. It is not possible from the quantitative data analysis alone to specify why this is the case, but clearly it is a matter that warrants further in-depth investigation.

Figure 13: Positive outcomes achieved for five selected outcomes by broad SMD group, Supporting People clients 2010/11

Source: Authors' analyses of SP Short-term Outcomes 2010–11, cases with IDs only
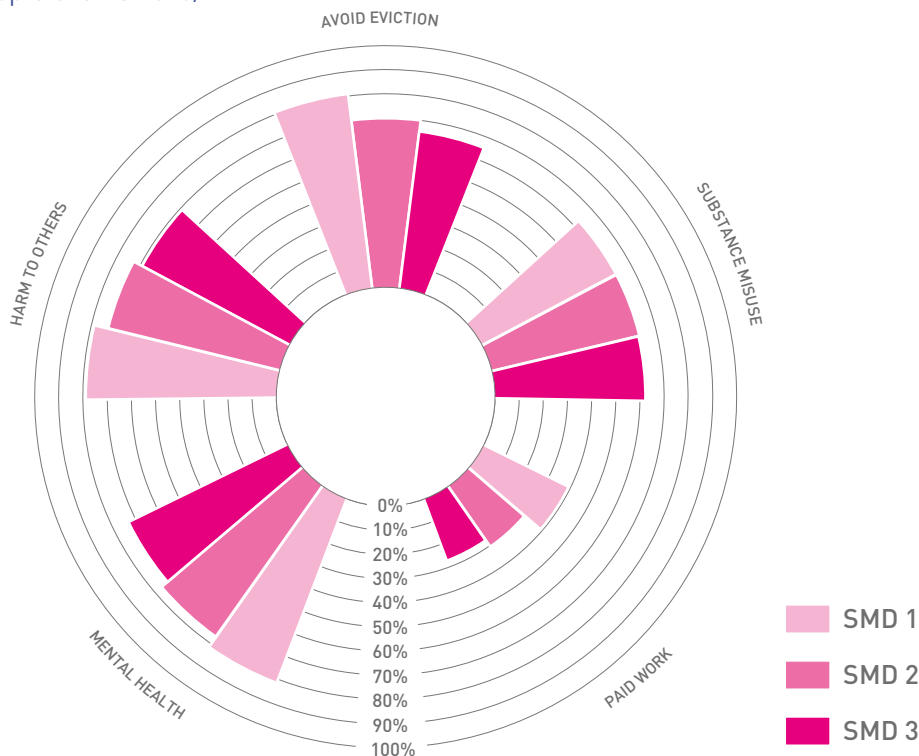
Substance misuse service outcomes

For the substance treatment population in England, Figure 14 presents a broad picture of the main types of outcome for drug and alcohol treatment journeys completing in 2011. These figures indicate a reasonable measure of success. Overall, about half of all journeys saw treatment completed, and the majority of these (particularly in the case of drugs) were completed drug-free.

However, more complex cases of SMD (2 or 3 domains) see somewhat lower levels of completion and drug-free outcome. Just over half of the SMD3 category achieved a successful completion, allowing for the (large number) transferred into the prison system (where they are expected to receive treatment under a different programme).

Figure 14 combines drug and alcohol treatment. Although the alcohol service reaches only a minority of people with serious alcohol misuse, for those it does reach, the completion

outcomes represent a slightly higher proportion than for drug treatment, particularly in the SMD3 cases (64% vs 53%).

With regard to drug treatment specifically, the highest levels of abstinence or reliable improvement are reported for the more serious target drugs (opiates, crack, cocaine). Moreover, change over time in drug treatment outcomes, from 2006 to 2011, shows completed cases rising from 30% to 64% of all cases excluding transfers. Broadly this is an encouraging picture. But again outcomes tend to be somewhat poorer for the most complex cases.

» **Despite reasonable success of drug treatment programmes across all categories, outcomes tend to be poorer for SMD3** «

Figure 14: Substance treatment journey discharge outcome summarised by SMD category 2011
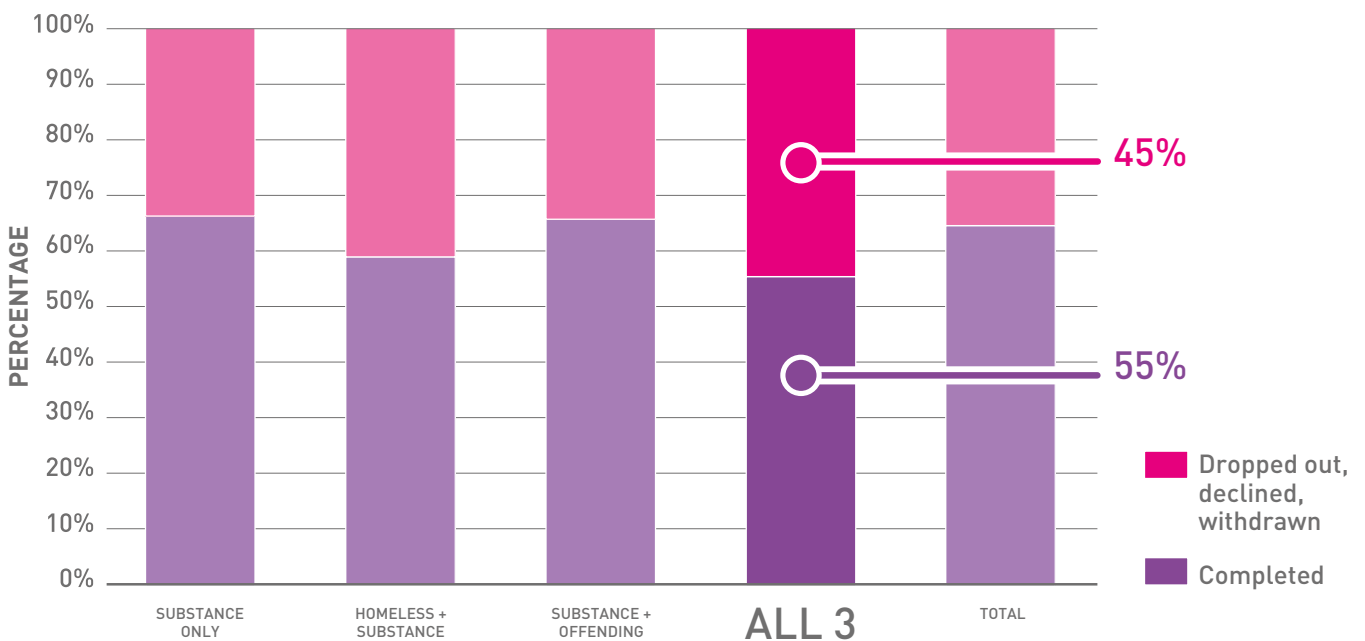
Source: Authors' analysis of NDTMS; note that cases transferred (mainly to prison) are omitted, as treatment is provided in a different way for this group post transfer

Offender outcomes

Finally, we consider outcomes[23] in relation to the offender population. The key objective of policy in this sector is to reduce re-offending, and a major purpose of the OASys instrument is to collect data on risk factors for reoffending. Figure 15 shows that there is a strong relationship between risk of reoffending and SMD, with the 'High' and 'Very High' risk categories proportionately much larger in the SMD2 and SMD3 cases than for those people in the SMD1 (offending only) group.

» **There is a strong relationship between risk of reoffending and SMD** «

Figure 15: Offender population numbers by probability of reoffending by SMD level (OASys offender stock estimate based on OPG score)
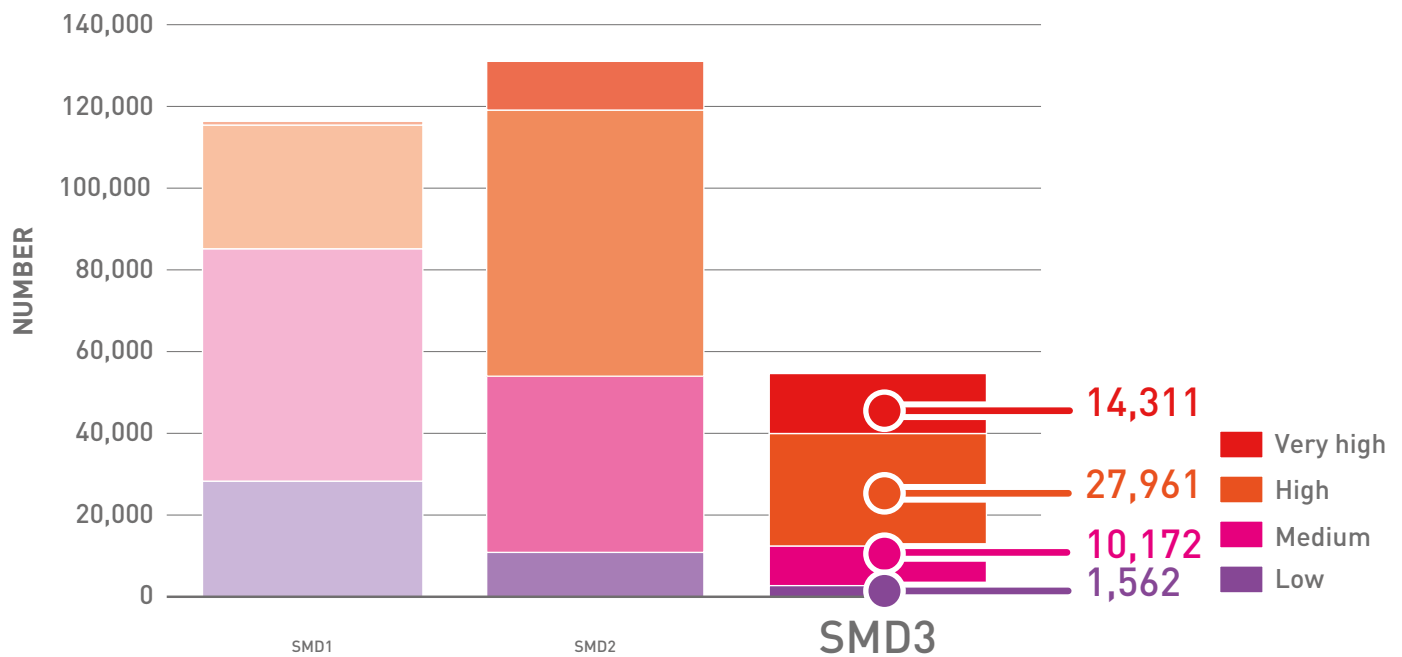
Source: Authors' analysis of OASys data on grossed offender population basis;
Note: OGP score is an index measuring probability of general reoffending

Costs

One important motivator for this research has been the belief that SMD creates significant costs for public services, in addition to the human costs for individuals and their families. The corollary of this is: that investment in more effective interventions might bring about significant savings or 'offsets' which might outweigh, or at least mitigate, the costs of investment. In times of austerity, especially, the reduction of costs to the state, and the generation of 'cashable returns' on new public spending, will carry significant political weight:

> "… we win more arguments by saying, 'Actually here's the cost benefit of investing in this group,' than we do by saying, 'These are vulnerable people who you've got some moral obligation to help.'"
> Statutory sector key informant

We have therefore attempted to estimate public spending costs associated with SMD. This involved several steps. First, we examined a range of sources for unit cost estimates relevant to the services and benefits received by people facing SMD, triangulating these key unit cost estimates from several sources, and identifying some suitable benchmarks for general levels of relevant spending on comparable general population groups. Second, we attempted to apply these to the datasets we have assembled for SMD populations. We focussed mainly on the MEH survey dataset, because this is the richest single source for this purpose. Subsequently, we attempted to apply estimates of typical costs for different SMD 'segments' to the broader composite picture of the overall SMD population derived from triangulating our core administrative datasets (see Appendix H for details).

» Severe and multiple disadvantage is conservatively estimated to cost **£10.1bn per year** across the SMD 1/2/3 populations «
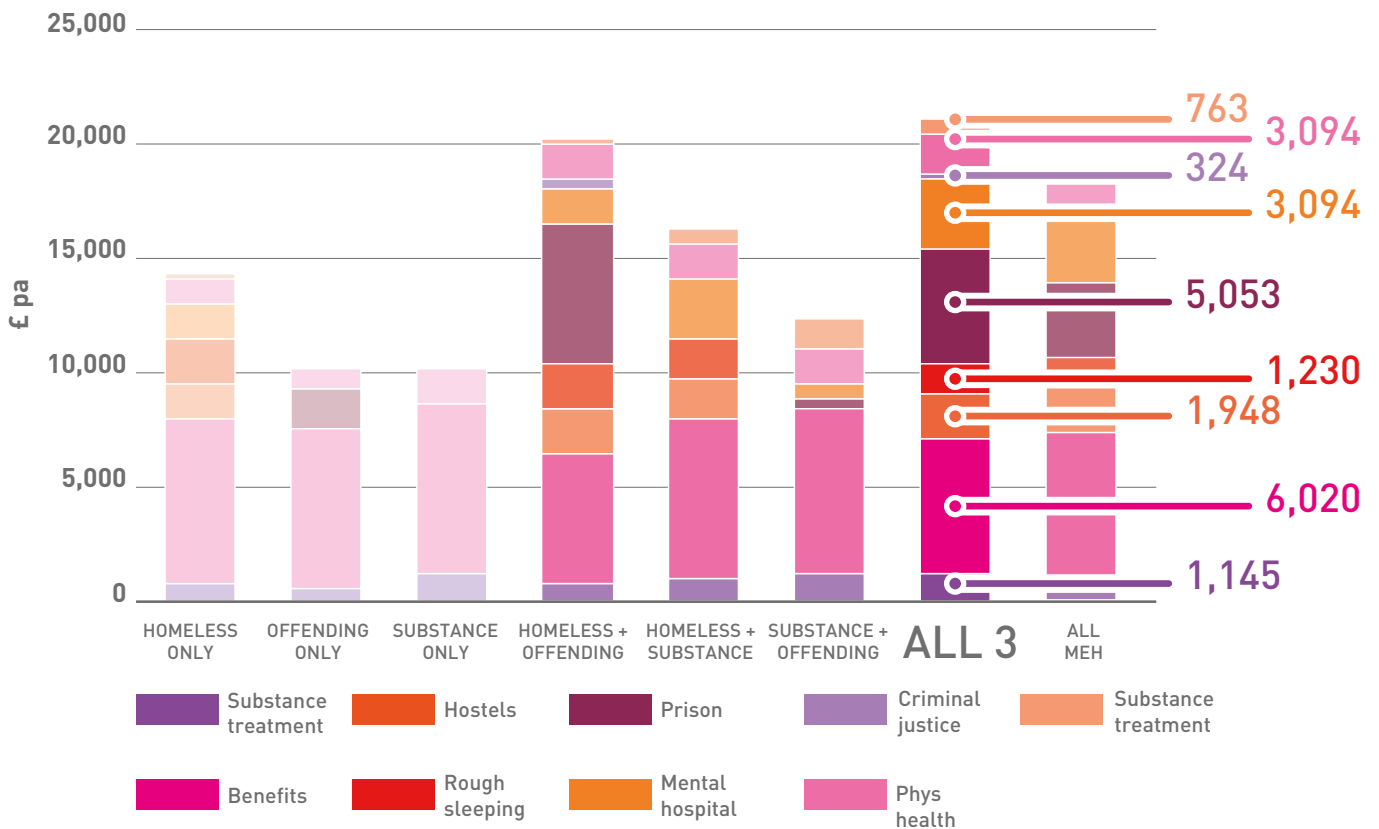
Figure 16 shows the estimated annual costs for the different SMD 'overlap' or segment groups; these may be compared with a benchmark of £4,600 per adult for public spending on the same range of services. The results suggest that, for the type of SMD population represented by MEH, total public expenditure relevant costs attributable are around £19,000 per year, 4–5 times the benchmark, with particularly high spend for homeless-offending, homeless-substance and SMD3 categories. The data in this analysis can be used to provide a grossed-up cost for our composite estimate of £4.3bn for the SMD2/3 populations, and a figure of £10.1bn for the wider SMD1/2/3 population. As explained above, these figures are indicative and not definitive so should be taken as a guide.

It has been suggested that these cost estimates are on the low side, particularly when compared with the study by Battrick *et al.* (2014) for MEAM. There are various possible explanations for this; the latter study is based on a more detailed, focussed intervention with a relatively small number of individuals in three areas. It has the advantage of more detailed data on numbers of incidents involving police, courts, hospitals and so forth, but one can be less sure how representative these cases are of wider populations. Comparison of costs of different elements suggests that the assumptions we have made in parts of our costing may be somewhat crude, leading to an underestimation of some cost elements such as criminal justice proceedings and physical health care. For other elements, including expensive institutional costs of prison and mental hospitals, we believe our estimates are reasonable as they are based on MEH respondent accounts of time spent in these.

We can also calculate accumulated 'career' costs (i.e. to date of interview), which average around £250,000 to date, as shown in Figure 17. More extreme cases push towards the £million mark on a whole SMD 'career' to date basis. The current SMD population have incurred cumulative costs to date of the order of £45–58bn.

Figure 16: Composition of annual public spending by detailed SMD based on 'ever experienced' (MEH sample)

Legend:
- Substance treatment
- Hostels
- Prison
- Criminal justice
- Substance treatment
- Benefits
- Rough sleeping
- Mental hospital
- Phys health

Source: Authors' analysis of MEH survey using methods and sources detailed in Appendix H

The composition of the cost estimates, and particularly the factors associated with exceptionally high levels of cost (mental health services and prison), underline the importance of (a) understanding and addressing the relationships between SMD and mental ill-health, and (b) the strong alignment between tackling SMD and the general policy of reducing reoffending.[24] These numbers certainly provide evidence of the potential for substantial public expenditure savings from more effective interventions.

» There are also huge social, emotional and societal costs associated with severe and multiple disadvantage including the **potential negative impacts on children** who live with or have contact with people facing SMD «

Figure 17: Composition of cumulative 'SMD career' public spending by detailed SMD category based on 'ever experienced' (MEH sample)
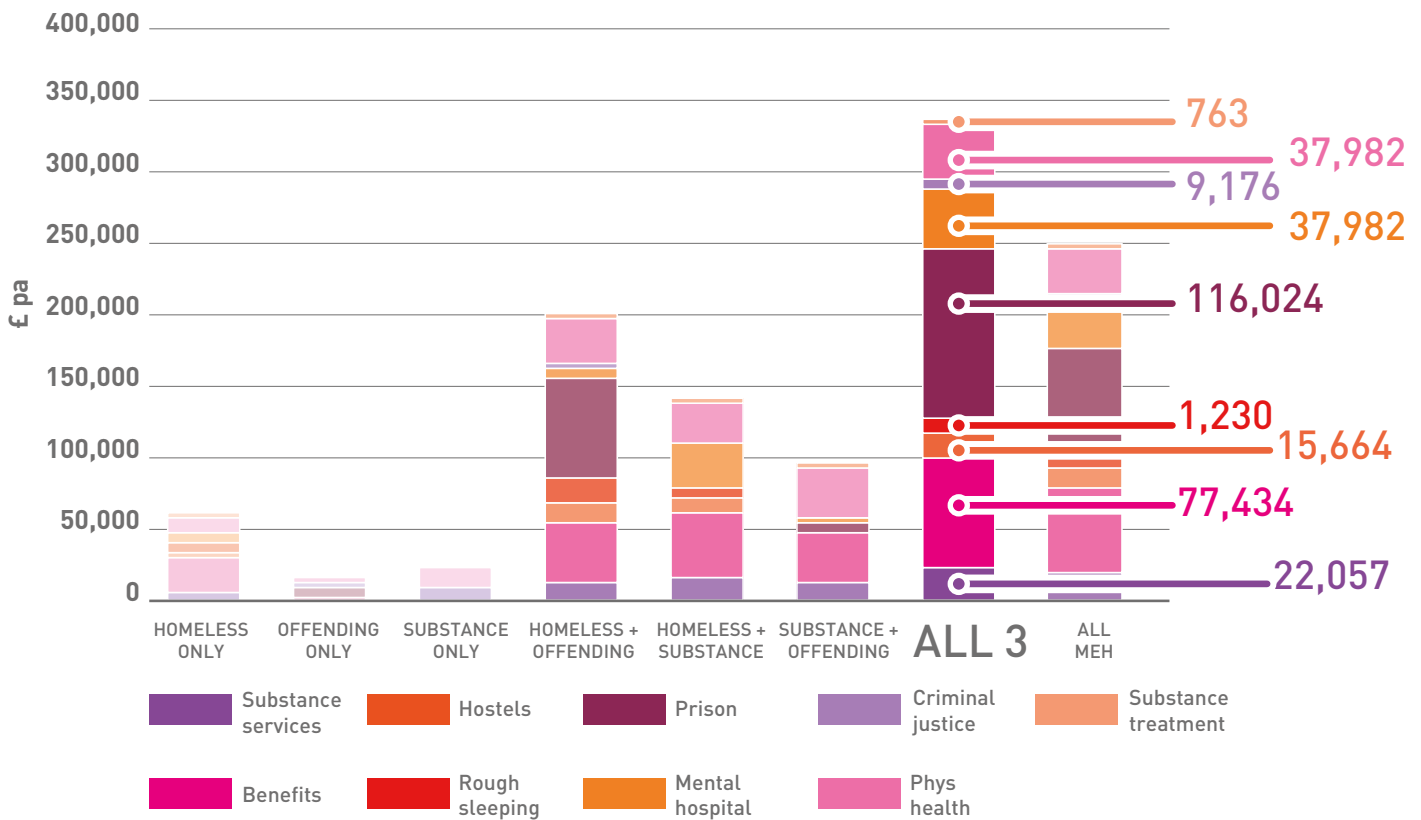
Source: Authors' analysis of MEH survey using methods and sources detailed in Appendix F

Moreover, these public expenditure costs of SMD are of course accompanied by very serious social costs, both for people facing SMD themselves and for the rest of society. The poor mental health and quality of life experienced by people facing SMD – even as compared with other poor and disadvantaged groups – has been stressed above. These social costs also, crucially, include the potentially negative impacts on children who live with, or have contact with, or are estranged from people facing SMD, and also on their partners and other family members who may be exposed to heightened risks of domestic violence (see Tables 2–3). Social costs (or 'externalities') impacting on wider society most obviously relate to the persistent and prolific offending and other aspects of social harm which may accompany SMD.

» The current cumulative cost of severe and multiple disadvantage could be as high as £58bn across the SMD 1/2/3 populations «

Conclusions, implications and future research

This study sought to provide a quantitative profile of SMD among people involved in the homelessness, substance misuse and criminal justice systems in England.

The profile reveals considerable overlap between these three populations involved in homelessness, substance misuse and criminal justice systems

Additionally it has shown that people facing this form of SMD suffer a much lower quality of life, not only than the general population, but also than other poor and vulnerable groups. The prevalence of overlap between these three groups, and the generally poorer outcomes for people in SMD3, highlights a need for greater collaboration between these three sectors. It is vital that professionals working in these fields recognise that they are very often working with the same people viewed through different 'lenses'.

Severe and multiple disadvantage seems to result from a combination of structural, systemic, family and personal factors

This evidence makes quite clear the *structural* roots of this form of SMD, both in terms of the strong association with some of the poorest parts of England, and the long-term economic marginalisation experienced by those who find themselves facing SMD. At the same time, these structural preconditions for SMD clearly interact with *family and individual* level sources of disadvantage – including childhood trauma and very poor educational experiences – to render some people at far greater risk of SMD than others living in similar circumstances of material deprivation and poverty. While this study was not designed to evaluate specific services, it is apparent from the outcomes data reviewed that current support *systems* struggle to deliver positive outcomes in more complex

cases, no doubt in part because the 'degree of difficulty' in achieving progress is that much the greater in these instances. The increasing policy interest in 'trauma-informed' services seems particularly pertinent with regard to SMD groups (CLG, 2010; DCLG, 2012), as does the growing emphasis on 'resiliency-based' approaches which seek to enhance the protective factors in vulnerable young people's lives, particularly with respect to their families and peer group (Viner *et al*, 2012).

People facing severe and multiple disadvantage are often single but that doesn't mean they don't have contact with children

Although people facing SMD are commonly thought of as "single", a majority have children or have contact with children. This research suggests that child contact with adults whom the system treats as single and childless may be much greater than imagined, and that practice and policy needs to start to consider a broader perspective on who is involved in the family.

» This evidence makes quite clear the *structural* roots of this form of SMD «

Linking administrative datasets will permit a more comprehensive picture to emerge

Despite its striking findings, this profile is in some ways exploratory: it lays out the parameters of an agenda to be addressed, rather than providing a definitive account of all of the terrain that it covers. The current rapid expansion in the possibilities for direct data linking – via combining administrative records of individual service users across service sectors – should in time allow for a more systematic picture of these populations, overlaps, service use, costs and outcomes to emerge (see also DWP, 2012). From November 2014 the Administrative Data Research Centre has been operational in each of the four countries in the UK, charged with commissioning, facilitating and undertaking linking of data between different government departments.[25] If it were possible to exploit the data linking possibilities between a range of government departments and key voluntary organisations, including the datasets noted above, but ideally also police, health, social security and tax systems, this would allow for much more systematic tracing of both the 'inflow' and 'stock' of the population of people facing SMD over time. In the immediate future, there is an excellent case for extending this SMD profiling work to Scotland, including using data linkage techniques, not least because the possibilities for this in Scotland appear currently more positive.

» **LankellyChase is pursuing a parallel study focusing on the ways SMD impacts differently on women and girls** «

Severe and multiple disadvantage takes different forms for different groups

Another key area for future research will be populations whose experience of severe and multiple disadvantage tends to be differently structured from the particular nexus of issues focussed upon in this profile. This most obviously includes women, and LankellyChase Foundation is pursuing a parallel study focusing on the ways in which serious and multiple forms of disadvantage impact differently on women and girls. There may also be a case for parallel studies on other populations who tend to be under-represented in the type of SMD focussed upon here, such as minority ethnic groups and young people or those over retirement age. Future statistical studies would require the sort of conceptual underpinning exercise that provided the foundation of this first SMD profiling exercise.

[25] For more information see: www.esrc.ac.uk/collaboration/collaborative- research/adt/index.aspx.

References

Battrick, T., Crook, L., Edwards, K. & Moselle, B. (2014) *Evaluation of the MEAM pilots – Update on our findings*. A report by FTI Consulting and Compass Lexecon for Making Every Adult Matter (MEAM).

Bauer, A. & Fernandez, J-L. (undated) *Valuing and Complex Needs Servicde in Hertfordshire – Economic analysis of person case studies*. PSSRU, LSE.

Brookes, N., Barrett, B., Netten, A.& Knapp, E. (2013) *Unit Costs in Criminal Justice (UCCJ)*. Personal Social Services Research Unit Discussion Paper 2855. University of Kent/ London School of Economics.

Cabinet Office/Social Exclusion Unit (2007) *Reaching Out: Progress on Social Exclusion.* www.cabinetoffice.gov.uk/media/cabinetoffice/ social_exclusion_task_force/publications/ reaching_out/progress_report.aspx

Clinks, Drug Scope, Homeless Link and Mind (2009) *Making Every Adult Matter (MEAM): A Four Point Manifesto for Tackling Multiple Needs and Exclusions.* London: MEAM.

Communities and Local Government (2010) *Mental Health Good Practice Guide. Meeting the Psychological and Emotional Needs of Homeless People.* London: CLG and National Mental Health Development Unit.

Cornes, M., Joly, L., Manthorpe, J., O'Halloran, S. and Smyth, R. (2011) 'Working together to address multiple exclusion homelessness', *Social Policy and Society,* 10: pp 513–522.

Curtis, L. (2013) *Unit Costs of Health and Social Care 2012.* Personal Social Services Research Unit, University of Kent. ISBN: 978-1-902671- 82-6.

Department for Communities and Local Government (2012) *Making Every Contact Count: A Joint Approach to Preventing Homelessness.* London: DCLG.

Department for Work and Pensions (2012) *Social Justice: Transforming Lives.* London: DWP.

Duncan, M. & Corner, J. (2012) *Severe and Multiple Disadvantage. A Review of Key Texts.* London: LankellyChase Foundation.

Fitzpatrick, S. (2005) 'Explaining homelessness: a critical realist perspective', *Housing, Theory & Society*, 22(1):1–17.

Fitzpatrick, S., Bramley, G. & Johnsen, S. (2013) 'Pathways into multiple exclusion homelessness in seven UK cities', *Urban Studies,* 50 (1): 148–168.

Fitzpatrick, S., Johnsen, S. & White, M. (2011) 'Multiple exclusion homelessness in the UK: key patterns and intersections', *Social Policy and Society,* 10(4): 501–512.

Fitzpatrick, S., Johnsen, S. & Bramley, G. (2012) 'Multiple exclusion homelessness amongst migrants in the UK', *European Journal of Homelessness*, 6 (1): 31–58.

Fitzpatrick, S. & Stephens, M. 2013, 'Welfare regimes, social values and homelessness: comparing responses to marginalised groups in six European countries' *Housing Studies*, 10.1080/02673037.2014.848265

Hampson, T. (Ed) (2010) *Hardest to Reach? The Politics of Multiple Needs and Exclusions.* London: Fabian Society.

Health and Social Care Information Centre (2013) *Statistics on Drugs Misuse: England 2013*. London: HSCIC.

Hecht, G., Barnsdale, L. & McAuley, A. (2014) *The National Drug-Related Deaths Database (Scotland) Report: Analysis of Deaths occurring in 2012. NHS National Services Scotland.* Available at: www.isdscotland.org/Health-Topics/Drugs- and-Alcohol-Misuse/Publications/2014-03- 25/2014-03-25-NDRDD-Report.pdf

HESOnline (2013a) *Hospital Episode Statistics: Admitted Patient Care 2011–12. Summary Report.* Health and Social Care Information Centre.

HESOnline (2013b) *Hospital Episode Statistics: Accident and Emergency Attendances in England (Experimental Statistics) 2011–12. Summary Report.* Health and Social Care Information Centre.

HM Government (2010) *State of the Nation Report: Poverty, Worklessness and Welfare Dependency in the UK.* London: Cabinet Office.

Homeless Link (2014) *Support for Single Homeless People.* London: Homeless Link.

Home Office (2013) *Drug Misuse: Findings from the 2012/13 Crime Survey for England and Wales.* London: Home Office.

Johnsen, S., & Watts, B. (2014). *Homelessness and poverty: reviewing the links.* Heriot-Watt University.

King, R., Bird, S.M., Overstall, A.M, Hay, G. & Hutchson, S.J. (2014) 'Estimating prevalence of injecting drug users and heroin-related death rates in England using regional data and incorporating prior information', *Journal of the Royal Statistical Society,* 177(1): 209–236.

Maguire, N. J., Johnson, R., Vostanis, P., Keats, H. and Remington, R. E. (2009) *Homelessness and complex trauma: a review of the literature. Institutional Research Repository* (ePrints Soton), University of Southampton.

Maguire, N., Green, A.E. & Willoughby, K. (unpublished) 'Psychological factors in homelessness: do emotion regulation difficulties mediate the relationship between childhood trauma and maladaptive behaviours?' School of Psychology, University of Southampton.

Maguire, N., Hughes, V., Matthews, K., Monwar, M., McClean, L. & Levell, V. (unpublished(b)) 'Personality disorders and psychiatric morbidity in the homeless population'. School of Psychology, University of Southampton.

Making Every Adult Matter (2008) *In From the Margins.* London: MEAM.

Making Every Adult Matter (2009) *A Four Point Manifesto for Tackling Multiple Needs and Exclusions.* London: MEAM.

Markus, F. *et al* (2013) *Unit Cost Database (v1.3),* produced by *New Economy* in Manchester.

McDonagh, T. (2011) *Tackling Homelessness and Exclusion: Understanding Complex Lives*. York: Joseph Rowntree Foundation.

McNaughton (2009) 'Agency, transgression and the causation of homelessness: a contextualised rational action analysis', *European Journal of Homelessness*, 9(1), pp. 69–84.

McNaughton-Nicholls, C. & Quilgars, D. (2009) 'Homelessness amongst minority ethnic groups', in S. Fitzpatrick, D. Quilgars and N. Pleace (Eds) *Homelessness in the UK: Problems and Solutions.* Coventry: Chartered Institute for Housing.

Morgan, S. (2014) *The Heroin Epidemic of the 1980s and 1990s and its Effect on Crime Trends – Then and Now.* Technical Report. London: The Home Office.

National Treatment Agency (2012) *National and Regional Estimates of the Prevalence of Opiate and/or Crack Cocaine use in 2010–11.* London: NTA Available at: www.nta.nhs.uk/facts-prevalence.aspx

OPCS (1997) *OPCS Survey of Psychiatric Morbidity Among Homeless People.* London: ONS.

Rankin, J. & Regan, S. (2004) *Meeting Complex Needs: The Future of Social Care.* London: Turning Point.

Revolving Doors Agency (2012) *Integrated Offender Management: Effective Alternatives to Short Sentences.* London: Revolving Doors Agency.

Revolving Doors Agency and MEAM (2011) *Turning the Tide – A Vision Paper for Multiple Needs and Exclusions.* London: MEAM.

Richards, M. & Abbott, R. (2009) *Childhood Mental Health and Life Chances in Post-war Britain. Insights from Three National Birth Cohort Studies.* London: Sainsbury Centre for Mental Health.

Roberts, M. (2009) *Drug Treatment at the Crossroads.* London: DrugScope.

Rosengard, A., Laing, I., Ridley, J. and Hunter, S. (2007) *Closing the Opportunity Gap – Findings of a Literature Review on Multiple and Complex Needs,* Edinburgh: Scottish Executive Social Research.

Sainsbury Centre for Mental Health (2009) *The Chance of a Lifetime: Preventing Early Conduct Problems and Reducing Crime.* London: Sainsbury Centre for Mental Health.

Schneider, J. (2007) *Better Outcomes for the Most Excluded.* Better Outcomes for the Most Excluded. Nottingham: University of Nottingham and Nottingham Healthcare Trust.

Shelton, J.N., Alegre, J.M. & Son, D. (2010) 'Social stigma and disadvantage: current themes and future prospects', *Journal of Social Issues*, 66(3): 618–633.

Singleton, N., Meltzer, H. & Gatward, R. With Coid, J & Deasy, D. (1998) *Psychiatric Morbidity Among Prisoners.* London: ONS.

Viner, R.M., Ozer, E.M., Denny, S., Marmot, M., Resnick, M., Fatusi, A. & Currie, C. (2012) 'Adolescence and the social determinants of health', *The Lancet*, April 28;379(9826):1641–52. Epub 2012 Apr 25.

Webster, C. & Kingston, S. (2014) *Poverty and Crime*. Joseph Rowntree Foundation. London.