

New conversations about
severe & multiple disadvantage

HARD EDGES SCOTTLAND

Heriot-Watt University
I-SPHERE
Lankelly Chase
The Robertson Trust

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severe & multiple disadvantage

CONNECTED

Hard Edges
Scotland

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Acronyms

A&E Accident and Emergency Department	DLA Disability Living Allowance	MARAC Multi-Agency Risk Assessment Conferences (for Domestic Violence)	SHeS Scottish Health Survey
ACE(s) Adverse Childhood Experience(s)	DVA Domestic Violence and Abuse	MEH Multiple Exclusion Homelessness Survey	SHORE Sustainable Housing on Release for Everyone
B&B Bed and Breakfast accommodation	ESA Employment and Support Allowance	MH Mental (ill-)health	SHS Scottish Household Survey
CP Criminal Proceedings database (Justice Department, Scottish Government)	FS Floating Support	SMD Severe and Multiple Disadvantage	SMD(5D) Five-dimensional SMD – homelessness, substance dependence, offending, mental ill-health, domestic violence & abuse
CJS Criminal Justice Statistics publication (Justice Department, SG)	GP General Practitioner	NHS National Health Service	SMD(3D) Three-dimensional SMD – homelessness, substance dependence, offending
CJSW Criminal Justice Social Work	GUS Growing Up in Scotland (Longitudinal Survey)	O Other	SPS-PS Scottish Prison Service Prisoner Survey
DA Drug & Alcohol/Addictions	H Health	PIP Personal Independence Payment	SW Social Work
DATWT Drug and Alcohol Waiting Times database	4HHIS Health and Homelessness in Scotland (Data Linkage research report)	PSE Poverty and Social Exclusion Survey	UC Universal Credit
DEST Destitution in the UK Survey 2017	HL Homelessness	SCJS Scottish Crime and Justice Survey	
	HLI Homeless Applicants Individual Record	SDMD Scottish Drug Misuse Database (alias SMR25a/b)	

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The photography that is woven through this report emerged from a co-designed, participatory workshop between people with lived experience, staff in services, Lankelly Chase and the photographer. We would like to extend our warm thanks to everyone who participated so openly and enthusiastically.

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FOREWORD

There is growing recognition that disadvantages or harms such as poverty, mental ill health, drug misuse, violence or homelessness put you at much greater risk of others.



This can be seen in the way childhood harms can foreshadow problems in adulthood, in the way some harms experienced by parents affect their children, and in the way some people face multiple disadvantages at the same time.

These important patterns are often obscured by data gathered by services and systems divided between individual presenting needs and between life stages. When we can't see these patterns, we are doomed to repeat them.

Hard Edges Scotland was commissioned by Lankelly Chase and supported by The Robertson Trust to bring separate datasets together to reveal how some harms interconnect in the lives of people in Scotland. It follows a similar study based on English data, published in 2015.

This report doesn't merely repeat the English study. It includes much more qualitative evidence from people with lived or frontline experience of severe and multiple disadvantage, as well as case studies from local areas. Additional data about people's experiences of mental health problems and domestic abuse also helps shine more of a light on the experiences of some women. This latter development is particularly welcome, as the definition of severe and multiple disadvantage used in the English study generated a largely male profile.

Perhaps the most serious finding is described as "the pervasive role that violence continues to play throughout



the life course of people experiencing severe and multiple disadvantage – whether in their childhood home, at school, in the local community, on the city centre streets, in hostels, in intimate relationships, or other settings in adulthood". The authors argue that the psychological effects of this "ever-present threat" mustn't be under-estimated.

Also striking is the extent to which some disadvantages appear to be growing out of failures to deal with others. Attempts to ration increasingly scarce resources, for example, are pushing demand elsewhere, creating further harm in the process. We hear from people whose housing situation or mental health has become so desperate that they offend to access help through the criminal justice system. This whole system effect cannot necessarily be attributed to the shortcomings of any one service and

helps explain the frustrations of frontline workers, and those they support, who are contending with dynamics beyond their control.

Despite some sobering findings, there is good reason to feel hopeful about the way severe and multiple disadvantage could be addressed in Scotland in the future. There is a determined policy environment and some promising initiatives including investment in Housing First, Community Planning Partnerships, the Poverty and Inequality Commission, the Independent Care Review and Rights, Respect and Recovery, the new alcohol and drug treatment strategy. This report creates an acid test for these and other initiatives: can they combine to ensure everyone in Scotland has the opportunity to live a good life?

Hard Edges Scotland makes a renewed case for taking a whole system approach to severe and multiple disadvantage, with sustained and deep collaboration and coordination required at all levels. Individual services are contending daily with its impact, but individually they cannot provide the solution. It is also a compelling argument for involving people facing severe and multiple disadvantage, and their support workers, in work to change systems. It is they who bear daily witness to the dysfunctions that arise from even the most well-intended policy. It is they who have learnt to navigate and survive the complexities of the systems we have created. And it is they who stand to gain or lose most from the results.



SUMMARY



INTRODUCTION

The central aim of this study was to establish a statistical profile of the extent and nature of severe and multiple disadvantage (SMD) in Scotland.

This builds directly on the report *Hard Edges: Mapping Severe and Multiple Disadvantage (England)* published by Lankelly Chase in 2015, which focused on a key manifestation of SMD involving adults facing issues of homelessness, offending and/or substance dependency.

We retain this original three-dimensional (3D) version of SMD used in that study, in part to aid comparability with England, but mainly because the research team believe that this original definition of SMD has validity in focusing tightly on this particular group who face an exceptionally high level of stigma and dislocation from societal norms.

At the same time, we recognise that the wider perspective brought by also considering mental ill-health (MH) and domestic violence and abuse (DVA) gives fuller recognition to a range of complex needs and experiences which tend to affect women to a greater extent. This wider perspective was informed by a further parallel study of gendered patterns of SMD (Sosenko et al, 2019) carried out for Lankelly Chase.

The range of datasets used to generate the quantitative profile of SMD in Scotland is

significantly different and much wider than that used in England, partly out of necessity, partly responding to additional opportunities, and partly to better inform the wider agenda set for this study. Given these data differences, great caution is needed when making direct statistical comparisons between the countries.

Alongside a quantitative analysis of the overall scale and patterns of both the original and extended definitions of SMD in Scotland, we also sought to use qualitative methods to delve deeper into the causes, experiences and impacts of SMD, as looked at from the perspectives of people with direct lived experience and frontline workers. While we also interviewed senior stakeholders at both national and local level, this report lays particular emphasis on perspectives from the 'sharp end' of frontline experience.

Across the six case study areas, there was a remarkable degree of consistency in the accounts given by people with lived experience and frontline workers. This high level of 'triangulation' across a substantial qualitative dataset, together with supporting quantitative evidence, inspires confidence that the conclusions below are robust.

SCALE & OVERLAPS

We estimate that, over a year, 5,700 people in Scotland experience all three of homelessness, substance dependency and offending; 28,800 experience two out of these three; and 156,700 experience one of these disadvantages only.

Overall, 876,000 people in Scotland have experienced one of these three 'core' SMD domains in the course of the whole of their adult lives, 226,000 have experienced two of them, but a much smaller number (21,000) have experienced all three.

Homelessness is the most common of these three SMD experiences when looked at through this 'ever' lens, suggesting that its impact spreads much further across the community than either offending or substance dependency, which seem more likely to be characterised by recurrent/ongoing involvement.

When one widens the SMD lens to include MH and DVA, one finds that DVA is of a similar scale to substance dependency and homelessness, both of which are rather larger than offending, while MH-only dominates in terms of sheer numbers with 205,000 'current' cases per annum in Scotland.

Whether looked at from a 'current' or an 'ever' basis, not only does the MH domain involve by far the largest numbers, a clear majority of people experiencing MH problems in Scotland do not

Offending is the most 'core' of all of the SMD disadvantages considered in this report, while mental health is the least.

face any of the other disadvantages that we are considering in this report.

At the other end of the spectrum, the offending domain involves the smallest numbers of people but also the highest proportion of cases with 'overlapping' forms of current SMD. Thus, offending is the most 'core' of all of the SMD disadvantages considered in this report, while MH is the least.



PROFILE

The profile of people affected by the original three-dimensional forms of SMD in Scotland is very similar to that in England (Bramley et al, 2015).

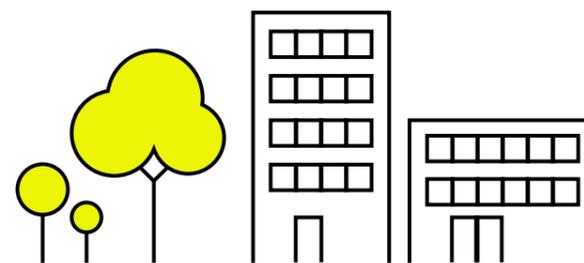
Thus the highest risks are associated with being younger (under 40), single, white and male. There are also independent associations with long-term sickness and/or a disability, and being a social tenant (or having no tenure at all). This original definition of SMD is very strongly linked to both household poverty and material deprivation, and the link with past poverty is clear in those datasets which include this.

Incorporating MH and DVA changes the gender profile of SMD, in that both of these 'single domain' experiences are majority female, especially DVA. However, even when these two additional domains are included as part of the mix, the most complex forms of SMD continue to be male-dominated.

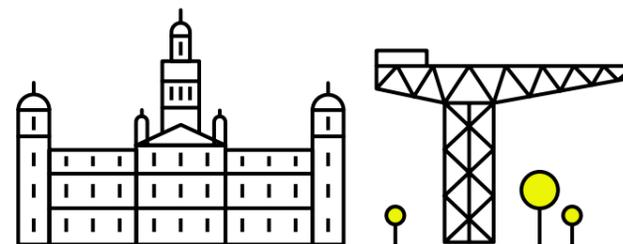
The inclusion of DVA in the definition of SMD weakens its link with poverty, especially when looked at on an 'ever' basis. The same is not true for MH, which appears to cast a long shadow over people's economic as well as emotional well-being on a sustained basis.

The highest risks are associated with being younger (under 40), single, white and male.

GEOGRAPHY



Rates of most aspects of SMD tend to be higher in urban than rural areas (aside from DVA), and there is a more pronounced tendency for rates to be higher in poorer and more deprived neighbourhoods.



In terms of the absolute numbers of people affected by SMD, Glasgow completely dominates, with nearly double the number of cases of the next nearest authority (Edinburgh).

5D

Once one widens the geographical analysis to five-dimensional SMD, MH dominates overall numbers across the country, as one would expect, while DVA is distributed in a different, less systematic fashion. Glasgow's overwhelming prominence in terms of absolute scale, including with respect to MH, is confirmed by this broadened analysis.



At local authority level, the highest rates of the original three-dimensional form of SMD are generally found in urban and poorer authorities, mostly in the central belt, with West Dunbartonshire, Clackmannanshire, Glasgow, Dundee, North Ayrshire and Aberdeen City showing high prevalence.



In all, seven Scottish local authorities - the four main cities, Fife, and North and South Lanarkshire - account for 53% of the total number of adults in Scotland with two or more of these disadvantages. This is clearly highly relevant to matters of resource distribution in tackling this particular form of SMD.

ROUTES IN – DRIVEN BY POVERTY, VIOLENCE & TRAUMA

The study evidences 'routes in' to SMD that are consistent with previous research, including the original Hard Edges study in England (Bramley et al, 2015), and also with earlier research on Multiple Exclusion Homelessness (MEH) (Fitzpatrick et al, 2013).

The quantitative research indicates that poverty is a significant background factor, which emerges ever more strongly the closer one focuses on the most extreme forms of SMD. There is also growing qualitative and quantitative evidence of the childhood trauma that lies behind adult SMD (Theodorou & Johnsen, 2017).

Most people interviewed had had difficult early lives involving a range of 'adverse childhood experiences' (ACEs), including physical and/or sexual abuse, disrupted schooling and, in some cases, local authority care.

In young adulthood, they had typically experienced poor mental health, substance dependency and difficulties in both the labour market and interpersonal relationships.

In particular, the pervasive role that violence continues to play throughout the life course of people experiencing SMD – whether in their childhood home, at school, in the local community, on the city centre streets, in hostels, in intimate relationships, or other settings in adulthood – warrants more emphasis than it currently receives in both policy and research. The ever-present threat of violence, and managing its physical and psychological impacts (Maguire et al, 2010), so that one is constantly living in 'survival mode', arguably forms the key thread linking all manner of manifestations of SMD and the behaviour of those experiencing it (McGarvey, 2017). Substance dependence and mental ill-health are obvious cases in point.



Poverty is a significant background factor, which emerges ever more strongly the closer one focuses on the most extreme forms of severe and multiple disadvantage

**“SHE'S NOT ENOUGH OF AN ADDICT.
SHE'S NOT ENOUGH OF A MENTAL
HEALTH PATIENT. SHE'S NOT ENOUGH
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GET LIKE A PACKAGE.”**

MISSED OPPORTUNITIES

In terms of ‘missed opportunities’ for preventative interventions in the lives of those currently experiencing SMD, schools and other educational services were a central theme raised by people with lived experience, service providers and national stakeholders.

Truancy and exclusion from secondary school, often coupled with early substance dependency, were usually the first flags in the early teenage years that a young person was at risk of adult SMD. Yet it was reported that education was a particularly difficult sector to engage in policy and practice development on SMD.

While some of the young people affected were formally ‘looked after’ by local authorities, many more were living unsettled lives, moving around friends and relatives’ houses, and may have been unknown to social work services as children.

For those young people who had been engaged with social work services as children, there were often painful memories of having been in care that made them feel hostile towards child protection social work services, at least at the

point of leaving care. The disruptive impact of frequent moves around care placements, and the apparently highly variable level and quality of support offered by individual social workers, were themes that emerged strongly from the interviews with service users. This report reinforces the point already made by many others over many years that young people, desperate to leave care as soon as they turn 16, often quite quickly come to regret this decision, and the door should be left open for them to return to care, at least until their early 20s (Joseph Rowntree Foundation, 2016).

CRIMINAL JUSTICE – THE LAST RESORT ‘SAFETY NET’?

A standout finding across all six case study areas was the extent to which the criminal justice system was used as the last resort ‘safety net’ for people facing SMD whom other services routinely failed to provide with the help they desperately needed.

This was brought home by the numerous examples given of people committing offences and/or requesting custodial sentences in order to gain access to a ‘safe place’ in prison and to ‘care’ of various kinds. We even heard of service providers seeking to have vulnerable people arrested simply in order that they could access the mental health and other services they needed.

The existence of a court order appeared to be the necessary ‘passport’ for access not only to an array of health and other support services, but also the main route through which any kind of coordination of care occurred for people facing SMD, if indeed it occurred at all. Criminal justice social workers were praised by some people with lived experience as the most consistent and helpful service they had encountered. Frontline service providers, too, generally acknowledged

that criminal justice teams provided the ‘stickiest’ and most proactive support that adults facing SMD could expect.

That said, both pre- and post-release support for prisoners was reported as far from perfect, with many still being released straight into homelessness.

HOMELESSNESS SERVICES – 'CARRYING THE CAN'

In the absence of a court order, local authority statutory homelessness services were the next most likely service to 'lead' on SMD cases, but this presented a host of issues.

In particular, while homelessness services and Housing Options teams may seek to make referrals to addiction and mental health services for SMD clients, they had no command over these resources, nor the necessary authority to coordinate timely multi-sectoral interventions for people with complex needs.

There was also much for homelessness services to do to get their own house in order with regard to the service they provide to people facing SMD. Administrative statistics indicate that homelessness rehousing outcomes are systematically worse for SMD groups and not improving over time. Moreover, it was evident from the accounts given by both people with lived experience and service providers in some case study areas that local authorities were routinely failing in their statutory duties to homeless people, turning some away some without the temporary accommodation to which they are entitled¹.

Further, discussion of one of the 'vignettes' (hypothetical but realistic stories used as a

prompt by the researchers) revealed the extent to which lack of a 'local connection' is treated as a bar to homelessness assistance in some areas, in contravention of the legislative arrangements that provide that only the 'settled' rehousing duty can be transferred between local authorities.

The highly variable quality of hostels and other forms of temporary and/or supported accommodation for homeless people across Scotland matches the findings of a recent national study (Watts et al, 2018). Evidence of the disappointingly 'light touch' and short-term nature of floating support often offered to people facing SMD after they have moved into their own tenancies is a useful reminder of the vital importance of open-ended, wrap-around support for those with complex needs being moved into permanent housing under the rapid rehousing and Housing First approach now being rolled out across Scotland².



The missing mental health services

A gaping hole in MH service provision was emphasised by virtually every service provider interviewed and a large number of people with lived experience too.

The extreme rationing applied by these services, acting under acute pressure, meant that even getting to the point of achieving an assessment could seem an insurmountable hurdle.

The 'one/two/three strikes and you are out' policy for those who missed appointments, reported across several case study areas, could almost be designed to eliminate the chances of those with chaotic lifestyles and unstable living arrangements from ever gaining access to the help that they need. Even for those who managed to access MH services, the over-reliance on prescription medication was widely criticised.

Substance dependency services in retreat

People with active substance dependency problems faced especially high barriers to accessing mainstream MH services, and in some areas there was also a sense that the availability of substance dependency services had declined in recent years, particularly residential rehabilitation.

We even heard of cases of people deliberately crossing local authority boundaries in order to commit offences that would enable them to access rehabilitation facilities in that area.

For those who managed to access residential services, there was often said to be a lack of ongoing support to aid their full recovery once they were back in the community. For community-based treatments, too, there were often substantial waiting periods, which were deeply unhelpful for those in crisis, and meant many 'windows of opportunity' to get people on the road to recovery were lost.

Nonetheless, some people reported a positive experience of rehabilitation and/or community-based substance dependency services, successfully stabilising or even overcoming their addictions, while others felt 'stuck on methadone' for long periods without the support they needed to come off it. These mixed results are also reflected in the quantitative outcomes data analysed.

Specialist domestic violence and abuse services that can't cater for survivors facing SMD

While almost all of the women interviewed had experienced DVA, and this was reported by service providers to be almost universal amongst women facing the most complex forms of SMD, there was less experience of specialist refuge and other provision than one might expect.

This at least in part reflects the fact that specialist refuge providers will not accept women with active addictions and chaotic lifestyles in some areas. Whilst this policy stance is understandable, given the imperative to keep refuges feeling safe for all of their residents, it does indicate the need to develop innovative provision for survivors of DVA facing SMD.

A benefits system that punishes SMD

As noted above, the strong links between poverty and SMD, particularly in its most extreme forms, was evident in the statistical analysis undertaken, and the ongoing freeze on working age benefits will be exacerbating the material deprivation faced by many people living with SMD in Scotland.

In line with concerns now being expressed across the political spectrum, **Universal Credit was viewed as a 'nightmare' by both recipients and providers who had experience of it, and the system modifications available in Scotland – fortnightly payments and direct payment of rent to landlords – did not appear to be routinely being offered to claimants with complex needs.** It is well known that benefit sanctions bear down particularly harshly on people with complex needs (Watts & Fitzpatrick, 2018), and that was evident in this study too. Many vulnerable people with lived experience had experienced difficulties with ESA, and with the transition from DLA onto PIP, and had needed the help of voluntary sector agencies to secure the benefits to which they are entitled.

CRISIS-FOCUSED SYSTEMS THAT CAN'T COPE WITH THE EFFECTS OF TRAUMA

Cutting across all of these findings was the fundamental inability of local and national service systems to address the needs of people who present with a range of complex and interacting needs, especially if accompanied by the challenging forms of behaviour that are often manifest in people coping with the long-term effects of sustained trauma including ACEs (Maguire et al, 2010).

This pervasive nature of trauma amongst people facing SMD was well understood by the service providers interviewed, but there was only limited evidence (in the larger urban areas) of the active development of trauma-informed services and/or psychologically-informed environments (Keats et al, 2012).

Moreover, the crisis-focused nature of the service interventions that people with lived experience typically received, coupled with the difficulties faced in accessing appropriate mental health services, meant that people facing SMD were

seldom getting the help they needed to manage and address this underlying trauma.

The crisis nature of service interventions also militated against the development of 'strengths-based' approaches, focused on future hopes and potential for a better, more socially productive life. It was notable that there was relatively little emphasis placed on helping people facing SMD (re)build positive family relationships, even though that was the overriding motivation for recovery identified by most people with lived experience.

A PAUCITY OF PERSONALISED, PROACTIVE, 'STICKY' SERVICES

The people with lived experience interviewed were very clear on what made for helpful services from their point of view: the provision of emotional as well as practical support, and 'personalised' support tailored to their specific needs.

But service providers explained that resource constraints often militated against this kind of approach, pushing them towards a 'one-size-fits-all' model.

People with lived experience appreciated frankness, accessibility and reliability in frontline workers, and also 'stickability', not giving up on them if 'they failed to engage'. However, assertive, proactive services that reached out to, and stayed with, vulnerable people were hard to come by in many areas.

The emphasis was instead often placed on people facing SMD taking the initiative or 'being left to their own devices' to seek and secure help. While many recognised the need to take 'ownership' of their problems, and responsibility for their own steps towards recovery, they

also needed the support, and challenge, of appropriate services to help them do this.

All of this reflected a general lack of clarity around coordination/case management in many SMD cases, unless social work or criminal justice have a clear statutory duty. In some areas the 'lead professional' model was considered an important step towards better support for individuals, with early evidence of success when implemented well. Despite this, it was not always clear who should/would lead on specific cases, though this was something that some Health and Social Care Partnerships were said to be actively trying to address.

THE NEED FOR NEW SOLUTIONS IN SMALLER URBAN & RURAL AREAS

There clearly were distinctions between the larger urban areas and the more rural and semi-rural areas in both the quantity and quality of services available to people facing SMD.

To some extent this is unavoidable: the small scale of the problem in many rural areas makes the development of very specialist services infeasible. It is also right and proper that resources be concentrated in the urban areas where need is greatest, most especially Glasgow.

However, means must be found to allow people from smaller urban and more rural areas access to the homelessness, substance dependency, MH and other services they may need.

Ways must be found to remove 'local connection' as a bar to assistance, especially when there are no appropriate services in the areas from which people originate.

While for some people from smaller towns and rural areas, it is far from ideal to have to move, or travel, to access services, others welcomed the relative anonymity of larger towns and cities, and explained how recovery can be hampered by everybody knowing everything about them in smaller places. These factors may lead to some drift to urban areas reinforcing geographical concentration, though we have not been able to quantify this in the context of the current study.



SIGNIFICANCE

People facing SMD have an extraordinarily poor quality of life including sharply heightened risks of both morbidity and mortality (Aldridge et al, 2018; Waugh et al, 2018), poverty and multiple deprivation, and social and economic exclusion.

There is also a heavy excess burden of cost for the public sector associated with more extreme cases of SMD, especially for the NHS (given the co-morbidity between substance dependency and poor physical and mental health), but also clearly for an array of other public services including criminal justice, social work, and social security.

One of the most compelling reasons to attend to SMD is the impact that the associated behaviours have on (other) vulnerable people, especially children and partners. The combinations of

parental substance dependency, mental ill-health and domestic violence, that shaped the childhoods of so many people currently facing SMD (Bywaters et al, 2016) indicate that these people's parents were themselves very often experiencing SMD.

All of this alerts us to the urgent need to prevent the damaging impacts SMD being visited on the next and subsequent generations.



REPORT

In January 2015 the report *Hard Edges: Mapping Severe and Multiple Disadvantage (England)* was published by Lankelly Chase. This report attracted considerable notice and has continued to generate interest from Government and a wide range of organisations. It sought to provide a statistical profile of one key manifestation of ‘severe and multiple disadvantage’ (SMD) in England, using this as a shorthand to signify the problems faced by adults involved in the homelessness, substance dependency and criminal justice systems while underlining the strong links with poverty and mental ill-health.



The central part of the *Hard Edges* research involved interrogating a range of datasets, both administrative and survey-based, to examine the characteristics and experiences of people in touch with services and experiencing combinations of those issues. It presented new estimates of national numbers with different combinations of problems, of their demographic and geographic profile, background circumstances, current quality of life, service costs and outcomes.

Although the original intention had been to look UK-wide, in practice the datasets used were largely specific to England. It became apparent that there was considerable interest in the possibility of conducting a similar study in Scotland, where the relevant datasets are distinct, and where there are also important differences in the policy and service delivery context.

At the same time, Lankelly Chase and other partner organisations became concerned that the original *Hard Edges* study was focused on a particular coalescence of disadvantages that tend to predominantly affect men. A separate study was commissioned to broaden understanding of SMD issues beyond the original three domains in order to cast light on any gendered differences in the manifestation of SMD – and the experiences of women in particular. In effect that study³ widened the scope of SMD to encompass mental ill-health and violence and abuse, while also placing more

emphasis on lifetime as well as current experiences. This study of SMD in Scotland has been able to benefit from the insights from this further study and adopts a framework to encompass SMD definitions from both the 'gendered patterns' study and the original Hard Edges.

During the early stages of this Scottish study, it also became apparent that it would be appropriate to conduct a significant qualitative element within the research that reached substantially beyond what had been attempted in England. A more in-depth and holistic analysis of local systemic responses was felt likely to significantly bolster the policy- and practice-influencing agenda that is the ultimate purpose of the study.

The central aim of this present study was therefore to establish a statistical profile of the extent and nature of SMD in Scotland, in both its original and expanded form. This included clarifying the patterns of overlap between the different specified domains and creating a fuller profile of those affected. In addition, the research sought to identify similarities and differences between England and Scotland, where appropriate. It also sought to illuminate both service provider and service user perspectives on the routes into SMD and experiences of interacting with multiple service systems, in order to identify requirements for national and local systems change.

The next section of this report presents the definitions of SMD used in this study, before the methodology adopted by the research team is then briefly summarised (see Bramley et al (2019) for the full Technical Report⁴). The main quantitative sections of the report detail the scale, overlap and socio-demographic profile of SMD in Scotland, its relationship with poverty and deprivation, and its geographical distribution. We then move on to foreground the qualitative experiences of people with direct personal experience of SMD, and the perspectives of frontline practitioners at the sharp end of assisting people in this situation, before drawing some overall conclusions and flagging some ways forward in this field.

DEFINING SEVERE & MULTIPLE DISADVANTAGE

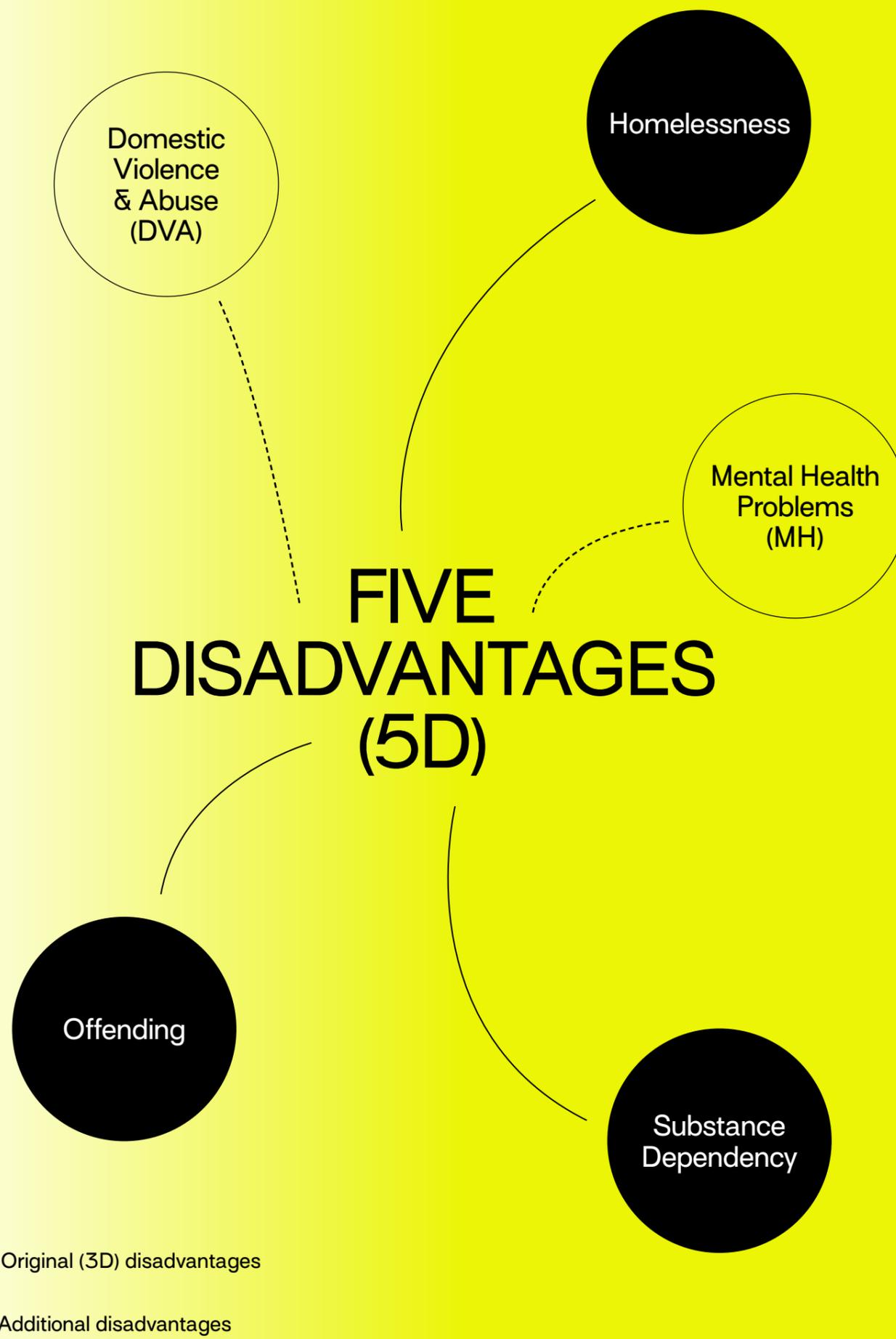
In the original Hard Edges study in England, an initial qualitative scoping stage laid considerable emphasis on designing and testing out the most appropriate definition of SMD to use in this research (Bramley et al, 2015).

This current study builds on that foundation. Thus we retain the original three-dimensional version of SMD(3D) – focused on homelessness, offending and substance dependency – in this Scottish study. In part, this is to ensure continuity and comparability with the English Hard Edges study. However, the research team also believe that this original definition of SMD has validity in focusing tightly on this particular group who face an exceptionally high level of stigma and dislocation from societal norms.

At the same time, we recognise that the wider perspective brought by also considering mental health (MH) and domestic violence and abuse (DVA) gives fuller recognition to a range of complex needs and experiences which arguably require more policy attention and responses from services, and which tend to affect women to a greater extent than the issues captured in the original SMD definition, which is strongly associated with men. Thus, in this Scottish report we have extended our analysis to also consider a wider five-dimensional version of SMD (5D). The definitional ‘thresholds’ used for each of these five key domains are summarised in Table 1.

While the precise parameters of these definitions inevitably vary depending on the particular dataset being drawn upon in, Table 1 provides a brief guide to the broad thresholds being applied in each domain and the datasets within which they are being applied (see Bramley et al (2019) for more detail). It is important to appreciate that, out of necessity, there are compromises between (a) the ideal ‘in principle’ definition, (b) definitions based on administrative recording systems, and (c) definitions which can be implemented in particular household surveys.

In the original Hard Edges study most of the emphasis was upon ‘Current SMD’, by which we mean the number of people experiencing each disadvantage in a year (though not necessarily at exactly the same time). In the gendered profile follow-up study in England, more emphasis was placed upon ‘Ever SMD’ definitions. One important reason for this was our greater reliance in that latter study on sample survey datasets, within which the number of cases with current experience of what are often relatively rare situations are too small to permit statistically viable analyses. As we will see below, a similar



Key to Sources

HL1: Homelessness LA case records
HHIS: Health and Homelessness in Scotland study (Waugh et al, 2018)
SHS: Scottish Household Survey
SHeS: Scottish Health Survey; PSE – UK Poverty and Social Exclusion Survey 2012
GUS: 'Growing Up in Scotland' Cohort Survey
DEST: 'Destitution in the UK' Survey 2017 (Fitzpatrick et al, 2018)
SDMD: Scottish Drug Misuse Database
SPS-PS: Scottish Prison Service, Prisoners Survey
PSE: Poverty and Social Exclusion Survey
SCJS: Scottish Crime and Justice Survey
CP: Criminal Proceedings statistics

Table 1: Guide to Core Definitions

Domain	Definition	Dataset(s) ⁵
Homelessness	<ul style="list-style-type: none"> Accepted as statutorily homeless/threatened with homelessness Self-identifying as 'homeless' Self-reporting: applying as homeless; sleeping rough; sofa-surfing; living in emergency/temporary or highly insecure accommodation. Combinations of recent housing problems as a proxy 	HL1, HHIS SHS, PSE SHS, PSE, GUS, DEST, SPS-PS SCJS
Offending	<ul style="list-style-type: none"> Being convicted, arrested or accused in connection with non-trivial crimes (i.e. excluding minor motoring offences) Self-reporting being in trouble with police Currently or recently in prison 	SCJS, CP, PSE, GUS DEST SPS-PS, GUS, HL1
Substance dependency	Drug and/or alcohol dependency, as indicated by: <ul style="list-style-type: none"> Engagement in drug treatment programmes Drug-related hospital treatment Drug treatment-specific prescriptions Self-reporting use of Class A drugs and/or dependence on certain Class B drugs (e.g. cannabis) Self-reporting heavy/hazardous alcohol use Self-identifying as a having an 'alcohol or drug problem' 	SDMD HHIS HHIS SCJS, GUS SHeS, SCJS, GUS DEST, SPS-PS, HL1
Domestic violence & abuse (DVA)	Being a victim of DVA, as indicated by self-reported experience of: <ul style="list-style-type: none"> Actual violence, coercive control or threats of violence, and/or stalking or harassment by partner/former partner(s) Any forced sex since age 16 DVA as reason for loss of home Self-reported experience of 'domestic violence' 	SCJS, PSE, GUS PSE HHIS DEST
Mental health problems (MH)	'Common Mental Disorders' (CMD) such as depression and anxiety – serious enough to achieve recognition in a primary healthcare setting – and psychosis and other severe mental health conditions. Indicated by: <ul style="list-style-type: none"> Relevant prescriptions Hospital treatment/admissions Referral agency or professional assessment Survey responses to multi-item survey scales and questions about long-term health conditions Self-identifying as having a mental health problem or support needs 	HHIS HHIS SDMD SCJS, PSE, SPS-PS, GUS DEST, HL1

issue affects the Scottish study. We therefore report on both 'Current SMD' and 'Ever SMD' cases in this report, but often the more robust, detailed and insightful conclusions derive from the 'Ever SMD' basis of analysis.

It is also important to be aware of two significant challenges associated with the wider SMD(5D) perspective, even when one confines this to a 'Current SMD' basis, and certainly when one extends it to an 'Ever SMD' basis. First, it tends to bring in its wake very large numbers, mainly because of the high population prevalence of common MH conditions such as depression and anxiety at a level which would be clinically recognised (e.g. by a GP). While one might opt to limit the definition to a range of more serious/severe conditions, this would not be practically applicable without a survey such as the Adult Psychiatric Morbidity Survey, which exists in England but not in Scotland. Even then, that does not deal with the objection that SMD may well involve mental health conditions at the lower level rather than at the very high level associated with, for example, in-patient treatment.

The second problem is that the number of separate combination segments which can theoretically be identified within SMD(5D) is too large to be comprehensible by the analyst or the reader⁶. We therefore typically reduce our analysis to 9 key 'category' segments, essentially each of the five domains singly, three groupings of 2 domains (2 from the original triumvirate, MH with any other domain and DVA with any other domain), and any combinations of three or more. We also generally offer a 'count' measure from 0 to 5 domains.

Even with these compromises, we still have potentially eight ways of analysing the data (3D v 5D, Current vs Ever, categories vs counts), which would be too testing on the reader to present in most cases. So it is necessary to be selective. In the analysis below we focus on either end of the possible scope of SMD – 'Current SMD(3D)' and 'Ever SMD(5D)' – unless there is some specific reason to depart from this approach, and choose more detailed categories and/or counts depending on what we judge most relevant to the particular point being made.

**“I JUST NEED SOMEBODY
TO TELL ME THAT I'M
DOING THINGS RIGHT.”**

METHODOLOGY

The original Hard Edges study was primarily a quantitative descriptive profiling of the phenomenon, although as noted above, it had been based on a more qualitative scoping stage. The core of the quantitative analysis was built on analysis of three administrative datasets, supplemented by use of two specialised sample surveys, one focused on ‘Poverty and Social Exclusion’ (PSE) and the other on ‘Multiple Exclusion Homelessness’ (MEH) (Fitzpatrick et al, 2013).

However, the quantitative methodological challenge turned out to be much greater in Scotland, in large part because of the much patchier and more diverse nature of relevant administrative datasets, alongside information governance issues which restricted access to some of the relevant administrative data. There are also specific limitations with regard to administrative data coverage of our ‘new’ domains: MH (where services are generally acknowledged as inadequate relative to need) and DVA (an often-hidden problem where specific services only address a proportion of more extreme cases).

We therefore placed significant emphasis on a clutch of general household surveys which the Scottish Government maintains on a rolling basis, alongside a range of specialist sample surveys. In addition to the PSE and MEH⁷ specialist surveys just mentioned, we have also been able to make use of a new ‘Destitution in the UK’ survey⁸, a bi-annual Prisoner Survey, and ‘Growing Up in Scotland’ (GUS), a child/family

cohort study which has been running for more than a decade, enabling investigation of the relationship between adult SMD and ‘Adverse Childhood Experiences’ (ACEs), a topic of strong current policy interest (Theodorou & Johnsen, 2017).

As Table 2 below indicates, therefore, 12 datasets were used in total in the Hard Edges Scotland analysis, including four administrative datasets (including an innovative data linkage project from Health and Homelessness in Scotland (Vaughn et al, 2018)), three general household surveys, and five specialised sample surveys, of which two cover the general population and three focus on users of particular services. A broad distinction may be drawn between the ‘services-based’ data (including all of the administrative data and some of the specialist surveys) and ‘survey-based’ data, which is not dependent on individuals’ use of services. As can also be seen, these datasets vary in the extent to which they cover SMD domains, but taken as a whole allow for the development of a comprehensive statistical picture of the situation in Scotland.

After an in-depth scoping out of each of these datasets, and their potential to contribute to the study, there was often a process of negotiating access to them, protracted in some cases and unsuccessful in others, due to data governance issues¹⁰. Standalone analyses of individual datasets were then undertaken, and a series of detailed working papers produced, before an overarching ‘integration analysis’ was conducted to combine the numerical estimates and profile information for the relevant SMD groupings, drawn from varying numbers of sources, depending on the specific issue under consideration. This ‘blending’ exercise entailed devising a set of weights to generate best quantitative estimates of the overall numbers and profiles, allowing for differences in coverage, overlap and reliability. A full discussion of the rationale, approach and assumptions made in this weighting scheme can be found in the Technical Report, together with details of the bivariate and multivariate analysis undertaken.

In addition to this multi-stage, multi-component quantitative study, there was also a very significant qualitative dimension to this Hard Edges Scotland study. As in England,

Table 2 Key Datasets

Dataset	Type	Primary disadvantage(s)	Other disadvantage(s)
Scottish Statutory Homelessness Statistics (HL1)	Administrative	Homelessness	MH, Substance, Offending, DVA
Health and Homelessness in Scotland (HHIS)	Administrative (data linkage)	Homelessness	MH, Substance
Prisoner Survey (SPS-PS)	Specialist sample survey (service users)	Offending	Homelessness, Substance, MH, DVA
Scottish Household Survey (SHS)	General household survey	Homelessness	
Scottish Crime and Justice Survey (SCJS)	General household survey	Substance (esp Drugs), DVA,	Substance (alcohol), MH, Homelessness
Scottish Health Survey (SHeS)	General household survey	Substance (alcohol)	MH
Multiple Exclusion Homelessness (MEH)	Specialist sample survey (service users)	Homelessness	MH, Substance, DVA, Offending
Destitution in the UK (DEST)	Specialist sample survey (service users)	Homelessness ⁹	MH, Substance, DVA, Offending
Growing Up in Scotland (GUS)	Specialist sample survey (longitudinal)	None	Homelessness, Substance, MH, DVA, Offending (for parents)
Poverty and Social Exclusion (PSE)	Specialist sample survey (household population)	None	Homelessness, MH, DVA, Offending
Scottish Drug Misuse Dataset (SDMD)	Administrative	Substance dependency (drugs)	Homelessness, Substance (alcohol), MH, Offending
Criminal Justice Statistics	Criminal Justice Statistics (published bulletins)	Offending	

we commenced the project with a series of national-level key informant interviews with stakeholders in the fields of homelessness, substance dependency, criminal justice, mental health, public health and domestic violence/abuse (15 in total).

However, unlike in England, we additionally conducted six in-depth case studies of local systemic responses to SMD. The selection of these case study local authority areas was informed by the statistical analysis undertaken for the study, with a view to capturing a cross-section of areas with higher and lower rates of SMD, as well as the inclusion of cities, large towns, and rural areas across Scotland, and also east, west, southern and more northern parts of the country.

In total, across the six case study areas, 25 local key informants were interviewed, eight focus groups were conducted with frontline workers (involving 47 workers in total), and 42 in-depth interviews were completed with people experiencing SMD who were using relevant services (10 women and 32 men). Both service users and service providers in the local case studies were drawn from across the homelessness, mental health, drugs and alcohol, criminal justice, and domestic violence sectors. The service users were deliberately sampled to prioritise those with the most complex experiences of SMD, in order to 'test' local system responses as much as possible. The scale of fieldwork varied between the different case studies, reflecting the fact that the size of the service network, and SMD population, differed significantly between the larger urban and some of the other case study areas. Prior to the case study fieldwork commencing, two 'Lived Experience Reference Groups', one male and one female, were established by Glasgow Homelessness Network to help shape the content of the in-depth interviews with service users (see Bramley et al, 2019) for details of all aspects of the qualitative components of the research).



SCALE

&

OVERLAPS

THREE-DIMENSIONAL SMD

Current SMD(3D)

Figure 1 presents our composite best estimate of the number of adults in Scotland currently experiencing SMD(3D), drawing on both services-based and survey-based data¹¹, and encompassing sources which cover both the private household population and groups (such as a homeless people) who may not currently be living in mainstream housing.

Based on a weighted analysis of all these sources, our annual estimate for Current SMD3(3D), that is people who have experienced all three disadvantage domains over the course of a year, is approximately 5,700.

When we look at the Current SMD2 (3D) 'overlap' category, we find that around 8,500 have a combination of homelessness and offending, a very similar number (8,300) have a combination of homelessness and substance dependence, and a somewhat higher number (11,900) experience offending and substance dependence, totalling 28,800.

Finally, we estimate that around 156,700 are experiencing one of the Current SMD(3D) disadvantages, comprising 33,600 who are engaged in offending only, 53,500 who are experiencing homelessness only, and 69,600 who are experiencing substance dependency only.

In total, around 191,000 people have a relevant experience across the three domains in a typical recent year. This suggests a national prevalence rate in Scotland of 42.9 per thousand for one domain of Current SMD(3D), 7.9 per thousand adults for Current SMD2(3D), and 1.6 per thousand for Current SMD3(3D).

Ever SMD(3D)

As explained in the section above on 'Defining Severe and Multiple Disadvantage', we also estimated the numbers for the "Ever 3D" definition in Scotland. This refers to people who have experienced one or more of the relevant domains during their adult lives, and these numbers are all naturally larger than those in Figure 1 (see Figure 2).

Overall, 875,000 people in Scotland have experienced one of these disadvantage domains (over one fifth of the entire adult population), 226,000 have experienced two of them, but a much smaller number (21,000) have experienced all three.

As is clear from Figure 2, homelessness is the most common of these three SMD experiences when looked at through the 'ever' lens, suggesting that its impact spreads significantly further across the community than either offending or substance dependency, which seem more likely to be characterised by recurrent/ongoing involvement. This is consistent with the findings of the homelessness and health data linkage project (HHiS), which revealed that a sizeable minority of the whole of Scotland's population (at least 8%) had been assessed as homeless or threatened with homelessness by local authorities between 2001 and 2016 (Vaugh et al, 2018).

Figure 1

Numbers of Adults in Scotland by Current SMD (3D)

Sources: Weighted combination of SCJS, GUS, HLI, HHIS, SDMD, DEST, SPS-PS, CJS

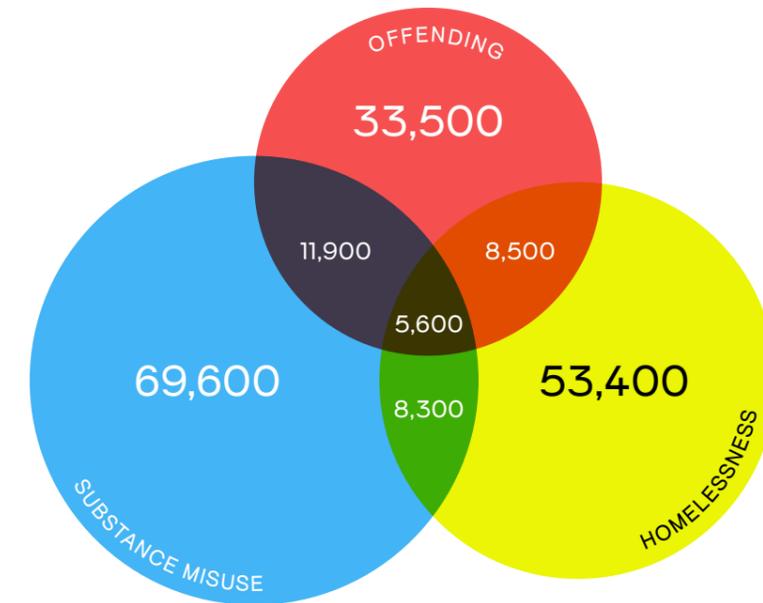
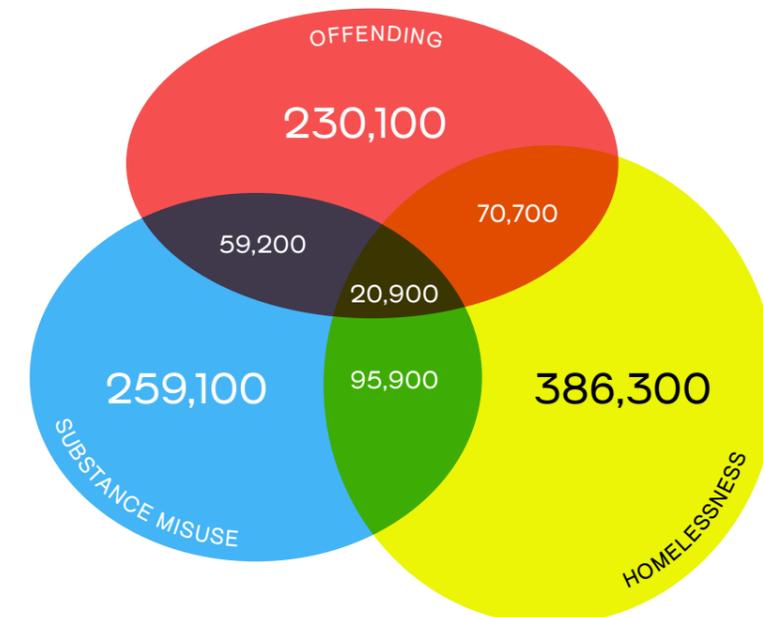


Figure 2

Numbers of Adults in Scotland by Ever SMD (3D) Categories

Sources: Weighted combination of SCJS, PSE, GUS, HHIS, SDMD, DEST, SPS-PS, CJS



COMPARISONS WITH ENGLAND

The most appropriate comparison point with England is the ‘Current 3D’ perspective on SMD, which was used as the main basis for the English study (Bramley et al, 2015).

Here what we find is that the national rate of the most extreme level of SMD – involving experience of all three disadvantages in the same year – is similar in Scotland to that which we found in England (1.6, compared with 1.5 per thousand).

However, the national rate for the key ‘threshold’ level that we used in much of the English analysis – having experienced two or three these disadvantages in the same year – is significantly higher in Scotland (9.5) than in England (5.7). In part this reflects the wider definition of homelessness used in the Scotland study¹² and its more generous statutory homelessness arrangements (see below). It also reflects differences in the methodology, with more use of surveys which cover people (particularly those who are drug or alcohol dependent, but also those experiencing homelessness) who are not using services, and some approximation in the thresholds which can be applied in these surveys. Thus the Scottish numbers will also

look larger relative to England, particularly for the ‘single domain’ cases but also for the SMD2 cases. While this may also reflect higher incidence of these issues in reality, we cannot say for sure that that is the case.

A key finding of the original Hard Edges study was that a clear majority (around two-thirds) of all homelessness service users and offenders had ‘current’ (within same year) experience of at least one of the other two SMD issues. The position was less clear cut for people with substance dependencies, 60% of whom were ‘substance-only’ cases. However, digging a bit deeper we found that for drugs service users the degree of overlap with the other two disadvantages was much higher (at 48%) than for alcohol service users (24%).

In England Hard Edges showed a pattern of strong overlap between homelessness, offending and substance use. The pattern in the Scottish study appears to be rather different, with far

less overlap between the domains. In all, 70% of current Scottish homelessness cases are homelessness-only, and 73% of substance dependence cases are substance-only. Offending demonstrates more overlap, but even here, only 44% of current cases have experience of at least one of the other issues (the most common overlap is with substance dependency), as compared with 63% in England. When looked at via the ‘Ever SMD(3D)’ lens (not used in England), levels of overlap rise a little, to one third of homelessness cases and two-fifths of substance dependency cases, but the offender SMD proportion stays relatively stable at around two-fifths.

issues of offending or substance dependence (see further below).

Likewise, the threshold used in surveys for drugs dependency is likely to capture more recreational/occasional use of illegal substances, thereby drawing in some people who are much less likely to face SMD.

We turn now to consider the wider five-dimensional SMD (5D) typology, bringing mental health (MH) and domestic violence/abuse (DVA) into the picture, again on a ‘current’ and then on an ‘ever’ basis.

Offending demonstrates more overlap, but even here, only 44% of current cases have experience of at least one of the other issues

Again, this discrepancy with England underscores the definitional and methodological differences just noted. In particular, the homelessness measures that we are using in Scotland capture a markedly different – much wider – homeless population than in England, where we were limited to the mainly single homeless group receiving Supporting People services. When you widen the lens to include homeless families as well as single people accepted by local authorities¹³, and respondents who report ‘hidden’ as well as ‘visible’ homeless experiences in household surveys (Fitzpatrick et al, 2019 forthcoming), you encompass, as one would expect, a great many more cases where homelessness is entirely unconnected with

FIVE-DIMENSIONAL SMD

Current SMD(5D)

Figures 3a-3b present our composite best estimates of the number of adults in Scotland experiencing the 'Current 5D' definition of SMD, again drawing on both services-based and survey-based data¹⁴. For reasons explained above, the data presented in Figure 3 is somewhat grouped, rather than our attempting to describe every conceivable permutation of SMD(5D)¹⁵.

Figure 3a shows the distribution of numbers into the main groupings identified. At the top are the most complex cases, with three or more disadvantages, numbering about 16,000 currently in Scotland.

One could therefore say that shifting the definition of the extreme 'core' SMD3 from the 3D to the 5D framework (i.e. to three out of five rather than three out of three disadvantages) raises the current numbers affected around three-fold.

The next three bars show combinations of two disadvantages, of which much the most common is MH combined with one other, numbering 41,000. Combinations of two of the original three SMD(3D) domains number 16,300, while combinations of DVA with one of these number 8,300.

Among single domains, it can be seen that DVA is similar in scale to substance and homelessness, which are rather larger than offending, while MH-only dominates in terms of sheer numbers with 205,000 current cases.

Figure 3b shows the SMD breakdown within each of the five domains (i.e. the extent to which all cases within each domain also have experience of the other domains). Obviously MH has by far the biggest numbers but most of these are not SMD on a current basis, i.e. they have no current experience of any of the other domains. Offending has the smallest numbers but the highest proportion of current SMD. DVA has similar numbers to offending but much fewer with current SMD.



Figure 3a

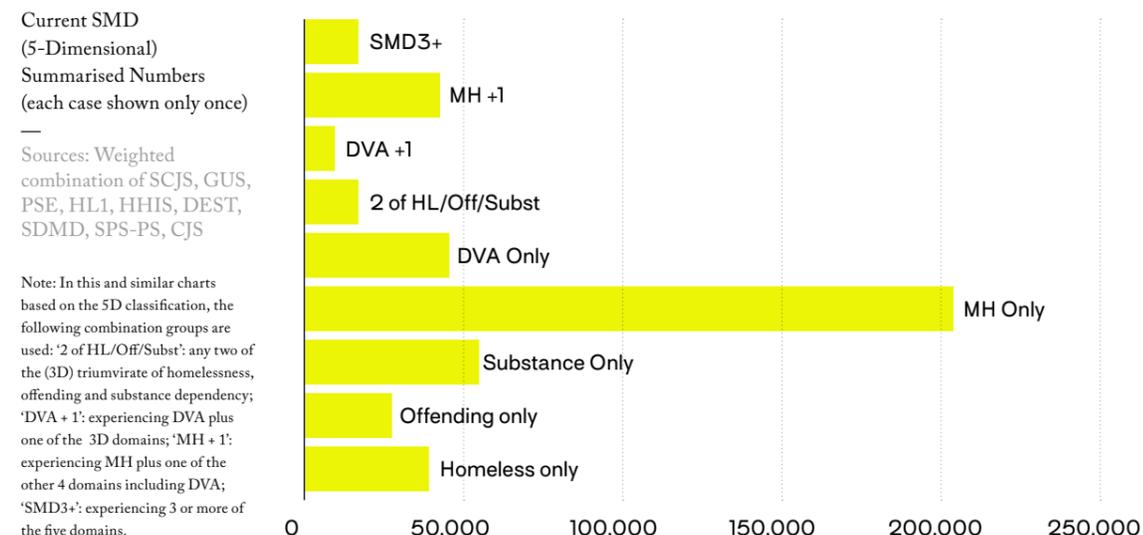
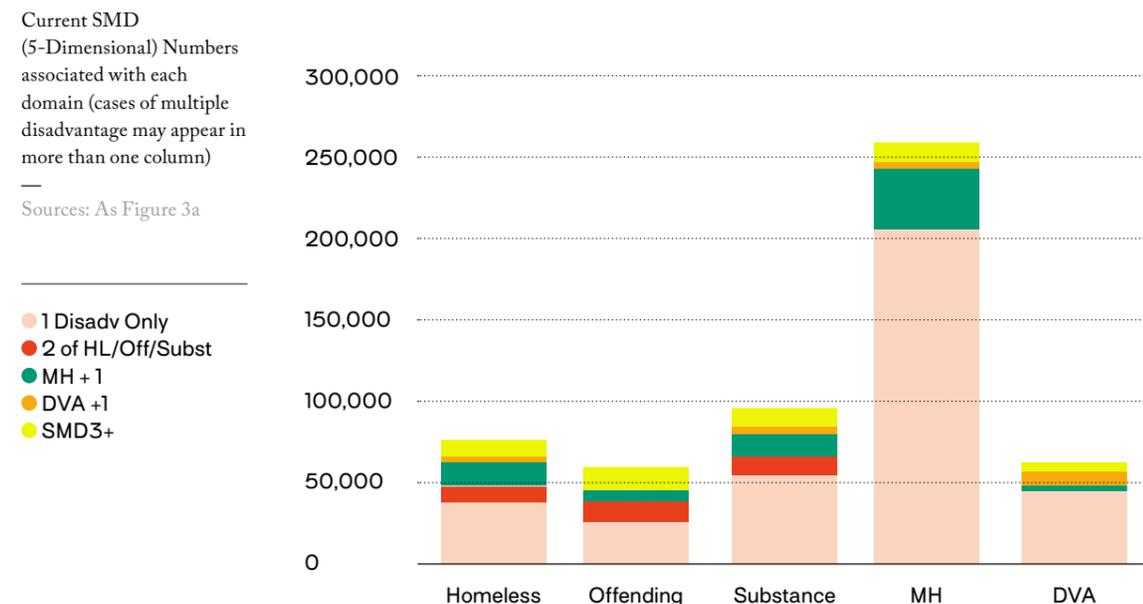


Figure 3b



Ever SMD(5D)

Finally, we turn to the 'Ever 5D' definition, in Figures 4a-4b. As with the 3D classification, shifting to an 'Ever SMD' from a 'Current SMD' basis raises the numbers very considerably. Note, though, that this multiplier effect is greater for homelessness-only and the original 3D combinations, and for the DVA-only and its combinations, than it is for MH, which tends to dominate the totals in the 5D classification. The persistence of MH conditions, together with some limitations of the ability of our survey sources to measure past MH problems, contributes to this outcome.

Overall, the results suggest that the number of adults with one SMD(5D) disadvantage would be 3.1 times higher on the 'ever' basis than on the current basis; those with 2 disadvantages would be 3.7 times more numerous, while those with 3 or more disadvantages would be 10.4 times more in number giving a total of nearly 166,000 for Scotland.

Figure 4b brings home the point that, over the lifecourse, the chances of someone having experienced several of these disadvantages is quite high. In other words, SMD appears much more common on an 'Ever' basis. Not only are the sheer numbers much larger than in Figure 3b, but there are smaller proportions of 'single disadvantage' cases across all of the domains. This is what we would expect, given that people have a wider 'window' within which to experience second and further disadvantages. It is important to appreciate that these disadvantages 'ever' faced may not be simultaneous, although the Waugh et al (2018) study does suggest an association between the timing of homelessness and 'peaks' in relevant health services interaction, albeit within a 'time window' which is longer than one year.

As can be seen, even from the 'Ever' perspective in Figure 4b, offending remains the most-SMD



oriented of all the domains. DVA looks similar to homelessness and substance dependence in having a slight majority of cases who have experienced more than one of these disadvantages. Mental ill-health remains the least 'overlapping' of all five domains, with 66% of relevant cases still being 'MH-only', even in the 'Ever' analysis. Thus a clear majority of all people with MH issues do not face any of the other disadvantages that we are considering in this report.

Figure 4a

Ever SMD (5-Dimensional)
Summarised Numbers (each case shown only once)

Sources: Weighted combination of SCJS, GUS, PSE, HL1, HHIS, DEST, SDMD, SPS-PS, CJS

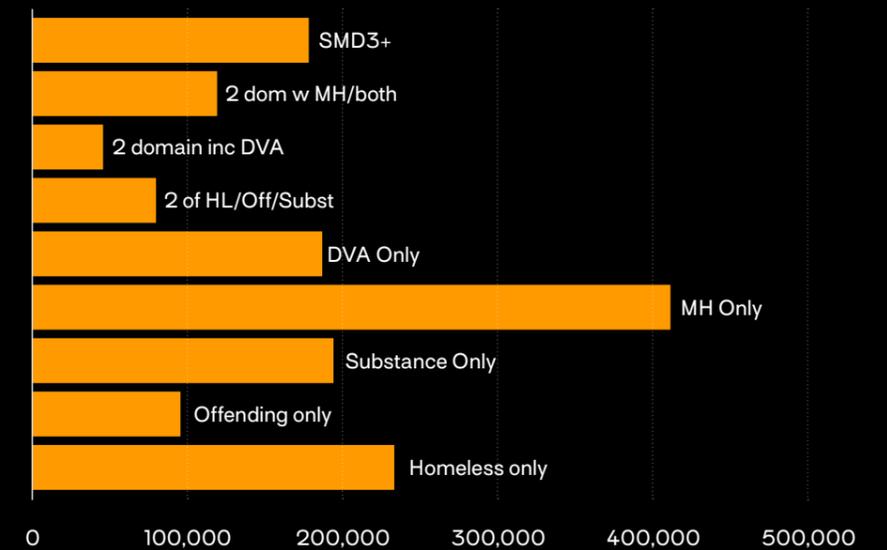
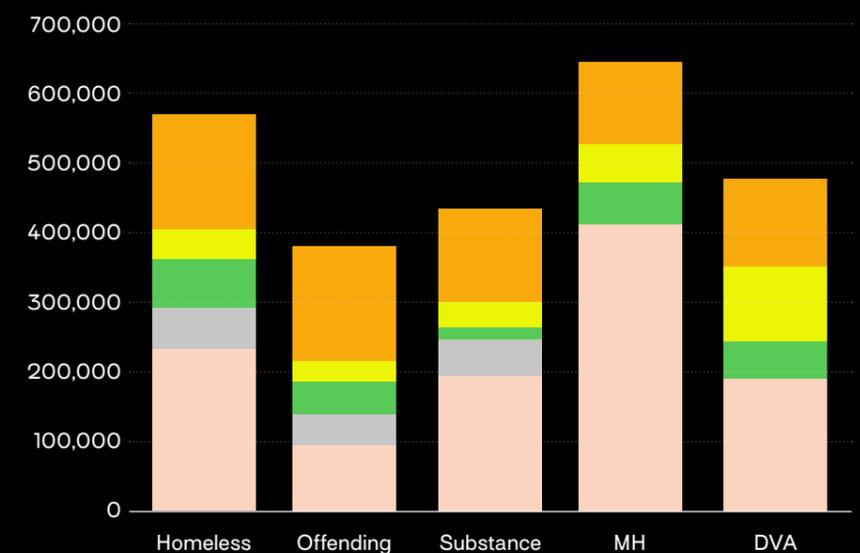


Figure 4b

Ever SMD (5-Dimensional) numbers associated with each domain (cases of multiple disadvantage may appear in more than one column)

Sources: as Figure 4a.

- 1 Disadv Only
- 2 of HL/Off/Subst
- MH + 1
- DVA + 1
- SMD3+



SOCIO- DEMOGRAPHIC PROFILE

In this section we present descriptive profiles of the SMD groupings in terms of basic demographic characteristics, including gender, age, ethnicity, family/household circumstances and housing tenure situation.

As in most of the subsequent analyses, we focus on two key classifications, Current (3D) and Ever (5D), while showing both combination categories and the more summary count measures (number of disadvantages).

GENDER

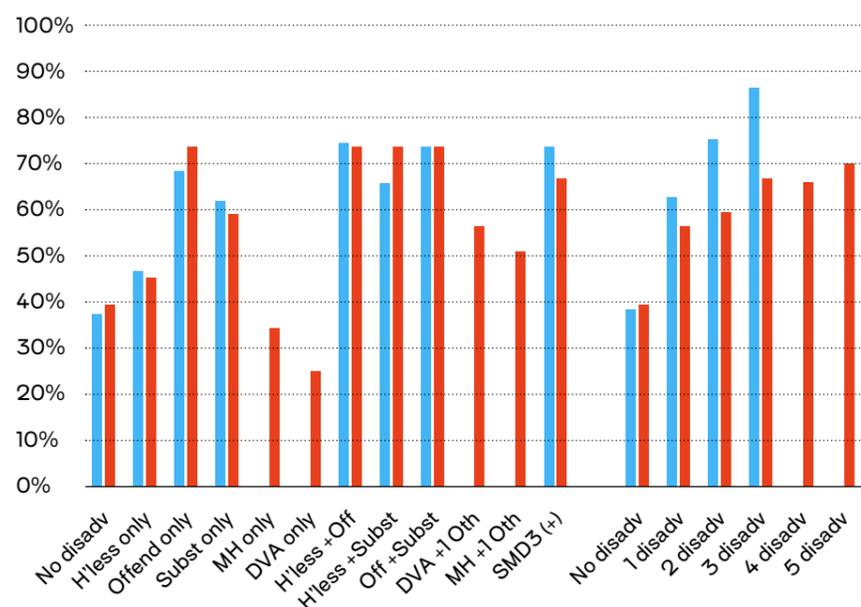
Using the Current 3D definition (blue bars in Figure 5), most SMD segments are majority male ('homelessness-only' being the sole exception), and the male share rises with the number of SMD experiences recorded.

Figure 5

Proportion of males across different SMD Categories and Counts under Current 3D and Ever 5D bases

Source: weighted combination of SCJS, GUS, PSE (Ever only), SDMD, HL1, DEST, SPS-PS

● Current 3D
● Ever 5D



This pattern is as expected and similar to previous findings for England (Bramley et al, 2015).

Under the Ever 5D approach (also included as red bars in Figure 5), the picture changes somewhat. Three single SMD domains are female majority, with three-quarters of 'DVA-only' cases, two-thirds of MH-only cases, and 54% of homelessness-only cases, being women.

However, combinations involving DVA or MH alongside one of the original SMD3 domains

tend to be more gender-balanced in their profile, while combinations involving three or more SMD domains are still majority male (about two-thirds).

Thus, even when the overall definition of SMD is expanded to include MH and DVA domains, those affected by the most extreme forms of multiplicity are still more likely to be men.

AGE

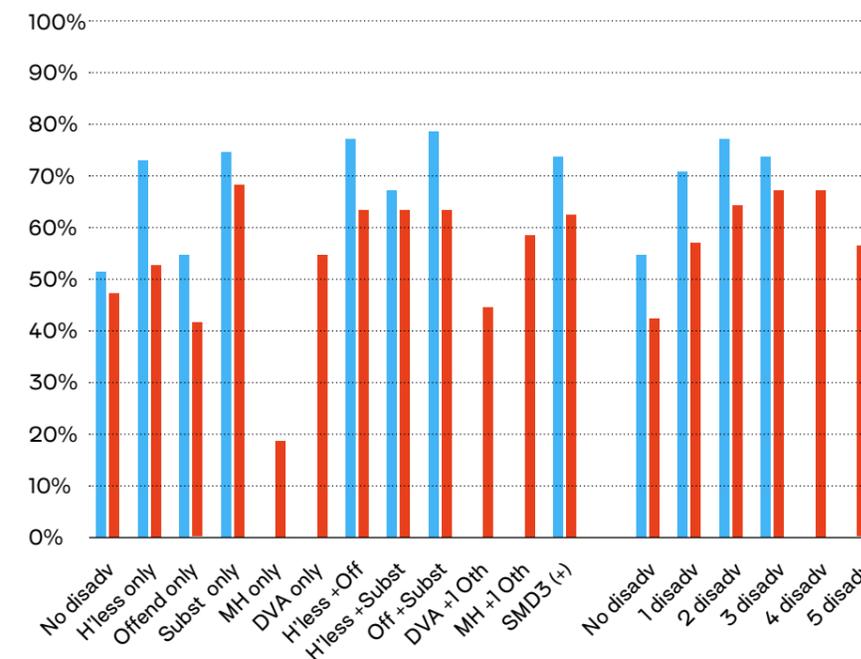
Most adults experiencing SMD are in the lower-to-middle age ranges, with relatively few in the youngest (under 25) band and very few over retirement age.

Figure 6

Proportion of Under-40s across different SMD Categories and Counts under Current 3D and Ever 5D bases

Source: weighted combination of SCJS, GUS, PSE (Ever only), SDMD, HL1, DEST, SPS-PS

● Current 3D
● Ever 5D



We can summarise differences between the SMD categories by focusing on the balance between over and under 40s. Here, we use a similar format to the previous figure to show the key patterns. Current adults facing SMD tend to be younger than the equivalent Ever SMD groups, logically enough, with the homeless and substance dependence cases younger than the offenders. Allowing for that, two of the original three domains (homelessness and substance dependence) tend to be predominantly young, while offending is a bit more balanced in age.

The MH domain, particularly on the 'ever' basis and for MH-only, is much older in profile. The proportion of younger adults rises with the complexity of need (SMD number), at least up to the level of SMD2 (3D) or SMD3 (5D).

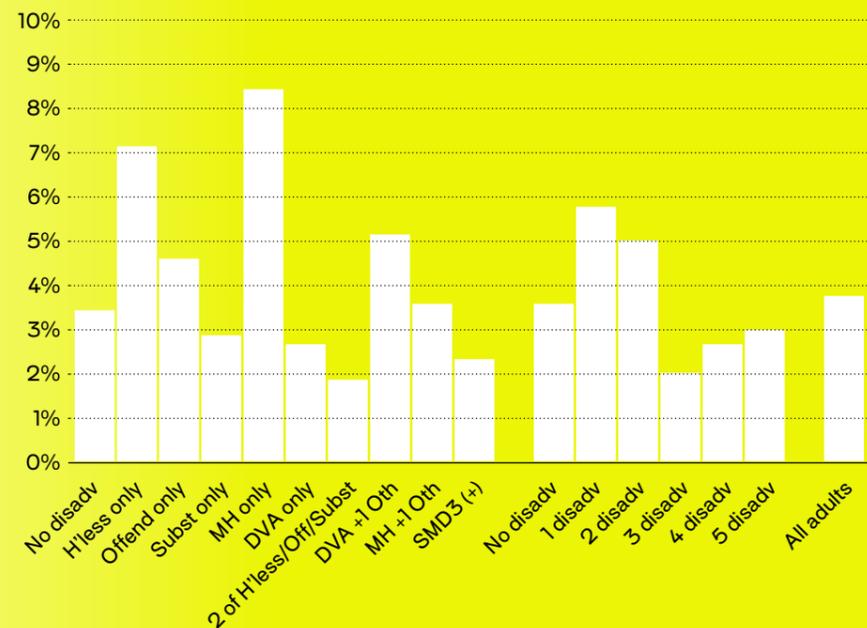
ETHNICITY

The overwhelming majority of people in Scotland are White¹⁶ and this tends to be even more the case for most if not all groups facing SMD (see Figure 7 below).

Figure 7

Non-White Ethnic share of Ever SMD 5D categories and levels in Scotland

Source: Weighted combination of SCJS, GUS, PSE, SDMD, HL1, DEST, SPS-PS



It appears that homelessness only and MH only are experiences which affect non-white groups more than proportionately, with substance dependence and DVA together with most SMD2+ combinations showing less than proportionate representation.



HOUSEHOLD & FAMILY STATUS

Figure 8 looks at the household type composition of SMD groups (effectively for those in private households). A broad three-way household classification of single adults of working age, families and ‘other’ households is used.

When we focus initially on the Current 3D classification, as can be seen in Figure 8a below, single person, working age households dominate almost all SMD segments, with families underrepresented, particularly among those with multiple disadvantages. Other household types (which includes older households) are also generally underrepresented. For the original 3D SMD categories, these single person households will be mainly men.

Figure 8b shows the picture in terms of Ever SMD across the 5 dimensions. It shows single person working age households disproportionately represented in all categories bar DVA-only, and again the dominance of these households tends to rise with level of multiplicity. **However, the original English Hard Edges study indicated that it would be a mistake to assume that these (largely male)**

single person households lived lives entirely disconnected from families with children.

Even amongst those with the most complex needs in England, in the SMD3 group, almost 60% either lived with children (their own or a partner’s or siblings or part of another family) or had ongoing contact with their children (Bramley et al, 2015). In the Scottish study there are some detailed differences in how these contacts are or are not reported in different sources, but it appears that the proportion of adults with SMD issues living with own or other children may be lower than in England. Nevertheless, quite a lot have children and some element of child contact, even if they do not live with them (approaching 40% of drug treatment cases and 63% of prisoners responding to the SPS prisoners’ survey).

Figure 8a

Single Person, Family and Other Household types of Current SMD 3D categories and counts

Sources: Weighted combination of SCJS, SDMD, HL1, DEST

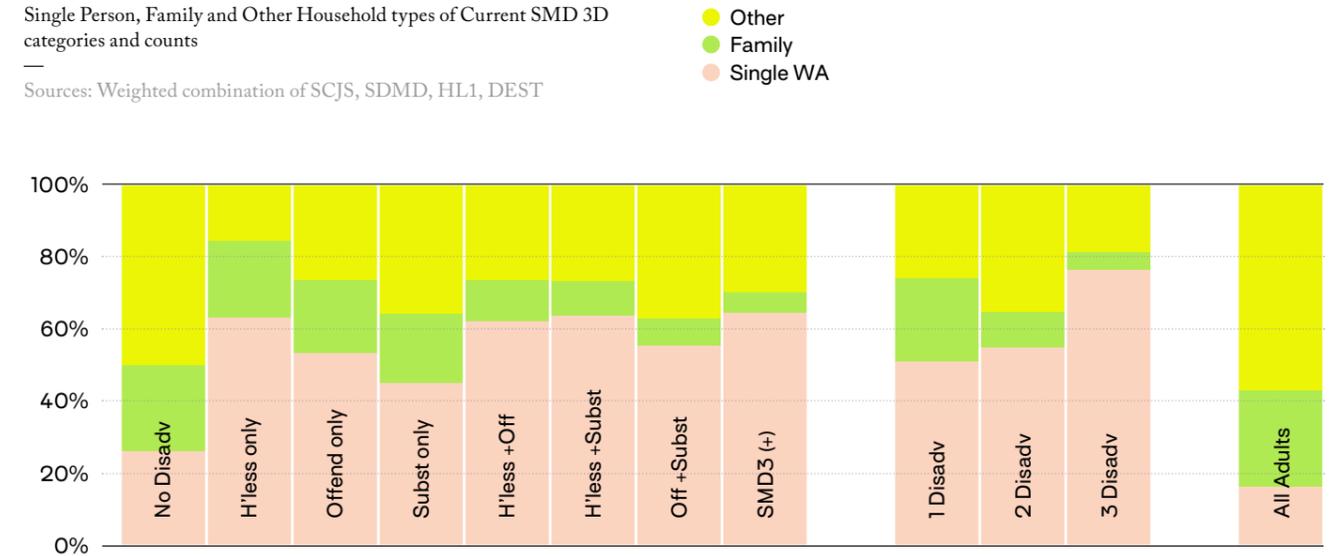
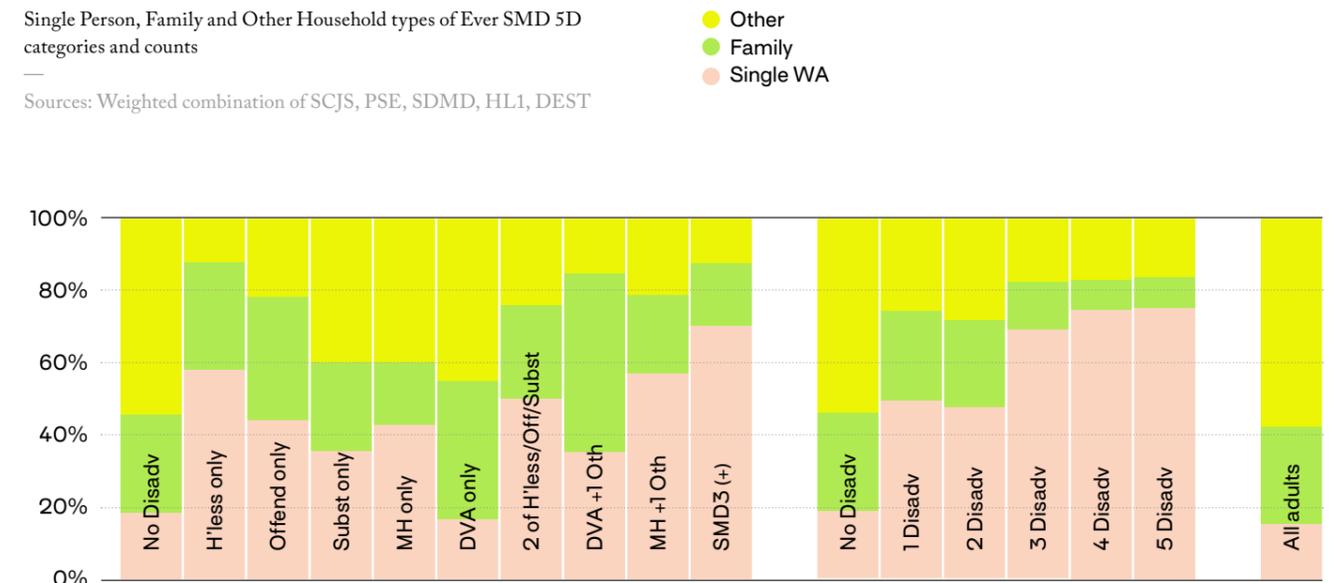


Figure 8b

Single Person, Family and Other Household types of Ever SMD 5D categories and counts

Sources: Weighted combination of SCJS, PSE, SDMD, HL1, DEST



TENURE

Figure 9a demonstrates that a high proportion of Current SMD(3D) groups have no conventional housing tenure but stay in some 'other' form of accommodation – hostel, B&B, with relatives or friends, and so forth.

This is particularly prevalent for those in categories involving homelessness, of course, and is particularly high for the most extreme SMD3(3D) group. Otherwise, by far the most common tenure for all Current SMD(3D) groups is social renting.

The patterns for Ever SMD (5D) are not dramatically different from those for the household population as a whole, with a much stronger representation of home ownership amongst people with backgrounds involving substance dependency-only and DVA-only in particular (albeit still underrepresented as compared with the population as a whole) (see Figure 9b). In sharp contrast, amongst the MH-only, homelessness-only and offending-only groups, and most of the combination categories, social renting is substantially more common than either home ownership or private renting.

Of course, in this case the tenure refers to the current position whereas the SMD experiences

will often have been in the past. This evidence suggests that experiencing some single domains (substance or DVA) does not necessarily lead to adverse housing outcomes in later life, but other single domain experiences can have such effects, while experiencing multiple domains of disadvantage does tend to militate against achieving or sustaining home ownership, while also risking significant periods without your own separate housing. Conversely, social housing is clearly an important resource for people who have experienced SMD.

By far the most common tenure for all Current SMD(3D) groups is social renting.

Figure 9a

Housing Tenure Situation by Current SMD 3D Categories

Sources: based on weighted average of SCJS, GUS, HL1, DEST

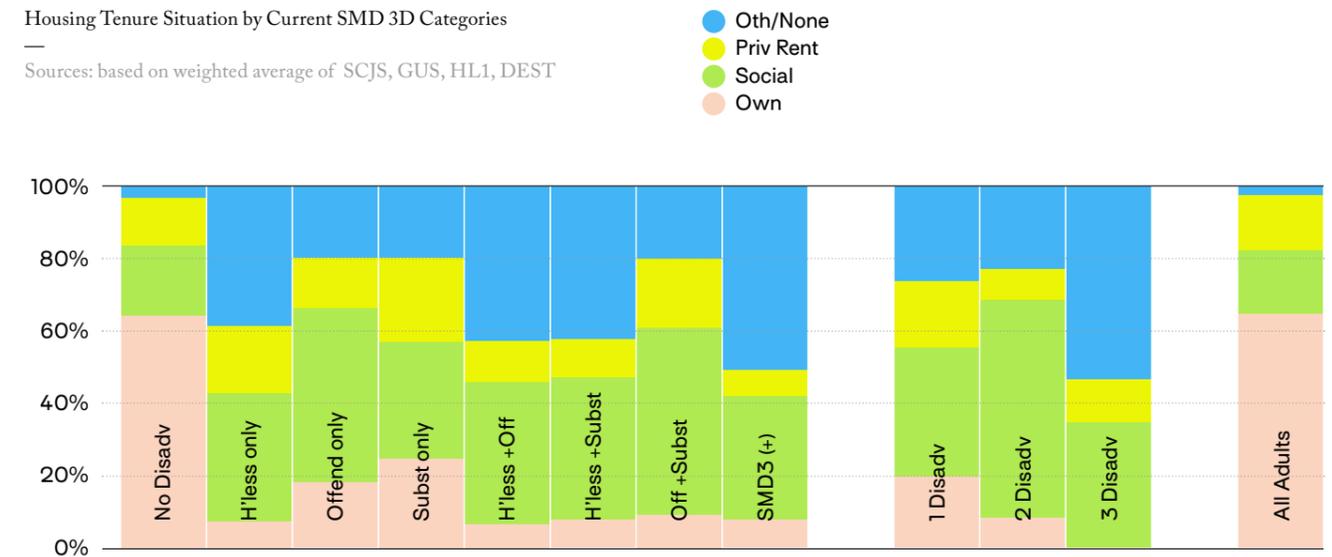
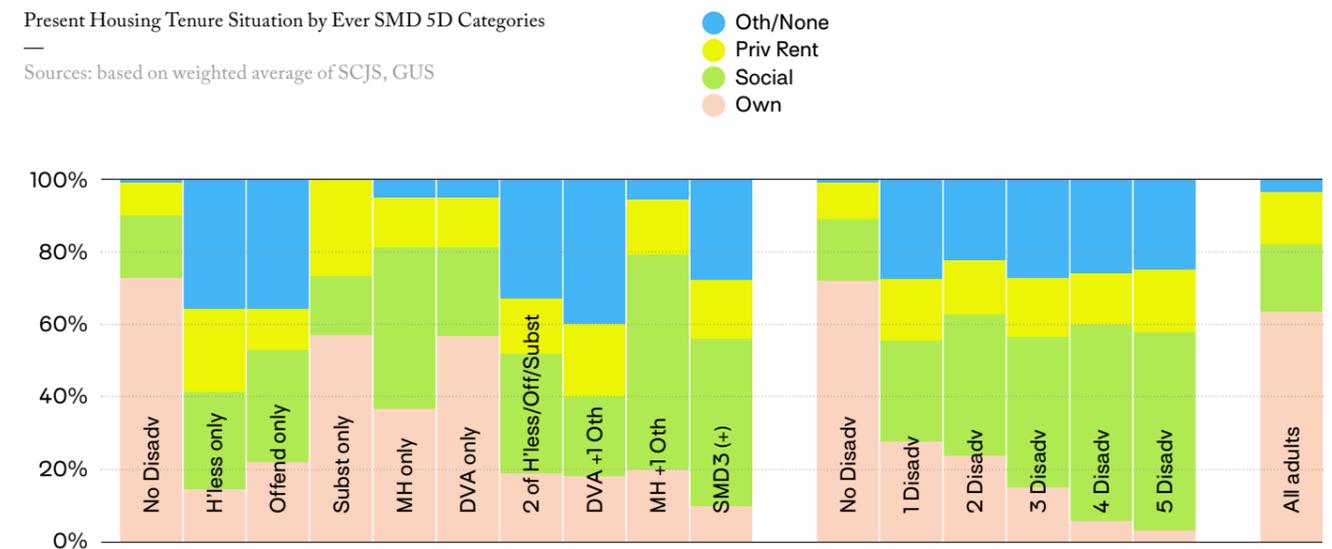


Figure 9b

Present Housing Tenure Situation by Ever SMD 5D Categories

Sources: based on weighted average of SCJS, GUS



**EMPLOYMENT,
POVERTY**

**&
MATERIAL
DISADVANTAGE**

Remember...

If you have put your CV on the computer desktop to upload it to S1Jobs or Universal Jobmatch, then **PLEASE DELETE IT WHEN YOU ARE FINISHED**. If you do not delete it anyone else using the computer will be able to read it. Thank you!



EMPLOYMENT

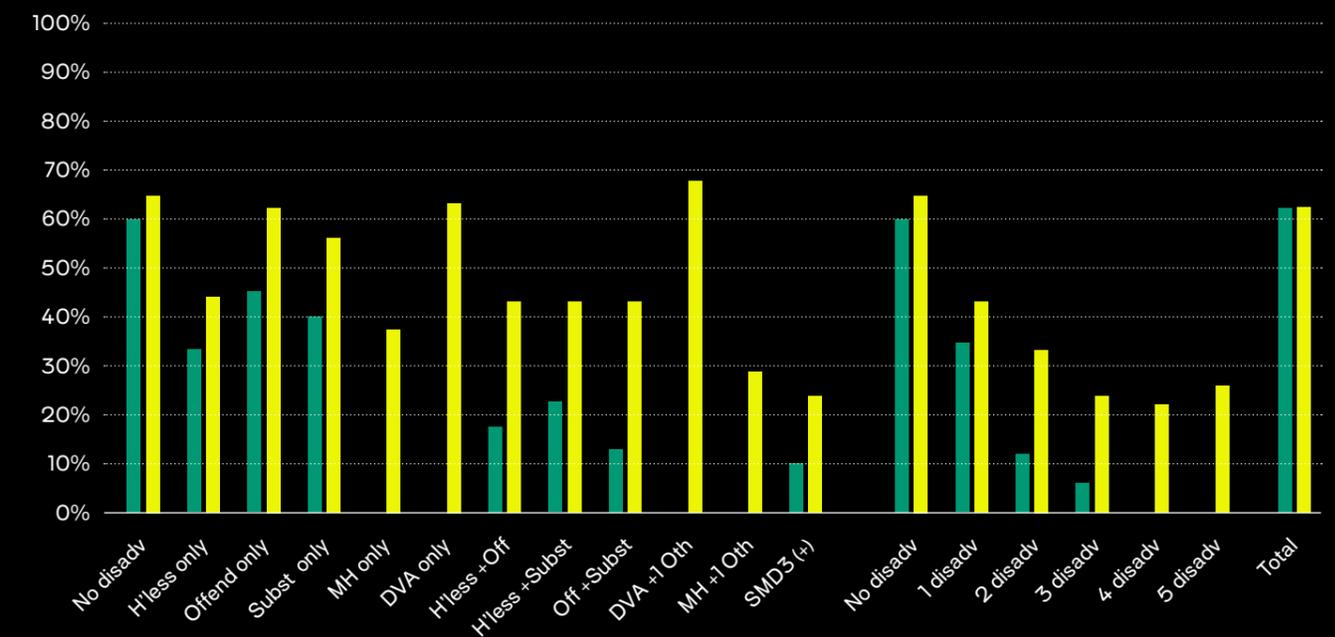
Figure 10 presents the present labour market position of people experiencing Current SMD (3D) and also Ever SMD (5D).

Figure 10

Present employment rate by Current 3D and Ever 5D SMD Categories

Sources: Weighted combination of SCJS, GUS, PSE (Ever only), SDMD, DEST

● Current 3D
● Ever 5D



As can be seen, adults experiencing Current 3D, even at the level of one disadvantage, have significantly lower engagement in paid work than other adults, while for those with two or three disadvantages, employment rates fall to somewhere in the range of 10-20%, compared with 63% of all adults in private households being in paid work.

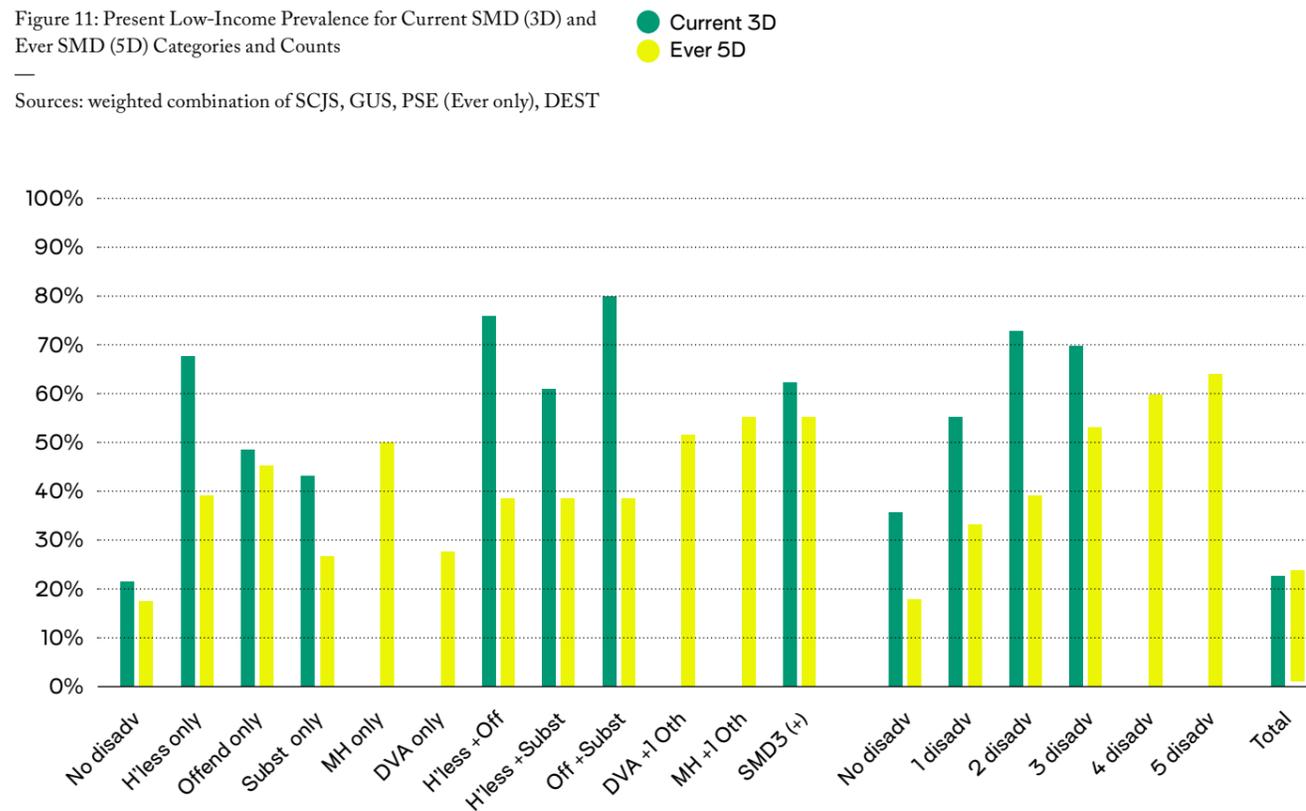
When we shift the focus onto the broader Ever 5D perspective, the current work picture is less starkly negative. **Adults with MH-only or homelessness-only experience in the background have lowered employment rates, but for the offending-only, substance dependency-only, and DVA-only groups, employment rates are close to the population average.** However, having experienced three or more disadvantages in the past is associated with a low employment rate of 23%.

HOUSEHOLD POVERTY & DEPRIVATION

Looking through the Current 3D prism, all SMD segments show markedly higher rates of present low-income¹⁷ than the general population (22%), ranging from 43% for substance dependency-only to 80% for offending and substance dependency (Figure 11).

Figure 11

Figure 11: Present Low-Income Prevalence for Current SMD (3D) and Ever SMD (5D) Categories and Counts
 —
 Sources: weighted combination of SCJS, GUS, PSE (Ever only), DEST



When looking at present low income across the Ever 5D spectrum, too, low income shares substantially exceed those for the general population in most segments, rising to 50% or higher for the MH-only group and several of the combination groupings. DVA-only and substance dependency-only are exceptions to this pattern.

The very strong association between present poverty and both simple and more complex forms of current as well as ever SMD is plain from Figure 11. **These poverty patterns are confirmed by a consistently sharp gradient in current material deprivation indicators between those with no experience of any of the five SMD domains and those with experience of three or more of these disadvantages: having no car rises from 19% to 59%; enduring material deprivation (combined with lower income) rises from 13% to 66%¹⁸; facing financial stress and debt rises from 22% to 79%; living in housing deprivation¹⁹ rises from 13% to 65%; facing severe poverty/destitution rises from 0.8% to 25%²⁰.**

Again, however, we often find that DVA (particularly on its own or in the past) is not so strongly associated with a heightened risk of most of these indicators of material deprivation and poverty, which has some echoes of findings from the gendered profile in England. DVA aside, this evidence of strong relationships with multiple measures of poverty and material deprivation, including destitution, both in the current period but also in the aftermath of SMD experiences, is very powerful and significant.

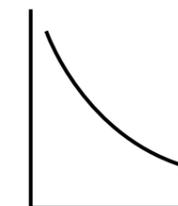
Care is needed in drawing inferences from this about causality. There are many grounds for thinking that causality runs in both directions, with past and current poverty increasing the risks of some forms of SMD (e.g. homelessness, MH brought on by the stresses of joblessness, debt or living on a very low or uncertain income), while at the same time SMD itself (addictions,

criminal record, mental ill-health) may reinforce poverty through worklessness, relationship breakdown, benefit sanctions, etc. With Current SMD, in particular, one may suggest such two-way causation. With Ever SMD, then one may think that the implication tends to be more towards earlier SMD causing or reinforcing current poverty. However, in later sections of this report we will also look at evidence of pathways into SMD, which strongly supports the arguments that poverty and other structural factors play a critical role in generating SMD in the first place.

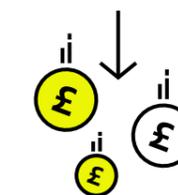
Compared with people having none of these disadvantages:



Having no car rises from 19% to 59%



Enduring material deprivation (combined with lower income) rises from 13% to 66%



Facing financial stress and debt rises from 22% to 79%

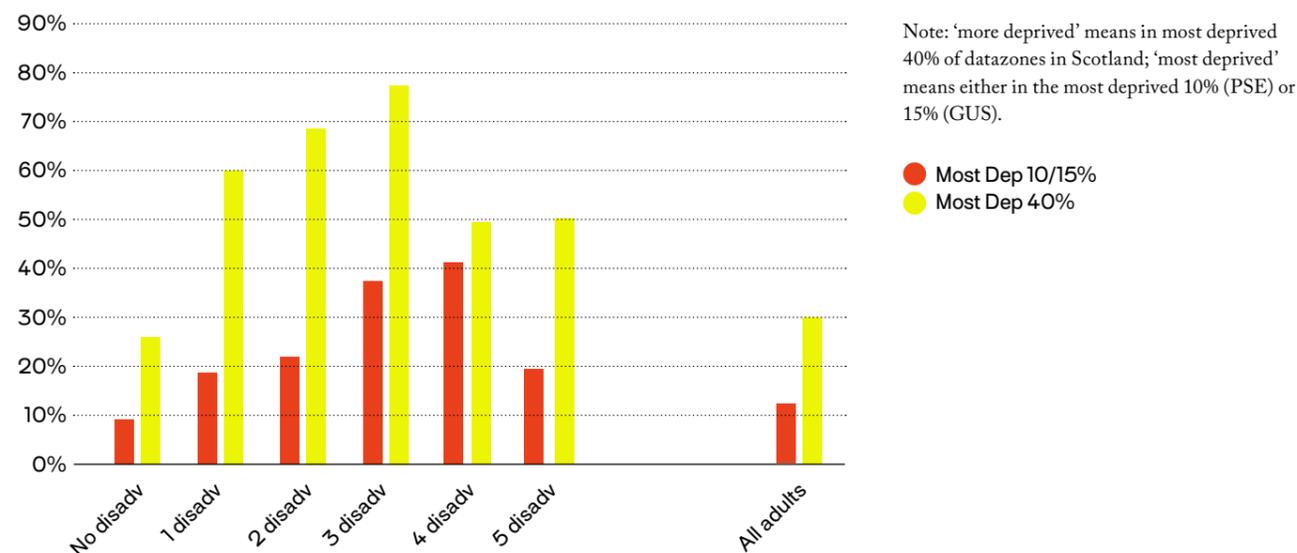
NEIGHBOURHOOD POVERTY & DEPRIVATION

Figure 12 looks at the pattern in terms of current residence in deprived neighbourhoods, using the Ever 5D classification of SMD.

Figure 12

Proportion of adults in more and most deprived neighbourhoods by Ever SMD 5D categories

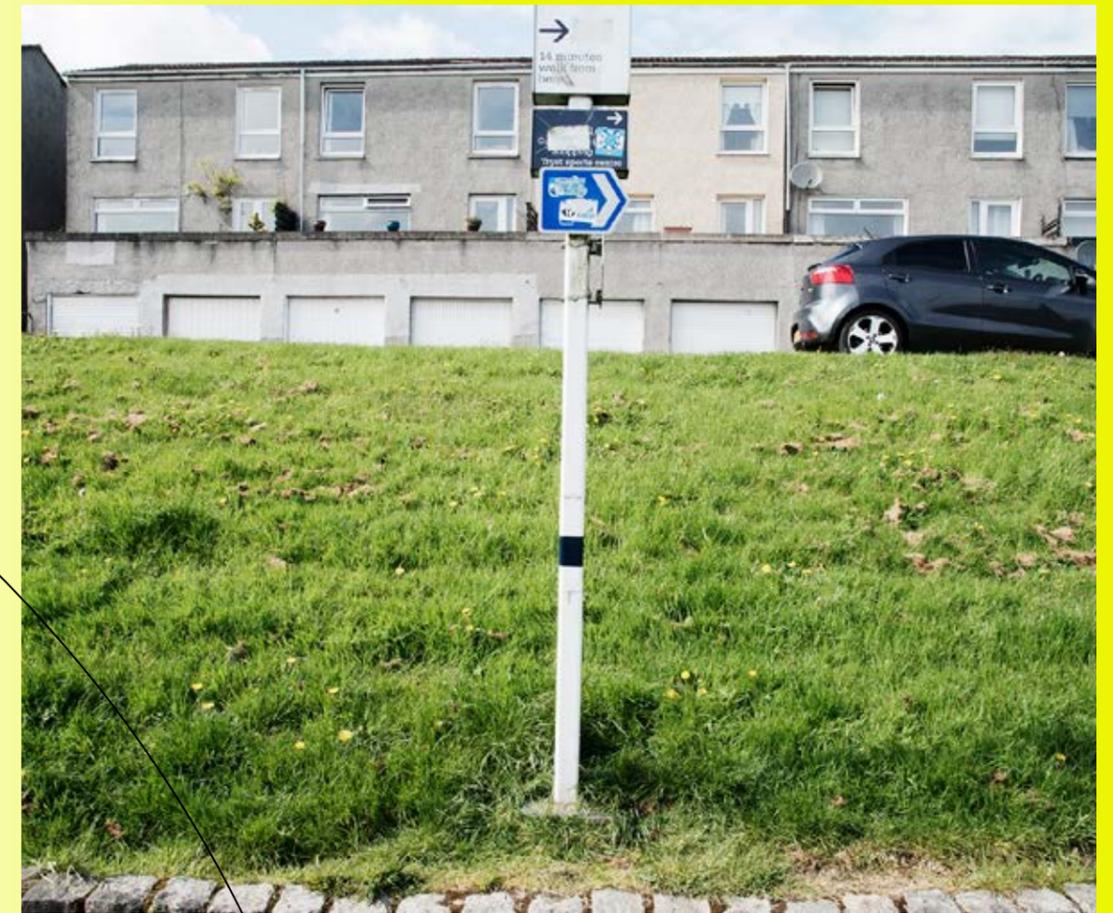
Sources: Weighted combinations of PSE & GUS (10/15% most deprived). SCJS & GUS (40% most deprived)



While not quite as strong as the relationships with individual poverty measures, there is still clearly a pattern whereby higher levels of SMD experience are associated with a greater propensity to live in deprived neighbourhoods: people currently experiencing three or more of these disadvantages are four times as likely to live in the poorest places as people with no such disadvantages.

Offending and MH seem to be the domains more associated with this tendency and, again, DVA seems to be the exception to this pattern.

As with individual or household poverty, we should sound a cautionary note about causality vs association. While there may be 'area effects' which generate or reinforce the risks of SMD (e.g. young people becoming involved with crime or drugs through local associates or gangs), there will also be quite a strong 'selection effect', whereby people who face SMD, especially given its strong association with low income, are more likely to end up (though housing allocation or 'sorting' processes, whether in the social or private sectors) in such neighbourhoods.



There is still clearly a pattern whereby higher levels of SMD experience are associated with a greater propensity to live in deprived neighbourhoods

GEOGRAPHY

URBAN—RURAL

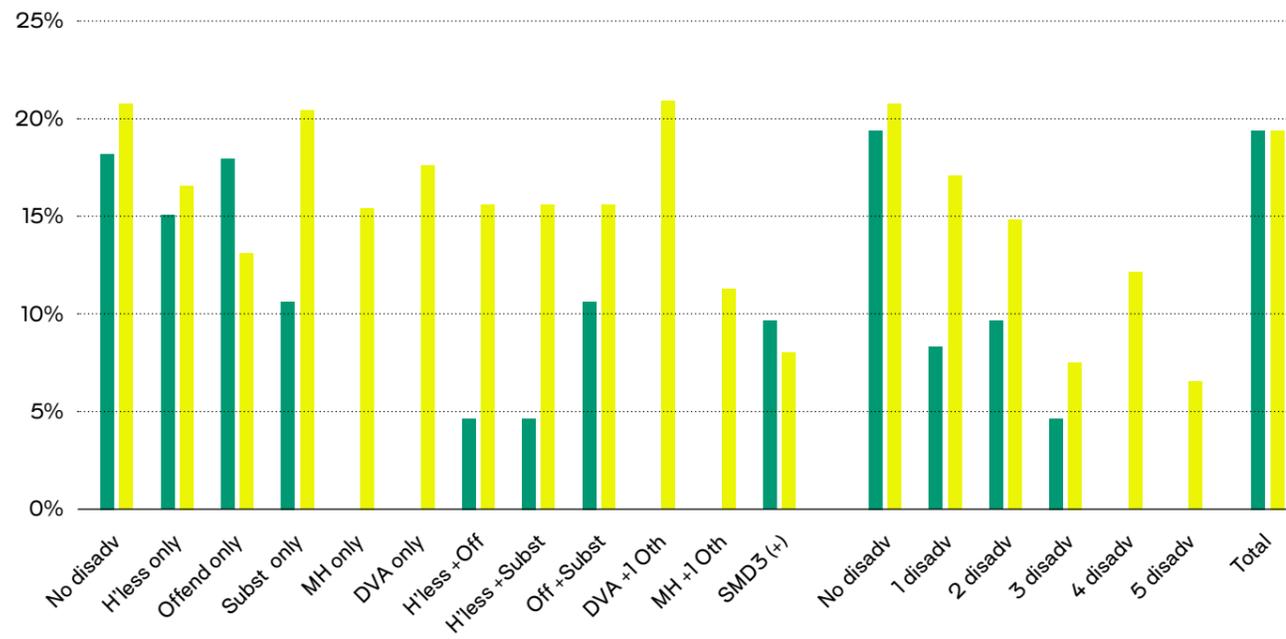
Scotland is a predominantly urban country, in so far as where people live, and this is even more true for those experiencing SMD.

Figure 13

Proportion of rural residents within Current 3D and Ever 5D categories by SMD categories and counts

● Current 3D
● Ever 5D

Sources: based on weighted average of SCJS, GUS and PSE



Looking at the Current SMD(3D) framework, the proportion of rural residents is significantly less than that for the population as a whole in most SMD segments except offending-only (Figure 13).

When we switch focus to Ever 5D, adults in categories involving DVA seem a bit more likely to be located in rural Scotland than do other SMD groups. Generally, the proportion of rural residents falls as the level of complexity rises.



The proportion of rural residents falls as the level of complexity rises

LOCAL AUTHORITY AREA

So far we have established that rates of SMD tend to be higher in urban than rural areas (aside from DVA), and that there is a more pronounced tendency for rates to be higher in poorer and more deprived neighbourhoods. We can now complement this by providing an analysis of SMD rates at local authority level²¹.

Figure 14 shows the rate and composition of Current SMD(3D), showing the categories with two or more disadvantages, while Figure 15 covers the same territory but using absolute numbers instead.

What is immediately apparent from looking at both of these charts is that affluent suburban districts and towns, and the Highlands/islands and some other predominantly rural areas, have low rates as well as low numbers of people experiencing these forms of SMD.

At the other end of the spectrum, the highest SMD(3D) rates are generally found in urban and poorer central belt authorities, with West Dunbartonshire, Clackmannanshire, Glasgow, Dundee, North Ayrshire and Aberdeen City standing out (Figure 14). Other authorities with fairly high prevalence include East Ayrshire and, perhaps more surprisingly, West Lothian.

While Edinburgh is middling with respect to the prevalence of these multiple forms of disadvantage, further disaggregation indicates that the capital has relatively high rates of 'homelessness-only' cases, as one would expect given the high housing market pressures in the city.

When one turns to the absolute numbers of people affected by SMD(3D) the striking dominance of Glasgow is plain to see, having nearly double the number of cases of the next nearest authority (Edinburgh) (Figure 15). In all, seven Scottish local authorities – the four main cities, Fife, and North and South Lanarkshire – account for 53% of the total number of adults in Scotland with two or more of these disadvantages. This is clearly highly relevant to matters of resource distribution in tackling this particular form of SMD.

Figure 14

Rates and composition of SMD(3D) by Local Authority (per thousand adult population, showing categories with 2 or more disadvantages)

Sources: Authors' analysis of HL1, SDMD, Criminal Proceedings and SCJS data, with appropriate grossing adjustments to allow for people not using services and to give annual stock-plus-flow numbers.

● SMD3
● Subst + Off
● Hless + Subst
● Hless + Off

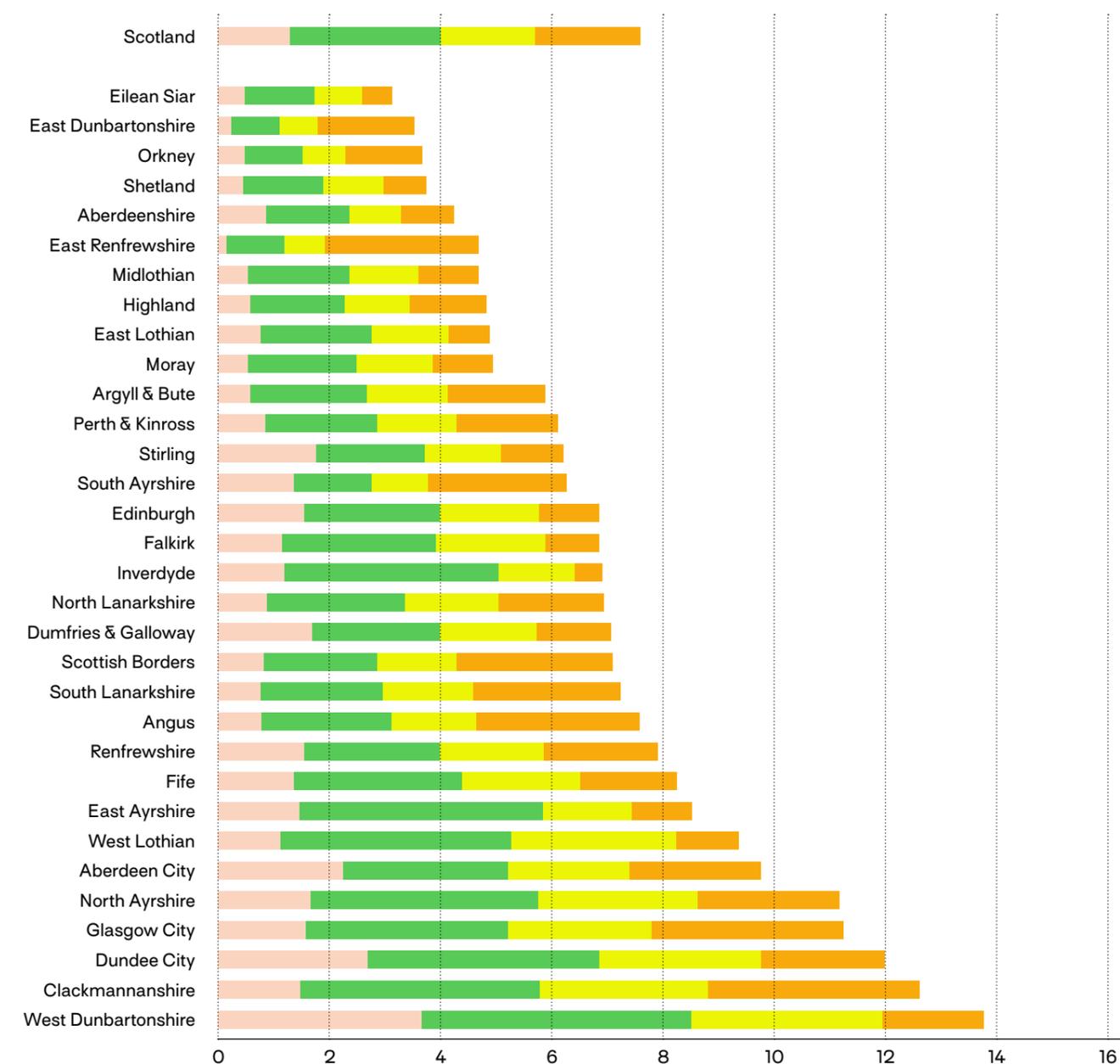
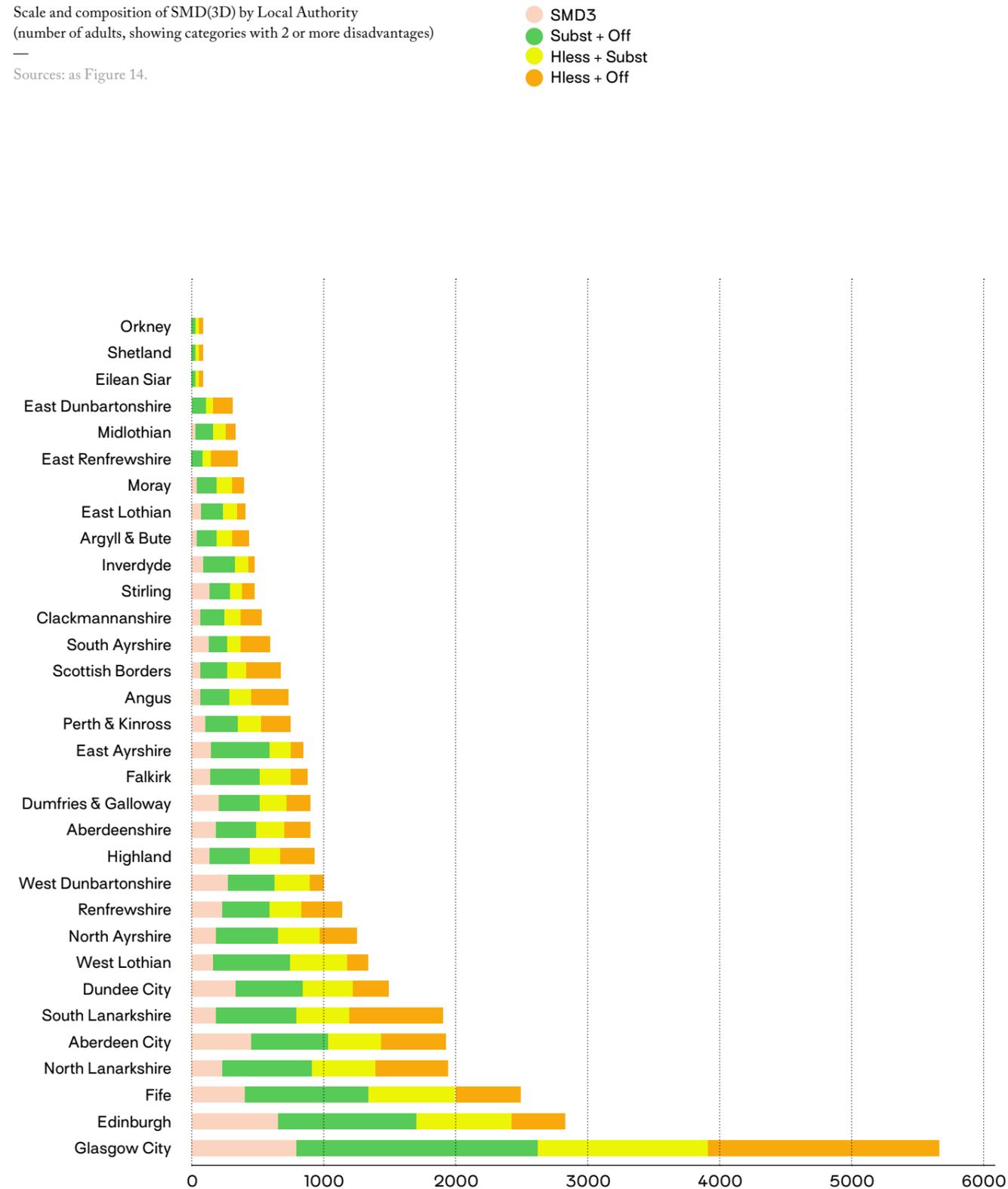


Figure 15

Scale and composition of SMD(3D) by Local Authority
(number of adults, showing categories with 2 or more disadvantages)

Sources: as Figure 14.



Turning to the broader Current²² SMD(5D) perspective, Figure 16 presents the rates for the main groupings of cases with two or more disadvantages. As can be seen, there are some differences in the shape of the distribution and the rankings, but it remains similar overall. Discounting the islands²³, the range from highest to lowest in terms of the original SMD (3D) groupings is 7.7 times, whereas for DVA+1 it is only 3.4 times, and the ranking is different, with little apparent relationship with poverty. For MH+1 the ranking is similar to the overall ranking, with a range of 5.9 times. However, for cases having three or more disadvantages the ratio is just under 4.0 times, reflecting that some of these 3+ cases will be orientated towards DVA and/or MH and so less skewed towards the poorest places.

The key points to emerge from this broadened SMD analysis are that mental health tends to dominate the overall numbers, and that DVA is distributed in a different, possibly less systematic fashion²⁴. Figure 17 also confirms Glasgow's overwhelming dominance in terms of absolute scale, including with respect to mental health.

Figure 16

Rates and composition of Current SMD(5D) by Local Authority (per 1000 adult population, showing categories with 2 or more disadvantages)

Sources: Authors' analysis of SCJS, HL1, SDMD and Criminal Proceedings

- SMD3D2
- DVA+1
- MH+1
- SMD5D3+

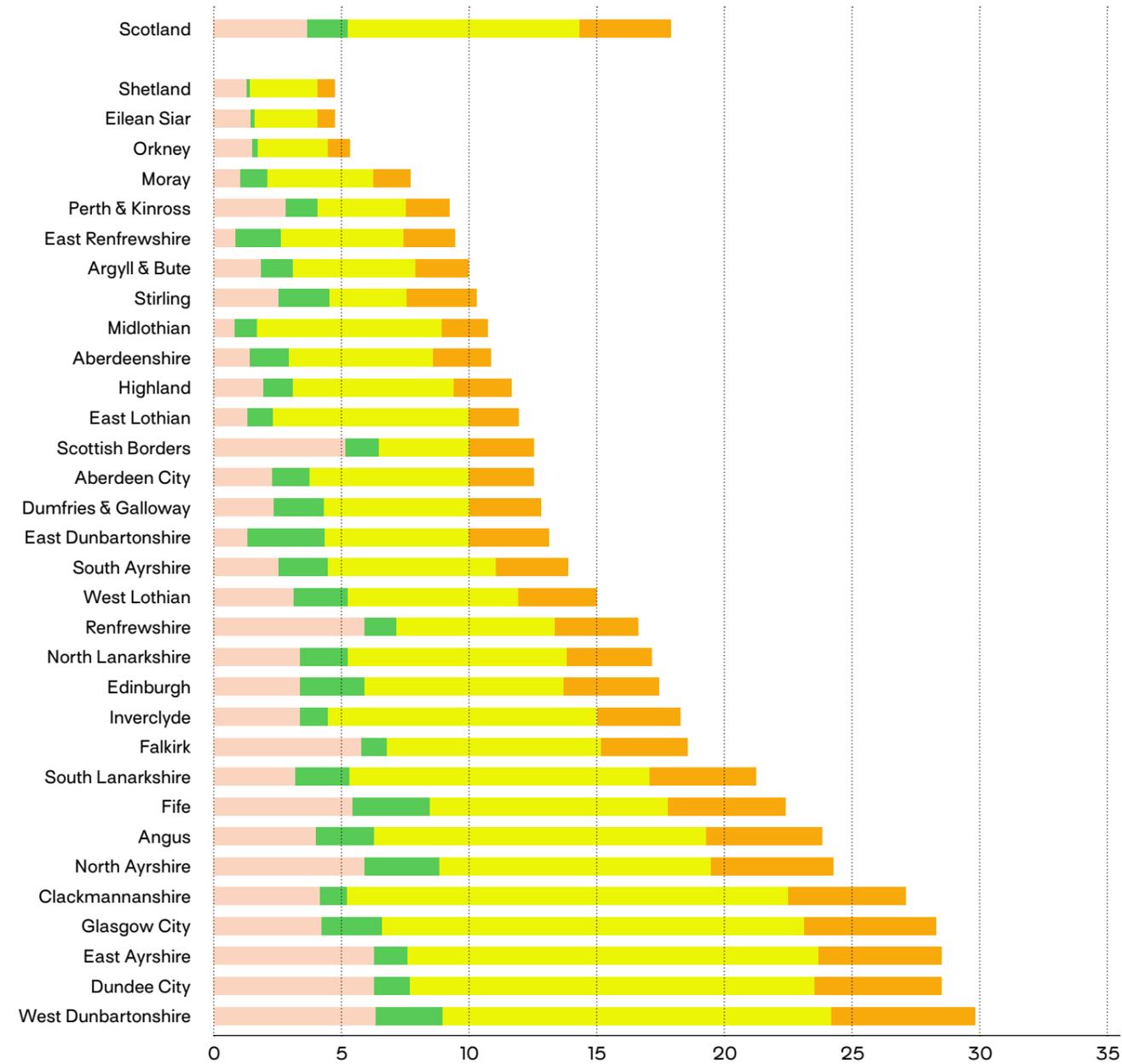
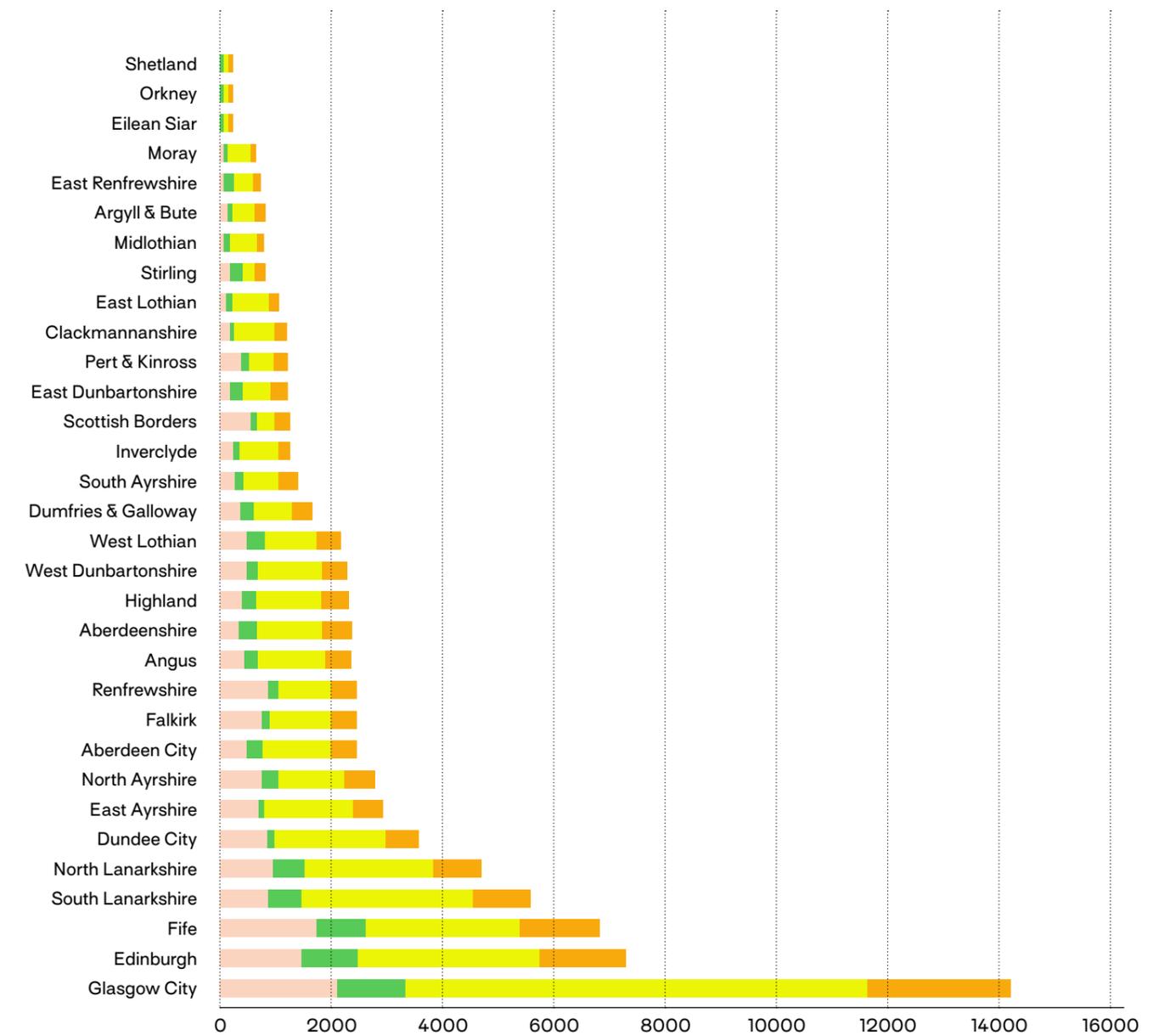


Figure 17

Scale and composition of Current SMD(5D) by Local Authority (number of adults with two or more disadvantages)

Sources: As Figure 16.

- SMD3D2
- DVA+1
- MH+1
- SMD5D3+



QUALITY

OF

LIFE

In this section we present evidence on a range of aspects of the quality of life of adults who are experiencing or have experienced SMD, including with respect to their health, housing circumstances, experiences of crime and fear of crime, and social exclusion.

Ideally, one would want to report equally on the quality of life of those adults currently experiencing multiple disadvantages and those of adults with past relevant experiences.

However, in practice the main sources we have for these indicators are household surveys and these are less effective at covering Current SMD, because (a) they omit the non-household and some transient populations, and (b) there are sample size restrictions. So we place most emphasis on the Ever SMD perspective in what follows.

HEALTH

In general, SMD is associated with much higher levels of long-term limiting illness/disability.

For Current SMD(3D), much (four times) higher rates of long-term conditions/disability are associated with the homelessness and offending domains, as well as rising steeply with combinations involving two or three relevant disadvantages, but apparently rather less with the substance-only category (see Figure 18). The Ever SMD(5D) analysis is more robust in terms of overall numbers and the range of datasets drawn upon, and also shows subjectively reported poor (“bad” or “very bad”) health (Figure 19). It shows that the level of ill-health or long-term conditions is rather less for those who have experienced homelessness or offending, or DVA, but is much higher for those with MH conditions, or combinations involving MH (five to six times that of people without any disadvantages). In general, the incidence of these health indicators rises with number of SMD domains, but what is critical is which disadvantage domains apply, with MH by far the most significant, followed by homelessness. There are some signs that the incidence plateaus above SMD2 (5D).

The strong association between poor health and homelessness was emphatically underlined by the findings of the administrative data linkage HHIS study (Vaugh et al, 2018). This found that people accepted as homeless in Scotland between 2001-2014 had a roughly five times higher chance of dying than people of the same age and gender living in the least deprived fifth of areas in Scotland, with death rates amongst the homeless cohort also double that of their non-homeless peers living in the most deprived fifth of areas. In the age range 25-45, the death rate was 10-20 times higher than the comparator group living in the least deprived areas, equating to 11,520 excess deaths in the homeless cohort over the period. Acute hospital admissions for adults in these middle age ranges were two-and-a-half times higher than average for those ages, and four-to-five times higher than for people living in the least deprived areas. A&E cases showed a similar pattern.

That adults with SMD have poor physical as well as mental health has also been shown from wider systematic reviews of research evidence (Aldridge et al, 2018). While acknowledging that they may well not receive an adequate level of response to some of their mental health problems (see below), it is nonetheless clear that their level of utilisation and associated cost to the NHS is significantly above that of the general population. This partly reflects the strong element of co-morbidity between physical and mental ill-health. PSE data shows that in general for working age groups the number of long-term health conditions (excluding MH) rises with SMD level, so that adults with SMD3 have substantially more long-term conditions than those with no SMD disadvantages; in the age group 45-54 the progression is from 1.8 conditions to 4.3 conditions per adult.

We have attempted an approximate analysis of the excess healthcare costs associated with the homeless cohort in the Vaughn et al (2018) HHIS study. The largest extra costs are in mental health prescriptions (£311m per annum) and acute in-patient and day cases (£306m), followed by prescriptions for substance dependency at £150m. The smallest items are actually drug treatment and out-patient appointments. The total excess financial cost of healthcare for people who have ever been homeless is £900m, which seems a big figure, compared with the annual Scottish Health budget of c. £13bn, although it should be recalled that ‘Ever Homeless’ in Scotland are about 10% of the whole adult population²⁵. This analysis also suggests that the excess costs for poverty and deprivation affecting people in the general population who have not been homeless amounts to £2.3bn. The total (2.3+0.9=£3.2bn) is roughly in line with Bramley et al (2016) estimates of the excess health costs in Scotland associated with poverty broadly defined (i.e. about a quarter of the health budget).

Figure 18

Long Term Limiting Illness/Disability by Current SMD (3D) (percent)

Source: Based on weighted average of SCJS and HL1

● LLTID

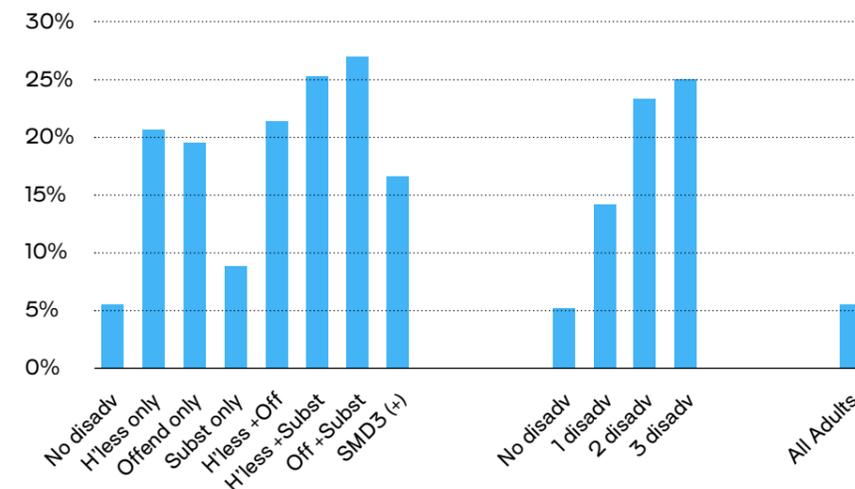
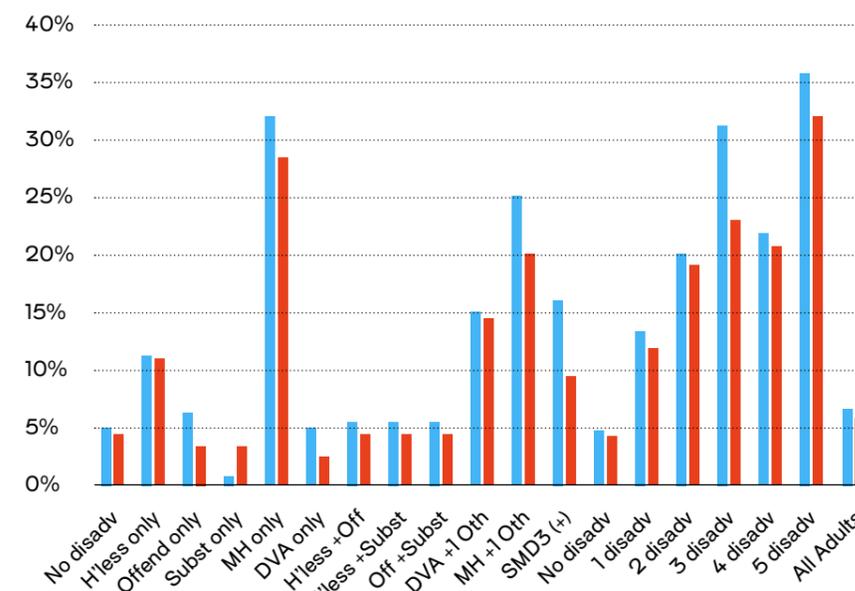


Figure 19

Long Term Limiting Illness/Disability and Subjective Poor Health by Ever SMD (5D) (percent)

Source: Based on weighted average of SCJS, HL1, PSE and GUS

● LLTID
● Poor Health



HOUSING

We have already referred in the section on poverty to the higher incidence of housing deprivation among the SMD groups. In this section we consider more qualitative aspects of housing which may contribute to or impair quality of life.



Figure 20 looks at two key measures: not being warm enough in winter (often linked to fuel poverty); and the home being in a poor state of repair. In this instance we focus on the Ever SMD(5D) perspective, so we are typically looking at the housing conditions 'now' of people who have experienced SMD disadvantages in the past, whether or not they are still experiencing them.

As can be seen, there is generally a very strong relationship between SMD level and both of these problems, with adults with experience of two or more SMD disadvantages having a five to eight times higher risk of being cold in winter and/or

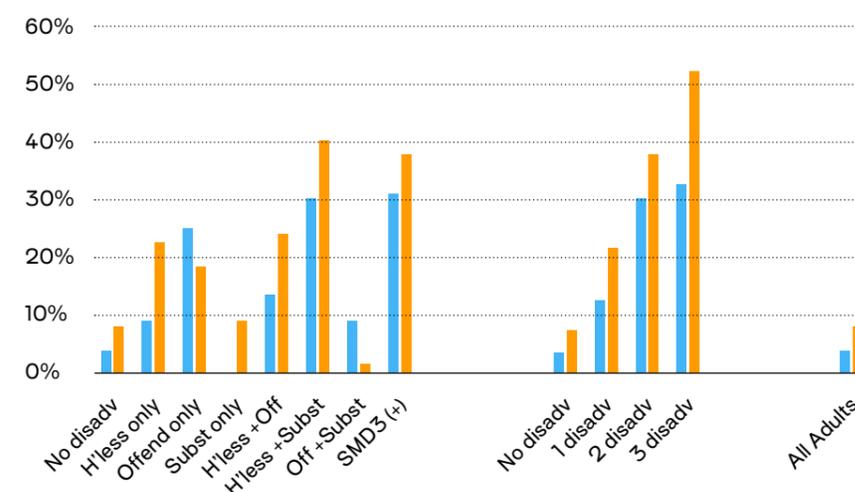
living in a house in poor repair than those who report no relevant SMD issues. Also note that, with regard to the specific domains, that it is not just those with experience of homelessness who score highly on propensity to have poor current housing quality. Having an offending history and being a survivor of DVA also seems associated with current poor quality housing, suggesting that both of these experiences tend to disrupt and limit housing opportunities and force people to accept poor conditions.

Figure 20

Experiencing Housing which is not warm enough in winter or in a poor state of repair by Ever SMD (5D) categories

Source: Based on weighted average of PSE and GUS

● Not Warm
● Poor Repair



WHAT HAS BEEN REVEALED IS A
HIGHLY PERVASIVE INCIDENCE OF
ACTUAL VIOLENCE, OR THE
CREDIBLE THREAT OF SUCH
VIOLENCE, THROUGH THE LIVES OF
PEOPLE EXPERIENCING SERIOUS
AND MULTIPLE DISADVANTAGE

CRIME & FEAR OF CRIME

As Figure 21 indicates, being a victim of crime and/or harassment²⁶ shows a strong relationship with Current SMD(3D) level, with rates four times as high for adults experiencing two or three of these disadvantages, as for people with no current relevant disadvantages.

This heightened risk of crime victimhood and harassment also affects people with homelessness-only or substance dependency-only issues.

By contrast, as Figure 21 also shows, fear of crime is not significantly associated with current SMD experiences. While there is slightly more evidence of a relationship when using the Ever SMD(5D) classification (see Figure 22), this seems to be driven by people with MH issues, who may well experience more anxiety about a range of issues including crime. Another factor is experience of DVA, which when combined with other SMD domains, is associated with having more worries.

These findings are consistent with wider research that indicates that groups at greatest risk of being crime victims (e.g. young, working class, male)

also have a higher probability of being poor and/or SMD, including in some cases involvement in crime as perpetrators (Maguire, 2012). Groups who are more likely to express worries about crime (older, middle class) actually have a lower risk of being victims, and are also less likely to be poor and/or experiencing SMD.

Figure 21

Indicators of concern about and being a victim of crime or harassment by current SMD (3D) categories

Source: analysis of SCJS

Note: Victim: being a victim of any of 8 common crimes in the last year; Worried: being very worried about two or more, or fairly worried about being victim of five or more out of 11 common crimes; Harassed: being insulted, pestered or intimidated, in person or by other means, in the last year.

● Harrassed
● Worried
● Victim

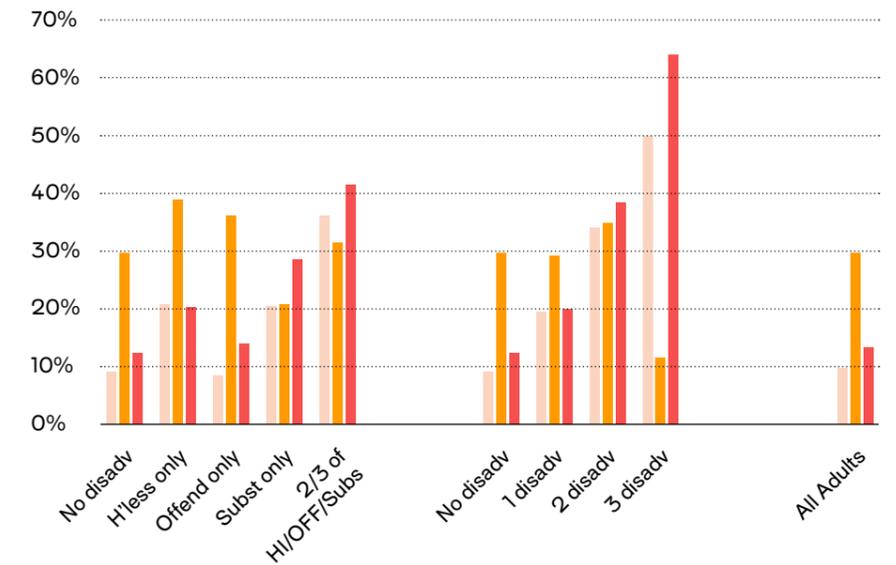
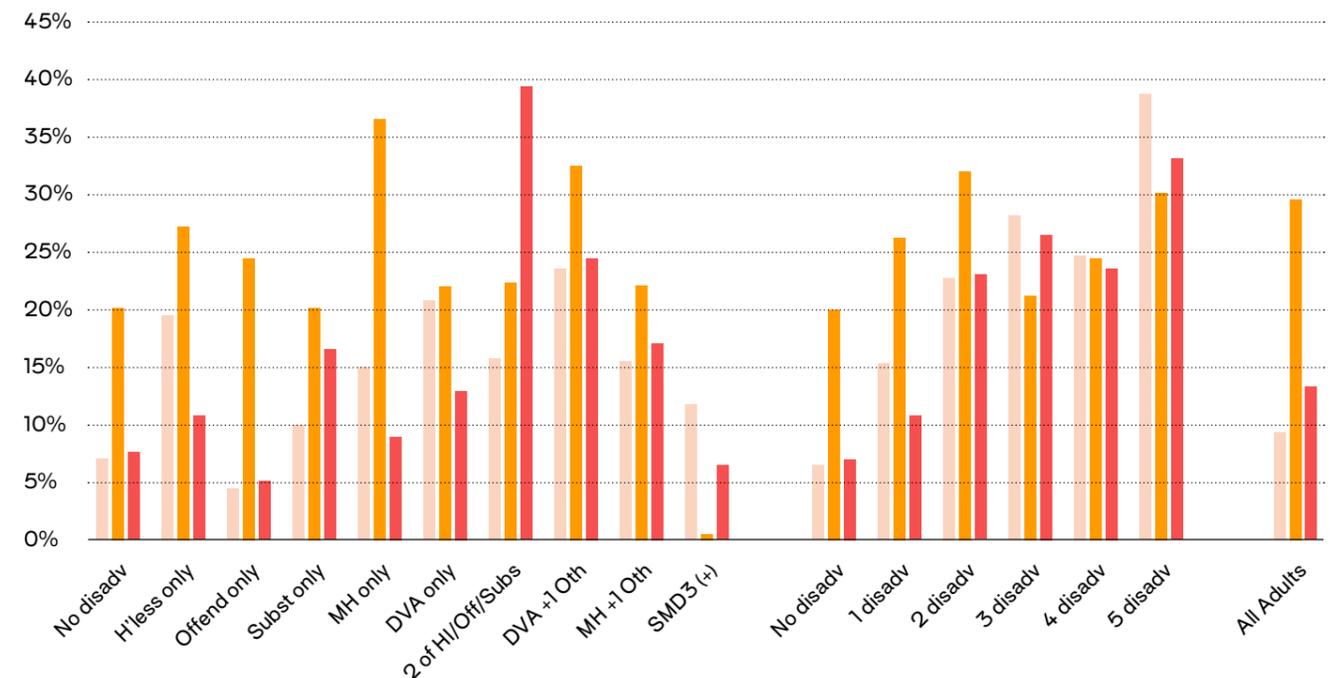


Figure 22

Indicators of concern about and being a victim of crime or harassment by Ever SMD (5D) categories

Source: Weighted combination of SCJS and PSE

● Harrassed
● Worried
● Victim



SOCIAL EXCLUSION

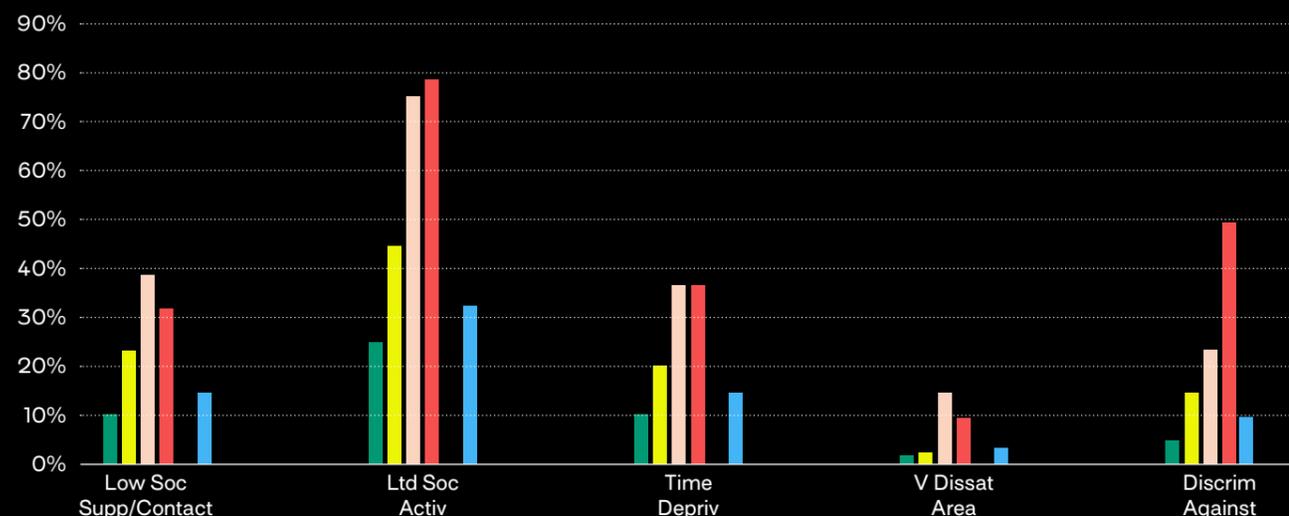
We have one data source (PSE) that captures a range of relevant information on the association between Ever SMD and varying forms of social exclusion.

Figure 23

Indicators of Social Exclusion by Ever SMD (4D) counts

Source: Authors' analysis of PSE-UK survey for Scotland, 2012.

● No disadvantage ● 3 disadvantage
● 1 disadvantage ● All adults
● 2 disadvantage

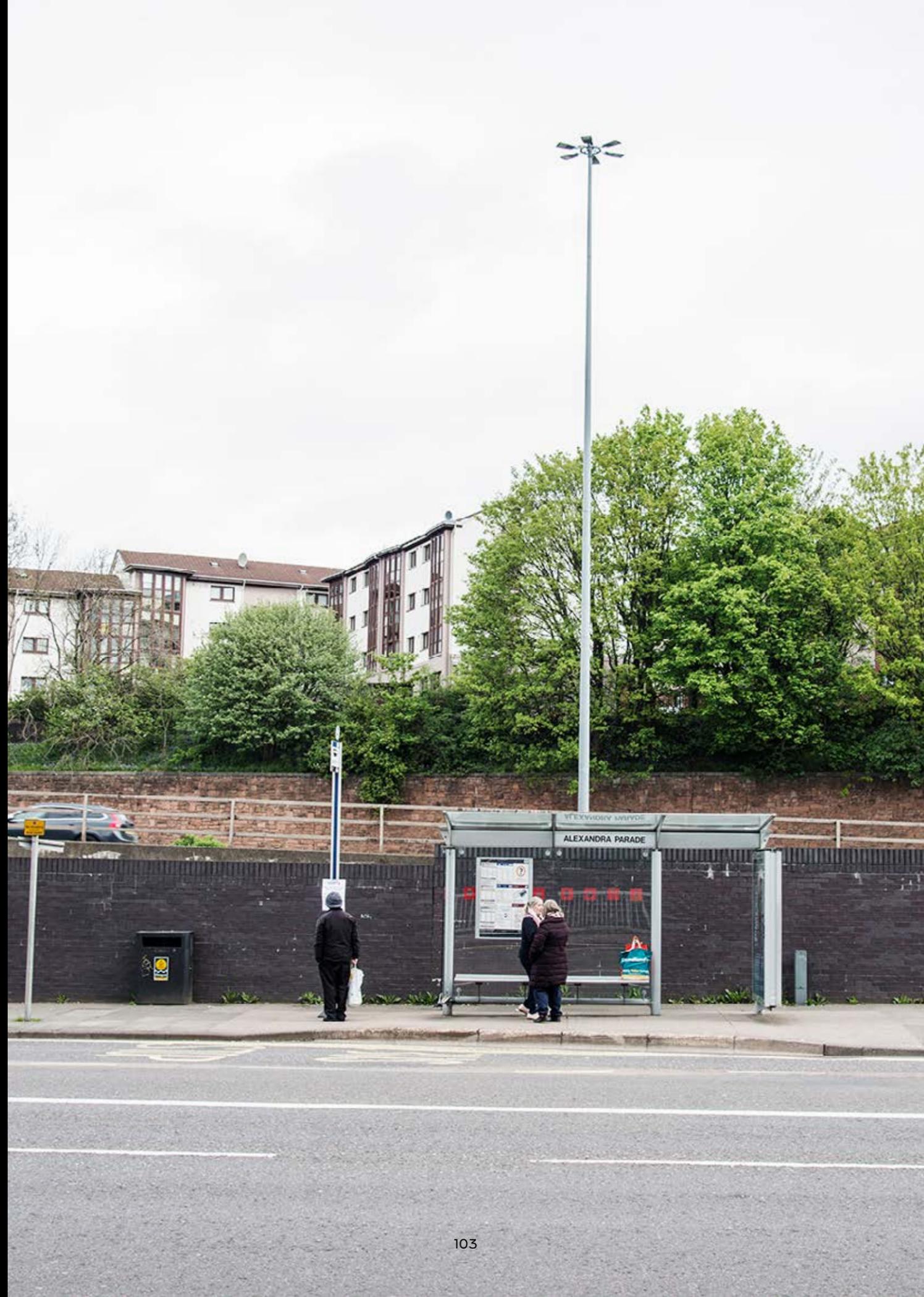


The PSE was a general household survey specifically designed to measure poverty and deprivation in detail but also to specifically provide measures across a dozen dimensions of social exclusion (Bramley & Bailey, 2018). Unfortunately, it did not include questions on substance dependency so it is only the remaining four domains that can be explored here (hence '4D').

Figure 23 captures two classic aspects of social exclusion, having low levels of social network contacts or support, and having limited ability to participate in social activities. We also include an indicator of time deprivation/pressure, a summary indicator of dissatisfaction with area of residence, and reported experiences of discrimination. For all five of these indicators, there is clear evidence of greater social exclusion being

associated with SMD. For people with experience of two or more SMD issues, one could say that these instances of social exclusion are typically three to four times higher than for those with no SMD experiences, with a rather more extreme difference in the case of being discriminated against.

Looking at individual SMD domains, it appears that MH tends to be implicated in the highest levels of social exclusion, particularly lacking social support/networks, limited social activities, and time deprivation. Homelessness seems particularly strongly associated with limited social activities and being discriminated against. The association with DVA experience is most pronounced in limited ability to participate in social activities.



This section of the report is primarily intended to give voice to the people actually experiencing SMD in Scotland today. As such it draws primarily on qualitative interviews conducted with 42 adults who were using relevant services in six areas of Scotland.

PERSPECTIVES OF PEOPLE EXPERIENCING SMD

It starts by examining how people came to be in this situation, their 'routes in', then moves on to look at their experiences of specific service

sectors, before considering more system-wide issues, 'missed opportunities' for earlier intervention, and their hopes for the future. As a

bridge from the quantitative data analysis into these more personal accounts, we start by summarising the statistical findings on 'risk factors' for

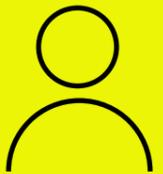
SMD, to highlight common factors which appear to be systematically related to people experiencing SMD.

ROUTES IN

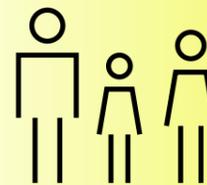
We were able to use multiple regression analysis on a range of household surveys²⁷, and one administrative dataset²⁸, to tease out the characteristics of individuals, households and areas that are significant in predicting heightened risks of SMD²⁹.

Characteristics of individuals, households and areas that are significant in predicting heightened risks of SMD

Echoing the descriptive statistical analysis presented above, we found that, other things being equal, the factors associated with higher risks of SMD30 included:



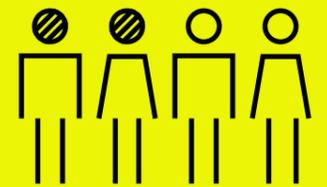
Being male



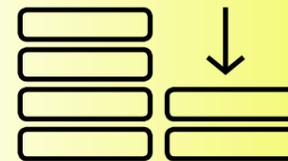
Being a younger adult (aged 25-45 yrs old)



Living in a single person household



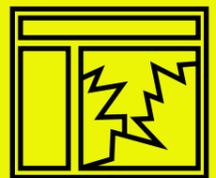
Being white (i.e. not ethnic minority or non-uk born)



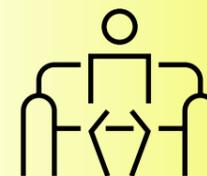
Having both past and current experience of poverty, financial difficulties and problematic debt



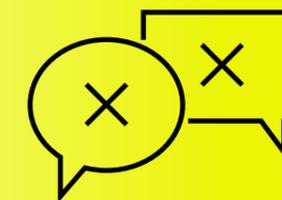
Social renting and, to a lesser extent, private renting



Living in a deprived neighbourhood



Being unemployed/living in a workless household



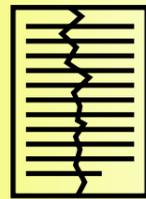
Having a low level of social support/networks



Long-term sickness and/or a disability

The in-depth interviews with people experiencing SMD who were using relevant services enabled us to delve deeper into the 'routes in' to SMD, and we found common trajectories which supported the findings of earlier quantitative analysis of pathways into 'multiple exclusion homelessness' (Fitzpatrick et al, 2011). The great majority of adults interviewed:

Had a difficult early life including a range of 'adverse childhood experiences' (ACEs) (Theodorou & Johnsen, 2017), and experiences of local authority care in some cases



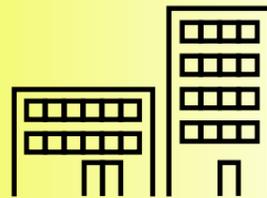
Had a disrupted schooling



Developed a substance dependency issue at either an early age, or after a particularly difficult life event



Experienced very poor mental health and, often, poor physical health too



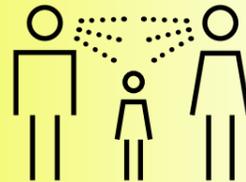
Had struggled to attain or maintain stable housing



Had struggled to enter, or retain a foothold in, the labour market



Had difficulties in their relationships with partners, often entailing violence or abuse



Often had disrupted relationships with their children (if they were parents)



Difficult early lives

Evidence cited in *Hard Edges* from the MEH survey (which included one Scottish city, Glasgow) showed very high levels of retrospective reporting of a range of traumatic or disruptive experiences in childhood by people experiencing two or more of the original SMD domains, with only 15% of the SMD3 group reporting no such issues (Bramley et al, 2015). Quantitative analysis of the GUS survey shows that, where there are parental SMD issues, such as substance dependency and mental ill-health, children are more likely to have additional support needs flagged or concerns about child development voiced. In these cases home life is more likely to be characterised by chaos vs order and by higher levels of conflict and adverse impacts on child development, which are accentuated as the child gets older (see Technical Report, sections 11.3 & 11.4).

The combination of parental mental ill-health, substance dependency and domestic violence was certainly heavily in evidence amongst the people we interviewed (Bywaters et al, 2016). Many interviewees talked about having a chaotic home life, with one or both parents drinking heavily and/or taking drugs:

“I was about, early teens, about 12, 13. We couldn’t bring any pals home from school, do you know what I mean? You didn’t know if your ma, or da, or their pals were going to be in there totally wrecked.” (Male, 40-44, urban)

Several chronicled the impact of having a father who was violent when drunk:

“...maybe every three or four months he’d go on a bender for two days drinking rum and cups of tea, and that was the only drinking he did, but it was Jekyll and Hyde, as soon as he had a drink in, I was gone.” (Male, 50-54, semi-rural)

“My dad was a drinker in his younger days, I always remember him coming home covered in blood... I remember always running up to him and saying ‘you’re covered in blood’, ‘It’s all right, it’s not mine son.’ I remember, and that kind of stuck in my head a little bit.”

(Male, 40-44, semi-rural)

More generally, and with very few exceptions, the family lives of interviewees were marked by violence and other forms of abuse, sometimes from mothers as well as fathers, and other adults:

“[My mum] battered us...not having my dad there, getting told all these things about him, and then having my mum batter me just for the least little thing, and saying, ‘This is because of your dad’, and all that. ‘Because you look like him’. Even if I pulled a face, it was, ‘You look like him, you wee...’” (Male, age 25-29, urban)



The family lives of interviewees were marked by violence and other forms of abuse

“My father was a paedophile, sex offender; he liked to abuse his children. He just was a nasty man, you know, he wasn’t nice and my mum, she had three jobs, she tried all her life... she wouldn’t leave this man for some unknown reason...So that’s why I was in homes and care most of my life.” (Male, 40-44, urban)

“I got abused when I was a child from my uncle. I’ve got obviously good memories of being with my mum, but with that happening, it’s... He’s dead now but...”

(Male, 35-39, urban)

The destructive impact that family violence could have on the mental health of all members of the household was evident:

“He [Father] was violent, abusive towards her [Mother] and then as I got older, I started copying it as well... because of what he done, it caused her to have mental issues, depending on alcohol and drunk...”

(Male, 20-24, urban)

“...then my dad left [and] my mum was quite violent towards my brother...So obviously that’s messed up his head. I didn’t have a great relationship with her. I know that’s affected my confidence and self-esteem.”

(Female, 30-34, urban)

Traumatic bereavement was another adverse life event that emerged in several of the individual narratives, and some found themselves under pressure as young carers, with even these relationships sometimes marred by a context of violence:

“I went to college, and then, because of the way my mum was with my gran, I became my gran’s full-time carer, so I was going to college then going to full-time carer for

my gran... then she [mum] kicked off, she went and flew at my gran, tried to put a TV over her head, and I kicked my mum in the stomach to get her away.” (Male, 25-29, urban)

None of the people interviewed who were using relevant services appeared to have come from a well-off background, though poverty was only occasionally explicitly acknowledged:

“I wasn’t born into much. I’m from quite a poor family.” (Male, 25-29, urban)

“Well, we weren’t rich and we weren’t poor you know what I mean. We always had food and we were always clothed you know what I mean.” (Female, 45-49, semi-rural)

“I wouldn’t say we were starving or anything like that.” (Male, 55-59, urban)

In some cases the problem was the distribution of resources within the household, especially in the context of parental substance dependency:

“My dad was working on oil rigs but with him being an alcoholic, we’d have a lot of money one day, and then the next day we’d have nothing.” (Male, 45-49, semi-rural)

A small number of interviewees emphasised that their childhoods were not marred by poverty:

“My mother worked full-time, my step-dad worked full-time, so they provided everything that I needed when it came to material comforts: computers, clothes, holidays.”

(Male, 45-49, urban)

“He [Father] was violent, abusive towards her [Mother] and then as I got older, I started copying it as well”

Care System

13 of the people interviewed had spent time in the care system, including foster care, children's homes, residential schools, secure units and kinship care.

“...my mum and dad, they took drugs and then it was drink and so... I was in foster care when I was little as well for nine months...I was with three different families within nine months, it was horrible.... Then I ended up going to stay with my granddad, so he's brought me and my sister up from I was nine-year-old...” (Female, 25-29, urban)

“I ended up going [into care] because I'd missed that much school with dogging³¹ school. They [Social Workers] were saying to my mum and dad, 'Well, she's out with parental control so she can't stay here with you. You seem to not be able to keep control of her' so I ended up having to move in with my auntie and uncle... it [subsequently this young person stayed in a secure unit] was all right... [I stayed in secure unit] until I was about 15... It was quite a hard school to be in, I would say. I left with no qualifications, no nothing, nothing like that, nothing.”

(Female, 30-34, urban)

Being moved frequently from one placement to another was a recurring theme, with another interviewee speaking eloquently about having had a positive experience of residential care but things going wrong when they were moved into foster care at age 16:

“So I fell in love with the staff [in the residential home] that was bringing me up. Because I was at a young age, they became solid people in my life, I liked the way everything was done....I went from residential to foster parents. [...] That foster placement, it was unrealistic for somebody like myself because... I went from being sheltered to put out into the world and I can just remember



having no rules and that was a buzz. ... I could do all these things without permission. When I was introduced to alcohol and all that sort of stuff... it's your environment that shapes and creates the person that you are, 100 per cent."

(Male, 25-29, urban)

Some talked about being offered some form of aftercare but rejecting it due to having a negative view of social workers, a decision which they later regretted:

"By the time I turned 16 I'd just had enough of social work. They gave me a form to sign and that was that; I signed that form and that was me, freedom, do you know what I mean? That was a mistake looking back now, I should never have done it but at the time I was only young and, as I said, I was just sick of the social work, so aye."

(Male, 35-39, semi-rural)

The quantitative analysis indicates that, not only are former looked after children overrepresented in the adult homeless population but, within that group, they are more likely to have compounded problems of sleeping rough, substance dependency and mental ill-health. There is also a strong association between offending (including imprisonment) and having been in the care system. Prisoners in Scotland have 10-15 times the baseline risk of care experience, with around 40% of the higher SMD level prisoners affected (including 27% who had three or more placements) (see Bramley et al (2019) Table 40).

There were many other people interviewed in this part of the research for whom there had been no statutory input from social work, but who nonetheless described very unsettled living arrangements as children, living with grandparents and other relatives, and shuttling between parents who were no longer together.

For a few interviewees, school had been a positive part of their early lives, at least until a specific disruptive event:

“I went to school. Actually I enjoyed school. Then I got a lassie pregnant just before my exams, so that just put my exams out the door.”

(Male, 50-54, semi-rural)

More often, though, schooling was characterised by persistent truanting and/or exclusions, sometimes to the point where people rarely attended school at all:

“From secondary upwards to fourth year, I did [truant] quite a lot – used to go into school and then – sign the registration and then back out the road again. I used to wait till my dad had driven off from the school gates!... I think the start was smoking weed and that... it was one of the rougher schools in [X] at that time. It was kind of different to what it is now. When we went to school we went to skin up, to fight...” (Male, 40-44, semi-rural)

Sometimes this effectively culminated in the individual ‘leaving’ secondary school early:

“I missed the last six months of school, I just never went back...Nobody chased me though, there was nobody on my back, take me back to school...” (Male, 45-49, urban)

Bullying seriously disrupted the schooling of quite a number of people interviewed, or simply made it a thoroughly miserable experience:

“I got bullied at school, so my mum took us out of school and she was basically helping us with my schoolwork at home... I think I went up to about second year in high school and that was when the bullying started. They’d set my clothes on fire.” (Male, 30-34, urban)

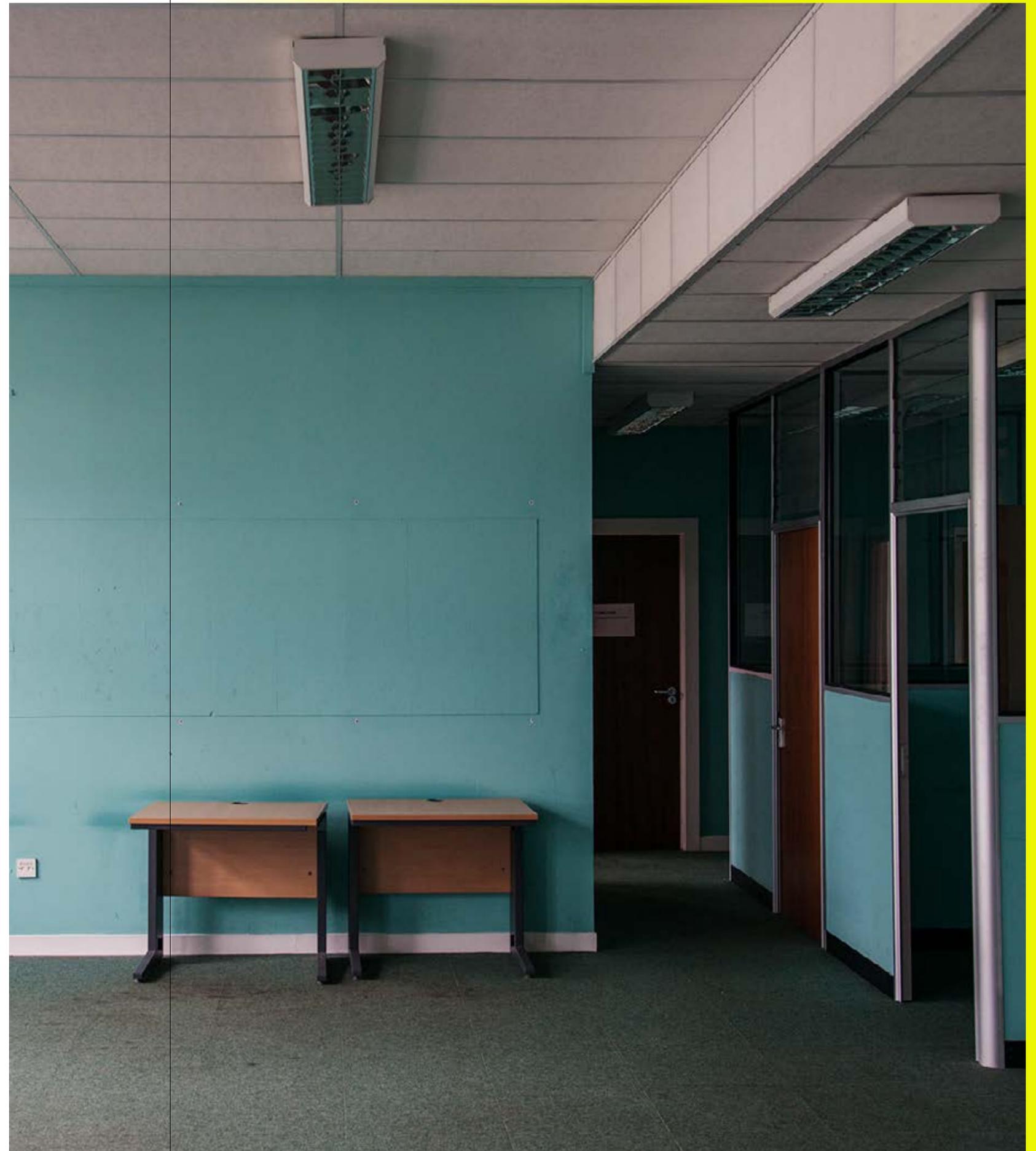
“I’ve got epilepsy and I’ve had it from I was ten-year-old so I was kind of un-liked at school and bullied at school for having epilepsy and taking fits and wetting yourself in front of people and all that. Children can be really, really horrible sometimes, so yes, I didn’t have a great childhood; I was a bit of a loner, to be honest, I didn’t have very many friends.” (Female, 30-34, urban)

“All the way throughout school, I’ve been bullied...I’ve always looked older than I actually am, and stronger than I actually am, so that used to make me a target for folk that were a bit older than me... Right the way through until, I think it was second year in high school, I got picked on pretty much every single day. I was in fights near enough every single day, both inside and outside of school.” (Male, 20-24, rural)

Learning difficulties were also in evidence for some:

“I couldn’t read or write a lot or do maths that well, so I got put back a class...I went to the high school and couldn’t handle 40 people in a classroom and one teacher. I couldn’t handle that so they put us in a specials class. I couldn’t handle that either because there was 15 people against one teacher, so they put us in a special school in [X]... It was like four teachers against 20 people, and I got more help that way. It was all right.” (Male, 25-29, urban)

The quantitative evidence for disrupted schooling was also very strong in the MEH survey, with 59% of the SMD3 group reporting truanting, 47% having been suspended and 45% gaining no qualifications (Fitzpatrick et al, 2013). Bramley & Fitzpatrick (2018), using earlier British Cohort Study evidence, showed the significance of school exclusion early school leaving and other ACE-type factors during the teenage years in predicting experience of homelessness up to age 30.



Often, absence from school was linked to heavy involvement in drugs or alcohol from a very early age (see also Fitzpatrick et al, 2013):

“From about 12 years old I’ve been drinking.... I’ve been smoking weed since I was ten years old.” (Male, 40–44, urban)

“We were buying bits of hash and just go away and get stoned. Then after the hash was finished, that’s when we’d all go into class but a couple of times you’ll get suspended and the police had to be phoned because the teacher knew that we were all off our faces.” (Male, 30–34, urban)

Three main routes to addiction in adulthood emerged. The first, evident amongst some older people interviewed, was linked initially to prescription drugs:

“I was on the drugs for 20 years, because I messed my back, and that. They basically started me tablets, the doctors and all the rest of it. They were real strong painkillers, and everything, and then it just escalated.” (Male, 50–54, semi-rural)

The second route, mentioned by a few interviewees, was substance dependency prompted by a specific traumatic event. This man, for example, linked his substance dependency with his mental ill-health after becoming unemployed:

“I went from earning a wage all my life, and being in a family environment, to losing my family environment, to ending up by myself.... that broke me a little. That could have killed me off... I was diagnosed with drug and alcohol induced psychosis many years ago.”

(Male, 40–44, semi-rural)

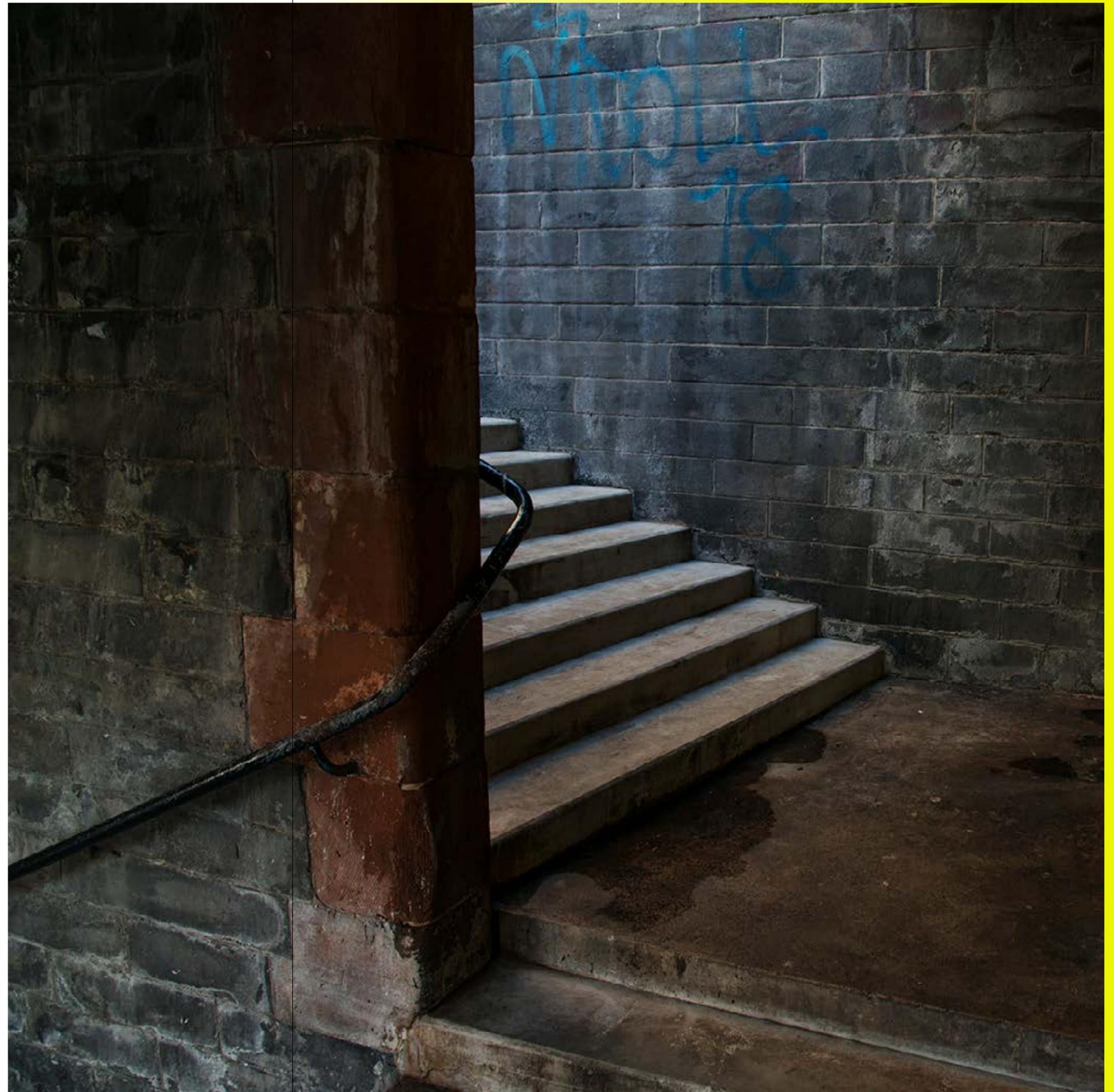
The third, and more prominent, route was trauma early in life, consequent low self-esteem and a sense of desperation leading to ‘self-medication’ via substance dependency. There was often then a vicious cycle between substance dependency and involvement in the criminal justice system:

“...maybe I’d been out stealing or trying to get money to get my drugs and when I was on certain kind of drugs, like Valium and diazepam, temazepam, like I’d be sleep walking and it’s like a red rag to a bull.... I wanted punishment for hurting them all and hurting my dad, losing my daughters...” (Male, 50-54, semi-rural)

“I started heroin in prison, so when I come out, that’s when I started shoplifting, stealing, doing anything and then just in and out, in and out, in and out. Then my family had nothing to do with us so it’s sleeping here, there, and everywhere.”

(Male, 30-34, urban)

“Because I had started using heroin I was basically going out and stealing and robbing for money every day so I was in a hostel, then in a jail, back in a hostel and wouldn’t be there long enough to get a house, know what I mean, because you’d just be back in the jail.” (Male, 35-39, semi-rural)



Poor mental and physical health

Virtually all the people interviewed using relevant services reported poor mental health, mostly related to depression and/or anxiety, and suicidal ideation was commonplace:

“I’m seeking psychology [counselling]. I need to focus. My thought patterns are terrible. I’ve got this – it’s an interruptive thought pattern. It’s not nice and calm. It’s stormy. I’m waiting to see psychology. Psychology’s the number one, maybe number two I need in my life. I just need somebody to tell me that I’m doing things right, like that reassurance is something that I strive [sic] on.” (Male, 25-29, urban)

The female interviewees especially spoke of their addiction as being triggered by their poor mental health:

“Heroin, Valium, alcohol – and I was just using it to try and block everything out that’s going on in my life. ... Just because everything that’s going on in my head, it’s just to block everything out.” (Female, 25-29, semi-rural)

“I was using as many tins [of gas] as I could get a day. It was just to block out reality.”

(Female, 30-34, semi-rural)

For several, the traumatic loss of a family member triggered a major mental health episode:

“I took just a major breakdown; I walked on to the actual railway bridge, wanting to... I stepped back, and then slept in a close....I broke down, and everything like that, and that’s the worst I got. Well, I thought that was the worst moment in my life I got to, until it came to Boxing Day, then I got a phone call saying my wee brother had just put a rope around... The worst thing was, he was in the jail when that happened, when he did it.” (Male 25-29, urban)

“I just need somebody to tell me that I'm doing things right”

The ubiquity of mental health issues among adults with SMD is consistent with evidence from Waugh et al (2018) HHIS study, which indicates that, where homelessness is combined with drug or alcohol issues, mental health issues are nearly always present as well.

Serious physical health and disability issues were also common, reported by almost half of all interviewees:

“I picked up hepatitis C... I've been through other stuff, getting my liver checked and everything, and the doctors are shocked that I've not got no cirrhosis.” (Male, 50-54, semi-rural)

“I go to the nurse twice a week to get my leg bandaged because I've got septicaemia and cellulitis in the leg from injecting... It's pretty hard; I limp everywhere I go.” (Male, 40-44, urban)



Homelessness and mobility

Within this broader context of unstable and difficult lives, with multiple challenges, people struggled to stay housed, and all but two of the interviewees (both of them female) had been homeless. A range of 'triggers' led to loss of accommodation, including relationship breakdown and bereavement.

However, for most people some combination of substance dependency, mental health problems, and offending undermined their ability to maintain stable housing:

“In the house I lived in at that time I ended up getting abused by other people and that and I was going away to get away from it all, the house was getting broken into... a person died in the flat I was putting my head down in so obviously that flat got closed off ... Other people could see what needed to happen. I couldn't, I was pretty much blinded with the heroin.” (Male, 40-44, semi-rural)

“Sleeping rough, yes, begging on the streets too, I was making like 60, £80 a day and that was feeding my drug habit, I was taking heroin, Valium, every day. ... ended up moving into that [hostel], I was in there for nine months, they got us a house... settled in there for a good while until all these people started coming to my door, do you know what I mean? So I gave my house up and ken what, I'm no going back there. After two years, went to where you go to declare yourself homeless and said 'look, I've been living on the streets for two years'. She went... you've got a house, I said 'I've no been near house for two year, I've been scared to go even near my house.'” (Male, 30-34, urban)

Migration between England and Scotland was a key part of some interviewees' homelessness stories, though not necessarily the original trigger for them losing their home:

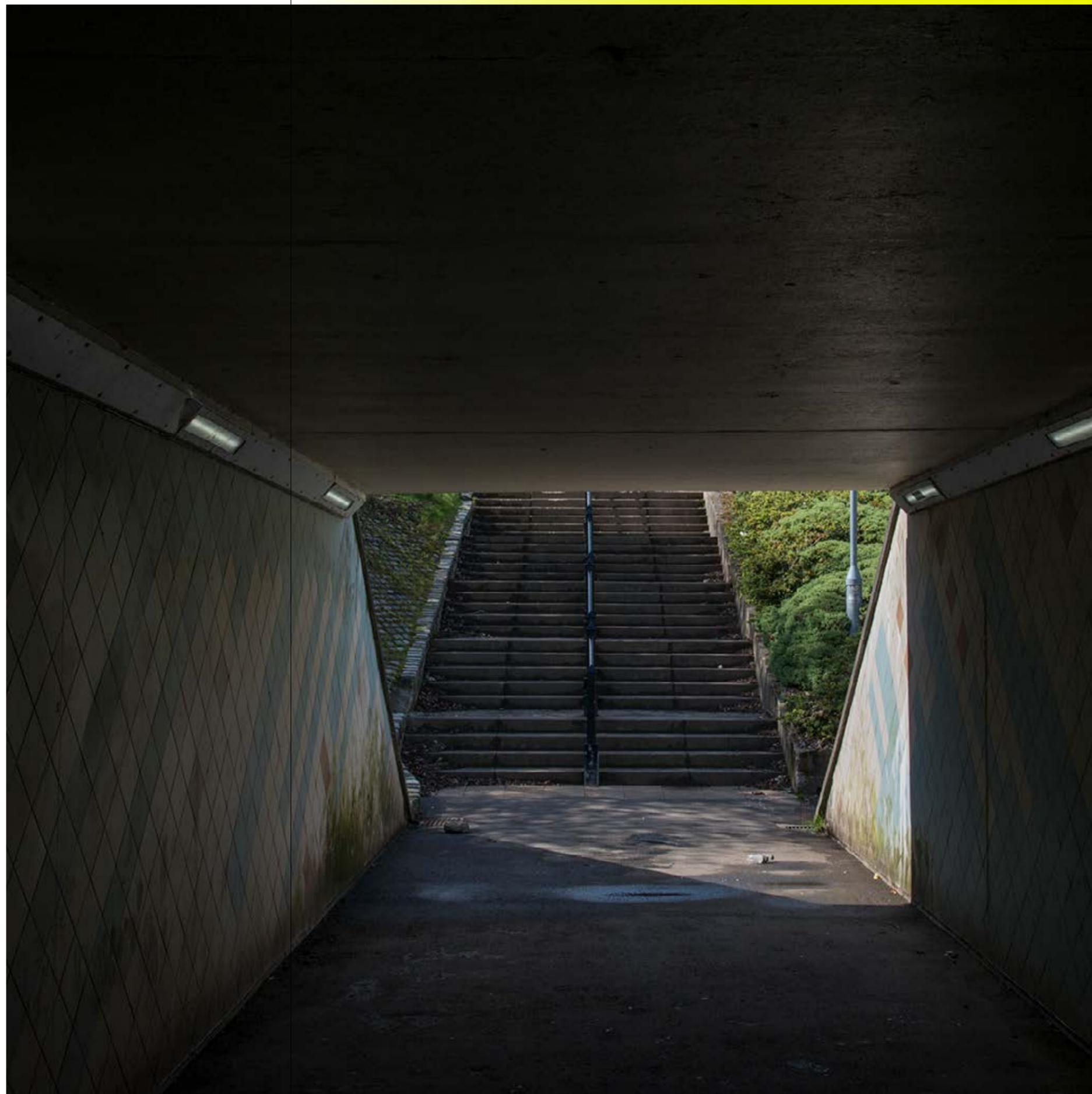
“I got barred from the hostel, it meant the only place I could sleep was in the park. Then I thought, well, if I can sleep on the park here, in [X], then I can sleep in a park anywhere...

When I first came to Scotland, I came to live rough. I was... told by the [charity] the only way I could access accommodation was to go to [local authority]... Unfortunately, when I got there, it was a bit of a scenario... because I never had such a thing as a local connection, they weren't responsible for myself. Basically, they left me on the street.” (Male, 40-44, semi-rural)

Some 'mobile' interviewees had repeatedly come back to their home town despite not being able to clearly identify the reason for doing so:

“I've been about aye, because obviously when you're in hostels and that, things happen and sometimes you're kicked out and there's nowhere for you to go and that, know what I mean? They'll not get you anywhere else, so I've had times where I've had to go to [English city] to stay...but I always end up back in [this town] for some reason, I don't know.”

(Male, 35-39, semi-rural)



Difficulties in the labour market

A few participants had employment histories, but only 2 were currently in paid work. Some of the older interviewees had left school early and went straight into unskilled jobs.

“...as a bin man I never learnt a trade and that’s one of my biggest regrets. I always thought there would be rubbish, but unfortunately, I got the sack, so it was the end for me... When I lost my job and ended up homeless. It was like, yes, I lost a lot. My self-respect went out the window.... you just end up falling and falling, and then if no one’s there to pick you up, you’re just falling into a big hole.” (Male, 40-44, semi-rural)

“I got thrown out of school when I was just turned 15, they said, ‘There’s nothing else we can do for you’, ... So, I went away working in the harbour, working on the boats when I was 15 and I was getting maybe £20 a day, a lot of money.” (Male, 55-59, semi-rural)

For another interviewee, loss of a job and simultaneous relationship breakdown rapidly descended into alcohol dependency, homelessness and experience of the criminal justice system:

“It started going wrong about September 2017. I lost my job. I split up with a girl that I was seeing, so I lost that and ended up having to go on to Universal Credit, and, because it was five weeks before I got any sort of payment, even then it was, like, only half of what I should have been getting. I ended up, everything got on top of me, so, instead of trying to look for a new job, I was sitting in the house and getting drunk. Basically, I was fucked, excuse the language!”

(Male, 40-44, urban)

Another person interviewed, with a strong work history, went from using alcohol as a crutch to manage social situations, to prolonged substance dependency and violent offending:

“Everything just slowly but gradually just disappeared away from me, everything”

“I’d worked all my life. I’ve never not worked from when I got out of school. I was always – I had a really bad confidence issue, like really bad, low confidence and low self-esteem...I used to have to drink to be around people.... Then I would drink faster so I could go out, and then it all just escalated... something would always happen, like something violent or something... I would always black out when I was drinking, like nine times out of ten, well, ten times out of ten, I would black out, and something would have happened.”

(Female, 30-34, urban)

This evidence both reinforces and illustrates some of the ways in which SMD is typically associated with low levels of employment, as reported from the quantitative evidence above.



“I was only 16 when she was born, so I was only like a young adolescent myself... From being homeless many times, when I was younger, from being homeless and then getting put into psychiatry wards. Getting sectioned and then put into psychiatry wards, and then getting put into prison... My daughter just says we’ve grown apart, but she hasn’t got no idea... She doesn’t really know the true story.” (Male, 40-44, semi-rural)

For another person, a destructive relationship with an ex-partner also meant he lost contact with his children:

“I tapped the door and she says, ‘You’re not getting them. I told them that you’re moving in with your son and his mum, and you’re up to tell them that you don’t want to see them any more.’ It just blew me away because that was the lassie I loved and we’re family and all the rest of it.” (Male, 55-59, semi-rural)

Due to a criminal record and his ex-partner accusing him of child abuse:

“...instead of fighting for them, I buried myself in drugs and alcohol and, before I knew it, 20 years had passed.” (Male, 55-59, semi-rural)

This pattern was similar for other people who also had no access to one or more of their children. In many of these cases there is an implication that these (mainly male) individuals were themselves perpetrators of domestic violence, though this was seldom explicitly admitted. However, the interrelationship between domestic violence, drug dependency, poor mental health and loss of children was a key narrative articulated by female interviewees:

“It was through drugs really, I would have to say, and getting in with the wrong guy. I started using drugs in 2015 when I met this guy. About two years later just everything [went] downhill: I lost my home, I lost everything that I owned. I wouldn’t say I lost my kids because my kids already didn’t stay

with me through domestic violence and stuff like that....

Everything just slowly but gradually just disappeared away from me, everything.

All your ambitions just go right out the window when you're in about drugs like that, especially. You're just caring about where your next fix is coming from. You're not caring about where your bills are coming from or your heat's coming from. You only care about that when you're sober."

(Female, 30-34, urban)

The quantitative evidence on the extent of child contact among adults facing SMD in Scotland is difficult to compare with the English Hard Edges study for reasons noted above, but does appear to suggest that a somewhat lower proportion of people undergoing drug treatment may have child contact. It is clear that the form of child contact varies systematically with level of SMD. For example, adults in drug treatment are less likely to live with their own children but more likely to have contact on a non-residential basis, especially those in the original SMD(3D) triumvirate. A majority of prisoners in the SPS survey have children, but progressively less of them are involved in their care or receiving visits from them the higher the level of SMD, particularly where homelessness is involved (see Bramley et al (2019), Table 39).

The interrelationship between domestic violence, drug dependency, poor mental health and loss of children was a key narrative articulated by female interviewees

Difficulties with wider social networks

Some interviewees were still in contact with their wider family, and gained occasional support from this source. For one female interviewee, her mother was a key supportive figure, bringing up her children, and helping her with benefit applications, as well as with meeting other needs.

However, these wider family relationships often remained difficult, in some cases because interviewees' relatives also had chaotic lifestyles and complex needs:

“...what happened was, my sister’s children... got taken off her because my sister went off the rails a wee bit, like with Valium. The children went in my mum’s care, so what social work says to my mum was, it’s only fair that ‘[name of interviewee] moves out of your house’ ... So my mum said look, go stay with your dad, I’ll go and phone him and tell him you’re going to stay with him. I lasted six days and then I was back on the streets because I couldn’t, my dad, he was treating us like a bairn.” (Male, 34–39, urban)

Some service users in rural and semi-rural contexts talked of the difficulty of breaking away from negative relationships in a small-town context:

“Everybody I know’s all drug users so you’ve got to kind of distance yourself from that, know what I mean? [X] isn’t a big place so fucking everybody knows everybody so that can be the hard bit, aye. I mean I try and not use and try, keep yourself on the straight and narrow but everybody you know outside, it’s all users so yes, you could get isolated, and that’s not good when you’ve already got mental health problems or whatever already, and you’re trying not to use drugs or whatever, it’s not helpful, know what I mean?” (Male, 35–39, semi-rural)

EXPERIENCE OF SERVICES



Criminal justice services

The quantitative analysis established that adults with SMD are systematically more likely to come into contact with the police, and their satisfaction level with that contact/service is likely to be systematically lower, as is shown in data from the SCJS (Technical Report, Table 39). This is partially borne out by the indicators ‘people have confidence’ in the police and ‘the police are doing a good job overall’, both of which gain lower scores of agreement among people with SMD in general, and particularly higher levels of SMD. These general patterns are probably inevitable and to be expected. However, there were more positive findings about other aspects of Criminal Justice services, particularly from the qualitative interviews (see below), but also from the Prisoners Survey (Technical Report, s.7.5).

Virtually all of the people interviewed had been in contact with the criminal justice system, mostly involving time spent in prison. Perhaps less expectedly, though, many made positive comments about at least some aspects of the help they had received via the criminal justice system.

Thus, there were numerous accounts of prison as effectively being a respite from the streets, where health needs in particular could be met:

“...it was prison for me, 20 years of it, in and out every year. That’s where I went to get peace and quiet, it’s where I went to get better and get healthier. I went to all the classes in there, AA meetings, the chaplaincy, the churches, everything... it was actually sorted in prison.

It really is the only place that can help you...

I’ve asked the judge ten times, please could I get a prison sentence, please, I need help. ...I need help your Honour, and he went “well jail’s not the place” and I went neither’s out here because it’s like [a] six-week waiting list, three weeks for this. By the time you’re getting there you’re at your wits’ end, spewing blood...”

(Male, 40–44, urban)

“When I went into prison they sorted my medication out.” (Female, 30–34, semi-rural)

In some cases, prison was even reported as the catalyst to a more dramatic positive change that saw long-term needs being addressed. For example, after living on the streets of a major Scottish city for six weeks, this person was arrested for spraying himself with ‘stolen’ deodorant in a shop:

“...because I had no fixed abode... all she could do was send me to jail... I did four or five weeks in [X] prison and then... I was transferred up to the local mental hospital...and I was in there for four months for an assessment... [they] diagnosed me with severe bipolar. From...

the hospital, I went into a.... really good hostel and then stayed there for nearly a year, until I got my house...so it was a bit of a ride... It was traumatic, really, at stages. Despair. That's all I can say [about] homelessness. You can feel despair.” (Male, 40-44, semi-rural)

Pre-release support was referred to as satisfactory by some interviewees, although the short time window available for this kind of support was criticised:

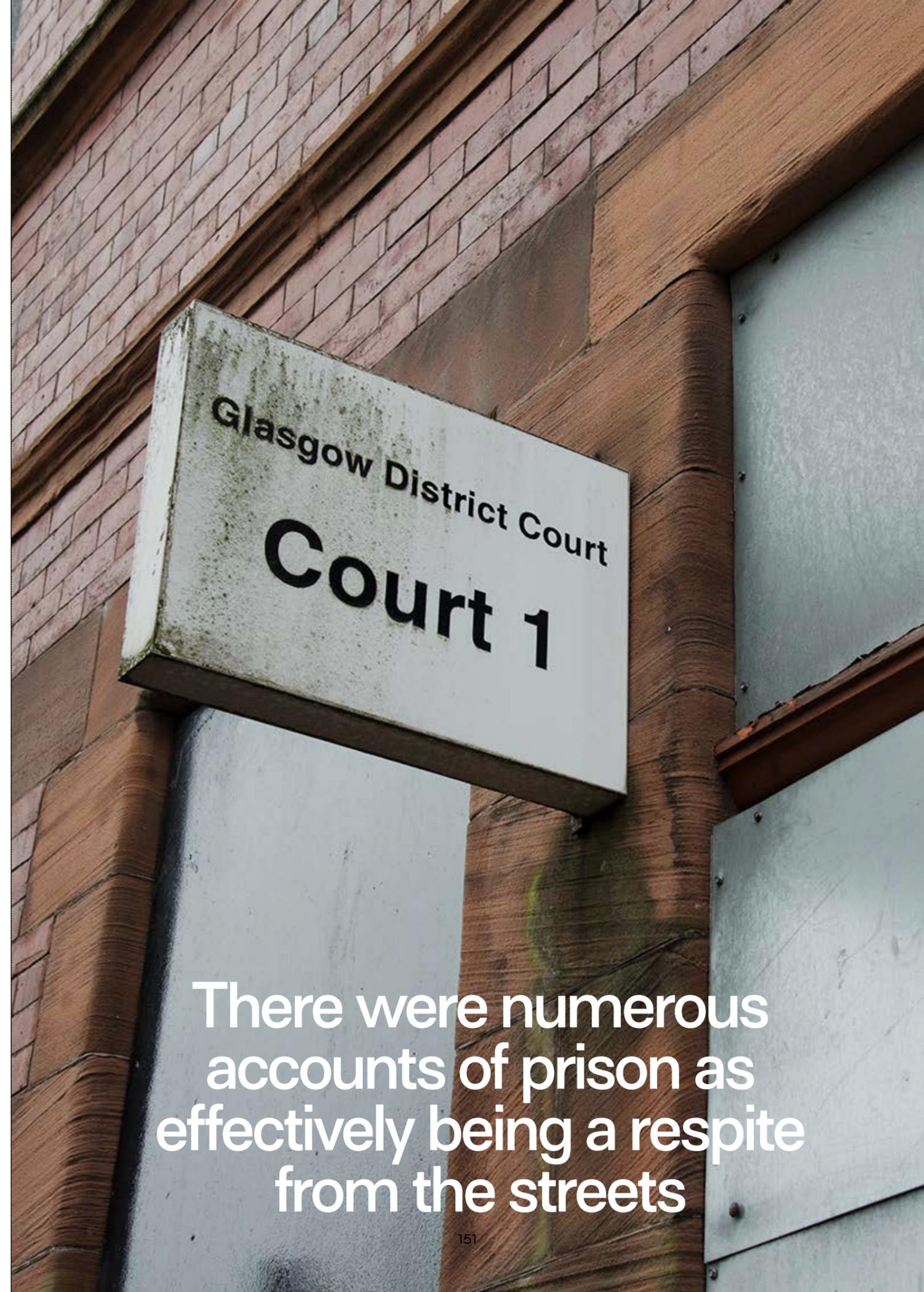
“See, now I've spoke to prison officers about that before and they can't really start it [pre-release support] any sooner...because the Jobcentre and the housing will not let them, because anything could happen in that four weeks, you could be back up at court and that.”

(Male, 35-39, semi-rural)

However, others reported being released from prison straight into homelessness, even when other needs had been addressed:

“Well, I thought that someone from the social work department, or the prison, or whoever would interview me and say, 'Right, we've got you somewhere to stay', because they done all that with my prescription. They were like, 'Right, we'll give you your dose in the morning before you get out, but the next day you go here at this time and they'll give you a prescription for your methadone so you can continue treatment, so you're not having a breakdown in treatment and relapsing.' So that was sorted, but the housing wasn't. So I came out to nowhere to go, type of thing. I was like, 'Right, what do I do with myself?' But I knew to go to the [homeless unit].”

(Male, 45-49, urban)



There were numerous accounts of prison as effectively being a respite from the streets

“Since they released me from prison believe it or not [been rough sleeping]. They released me to nothing and I have been like that since.”

(Male, 40-44, urban)

Likewise, post-release support with avoiding reoffending was not always viewed as adequate:

“I had a social worker, and they were hopeless. All they done, you go in, I know you’ve got to tell them, but I was in two seconds and out. ‘Any problems?’ ‘No.’ Away, that was it. ‘On you go.’”

(Male, 45-49, semi-rural)

However, there were three female interviewees, all from the same urban area, who had particularly positive experiences with criminal justice social workers. One woman explained how they had worked with her on her mental health problems, not simply in order to meet the requirements of her court order, but also to ensure that she was socially included in a broader sense:

“...I’ve always had bad anxiety... [going out]... with the pram and stuff like that. I had to force myself, so I thought this is not – I can’t let this take over my life. It’s just not going to work...The social workers were great; my criminal justice worker was great. Everybody. Like they would meet me in the town, just slowly starting off and stuff like that...And I had a family support worker as well, and they were brilliant, like they were just fantastic. I honestly can’t praise them any more, and through doing that I was then building my confidence up and stuff like that, and then I started looking into wee groups to go with her [daughter] and stuff like that. Then slowly but surely started talking to [my] family again.” (Female, 30-34, urban)

To enable her to complete her community service, she was supported with a nursery place which she felt had really benefited her daughter:

“I had to get back to my community service, the social worker and that were helpful in getting [daughter] into nursery. They paid for it at the start and stuff like that, and that’s been brilliant for her development because it was only me and her. She was only around me so she was going to be dead clingy to me and stuff like that, but she’s just come on leaps and bounds since she’s been in the nursery and she’s just doing brilliant.” (Female, 30-34, urban)

Criminal justice social workers were also praised by this male sex offender living in a rural area:

“When I was in prison they were talking about social workers and they all got a bad rap but when I came out and when I talked to the social worker inside, they were perfect and they were straight talking, they tell you what they expect and what they expect from you and asked, what I expect from them and all that, so it was great.... All layman’s terms and all that, no big words.” (Male, 55-59, rural)

Addiction services

Addiction services were also a prominent part of life for many people interviewed. Sometimes there was the requirement to attend these services via court orders, and in other cases, people had self-referred in an attempt to manage or eliminate their dependency and desist from the associated behaviours. Many had commenced methadone programmes whilst in prison.

As with criminal justice-related services (especially criminal justice social workers), there were positive examples across a range of case studies where addiction services had worked successfully with people to reduce harm or to enable them to achieve abstinence:

“I started on the Antabuse³² four weeks ago and it’s the best thing ever for me. You don’t even think about drinking because I can’t drink... I’ve not touched heroin for years now because I get enough methadone and if I take heroin it doesn’t work...The worst part of an addiction is the psychological part, I would say, 100 per cent... if I wasn’t on Antabuse I’d have a drink. I couldn’t not drink without Antabuse... I’ve got a support worker through my methadone, a young lassie, brill lassie.”

(Male, 55-59, semi-rural)

“I attend [alcohol abuse service] once a week... I’ve found it’s really good... because, basically, I’ve started talking to people more, you know what I mean, so I’ve cut it way down, even going, say, about two or three days dry.” (Male, 40-44, urban)

One female interviewee would have preferred access to a residential rehabilitation clinic and found that there were none available, but nonetheless appreciated the community-based support she had received:

“...there’s not really rehab for lassies. But I did get sent to the [community-based addictions service]. I’d self-referred myself there, actually, a few years ago, and then I got court ordered...so my criminal justice worker sent me to the [community-based addictions service], and I worked with [staff] in there. I still talk to [this staff member], I still go in and see her now and again. She was dead helpful.” (Female, 30-34, urban)

Another woman who had managed to access residential rehabilitation in another case study area was positive about the experience:

“The first week was murder, terrible! But after that, it was fine, it was good. Got you up and got you motivated and stuff, and it helped me obviously get back in with my family to see my kids and stuff. ... I think if I didn’t get into rehab, I wouldn’t have been here, I was that bad.” (Female, 25-29, semi-rural)

Waiting time for rehabilitation places or even community-based treatment could be a major problem for people interviewed, particularly those who were homeless:

“Six weeks was the shortest time to get any rehab and they put you through all these tests, test, test it. It’s impossible it really is; personally it’s impossible. You’re asking for help there and then, you’re saying to them, ‘I want to do this’ and then by after six weeks you’re – I mean six weeks on the streets, living, peeing and shitting in a corner, you’ve no toilets...” (Male, 40-44, urban)

“Well, a lot of the time when you’re sitting and you’ve hit rock bottom and you’re trying to get to the addiction services and you want the help there and then...By the time you get an appointment with the addiction services you’re in a different place, you know what I mean... When I needed their help, I couldn’t get their help you know what I mean, because I needed them there and then. Sometimes you’ve got to wait 12 weeks for an appointment, maybe longer to try and get put on a blocker or a methadone programme.” (Female, 45-49, semi-rural)

A key fear for many women in particular was their children being taken into care, however there were cases where it seems to have been possible to avoid this outcome, with the right kind of support made available to vulnerable mothers with complex needs

Some people were struggling to come off methadone prescriptions or to get the intensity of drug treatment support that they felt that they required:

“I’m stuck on methadone now 13 years for now, know what I mean, now feel I don’t need it and I feel I could go on without it now, know what I mean? (...) I don’t really see anybody, you know, it’s just basically go and pick a prescription up. I’ve not got a worker, not got like a counsellor that’s - so I feel as if I’ve just been left, you know what I mean? Basically, ‘There’s a methadone prescription, away you go man’, know what I mean?”

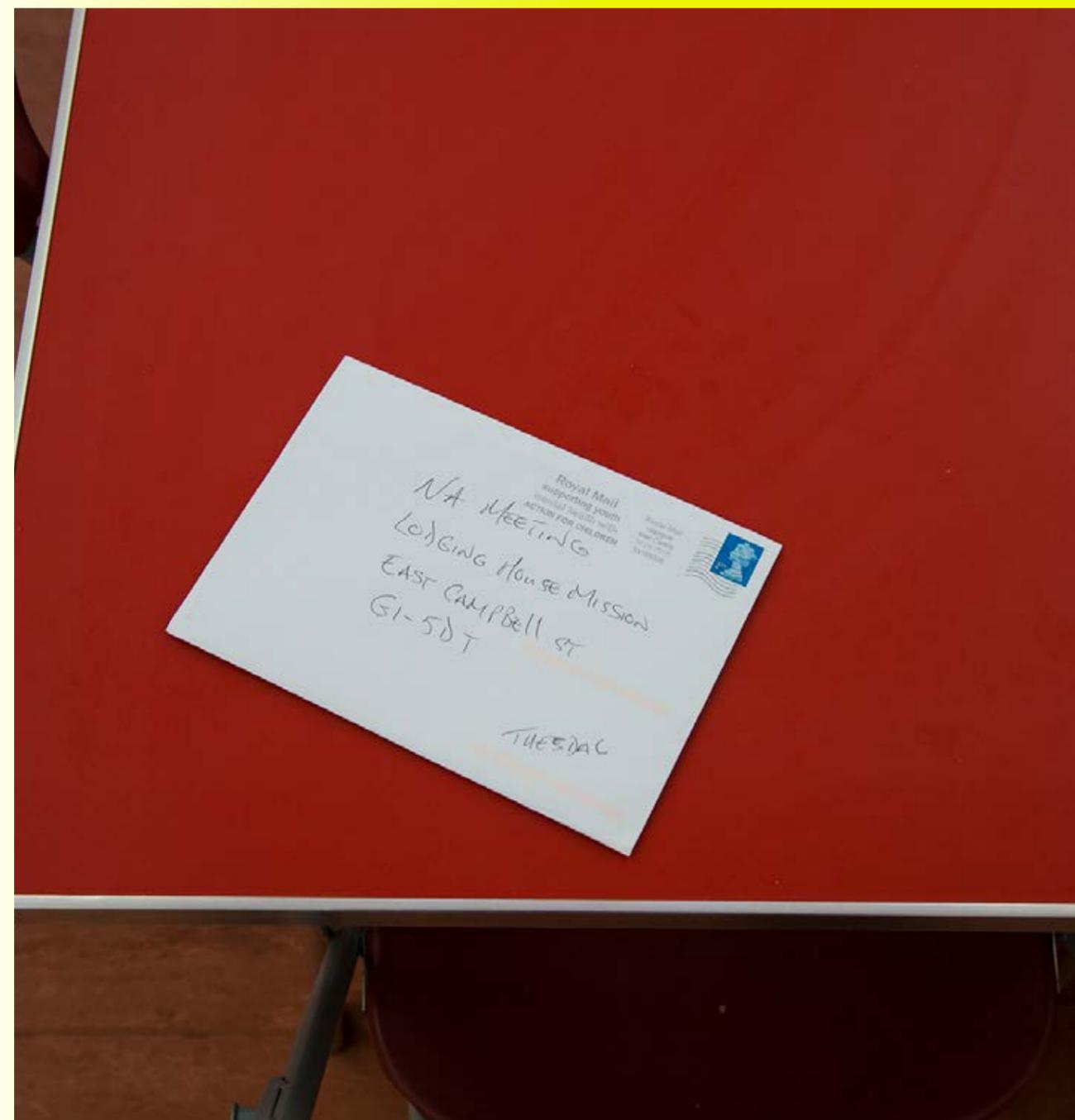
(Male, 35-39, semi-rural)

However, another woman who has been on methadone for 11 years felt she was not ready to come off the treatment:

“I don’t want to be on it for the rest of my life, but right now it’s stabilising me. If I came down off it I would just be setting myself up for a failure straightaway, and I recognise it and realise that.” (Female, 30-34, semi-rural)

A key fear for many women in particular was their children being taken into care, however there were cases where it seems to have been possible to avoid this outcome, with the right kind of support made available to vulnerable mothers with complex needs:

“At first I was a bit afraid about going because my kids are under social work. I didn’t want anybody to know that I’d been using drugs or anything. But once I’d told everybody I felt a big weight lifted off my shoulders. I told my mum and my dad what I had been doing, because nobody knew that I was living like that. People just thought that I was still living at home and everything was all right because I didn’t look... as if I slept in closes [stairwells] or anything like that. I was



lying to everybody all the time but the - yes, the drug services have been a big help to me...” (Female, 30-34, urban)

Quantitative analysis of the drug treatment dataset tends to confirm a picture of treatment outcomes being mixed and often less positive than one would wish to see (see Technical Report .s.8.1). Overall, and depending how one counts certain cases where the outcome is unclear, one can say that between 29% and 43% of drug treatments were successfully completed. This proportion was lower for those in the more complex SMD groups, particularly where homelessness was involved. These figures appear to be rather lower than those reported for comparable services in England (Burkinshaw et al, 2017; Bramley et al, 2015).

Homelessness

Virtually all people interviewed had made homelessness applications, usually on several occasions.

This is in keeping with Waugh et al's (2018) findings that almost half (46%) of people who had experienced homelessness alongside substance issues since 2001 (almost all of whom also had MH problems) had made repeated homelessness applications.

The application process was generally appraised as straightforward, although one interviewee bemoaned the lack of personalisation:

“...obviously they do that every day and you just feel as if – they don’t even look at you sometimes when they’re filling in the paperwork, it’s just a case of your name, blah, blah, and they’re like that.” (Male, 35–39, semi-rural)

There were mixed reviews of statutory homelessness services, which turned very much on the housing outcome achieved at the end of the process. For example, one person described the service they had received as ‘first class’:

“Two weeks ago, I got a permanent property that I’m happy with. They’ve given me help and that.” (Male, 50–54, urban)

However, another interviewee from the same urban area found his assessment for permanent housing stalled several times due to the service saying he was not ‘engaging’, while he felt that they were insufficiently proactive:

“The homeless [service], for example, are always telling me that. ‘Well, you’re not engaging’, but I’m like that, ‘But I’ve given, made an application, so I’m assuming you might get in touch with me’, do you know what I mean? I’m thinking...I’m homeless, so it was long [time before I heard from them] ... nothing, so I would expect you would just phone or something.” (Male, 25–29, urban)

Interviewees in more pressurised housing market areas reflected on the difficulties they faced in getting suitable rehousing, or even their basic statutory needs met:

“If you want something decent you have to wait at least over a year. It’s getting worse now though...Rubbish, rubbish. My council officer couldn’t even find my house when she was taking me to view it. I had to show her. She kept getting my name wrong. She put me in a damp flat knowing that I’ve got asthma. Twice

she put me in the same flat. So I got moved out. They painted over it and put me back in it again. [...] I think a lot of them haven't actually been trained to deal with it so they don't really bother. They just say, 'Yes, oh you're a drinker, all right, see you.'" (Male, 35-39, urban)

"It's really bad now, it's just ridiculous that you cannot get a B&B. You've gone to the council, you need to be going for three weeks and you need to be there every morning at half past eight and to just try and get a bed and breakfast, and you're going to get told no at least 20 times: no, no, no. [In the past] it was easy enough; it was you'd just go to the council and you'd get a B&B every time, hostels or..."

(Male, 40-44, urban)

The picture of SMD adults achieving less good housing outcomes through the homelessness services is confirmed by our analysis of the HL1 data for the period 2013-17 (Technical Report, s.8.2). In Scotland a majority (59%) of all homeless households accepted by local authorities obtain rehousing into social housing. While this is even more the case for 'homeless only' cases (62%), the share drops off for some of the SMD groups, with only 50% of SMD2 (3D) and only 33% of SMD3 (3D) getting social housing. Homelessness with DVA and homelessness with MH are groups which do rather better, with shares similar to homeless-only (62% and 58% respectively). Comparing with the earlier period (2007-10), social tenancies have increased as a destination for statutory homeless households in general, but least for those who are SMD3, have substance use issues, or with MH problems. Concomitantly, there have been no reductions in the proportions of some SMD groups ending up in hostels, returning to previous accommodation or moving in with friends and relatives, unlike the situation for statutory homeless households in general.

A key theme in the urban areas in particular was the variable quality of hostels and other temporary accommodation used by homelessness services (see also Watts et al, 2018). While some specific hostels were praised others were consistently described as 'bad':

"...X is...night and day compared to the other ones... it's not in your face, no one's pushing you to drugs down there. You've got a cooker, you can cook your own food, you've got that sense of freedom down there which I'm really,

I'm really enjoying it... With the help of talking to these at [X] and they're really good down there at supporting you and anything you need, whether it's budgeting, whether it's cooking, whether it's social services, whether it's court. It's good to have that on hand, do you know what I mean, when you need it." (Male, 25-29, urban)

Another point made was the inappropriateness of some provision from an equalities perspective³³:

"...I know the [X] is a [religious] place, and all that, but they've got to realise they're letting people in what are under the LGBT group... I've been, like I said, in that centre for about six or seven months, and the staff think I'm the only one in there what's actually gay, but it's not true. There's actually a couple of boys in there what are bisexual, and they're not even out, because they don't feel like they can come out because of their families, and they don't have any support..." (Male, 25-29, urban)

No matter which hostel people had been to in the past, a recurring theme was the stress and short notice of needing to move on:

"I'm fed up packing and moving, packing and moving. I had it all growing up, I had it going into one care, to another care home, to the last one I went to, and now I'm bouncing about and I can't do it any more" (Male, 25-29, urban)

There was also disappointment with the inadequacy of 'floating support' in some temporary furnished flats:

"You're just basically left. I mean I moved into that temp furnished and you're meant to have a support worker...and they might come out and see you once a week or whatever but to be honest with you I think I've only seen the

woman twice the full time that I was in the flat and that was it....she didn't have to say much else to be honest with you, know what I mean? She was just basically coming out to see me because she had to!" (Male, 35-39, semi-rural)

The extra security and peace of mind attached to permanent social housing was articulated by some interviewees:

"I've got the stability that it's local authority, where I know that the council will follow all the laws and procedures to the best of their capability. Whereas if it's private rented, you're not always guaranteed backing with a private landlord. I have got the peace of mind that I'm council. I wouldn't never go back into private again, no." (Male, 40-44, semi-rural)

Several interviewees in one semi-rural area commented on enjoying being allocated a permanent home in a smaller, more rural area:

"[X village] is beautiful... A little local pub, and a couple of local drinking holes... it takes ten, 15 minutes to get out to in the car, but then that saves the idiots on a Friday night taking the hour walk past the window. Better than being in the city centre, I think." (Male, 40-44, semi-rural)

But rurality also caused problems for some people:

"I think just now the only thing that bothers me is boredom. Being stuck in the house, not being able to get out of that. For somebody to come up normal, it's ten minutes from my house to the shop, but for me it's an hour to the shop, and an hour back." (Male, 50-54, semi-rural)



Mental health services

Many people had been in contact with MH services over the years. Positive experiences of these services were hard to come by, but Community Psychiatric Nurses (CPNs) were praised by two interviewees with severe and enduring problems.

“It was good to have a CPN when I came out of hospital, a nurse who met up with me once a week for so long. We had to have a coffee. That kept me focused. I didn’t want to get into trouble, and I would tell them, ‘Oh, I’ve done this, or I’ve done that.’”

(Male, 40-44, semi-rural)

“Well, I see the same CPN; it’s now monthly. But I see him every month. A great guy; I could talk to him about anything. He’s put me right at my ease, and I think it’s broke me out of myself a bit, because I used to be a bit reserved, and I wouldn’t talk about certain things, and stuff like that. But, aye, it’s all been good, aye.” (Male, 45-49, urban)

Many others were critical of mental health services, emphasising that you had to be at absolute crisis point before any help was forthcoming:

“...you have to self-harm before they even listen to you.” (Male, 25-29, semi-rural)

“I had to go to the extreme lengths of severely battering my own head against the wall to the point where I was causing blood to come out before they started listening. Then within five minutes of me doing that, they all come rushing in...Aye. I was not listened to, ignored, and not taken seriously.”

(Male, 20-24, urban)

The Lived Experience groups had emphasised precisely the same point, and also criticised the inadequacy of reliance on prescription medication for mental health problems. This latter point was again strongly reinforced by interviewees:

“Just tablets through the doctor but not really helping us, no; put you to sleep at night and that’s about it.” (Male, 35-39, semi-rural)

“...they usually go for the pill and goodbye strategy. ‘Try this one, if it doesn’t work, come back.’... I’ve been on a lot, diagnosed when I was 19 with severe depression and stuff and I’ve been on medication ever since. I think I’ve been through 12, 13 different types for depression alone.... I’m pretty sure I’ve probably cycled back to a few.” (Male, 20-24, urban)

“I went through seven different doctors and gave them my [mental health] symptoms and my daughter was sitting right outside. I gave them my symptoms and I was like that. She was like that, ‘It sounds like you’re depressed and that. Antidepressants and that.’ Well, I was on Valium before, so I know what medication, what ... and they’re like... the next [appointment] is...six, seven weeks [later], and I was like ... I got that annoyed because my daughter was like, ‘Dad, you seem to be going in a circle.’ I says, ‘Aye. That’s why I’m taking you with me because I think I’m losing it.” (Male, 55-59, urban)

“A great guy; I could talk to him about anything. He’s put me right at my ease, and I think it’s broke me out of myself a bit”

Domestic violence services

While most of the female interviewees had experience of DVA, only a minority reported experiences of DVA-specific services, possibly in part because services such as refuges do not accept women with active drugs problems in some areas.

However, the difficulty of escaping perpetrators in smaller towns, even once in a refuge, was apparent from this account:

“I left him umpteen times. (...) [I got] myself into [refuge] to get away from that. Once they got me there, it only took him a couple of weeks to find me.” (Female, 25-29, semi-rural)

Another woman from the same case study area illustrated the long process and setbacks that can be involved for survivors of DVA, even if they manage to access specialised support:

“I would say the first time I went [into a refuge], my heart wasn't really in it, because I had just lost my weans. Do you know what I mean? I was listening to other weans greetin and all that. It was all uphill, so I never gave it a chance. I was there for two days and left. So I just couldn't take it any more. [The second time used DV services] I've worked with [refuge provider] for over a year. I had an outreach worker, and I'd done.. a 13-week Moving On Group thing, as well. It's recognising domestic violence, but then I went straight into a relationship like that again.” (Female, 30-34, semi-rural)

There was no mention in these interviews of Perpetrator Programmes perhaps because such programmes are not much developed or supported in Scotland.³⁴

Social work services

As noted above, there was significant praise from people interviewed for the work undertaken by some criminal justice social workers, but the relationship with child protection social workers was, perhaps predictably, often expressed in more pejorative terms.

Some people's dim view of child protection social work stemmed from their own negative experiences when in the care system:

“I think I was 16, 17 years of age, when I was meant to be getting my own flat, I found out my social worker had made it very clear to my mum that she wasn't welcome at that meeting, that she had no right to be there, there was no place for her there, and it actually made my mum cry, because they made her feel so horrible, like, she wasn't allowed to be at a monumental step in her own child's life.” (Male, 20-24, rural, CSE)

Given the imperative to keep children safe from harm, especially in the context of family violence and/or substance dependency, relationships between child protection social workers and interviewees who were parents were often fraught with conflict:

“...because he [ex-partner who had hospitalised interviewee] went on the run. He wasn't caught straightaway... ‘Your children will be returned to you once he gets caught.’ Then obviously he gets caught three months later and I've been smoking - I wasn't taking drugs. I'd been smoking hash and drinking and stuff like that. So now I've needed to prove myself to them before they can give me my kids back. I'm honest with them: I've said to them, ‘Yes, I'm drinking a bottle of cider every day’...I used to think, well, I'm being honest and you're just all shooting me in the face with the stuff that I'm telling you sort of thing, so using that against me.” (Female, 30-34, urban)

The wide variation in the quality of support offered by individual social workers was a theme picked up by several interviewees. This young woman was very critical of a social worker that she felt had been unresponsive to her needs:

“She used to tell me that, ‘Oh, phone me whenever you need me.’ I used to phone her

nearly every single day and she would never, ever answer me... The only time she would speak to me, it was obviously when she came to see me once a week and that was with a worker sitting there. So, I couldn't really speak about anything, really, that I felt comfortable speaking about. I used to text her...I'd phone her when I had money on my phone and she used to just ignore me all the time." (Female, 18-19, urban)

Her current social worker, on the other hand, was:

"....absolutely brilliant! She's a Godsend, she's helped me with so much, like today with the housing and just stuff like that, stuff that I wouldn't have been able to do myself. She's really, really helped me with, whereas...my social worker back in the day, she wouldn't have helped me with anything... Stuff like when I used to go and see workers and stuff, they would be late for stuff...It sounds so picky but it's just she's never late for anything, she's always there, she's all the help in the world, everything that she can possibly help with, she will, and she goes out of her way to actually try for you." (Female, 16-19, urban)

A young man, who had committed sexual offences and had a history of mental ill-health and experience of care, also reported contrasting experiences of social work services, with the team in the rural area he now lived in offering a much better service in his view than the city-based team that he had previously interacted with:

"The [city] team, there was a few things I could say there, but I'm trying to keep it polite and civil. Actually, the whole of [city social work], but, never mind on that. The [rural social work team], they've been exceptional in the help that they've given me." (Male, 20-24, rural)

"It sounds so picky but it's just she's never late for anything, she's always there, she's all the help in the world"

Benefits

Another service that came in for mainly negative comment was Department for Work and Pensions (DWP) services. However, in this case this related mainly to money, or the lack thereof, rather than relationships with individual staff members.

In fact, people often felt that there was no relationship with individual staff members in this rather 'faceless' bureaucracy:

“I don't know, the benefits system's all changed, and having to phone people. You don't really get to see people face-to-face any more. It's a different person you're seeing every time, you've got to go over the same thing. You're telling your story over and over again, you know what I mean? Answering the same questions time and time again, filling in the same forms. It's just, everything seems harder to access. ...Aye. I find that difficult to keep up with, really. That's stressful, stuff like that. I feel as if I need a mentor for stuff like that.”

(Male, 50-54, urban)

The difficulties that people with complex needs and chaotic lifestyles faced in meeting the benefit conditionality requirements was evident:

“Never had any money for about four months ... I have no family and that, man, and aye, I lost all that. I've had to use stuff like them [foodbank and soup runs] recently, aye. Sometimes when you phone [DWP] up, man, they offered you a foodbank, you're that annoyed... last time I didn't even miss an appointment. They just told me I missed an appointment and I told them, 'I never got the letter', and he told me, 'That's no! - I'm sorry, we can't accept a reason for missing an appointment.’” (Male, 25-29, urban)

“I just got taken off my [18 month] sanction this year. That's when I started begging. I never used to beg but I had to do it because I had no other way of getting money. I didn't steal. Foodbanks are no good to me. They only do so much.” (Male, 35-39, urban)

Whereas another interviewee who had committed sexual offences and had problems with his mental health, but seemed generally stable and motivated, with no substance dependency issues, had a very different experience:

“The DWP, the Jobcentre, they’ve been exceptionally good. They’ve been exceptionally understanding, and really helpful.” (Male, 20-24, rural)

Universal Credit was described as a ‘nightmare’ by those with experience of it. Issues included the long waiting time to receive the first payment and the sense that local Jobcentre staff did not fully understand the way Universal Credit works:

“In the olden days, they could at least tell you, ‘You’re not getting it because you’ve done that’, instead of going, ‘I don’t know, you’re just not getting it.’” (Male, 45-49, semi-rural)

People’s accounts of Jobcentre staff revealed that some were proactive in informing clients about options such as benefit advances while others were more reactive. For example, one interviewee had arranged fortnightly Universal Credit payments and direct rent payment, as is permitted in Scotland but not elsewhere in Great Britain, but this was only because he enquired about these options.

Lack of computer skills and struggles with form-filling were also raised:

“I don’t really fill in forms. Well, I do fill in forms, but I’ll get help for maybe the [charity], or just a support person; somebody to support me. Because I’ll end up putting the wrong things in, the wrong information in, or not enough information in.” (Female, 30-34, semi-rural)

Other people raised issues they had had with disability-related benefits, especially Employment Support Allowance (ESA), and the transition from Disability Living Allowance onto Personal Independence Payments (PIP). It was clear in many cases that they had needed the help of voluntary organisations to secure the benefits to which they were entitled.

“[I went from] ESA to Jobseeker’s, and then they stopped my PIP at Christmas. But I had a series of appeals; two appeals at the Department of Work and Pensions. A so-called independent appeal. But it didn’t feel very independent, because from what I was feeling

it was like negativity. It wasn’t like a positive thing; it was like [makes angry noises]. It was like police interrogation almost. I was like, wow. Do you know what I mean? They didn’t seem to have any empathy or sympathy.”

(Male, 45-49, urban)

People often felt that there was no relationship with individual staff members in this rather ‘faceless’ bureaucracy

SYSTEM-WIDE ISSUES

Across all of the people interviewed who were using relevant services, good services seemed to be characterised by two key interlinked features:

The provision of emotional as well as practical help, and 'personalised' support tailored to the specific individual.

“They [hostel staff] are there to speak to if you’re upset about something, like you may be having a bad day or that.” (Female, 45-49, semi-rural)

“There’s no point just going through the same plan as everybody goes through, know what I mean?” (Male, 35-39, semi-rural)

“I think it’s recognising where you are. It’s not just their plan for you; you’re putting a bit of your work plan into action as well. So you’re both working on it: you and whoever the organisation you’re working with.”

(Female, 30-34, semi-rural)

Some voluntary sector services, as well as some social work and other statutory staff (see above), were thus praised for providing practical support in an emotionally sensitive way:

“...there’s somebody here [day centre] if you need to speak to someone. They’re helping me with any paperwork I’ve got, appointments that I need to keep, basically just they help around the house. If it was any further than that I’d probably have lost the house just through stupidity, through not keeping things right or whatever, but this place helps me in hundreds and hundreds of ways.” (Male, 40-44, semi-rural)

“...if there’s anything wrong with your benefits, with your housing, anything, they’re pleased to help.” (Male, 54-59, semi-rural)

“...the staff are friendly and they talk to you like you’re human, not like you’re just another client or something.” (Male, 35–39, urban)

It was very clear across the piece that people’s perception of services – particularly those services with which they had sustained engagement like social work, hostels, addictions and (in fewer cases) mental health – depended overwhelmingly on how individual workers engaged with them at a ‘human’ level.

“So just make yourself friendly to them. Just go out and approach them. Not everybody is as bad as you think. Alright people will tell you to eff off, but a lot of people won’t. Just make it more accessible and make it freer.”

(Male, 35–39, urban)

These individual relationships and attitudes mattered much more to them than ‘systems’ or broader organisational features. People interviewed appreciated frankness and reliability in frontline workers, and also ‘stickability’, not giving up on them if ‘they failed to engage’ or missed appointments on occasion:

“I missed an appointment, but they got me mixed up with the appointment dates... it wasn’t my fault, so it’s sad, again, but obviously you can’t, if you get cheeky with them, they’re just going to get you lifted³⁵ anyway.”

(Male, 50–54, semi-rural)

“It would be nice to think that no matter what issues someone has had, they’ll always have a roof over their head. I don’t like the thought of everything where you can still end up out on the street if this goes wrong in a hostel. You can end up literally homeless. I think there should always be somewhere for someone, no matter what issues they’ve got...”

(Male, 40–44, semi-rural)

With regard to services focused on more directly ‘material needs’, and with which they had more transitory contact, like social security and statutory homelessness services, people’s perceptions were more directly aligned with practical outcomes than with

the emotional engagement of the workers they encountered. Nonetheless, while some people can cope with new technology and are happy to deal with services at a distance, it was clear others prefer more personal contact:

“I prefer seeing people face-to-face. See just giving people phone numbers all the time, and then putting them on hold, and stuff like that, that’s really, really frustrating. I like to get given an appointment, and go and see somebody. To give people phone numbers all the time, and I’ve no computer skills whatsoever, and, ‘Go to www.’ That all just goes over my head.”

(Male, 50–54, urban)

The potential role for peer support from people who had been through SMD themselves was a strong theme emphasised by the Lived Experience group, who took the view that peer relationships are often more positive than professional ones as they are built on a shared understanding of the damage caused by being judged, the importance of hope for the future, and the reality of the fear felt by people every day³⁶. This theme of peer support didn’t arise as often with the service users interviewed, perhaps because few had experience of this model, but one service user did comment:

“I suppose what I’m really getting at is there’s something major missing there. There needs to be something there that people – I needed somebody to be there and tell me what [life] was like outside of foster care, like a befriender, a mentor, a positive role model. [...] I never had that, no. There was role models in my life, and that was characteristic role models for behaviour and things like that, but to actually give you insight on what the world’s like, nobody tells [you] about these things. You learn them for yourself and you get to a certain age and when you’re applying for jobs, you get turned down because you’ve not got the required experience. There’s something missing there.” (Male, 25–29, urban)

With regard to services sharing information about their clients, feelings were mixed. Most interviewees seemed happy with the idea of their details being shared across agencies with their consent:

“I think it’s a case of giving your story over and over again, you know what I mean? I think it would be better if they did know your story. You’re basically going from the one to the other, to the other, and telling the same thing over and over again. Then they’re sitting there writing it down and putting it in their file. See if I could give them my consent, ‘You contact them’, ‘You contact them’... [at the moment] It’s a wee bit splintered.” (Male, 40-44)

“The amount of times I’ve been to – so I’m trying to get moved into this hostel, but the amount of times I’ve been there and had to answer the same questions, it’s repetitive. I’m like, ‘Just put something on the system, so you can look it up, see what I’ve said to you before’ but no they don’t do that. That is irritating. It’s time-consuming. Time stops you from moving forward because it makes things boring. So if you’re constantly going back to the council and that, and you’re giving the same speech...”

(Male, 25-29, urban)

However, another view was that there was no guarantee the staff receiving a referral would read past the first line of any notes, and this may mean the individual was (mis-) judged on the ‘headline’ notes without getting to know them and building a trusting relationship:

“I understand it would be better if one person passed it on, but then are they going to read [it]. It’s like they don’t read your files so it doesn’t really matter whether they picked it up or not.... Yes and that’s it and then you need to explain yourself anyway so...” (Female, 30-34, urban)

“...it’s always good to have somebody to know your situation and not have to sit and explain yourself over and over again, but on the other side you don’t want to be judged by what your [past] so there’s two different sides to that.”

(Male, 35-39, urban)

These concerns echoed issues raised in both of the Lived Experience groups, although particularly in the men’s group that:

staff in services look at your past before your future, judging you on ‘bits of paper’ rather than getting to know you and taking you ‘at face value’.



MISSED OPPORTUNITIES

Asked about missed opportunities for earlier interventions that could have helped them avoid SMD as adults, some service users could not identify any such opportunities, or emphasised their own agency and that of other people in a similar position

“I would say things happen to people and the decisions people make, I suppose, in life. I think the decisions I made in life were taking me down the path that I was going down and, in my opinion, the first service out of the three that we’re discussing. The first service I accessed was for help with my addiction. I can’t say I was let down by that at all. I couldn’t have got in there earlier because I had to identify it first. I think that’s the case no matter what. You’ve got to identify it yourself. You’ve got to recognise you’ve got a problem and address it.” (Male, 50-54, urban)

But amongst those who felt they could identify missed opportunities, education and schooling was a recurring theme:

“Yes counselling at school; I never got any counselling at school, or one to one. Just one teacher shouting and bawling, trying to get 40 people to listen. Everyone else playing on their phones - or it was computers at the time. Not interested... Everyone just run amok. That’s where my downfall is, at school.” (Male, 20-24, urban)

There were also issues that became apparent at school that earlier social work intervention might have helped with:

“When I was a kid, I had really bad behavioural issues, and my mum kept asking for support with me, and she kept getting told from social work, ‘Oh, there’s nothing wrong with him.’ They kept putting it down to bad parenting. When I was eight years old, I went and got a

test done. I didn't complete the test, but I'm on the... autistic spectrum.... they said to my mum, that I was on the spectrum, they just didn't know whereabout to medicate, so, all growing up, my mum was asking for support. All growing up, there was no support. Then when I was in behavioural schools, and the fights, and everything, were still kicking off, I was still getting no support. The school was trying to support me, social work weren't."

(Male, 20-24, rural)

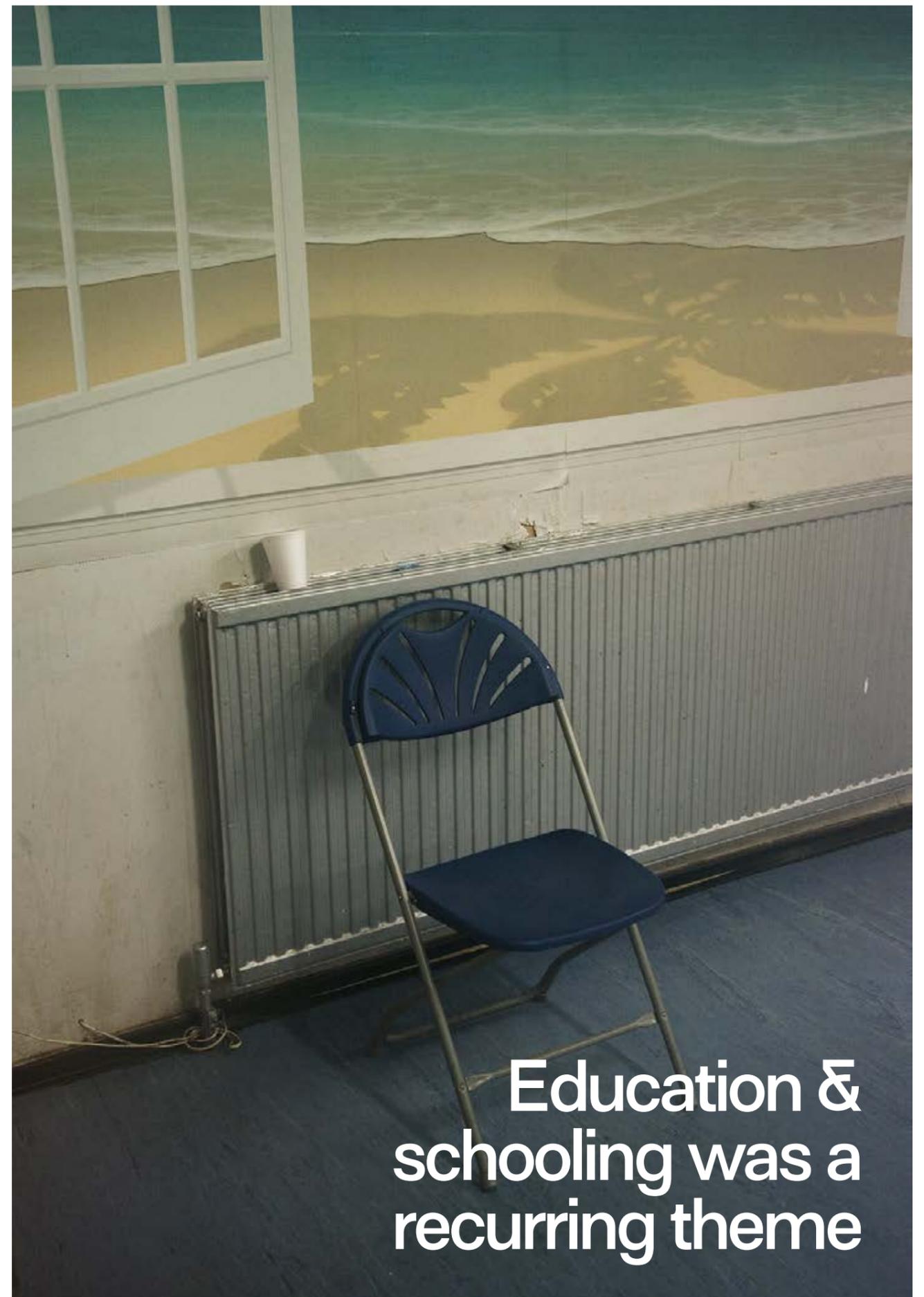
The point at which they left care was identified by others as a missed opportunity, allied with the inability to return to care and receive help when they were readier to accept it:

"When I left care, I think that was the main one, obviously. I know I was saying, like I say I didn't want any help but after that, after a lot of years I realise I shouldn't have done that and it was too late, so... basically once you've signed that, social work have washed their hands of you. Aye, and I always think, oh fuck, if I'd never done that things could have been different, know what I mean, but it's... I think I would have probably stayed in the supported accommodation for longer, a good bit longer..."

(Male, 35-39, semi-rural)

Another recurring theme was earlier access to mental health support and/or substance dependency support, with this individual flagging opportunities to intervene via the criminal justice system:

"I started a couple of wee charges when I was about 17, 18, 19. I was getting a couple of charges here and there, and it was all drink-related. I think if...somebody new comes into court, a new charge, first charge, and it's drink-related, some sort of help there because



it could escalate to what happened with me. Obviously, I lost everything, like that, totally everything because of it. I think maybe at the very start of trouble happening...Nip it in the bud there and then...but [also] I think, see, hearing it from somebody that's actually been through it and stuff like that, that would have been maybe a wee bit of an eye-opener as well.” (Female, 30–34, urban)

The theme of having a service network with 'no wrong door' came through strongly in the Lived Experience Group discussions and was picked up by this individual:

“Well, I'd like to think that people should – or I think people should have noticed it. A) I was walking about zombified out of my head, 2) I was walking about dirty, dishevelled, all the rest of it; everything that goes with drug abuse. So surely someone – because I was still having to go to get my prescription every fortnight and whatnot, go to the housing and stuff like that. I'd like to have thought that someone should have picked up on that and referred me somewhere. That would have been good. I think workers, in housing departments, and stuff like that, that are dealing with people who are called vulnerable, through drug abuse, or mental health issues, or whatever, they should keep an extra eye out for them. [...] And offer support, aye. They should be, maybe, not retrained, but trained in a different way to be more compassionate.”

(Male, 45–49, urban)

This suggestion for training to emphasise compassion and kindness in service delivery chimes strongly with new elements in the Scottish Government's National Performance Framework, but this 'relational' approach to welfare services is not without its critics (see the discussion in (Unwin, 2018)).

“They should be, maybe, not retrained, but trained in a different way to be more compassionate”

HOPES FOR THE FUTURE

“My absolute target in life is to make sure that my kids will never ever see anything that I’ve seen”

A key missed opportunity identified by the Lived Experience groups was that in all of their interactions with an array of services, there was seldom any attention paid to the positive potential they may have or their hopes for the future. Group participants were not looking for the language of ‘goals, assets, or aspirations’ (seen as remote), just a sense that they could have something worth living for and may even be able to make a constructive contribution to the lives of others.

**Overcoming addictions;
establishing and maintaining
a settled home; and (re)
building positive family
relationships, particularly
with their children**

Looking to the future or identifying priorities was certainly difficult for some service users we interviewed:

“I don’t think about it, to be honest. I don’t. Just every day, you take it a day at a time. (...) You asked me what do I like doing, and I can’t even tell you.” (Male, 45-49, semi-rural)

“Not got much motivation for a lot of things, hey.” (Male, 25-29, semi-rural)

But for those able to identify hopes for the future, these consistently focused on three intertwined priorities: overcoming addictions; establishing and maintaining a settled home; and (re) building positive family relationships, particularly with their children:

“So I got pregnant and I just thought I don’t want her to have the life that I’ve had, and I want to actually give her a good life. It doesn’t matter, I’ve not got a lot to give her, but as long as I’m there for her and she knows I’m there for her and she knows I love her, then that’s the main thing. But through drink that’s not going to work because if I drink I’m not going to stop drinking, and it’s not going to be a nice life for her.” (Female, 30-34, urban)

“My future is hopefully to get this house properly sorted the way I want it, have a nice home, a nice place for my son to actually come when he does come.” (Male, 40-44, semi-rural)

“My absolute target in life is to make sure that my kids will never ever see anything that I’ve seen, and I’ll leave something behind and to give him a bit of a head start in life. All of that’s motivation for me...I’m not a bad person but the way my head is... Honestly, I literally get to a point where it’s a fantasy

we'll meet, where I'm like right, 'I'm your dad,' and...just loads of wee pressures like that."

(Male, 25-29, urban)

For those who felt stuck on methadone, coming off this was often a prior goal:

"I'd like to come off methadone. I've started the reduction, but I'm scared. I've got a fear of not going for it in the morning, not having that drink of methadone in the morning, although I don't feel like I'm on anything... but I've got a fear of not going for my methadone in the morning, it's a strange thing... I've kind of accepted who I am, what I am and you know what I mean? I'm not married, I'm on my own. I sometimes get - I feel lonely. I'd like to get a partner, but I don't feel like I've anything to offer ... I would like to go back to work." (Male, 55-59, semi-rural)

"I want to get off this methadone before I do anything.....see, my dad says to me, son, if you get off that methadone in a year, I'll get you driving lessons, I'll buy you a car, that's what he says he's going to get is driving lessons and buy us a car." (Male, 30-34, urban)

Several people interviewed had a trade or work experience in their background and wished to return to this in future or were pursuing volunteering or college opportunities. For some, this was combined with the theme of 'giving something back' to those who had helped them, or to people experiencing similar trauma to that which they had faced:

"...they want me to work on my health, and my mental health as well first. Once I'm in a good place with that... I still try and do volunteering, and all that. I used to be a volunteer for [charity], doing a cooking class, and teaching young people about budgeting,

"I actually felt great, and even all the staff loved me, and they praised us"

homemade cooked meals... I actually felt great, and even all the staff loved me, and they praised us, and they went like that, 'All the young ones, they can't stop talking about you. They love it. They get you, they can actually talk to you, and it's good because some of them don't feel like they can talk to us', because I've been through the same situation." (Male, 25-29, urban)

"I'm thinking about going back to college to do a social care course, so maybe work with ex-drug - well, people that have got drugs addictions or alcohol addictions, or even work in hostels or something, to give something back. Do you know what I mean? Because if it wasn't for places like hostels and that, I would have had nowhere to stay for five years." (Male, 45-49, urban)

FRONTLINE SERVICE PROVIDER

In order to bring into sharp relief the contrasts and continuities between system responses to people facing SMD in different parts of Scotland, we conducted 'vignette' analysis with focus groups of frontline workers in six case study areas.

Vignettes are hypothetical but 'typical' cases, intended to provide a discursive 'safe space' for workers to explore what happens in practice in such cases. The vignettes were constructed to probe at the 'boundaries' and dilemmas of responses where possible, and were based on extensive prior qualitative and quantitative research in this field (for example, Fitzpatrick et al, 2013; Bramley et al, 2015).

By placing the person, rather than the services, at the heart of the analysis, vignette analysis is also intended to bring a whole system and its interactions into focus. By and large the participants in the focus groups found the vignette cases recognisable and relevant to their practice, and commented extensively on how such cases would typically be responded to by services³⁷.

PERSPECTIVES

1 MARY

Mary, who is now aged 20, had a difficult childhood and spent a few months in care when she was 14 years old after running away several times.

Mary left home aged 17, after a particularly bad fight with her stepfather who has an alcohol problem. At first she stayed with an aunt, and then various friends. She moved in with an older boyfriend for a while and when she was living with him developed a heroin habit. They split up when he beat Mary up so badly that she was briefly hospitalised. She then approached the local authority for help and was placed in a homeless hostel, after completing a residential rehabilitation programme for heroin addiction. She is currently 'clean', but says it is very difficult to avoid using again when "surrounded by users" in the hostel.

Though Mary has never been to prison, she has been convicted of shoplifting several times, which she says she did to support her drug habit and that of her ex-boyfriend. She has a history of self-harm and has attempted suicide at least once. She is still afraid of her ex-boyfriend, though he hasn't tried to contact her for a while.

Most focus group participants agreed that Mary's case sounded very familiar, although one did comment that, typically, Mary would have a child:

"She doesn't have children yet which would open up a whole other avenue of other agencies being involved and vulnerabilities." (HL, urban)

Across the case study areas, a whole array of services were identified as being relevant in Mary's case – addictions, statutory and voluntary sector homelessness services, criminal justice, specialist domestic violence services, and mental health – but there was far less agreement on whether in practice she would actually receive these services.

In particular, and strongly reflecting points made by the service users interviewed, there was serious doubt cast on whether she would be able to access the mental health support that she needs, especially if she starts using heroin again:

"Actually accessing mental health services is really hard in [X] ..." (SW, urban)

"...we've experienced this a lot at.... when someone, so to speak, goes off the rails, we phone the mental health services that they're engaging with, however they won't engage with them if they have used because their condition at that time is drug-induced. So they won't even bother coming." (HL, semi-rural)

Another problem identified in virtually all case studies was a shortage of local drug rehabilitation services, which were often described as either non-existent or "really thin on the ground". Access to these services was said to have declined in some areas in recent years. In one urban case study, a desperate situation was said to have occurred in a few cases whereby women in particular would commit a crime in a nearby city in order to gain access to the rehabilitation facilities there:

"...we have had women who have actually deliberately gone and offended and committed an offence in [X] to appear in [X] Sherriff Court"

so that they could have access to [rehab]... my understanding is, [these rehabs] are inundated as well, so the agreement is that organisations like [rehab service] ...are all just for [city] people... but if you commit your offence in [city] and you appear in a [city] court you will be considered for [a rehab service in the city] .”

(CJSW, urban)

Some focus group participants thought that Mary would be entitled to through-care support from social work, on account of her care background. But one group was swiftly corrected on this assumption by a social worker in the room:

“Because she was in care when she was 14. So she wasn't looked-after and accommodated by a local authority at the time for her 16th birthday so she wouldn't have access to child care through care services.” (CJ, urban)

However, another social work colleague thought that there was a “a bit of a grey area”, for example if Mary’s offending meant that a court report was requested from social work on account of her offending, it may be that through-care services would be explored as a possible avenue for support. It was generally agreed that, if Mary had a court order against her, criminal justice social workers would likely coordinate her support:

“...women involved in the criminal justice system, like Mary, often have very complex issues, very complex needs, and no one agency is going to meet all those needs. So our service, the [criminal justice social work service] is very much getting the women linked-in to as many support networks as possible and that doesn't mean signposting because signposting very often doesn't work. You physically need to take women into places for the first couple of occasions.” (CJSW, urban)

In the absence of a court order, the consensus across most case study areas was that homelessness services would be in the lead. The difficulty here, though, is that homelessness services have little power to command the wider support services that someone like Mary needs:

“...we've experienced this a lot at.... when someone, so to speak, goes off the rails, we phone the mental health services that they're engaging with, however they won't engage with them if they have used because their condition at that time is drug-induced. So they won't even bother coming”

“Well, I think once she is homeless there is a statutory duty to find her accommodation and that would certainly mean my team [homelessness services] and that's about the only thing that would be around her that has something that must happen. I think it is easier when you've got somebody who's on an order with social work because there just seems to be more resources that can get put in place. All I can do is put them into supported accommodation, a hostel and get a bit of housing support and that's – as well as making the referrals that everybody else can make but referrals don't always pan out. Sometimes they take months to get back to you... It's difficult.” (HL, urban)

Across all of the urban case study areas, there were major concerns expressed about Mary's ability to stay off drugs while living in a hostel with other users:

“...you're not going to be staying clean if you're in a homeless unit in [X city]. There's absolutely no way that's going to happen. 100 per cent not.” (DA, urban)

“It's very difficult to go and get clean, and still [be] living in a hostel full of drug users.”

(HL, urban)

However, it was far from clear that any action would be taken to help her move out of this damaging environment:

“I mean if I was her caseworker and she was coming back and saying the hostel environment was making her feel that she was going to relapse then for me I would move her, I'd move her into a temporary furnished flat. Whether that's a typical thing

that happens...I couldn't say whether my colleagues [would do the same] (HL, urban)

In one urban case study, the point was made that, while at age 20 she would in principle fall under their youth-focused Housing Options service but it was very difficult because “...you know, obviously she's very vulnerable but we do have to look at 16 and 17-year olds for accommodation first.” (HL, urban). More generally, the sharp drop-off in support post-16 was remarked upon:

“...it's like a cast of thousands when you go to children's hearings and then they hit that magic age of 16 and then there's no one there... So by the time you get to 20 you're very disillusioned I would think at the services... and damaged.” (H, urban)

“I would say in this scenario, this girl's done really well to get what she's got, but she'd kind of be left to her own devices, now. If she wants to go to [drug services], it's up to her to do that.... the hostel I would think would, maybe encourage it or suggest it, but nobody would want to take a lead role. It would have to come from her, I would suggest...” (DA, urban)

Another common unmet need identified was around keeping Mary safe from further domestic violence. Survivors with addiction problems (even when on methadone) were often said to struggle to access specialist refuges. One homelessness practitioner told of a recent case where:

“They [refuge provider] kept asking about her [service user] addiction and how chaotic she was.... I'm just like, 'Why are you asking all these questions. This is a woman that's fleeing domestic abuse?' I put the woman on the phone to [them] and she'd come off in absolute tears saying the way she was spoken to, the questions she was asked, it made her feel like she was a perpetrator. I actually went back on and made a complaint

about it because I was just so angry...” (HL, urban)

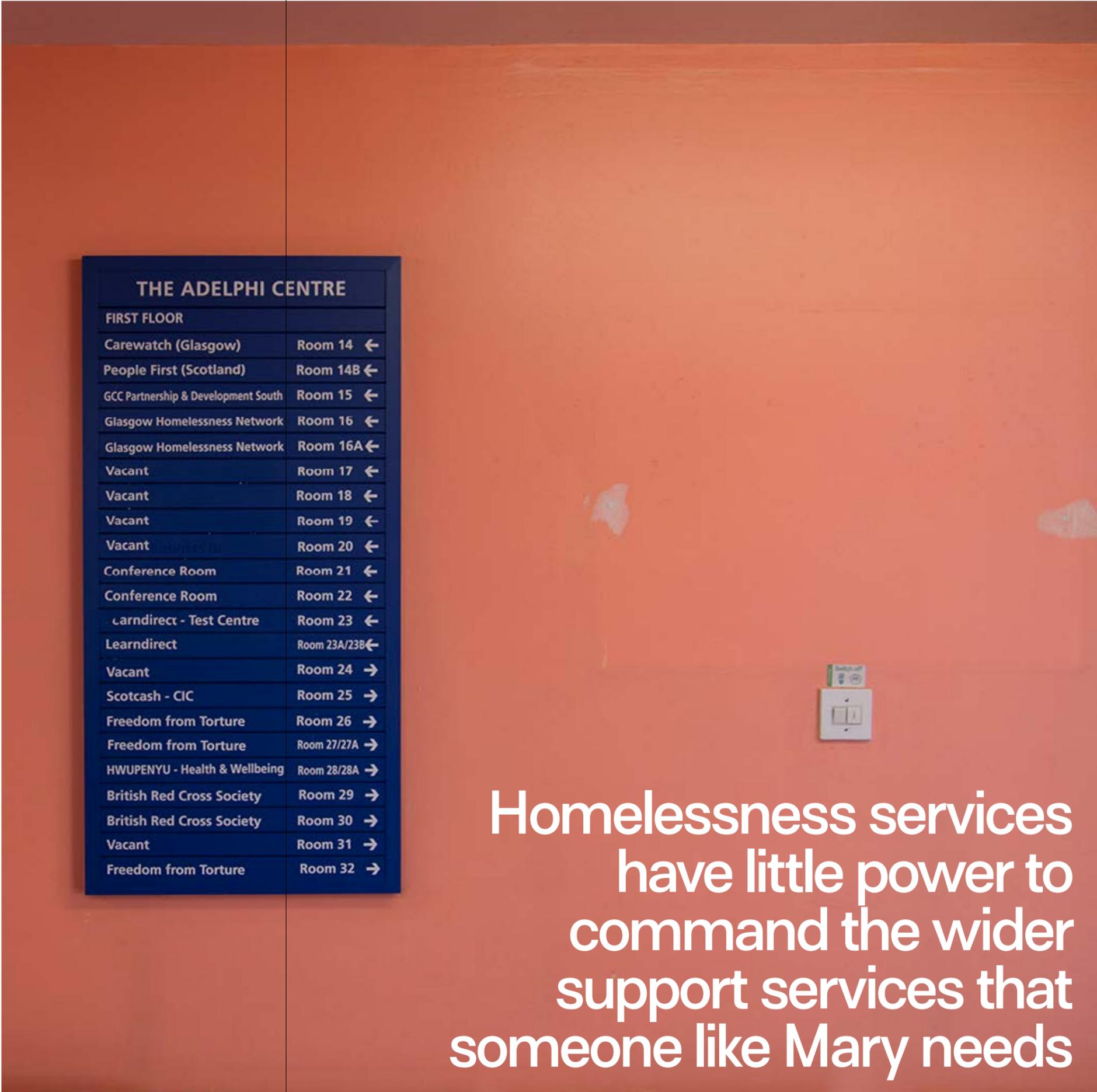
A further option mooted in just one (urban) case study area was that, in light of the extreme nature of domestic violence that Mary had experienced, that she could be discussed at a Multi-Agency Risk Assessment Conference (MARAC). This would involve third sector agencies, housing/homelessness, mental health, education, addictions, domestic violence services, police and other services, and should result in an action plan to support her to which they all sign up. However, some of the third sector workers present had not heard of MARAC, despite very frequently supporting women who were living in continued fear of their abusive ex-partners:

“In my ignorance I've never heard of it [MARAC], which is quite shocking really in all the years. And I was just thinking of one service user just very recently... she would tick all the boxes, completely and utterly...I've learnt something new today.” (O, urban)

It became apparent that, whatever the shortcomings of the response to Mary in the relatively 'service-rich' urban areas, in the semi-rural and rural areas it was generally weaker again. In one of these areas, there was a strong emphasis on Housing Options staff sorting out practical matters for Mary, such as assisting her with benefit applications and checking whether she may qualify for 'Domestic Violence Easements' on conditionality requirements. Consideration would also be given to whether there is a risk of DVA and accordingly whether Mary should go to a hostel or temporary accommodation or whether to refer her to specialist refuge accommodation.

Rather shockingly, however, in another semi-rural area, such was the absence of relevant crisis support for someone in Mary's position, that frontline workers there said that, should she appear to be a danger to herself, they would seek to have her arrested:

“We would make a point of getting them arrested, probably for a breach of peace so that they're in a safe place. I mean imagine it is a Friday night that they get picked up, they're in the cells until Monday and hopefully they're assessed by the



THE ADELPHI CENTRE	
FIRST FLOOR	
Carewatch (Glasgow)	Room 14 ←
People First (Scotland)	Room 14B ←
GCC Partnership & Development South	Room 15 ←
Glasgow Homelessness Network	Room 16 ←
Glasgow Homelessness Network	Room 16A ←
Vacant	Room 17 ←
Vacant	Room 18 ←
Vacant	Room 19 ←
Vacant	Room 20 ←
Conference Room	Room 21 ←
Conference Room	Room 22 ←
carndirect - Test Centre	Room 23 ←
Learndirect	Room 23A/23B ←
Vacant	Room 24 →
Scotcash - CIC	Room 25 →
Freedom from Torture	Room 26 →
Freedom from Torture	Room 27/27A →
HWUPENYU - Health & Wellbeing	Room 28/28A →
British Red Cross Society	Room 29 →
British Red Cross Society	Room 30 →
Vacant	Room 31 →
Freedom from Torture	Room 32 →

Homelessness services have little power to command the wider support services that someone like Mary needs

medical team at the prison cells and they take it from there really.” (HL, semi-rural)

In the rural case study the sense was that Mary would end up being signposted here and there but with only one agency having a statutory duty – homelessness. While homelessness may seek to make referrals to other agencies, no one would take an overall coordination role. If she failed to attend an appointment with addictions services it was described as “one strike and you are out”. Again, it was flagged that mental health services in particular would cease to work with Mary if she was “not engaging”, with the long waiting lists for these services stressed.

It was noted that the wide geographical spread in this rural area made attending appointments difficult for many service users, and transport costs could be a particular barrier in both rural and semi-rural areas, as well as making the delivery of peripatetic services more challenging:

“...one of the challenges is trying to have some sort of equity of service across the whole [local authority area] because everything is quite [large town] centric, and certainly in terms of the specialist substance use services they are predominantly based in [large town]. Again, there are good reasons for that. I mean we have feedback from a number of people in rural areas, actually they prefer to come into [large town] because they have the anonymity, but that is if they have the transport to actually get into [large town]. Obviously, if they don't have the transport, then that's an issue we have to try and address.” (KI, H, semi-rural)

Generally, across the case studies, there was a sense that Mary was the kind of person who would ‘fall through the cracks’ between the services and, unless she were on a court order, there would be little coordination of her case:

“...she's not enough of an addict. She's not enough of a mental health patient. She's not enough of a criminal, you know. She's just not enough of anything to get like a package. So she would be one of those people that would fall off because – until a crisis came.” (KI, DVA, urban)

Focus group participants suggested services can be very proactive in developing a coordinated plan to meet the needs of children, but when it comes to adults:

“...the onus is upon the adult to then go and look for that support. When you're dealing with the likes of [substance dependency treatment service] because of their heavy caseload, you know that someone has difficulty with relapse but if they don't turn up for appointments they get a couple of shots and then they're closed and whereas you need someone like that to actually take them literally by the hand and do that TLC stuff to get them through the next stage because they haven't got the framework to support themselves I would say.” (O, urban)

2 JOHN

John is 44. He had a fairly stable upbringing, though his family didn't have much money.

John worked as a painter and decorator after he left school but by his late 20s he had developed a serious alcohol problem, split up from his long-term girlfriend and lost various jobs. John has been involved with a community rehabilitation programme in the past but is currently drinking quite heavily on a daily basis. He has a 10 year-old son from a short-lived relationship whom he rarely sees.

John was evicted from his social tenancy for rent arrears, slept rough for a few months and then moved into a hostel where he has been for more than a year. He spends a lot of his time drinking in a public park as part of an established 'street drinking school'. He has served a prison sentence for assaulting his ex-girlfriend.

Across many case study areas, a dilemma identified with cases like John's was that on the one hand, there was often an acute lack of residential rehabilitation facilities, if he was ready to stop drinking; and on the other, there was also often an absence of 'wet'³⁸ accommodation options, if he was not.

In one urban area, there were alcohol recovery services available, including 'sticky' key workers who could help with a host of practical issues, and also supported hostel facilities that were dry. But all this was predicated on his being ready to address his drinking.

In another city case study, practitioners emphasised the likelihood that John would also have a mental health issue. Echoing points made by a range of service users, one frontline worker here, and several elsewhere, associated John's case with a strategy of some service users to deliberately go to prison in order to find a place of some care:

"...for some clients, I'm sure like John, who will deliberately go and do things like shoplift so they'll get a custodial sentence, because it's safety, security, they're looked after, they'll get care. Some people - like is not the word; that's completely the wrong word, but it's those other things that - so they're not like, 'Oh, fantastic, I'm going to jail', it's not like dancing down the street, but it's like a bit of relief."

(HL, urban)

"...certain people go out intentionally to break the law, so they can go inside... I had a female today - she's due at court tomorrow and she's asking the judge for her sentence.... I mean some of them in that situation see prison as the only solution for them to be able to go and get help... a few weeks ago she said she was actually thinking about going out and committing a crime, so she would be arrested."

(HL, semi-rural)



“Like this gentleman...He felt extremely secure in prison. He had a job in prison. He has purpose in prison. If he needed to see a doctor he could see one that day. If he needed whatever it got done immediately whereas where you come into the big wide world that doesn't happen...” (HL, semi-rural)

In the remaining urban case study, hostel support workers were said to be the main likely support for John, with local ‘wet’ facilities available. It was thought that he may well be offered access permanent accommodation, but some voluntary sector frontline workers commented that there was a high likelihood of John returning to their hostel when the tenancy failed:

“... it becomes a bit of a revolving door that we find it hard to engage with them once they move into their tenancy and they end up losing it at some point in the future...” (HL, urban)

This voluntary sector service would continue to support John after he got his tenancy, but only for eight weeks, which was considered likely to be insufficient. While addictions services in this area might also engage with John:

“They have very short-term interventions with alcohol services and there's not that kind of stickability from our alcohol services when it's kind of, 'Well they don't want to attend, that's fine.'” (CJSW, semi-rural)

In one of the semi-rural case studies, a priority intervention in John's case was said to be ensuring that he has housing support (because he has been evicted for rent arrears) and linking housing support with addiction services. There was a lot of emphasis placed on people like John actively ‘engaging’ with the available services, rather than the services reaching out to them:

“...it's that they come and they ask for help and they want it. It's a choice.... It's a three-week waiting list, then they get referred and then they go into an allocation meeting and everything, but it's down to them if they attend their appointments. If they don't they would go back to the beginning again.”

(DA, semi-rural)

“It is ultimately their decision whether they engage, because [you can] knock their door and be annoying and stuff, but it's whether they engage or not.” (FP, semi-rural)

In reflecting on the limited assistance that John would receive with his alcohol problem, a participant in the other semi-rural case study stated:

“They go to [X] Hospital to a ward, they're there for seven days but it's their [service user's] responsibility to look for any care or any support that they want after the programme... They're there for seven days and it's an intense programme and then after that seven days, bye. See you.” (HL, semi-rural)

In order to experience full residential rehabilitation services, John would need to travel far from this semi-rural area, and on his return it is unlikely that longer-term support would be made available to him:

“If people have got no accommodation and they went through maybe six months of rehab and then they come back to [X]... and start again and they're given an empty shell of a house. They're given no support worker... Basically they come out of rehabilitation, that door shuts behind them and they're on their own, which must be extremely frightening at the end of it. The thing is I mean anybody

I feel that's going through this process of rehabilitation has the right to structured support and part of that support plan should be what is there and what do we need to put in place for this person, when?” (HL, semi-rural)

In the rural case study, it was again thought homelessness would take the lead role, and maybe the only role (unless criminal justice also had a statutory duty). Nonetheless, it was thought it would be difficult for John to get another social tenancy because of his rent arrears. While there is a local protocol in place for those leaving prison to ensure that there is somewhere for them to go on release, this was reported as yet to be tested. Unless John wanted to stop drinking then it was thought unlikely that mental health services would supporting him, though it was possible that addictions services would “keep plugging away” so there isn't a missed opportunity in the future when John is more open to help with his drinking.

Housing First³⁹ was mooted as a potential option for someone like John in a couple of (urban) case study areas. In one, there was support for the model, but also a caution that it “won't work for everyone”. In another area, where there had been several years of experience with Housing First, there was considerable enthusiasm. Housing First was said to have ‘stickability’ that worked well for people with complex and multiple needs. The wrap-around and peer support provided in the Housing First programme was viewed as exemplary by participants in this focus group:

“They've [Housing First] got a peer worker. I mean that's one of the big things. There's been somebody who's either went through criminal justice, homeless, addictions or mental health and has come out a year or two clean and have done bits and bobs of voluntary work... When I hear ‘peer work’ I usually close my eyes because it's usually that they bring somebody, oh this person used to be ... It feels quite patronising but [this] one's brilliant.” (HL, urban)

Although John has a child, children's social services here and elsewhere would not be involved in supporting him unless the child was living with him or “something is flagged up”. Nor were perpetrator programmes to address his DVA mentioned in any of the case study areas.

Across the case studies, the lack of timely coordination between services in cases like John's was remarked upon:

“Whether they're in the hostel, whether they're in prison, whether they're in rehab, anything

like that, it's about the communication and the coordination of what's to happen then I think that's missing... they run like hamsters here and then they're going round and round and round and round.... no ongoing support for the adults in this position.” (HL, semi-rural)

“Because you would speak to them potentially when they were in a slightly more stable place and say, 'Right, let's do this. Let's get it all organised, let's get it done'. By the time it takes to actually arrange everything and get them organised, then they could be away from that stable place.”

(DA, urban)

Time and again, the point was made that health services can be particularly uncompromising when it comes to people like John:

“...it's three appointment letters and then you're off, case closed, which is maybe fine for you and I, but when you are talking about this vulnerable group who have addiction issues, mental health issues, do they really stay in the house at the address that they gave? No, they don't. Three appointment letters and then that's the case closed.”

(CJSW, semi-rural)

That said, for service users such as John, who have known abilities and skills from earlier in life, there was some optimism amongst focus group participants that, whilst assisting him would throw up many challenges to the system, it is possible for him to have long-term positive outcomes with the right sort of help.

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3 MICHAEL

Michael, aged 34, has been sleeping rough 'off and on' for nine years. He started smoking cannabis and binge drinking when he was 14 and has been injecting heroin since he was 21. He begs on a daily basis to fund his habit.

Michael has only recently moved to this city/town/area from another part of Scotland. His health is poor: he suffers from Hepatitis C and has bad abscesses on his legs resulting from intravenous needle use. Michael was a serial school truant, has no qualifications and has never had paid employment. Some of the workers he has been in contact with suspect he may have mild learning disabilities but there's been no formal assessment.

Across all of the case study areas, Michael was thought to be a particularly difficult case to manage. It was thought unlikely he would receive much support, if any at all, and that any assistance forthcoming (such as it was) would be uncoordinated and targeted on meeting only his immediate crisis needs:

“Unless someone makes an adult protection referral and then a whole legal process kicks-in where the council officer has a duty to investigate and potentially get some kind of formal assessment as to what his disability, what his needs are.” (CJSW, urban)

A key challenge was that he would struggle to gain homelessness support from the local authority unless he could establish a 'local connection', which would not be easy:

“It would depend how long he was sleeping rough I guess and where he was sleeping rough. It's a fairly strict six months, if you don't have any other local connection which would be a family member or a job and full-time education. If it wasn't six months then it would - well it would depend. If it was me, I would get in contact with his local authority and find out a wee bit of background about what's happening. Depending on the time of the day, you know, it may be possible to get him into accommodation because he's entitled to a 28-day investigation [period].”

(HL, urban)

Unless the local authority accepted a statutory homelessness duty, there would be only the voluntary sector and churches to help with his basic needs, even in the larger urban areas, unless he was picked up by the police or had been admitted to hospital. In a semi-rural area:

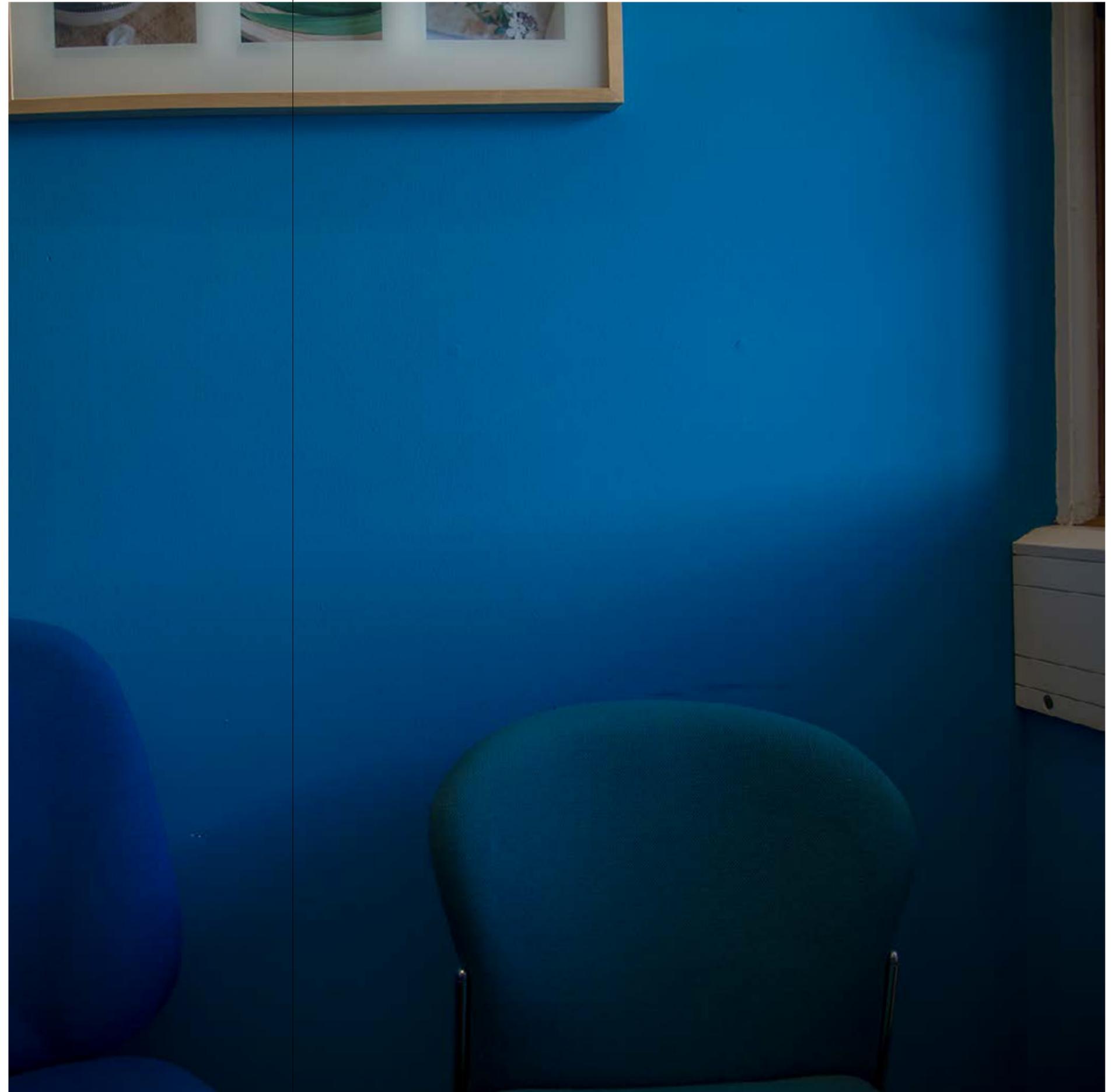
“...although they wouldn’t be housed they could still come up here and get their meals and things like that, even if they didn’t have a local connection. If they presented here as homeless, we would still like support them with filling in forms and meals and could have a shower and things.” (HL, semi-rural)

In the rural case study, it was thought that homelessness would take ‘lead’ but this may only be to “send him back to where he came from”. Even if he was picked up by a GP/hospital he would then be referred on to homelessness services, which may prompt the same outcome.

In one of the urban areas, specialist medical treatment to deal with his physical health problems would be available and not so dependent on local connection, but access to a methadone prescription may take some time to sort out because relevant services are “so short-staffed, and [service users] have to jump through lots of hoops.” (H, urban). Stigma and other difficulties with accessing mainstream health services were emphasised:

“When it comes to the abscesses and things like that, that are on Michael’s legs, we have nurses with us at all times, and we do get a lot of people coming in for things like abscesses. They don’t want to go to their GP because they feel like there’s a stigma.” (H, urban)

“One of the barriers there actually for a lot of my clients maybe coming from hostels, it’s self-worth. So they’ll say that every service they’re accessing or like GP, primary or secondary care for instance, they feel like they’re being



treated in a very ‘down’ way and they say they need me to be with them because they can’t put their point across or they don’t feel they’re being listened to or they’re treated very differently when I’m not with them.” (O, urban)

In a semi-rural case study, too, they worried that health professionals may not assess him properly whilst he has an active addiction:

“...when the assessment comes and they [service users] fail to attend, you know, it tends to be the three strikes and you’re out. You’ve had an appointment with the hospital, you fail to attend. We may intervene and try to phone back, absolutely. There were special circumstances, they forgot the appointment, blah blah blah, and they may get issued another one but there’s definitely not a third one. That’s as far as it goes and they’re struck off.” (HL, semi-rural)

The discussion of Michael’s case brought into light other barriers to information-sharing between services. While statutory services such as health and social work were generally able to access relevant information, their counterparts in other services, especially voluntary sector practitioners, often reported a whole host of practical as well as data protection issues:

“It’s very difficult.... I think it’s culture, and practicalities. It’s also data protection issues, because a lot of people don’t understand data protection, in my experience. They see it as a big wall through which nobody can talk, but usually if you get the right permissions you can. So that’s a big issue as well. There’s also the case that Michael rocks up and says, ‘I used to see Joe at the centre in Birmingham. What was it called? I can’t mind.’ You’d be surprised how many people work with services who don’t know the name of the

Learning disability is commonly undiagnosed for people like Michael which can complicate their access to services

service they're working with. What you tend to find is there's also a lot of people who have different names, different identities. [...] Sometimes they've legally changed their name, and sometimes they give a different name. So that's a difficulty." (HL, urban)

Focus group participants across the case studies commented that learning disability is commonly undiagnosed for people like Michael which can complicate their access to services. Some discussions focused on the extent to which his cognitive abilities may have been impacted by substance dependency to the extent that it would be difficult to distinguish this from the learning difficulties. One urban group highlighted that an important matter here would be registering him for PIP, and once through this process his support need may be identified. The difficulty may be if his symptoms are mild, and they:

"...don't fit into any category to get support with that, and it's all gone down to addiction and so on. I don't really know what we do about that. I don't know where we find an answer to that." (H, urban)

The need for effective outreach services to connect with people like Michael was emphasised in one urban case study, and their absence lamented:

"He may not want support, and even if he does he may not know where to go nor want to give up his [begging] pitch. The best way to reach Michael would be to go directly to him, but this is not always possible in terms of the resources or the ethos of services." (O, urban)

So too, the failure of the current system to address the trauma that clearly lies behind his current circumstances:

"...how many lines is that [vignette]? You know that somebody's experienced significant trauma just based on that information and nobody will work on that." (HL, urban)

Discussion of this vignette again surfaced the use of the criminal justice system as the ultimate safety net:

"I'm sitting here thinking it's awful that at the point that he's going to really get [a] lot of support is when he does actually commit an offence. Because then he'll come in for reports and then you can say, 'Right, health. Break it all down in the various bits'. If he was to get a Court Order then you can say, 'Right, okay...housing here, you know, mental health. I can start writing to the GP and I've got that ability to do that, but [not] until he crosses that line, which he shouldn't have to.'" (CJSW, urban)



CONCLUSIONS

CONCLUSIONS

The Summary presented at the beginning of this report presented a relatively detailed and comprehensive account of the research findings. The purpose of this concluding section is not to duplicate this, but rather to draw out some of the major highlights, themes and lessons.

We would argue that the evidence and conclusions of this study add validity and further weight to the focus on SMD, both the original tighter (three-dimensional) and the extended broader (five-dimensional) definitions. We have shown that the people affected suffer the most extraordinary array of adverse outcomes in economic, social, health and wellbeing terms, while facing an extremely patchy set of service responses. We argue here that there is a powerful moral imperative to address these issues, as well as pragmatic economic and public interest reasons.

It must be recognised that there are distinctive, and potentially controversial, policy discourses which may be aroused when focusing on people experiencing SMD. These had a significant airing when think tanks and some UK Government

ministers sought to change the definitions of poverty, changes which were decisively rejected in Scotland. It was suggested that '.... the key drivers of poverty are family breakdown, educational failure, economic dependency and worklessness, addiction and serious personal debt' (Centre for Social Justice, 2012, p.4), a highly tendentious and misleading statement (Bramley & Bailey, 2018 p.353) but one which surfaces a view that, for certain groups (notably those with substance dependencies), poverty is a product of their own behavioural choices.

Clearly, drug or alcohol dependencies can contribute to worklessness and exacerbate poverty, and may be associated in some cases with family breakdown (possibly involving violence or abuse), with similar effects. However, what this report should have made abundantly





clear, particularly from the section based on personal accounts of 'routes in', is that adults currently experiencing SMD had generally had terrible, traumatising experiences in childhood and adolescence, for which they cannot be held responsible as adults. Furthermore, the statistical evidence, particularly from datasets with a longitudinal element, shows that the causation runs strongly the other way too, from poverty to SMD, often via educational failure, family breakdown and debt (Bramley & Fitzpatrick, 2017; see also Bramley et al (2018), s.13 & 15).

In engaging with SMD it is inescapable that issues of agency and choice are involved, and services are trying to break cycles of recurrent harmful choices as well as providing support. It is not easy and service outcomes will not always look positive, especially in the short-term.

Another aspect of the argument about the relationship between SMD and poverty concerns matters of scale. It is certainly misleading and damaging to argue or imply that SMD 'accounts for' a high proportion of overall poverty (as in, for example, Centre for Social Justice, 2012). Bramley & Bailey (2018, p.354) pointed out that SMD as measured in the original Hard Edges England study equated to between 2% and 5% of general poverty at that time; in our more recent study of Destitution in the UK (Fitzpatrick et al, 2018) we estimated that SMD accounted for about 15% of that most severe form of poverty, expanded to include experience of DVA, on an annual basis.

However, these comparisons do of course depend upon the definition of SMD; the former very low figure refers to the narrower original three-dimensional version in its 'Current' form.

The wider five-dimensional versions, or from the 'Ever' perspective, do involve greater numbers of people. However, for these wider definitions, the arguments about people making 'bad choices' do not apply in the same way. What this wider array of definitions and measures do show is that a larger number of people are touched and affected by SMD, or by at least one of its key components, taken over a lifetime. Particularly striking was the long-term negative impact of mental ill-health, and of homelessness, on economic as well as personal wellbeing.

We would argue that there is a moral imperative for society to try to help people experiencing SMD to 'recover' and move forward to a more positive situation. At the most basic humanitarian level that obligation stems from the suffering which people are experiencing. However, as the accounts

of 'routes in' make clear, there is a strong social justice case for helping people whose early life contained so many damaging experiences over which they themselves had no control. Further, the array of quantitative as well as qualitative evidence on the current quality of life of people with current or past SMD, as presented in this report, shows that people are being 'punished' many times over for transgressions whose roots were largely in childhood and not their responsibility as adults.

In this study, what has been revealed is a highly pervasive incidence of actual violence, or the credible threat of such violence, through the lives of people experiencing SMD (echoing McGarvey, 2017).

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In addition, there is a more utilitarian case to be made, once one counts the sheer financial and economic excess costs of SMD in terms of healthcare, crime and justice, benefits, and so forth; costs which were documented more selectively in this study but on a more comprehensive basis in the original Hard Edges study in England (Bramley et al, 2015). We would further argue that there is a common public interest in tackling conditions which contribute significantly to antisocial behaviour and lowered levels of trust and social capital in communities.

Sociologists sometimes talk of the 'symbolic violence' that certain classes in society experience as a result of the dominance of other groups.

Domestic and other forms of violence and threat underpin many of the Adverse Childhood Experiences (ACEs) which strongly influence youth transitions and the establishment of patterns of behaviour in adulthood which can be so challenging for services trying to help.

It has been generally understood that SMD tends to carry with it an additional burden of stigma beyond that just associated with low socio-economic status, and this may adversely affect the attitudes of communities, and of service workers, towards people experiencing it. While it may be argued that there has been some progress in opening up public discussion of some SMD-related experiences, including mental ill-health and DVA, and to some extent homelessness, such that they become somewhat more subject to public understanding and sympathy, this is arguably much less the case with substance use and offending, given their 'transgressive' nature (Bramley et al, 2015). A broader public and political understanding of the root causes of the whole spectrum of these SMD experiences, and of the devastating impact they have on people's lives, would, one would hope, help bolster constructive responses at both a personal and systemic level.

At the outset of this research there was an expectation that we would find much evidence of 'service silos' and a lack of holistic, 'joined up working' in responding to the multiple issues which people experiencing SMD typically have. The accounts of individuals experiencing SMD certainly confirm their multiple needs, and their

many frustrations in terms of ability to access relevant services, but they also highlight great variation in both the degree and appropriateness of response within and between service sectors. These seem to reflect both the presence or absence of relevant statutory rights and duties, and also the differing extent to which resources match needs, with MH services being clearly identified as the most inadequately resourced service relative to need (and hence least responsive). There is an obvious requirement to identify a clear lead worker who provides continuity of contact and case management, from whatever base service is most appropriate, and ways of achieving this should be addressed by Health and Social Care Partnerships.

Local service availability and quality also clearly varies a good deal geographically, as revealed by our case studies, with cities, semi-rural and deeper rural areas facing distinctive challenges. The cities have a high prevalence of SMD cases and face very large numbers, which is clearly challenging, but have the advantage of being able to develop or maintain more specialist services. It seems wrong that people living away from the cities should be denied access to specialised services, but they may need to travel to use them.

The individual accounts of routes into SMD through childhood and adolescence identify the key opportunities for upstream prevention, which lie especially in the education sector. Truancy and exclusion should be treated as strong warning signals, particularly when combined with early substance use, and much more substantial resources should be deployed to get children and young people back on track at this stage. Cuts in 'non-statutory' services like youth work need to be critically challenged as well, as these may play a key diversionary role in the teenage years.

The study highlights much good work within the criminal justice system, but it must be acknowledged that relying on this as a 'backstop' is an absolute last resort and not remotely a desirable longer-term strategy. Significant Scottish research on youth transitions and crime suggest that it is better to keep younger people out of the criminal justice system as far as possible (McAra & McVie, 2016).

The key role played by statutory rights and duties in forcing some sort of service response is aptly

illustrated by homelessness services, so often left to 'carry the can' when other services should be stepping up. But even when such duties exist they are not necessarily fulfilled in contexts where there is great pressure on resources, as can be seen from evidence of the large number of cases where homeless people are not secured the temporary accommodation to which they are entitled.

In addition to resource inadequacies, most notably in MH services but also in substance treatment, some gaps were identified: that is, situations where there were apparently no relevant services for particular types of case. This appeared to be the case in relation to DVA services for women who experience SMD, suggesting a need for innovation and possibly learning from elsewhere across the UK. Concerns were also expressed by some frontline workers about the lack of services for male victims of DVA, even in urban areas.

While resources are important in some cases, it is also the case that much can be done through workforce development and service design, and this may be key to some of the changes which are sought. There is much evidence from the qualitative studies of highly variable quality within service types between particular establishments (e.g. hostels) and between particular individual workers (in social work), which suggests a need for training, development and peer review. The wholesale development of psychologically- and trauma-informed environments is clearly critical here, and likely involves a coordinated training and development programme across a range of sectors. The new emphasis on 'compassion, kindness and dignity' heralded by the Scottish Government also implies a need for many organisations to reflect on how they deal with people, particularly those in need of emotional support, as is so often the case with those who face SMD.

Two final recurring themes from the qualitative research were 'stickiness' and 'timeliness'. The former refers to a style of case management where the worker remains 'on the case', working persistently and assertively to achieve progress and not giving up on people who 'fail to engage'. 'Timeliness' of service response was identified as critical in certain instances, notably substance treatment. There is a great premium



on seizing the moment when people are ready and motivated to change and engage with treatment. Delay can mean that the opportunity for progress is lost.

It is hoped that the findings from this study can help to inform a number of policy developments already in train in Scotland in the coming period, including the recently published 'refresh' of the Drug and Alcohol Strategy, and reviews of Youth Justice and wider justice policy, and of mental health services. We also hope that it may contribute to review of the Scottish Government's Performance Framework and key outcome indicators contained therein.

We believe that fuller use and value could be derived from a number of the data systems and surveys operated in Scotland, to better inform policy awareness and effectiveness evaluation, through the use of data linkage. However, our experience on this project, and recent experience of other colleagues working in this field, indicate that there are significant 'data governance' barriers currently preventing this which Government and other key stakeholders should endeavour to address as a matter of priority.



ENDNOTES & REFERENCES

ENDNOTES

1 https://www.heraldscotland.com/business_hq/17361039.world-class-housing-laws-risk-being-rendered-useless-by-repeated-breaches

2 <https://news.gov.scot/news/ending-homelessness>

3 The report by Sosenko et al (2019) is published in parallel with this report.

4 Hard Edges Scotland Technical Report

5 Note that further information on these datasets is provided below in the Methodology section.

6 In the SMD(3D) case there are 3 (single domains) + 3 (combinations of 2) + 1 (combination of all 3) making 7 categories overall. With SMD(5D) there are 5 (single) + (4+3+2+1=10 combinations of 2) + (3+2+1=6 combinations of 3) +(5 combinations of 3) + 1 combination of all 5 making 28 categories in all.

7 PSE 2012 Survey has a boosted sample for Scotland which means specific analyses for Scotland are viable, but MEH was targeted on selected services in seven cities of which only one was in Scotland. For this reason we do not include MEH in the systematic integrated analyses but refer to it on specific issues as appropriate.

8 This involved a survey in 2017 of nearly 3,000 users of crisis services in 16 areas across the UK, including two case study areas in Scotland (Glasgow and Fife).

9 The direct focus of this survey was extreme poverty and destitution, not homelessness; however, services for or used by homeless people were a significant part of the sampling frame and more detailed indicators of homelessness were available than for the other domains

10 We were required to apply to use SDMD via the NHS Scotland Public Benefit and Privacy Panel (PBPP) process, facilitated by the Administrative Data Research Centre, which took 11 months to secure approval and several more months to conduct the analysis in the ADRC secure lab facility. We applied to use the LS/CMI data (equivalent of the Offender Assessment System data used in the English Hard Edges Study) but this application remained stalled at the end of the two-year life of the project. We had expected to obtain additional tables from the Homelessness and Health in Scotland (HHiS) study, having contributed to the original research design and proposal, but permission to access these data were denied at a late stage in the project life.

11 It is also worth noting that, where we have evidence to indicate that there are significant groups experiencing a particular disadvantage but not using (particular) services, then we do adjust for this in the service-based estimates included in the weighting. Salient examples include homelessness, where evidence from SHS suggests that only 70% of people reporting experiences of homelessness retrospectively say that that they applied to the local authority; and substance (drugs) dependency, where the evidence from the HHiS study and the SCJS both suggest that the drug treatment programme (reflected in SDMD) is only capturing a minority of current drug users. There is also the issue of alcohol dependency which is not adequately measured through the service-based approach.

12 In Scotland we follow the statutory definition and so include homeless families, whereas in the English Hard Edges study the main focus was on single homeless people using Supporting People services.

13 The statutory homelessness arrangements are much more generous in Scotland than elsewhere in the UK in that single homeless people as well as families with children are entitled to rehousing (Davies & Fitzpatrick, forthcoming).

14 While the general approach of combining survey and survey-based estimates works in nearly all cases, for the category 'DVA only' there is insufficient service-based data to use

15 It may also be noted that the numbers for homeless, offending and substance-only are somewhat lower than in Figure 1, logically, because some of the people classified in this way in the 3D approach also have one (or more) of the additional disadvantages (MH or DVA).

16 Based on Scotland's 2011 census data – see: <https://www.scotlandscensus.gov.uk/ods-viualiser/#view=ethnicityChart&selectedWafers=0&selectedColumns=0,1,2,3,4,5,6&selectedRows=0,7,12,16>

17 The low-income indicator essentially focusses on the bottom quintile of equivalised income, or a similar measure, and draws on four datasets.

18 Based on (a) PSE survey, lacking 3 or more from standard set of consensually agreed material deprivation items, and having low equivalised net income after housing costs; and (b) Destitution survey, being destitute as defined in Fitzpatrick et al 2018, lacking two or more core essentials and/or having very low income.

ENDNOTES

19 This is a composite of standard housing need indicators including concealed and sharing households, households with affordability and security problems, overcrowding, suitability and condition problems, and also staying in hostels, temporary accommodation or sofa surfing with friends/relatives (see Technical Report for details).

20 This is mainly derived from the Destitution in the UK studies, but also using PSE data. See Technical Report for a detailed account of all of how these measures of material poverty were derived.

21 It is important to note there is some estimation and controlling involved in deriving these figures at local authority level. They should be treated as approximate estimates of the recent numbers. They are based mainly on three administrative datasets (SDMD, HL1, Criminal Proceedings), all subject to various grossing up adjustments to allow for people not receiving services and the difference between 'flow' and 'stock and flow' basis. Criminal Proceedings LA tables are 'experimental statistics' based on postcodes, which are only present for 82% of cases. There is also use of one sample survey, SCJS, which obviously is subject to wide confidence margins at this level. Information relating to the island authorities is particularly limited.

22 In this case, we focus on Current SMD 5D, rather than Ever SMD (5D), because local authorities and other bodies concerned with responding to these issues are likely to be more concerned with current numbers.

23 There are data limitations which mean these estimates for the island authorities should be treated with particular caution

24 DVA is also affected by data limitations, as one of the administrative datasets used in this analysis (SDMD) does not cover DVA.

25 The figure of 10% allows for people experiencing homelessness who did not apply to the local authority.

26 This could range from outright hate crime to various forms of anti-social behaviour.

27 In particular, PSE, SCJS and GUS. GUS has the added advantage of a panel structure that helps clarify the chronological order of experiences.

28 SDMD

29 Bramley & Fitzpatrick's (2018) paper 'Homelessness in the UK: who is most at risk?' in Housing Studies took a similar approach.

30 In all of the models we focused on the widest forms of SMD possible within that specific dataset, usually SMD(5D).

31 'Dogging' is Glasgow/west of Scotland vernacular for truanting.

32 A drug used to support the treatment of chronic alcoholism by producing an acute sensitivity to ethanol

33 Reference to be added to LCF-funded LGBT LCF work.

34 https://whatworks.college.police.uk/Research/Systematic_Review_Series/Pages/DA_perp_prog.aspx

35 Scottish term for being arrested by the police

36 The full report of this Lived Experience Group is included as Appendix A of the Technical Report.

37 Most of the quotations and evidence in this chapter comes from front-line staff, but in a few cases more senior 'key informants' (KIs) are quoted. The key to services is: CJ: Criminal Justice; CJSW: Criminal Justice Social Work; DA: Drugs & Alcohol/Addictions; DVA: Domestic Violence and Abuse; FS: Floating Support; H: Health; HL: Homelessness; O: Other; SW: Social Work

38 Accommodation which allows residents to drink some alcohol

39 Housing First involves rapid access to ordinary (private or social) rental housing for homeless people with complex needs, coupled with intensive and flexible support, provided on an open-ended basis.

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