New conversations about
severe & multiple disadvantage

HARD EDGES SCOTLAND

Summary Report

New conversations about
severe & multiple disadvantage

CONNECTED

Written by

Glen Bramley
Suzanne Fitzpatrick
Jenny Wood
Filip Sosenko
Janice Blenkinsopp
Mandy Littlewood
Claire Frew
Toriqul Bashar
Jill McIntyre
Sarah Johnsen

Hard Edges
Scotland

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

Contents

1

2

3

Acronyms list

A&E Accident and Emergency Department

ACE(s) Adverse Childhood Experience(s)

B&B Bed and Breakfast accommodation

CP Criminal Proceedings database (Justice Department, Scottish Government)

CJS Criminal Justice Statistics publication (Justice Department, SG)

CJSW Criminal Justice Social Work

DA Drug & Alcohol/Addictions

DATWT Drug and Alcohol Waiting Times database

DEST Destitution in the UK Survey 2017

DLA Disability Living Allowance

DVA Domestic Violence and Abuse

ESA Employment and Support Allowance

FS Floating Support

GP General Practitioner

GUS Growing Up in Scotland (Longitudinal Survey)

H Health

4HHiS Health and Homelessness in Scotland (Data Linkage research report)

HL Homelessness

HL1 Homeless Applicants Individual Record

MARAC Multi-Agency Risk Assessment Conferences (for Domestic Violence)

MEH Multiple Exclusion Homelessness Survey

MH Mental (ill-)health

NHS National Health Service

O Other

PIP Personal Independence Payment

PSE Poverty and Social Exclusion Survey

SCJS Scottish Crime and Justice Survey

SDMD Scottish Drug Misuse Database (alias SMR25a/b)

SHeS Scottish Health Survey

SHORE Sustainable Housing on Release for Everyone

SHS Scottish Household Survey

SMD Severe and Multiple Disadvantage

SMD(5D) Five-dimensional SMD - homelessness, substance dependence,offending, mental ill-health, domestic violence & abuse

SMD(3D) Three-dimensional SMD – homelessness, substance dependence, offending

SPS-PS Scottish Prison Service Prisoner Survey

SW Social Work

UC Universal Credit

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.

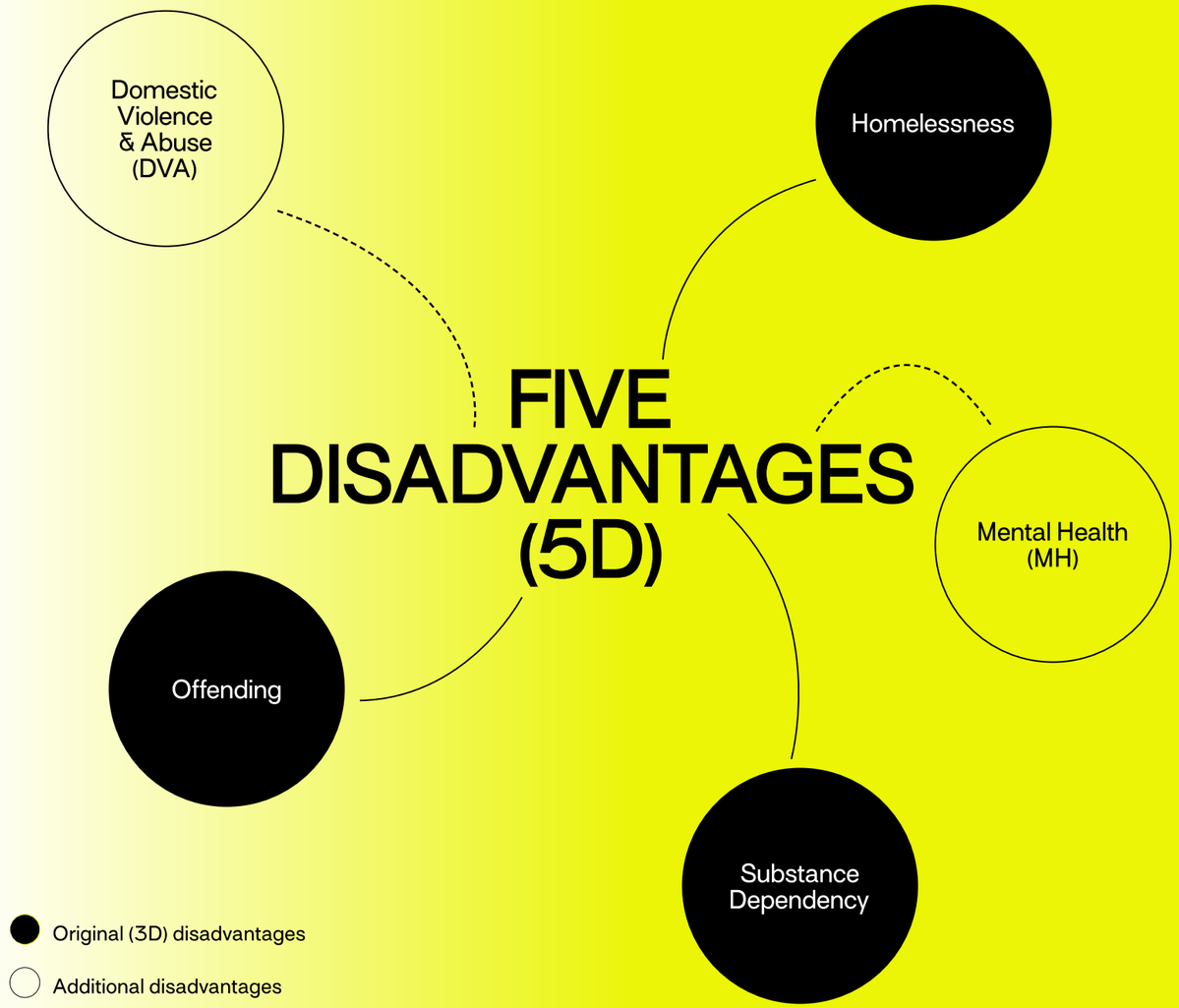
We retain this original three-dimensional (3D) version of SMD used in that study, in part to aid comparability with England, but mainly because the research team believe that this original definition of SMD has validity in focusing tightly on this particular group who face an exceptionally high level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



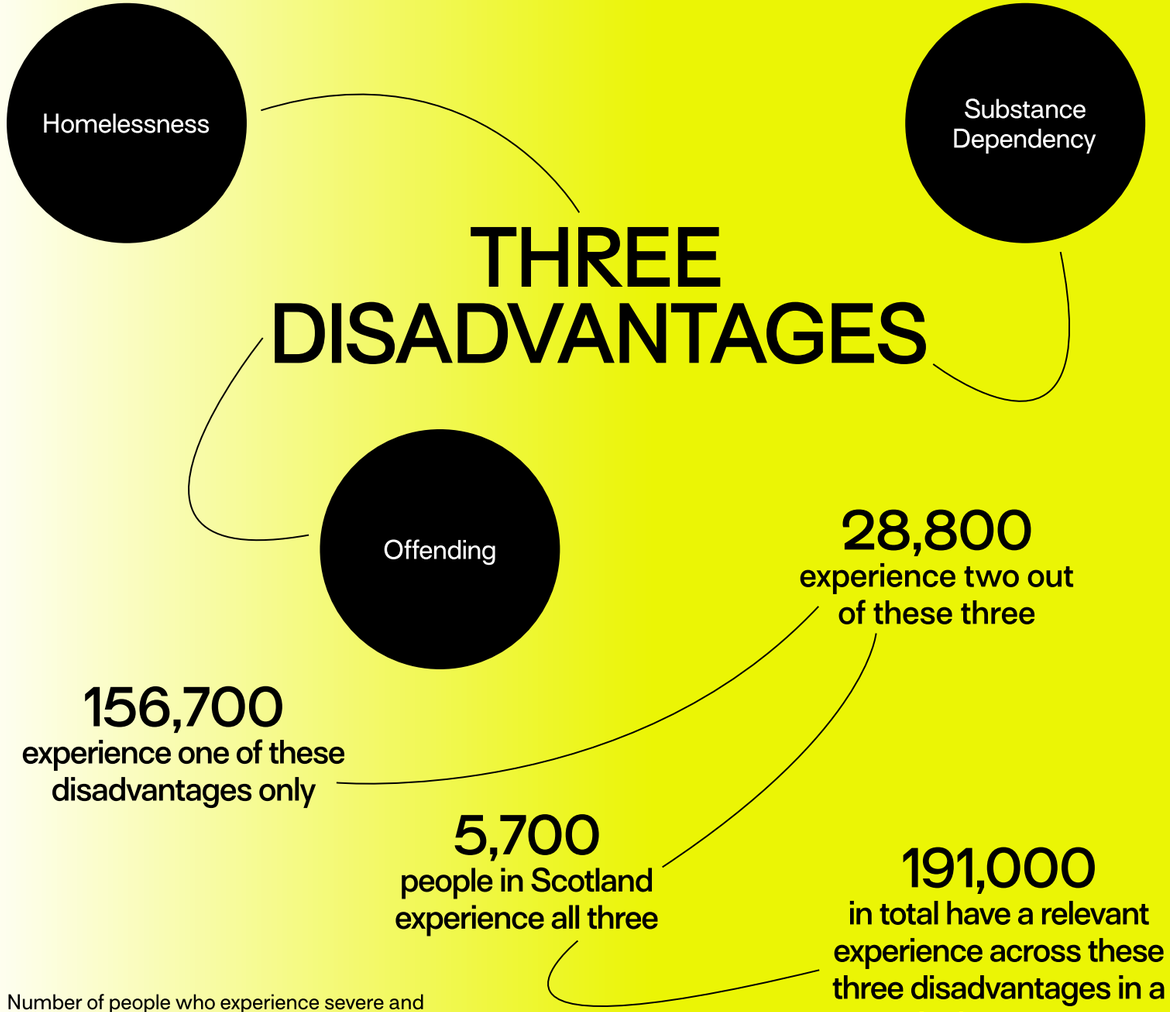
We estimate that, over a year, 5,700 people in Scotland experience all three of homelessness, substance dependency and offending; 28,800 experience two out of these three; and 156,700 experience one of these disadvantages only. Overall, 876,000 people in Scotland have experienced one of these three 'core' 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 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.



Number of people who experience severe and multiple disadvantage (3D) over a year in Scotland

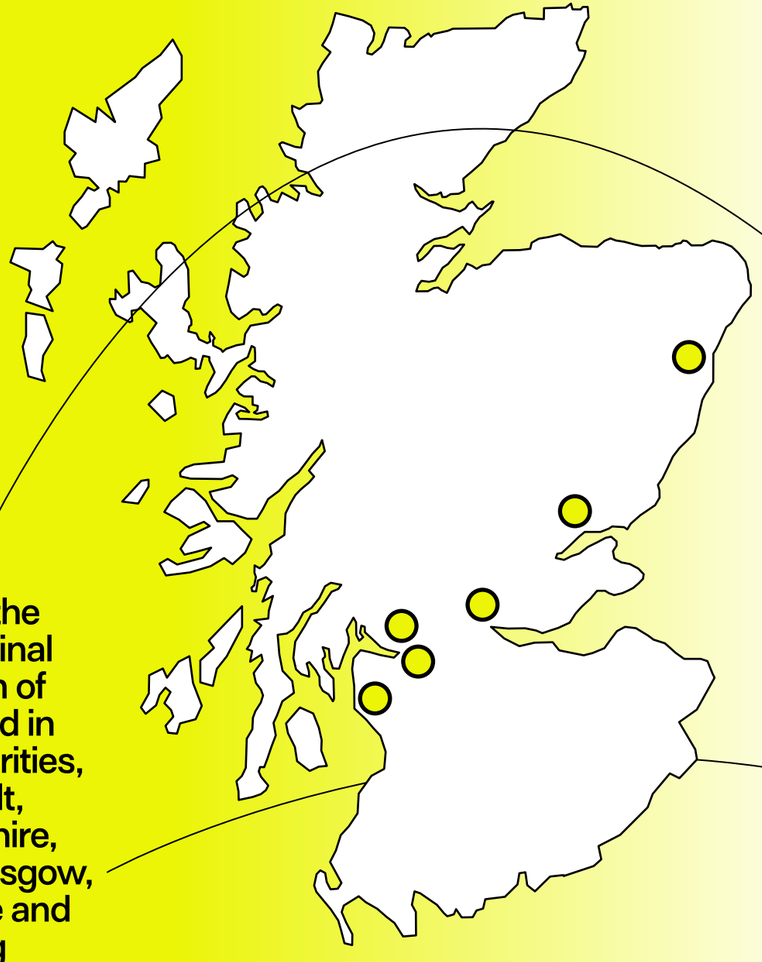
Profile

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).

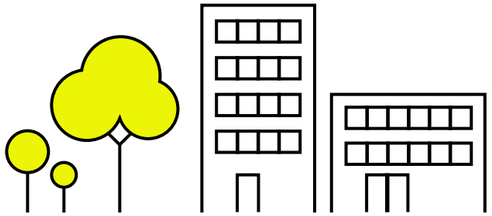
Thus the highest risks are associated with being younger (under 40), single, white and male. There are also independent associations with long-term sickness and/or a disability, and being a social tenant (or having no tenure at all). This original definition of SMD is very strongly linked to both household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

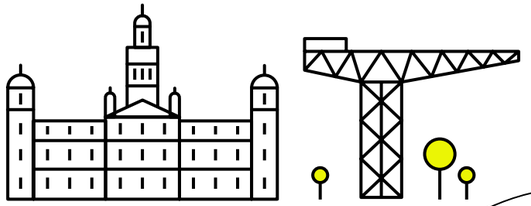


At local authority level, the highest rates of the original three-dimensional form of SMD are generally found in urban and poorer authorities, mostly in the central belt, with West Dunbartonshire, Clackmannanshire, Glasgow, Dundee, North Ayrshire and Aberdeen City showing high prevalence.



Rural & urban

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.



Glasgow dominates

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).

A broader view

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.

7 local authorities

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.

MISSED

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.

Truanting 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

OPPORTUNITIES

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).

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

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 entitled[1].

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 Scotland[2].

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

[2] news.gov.scot/news/ending-homelessness

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.

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.

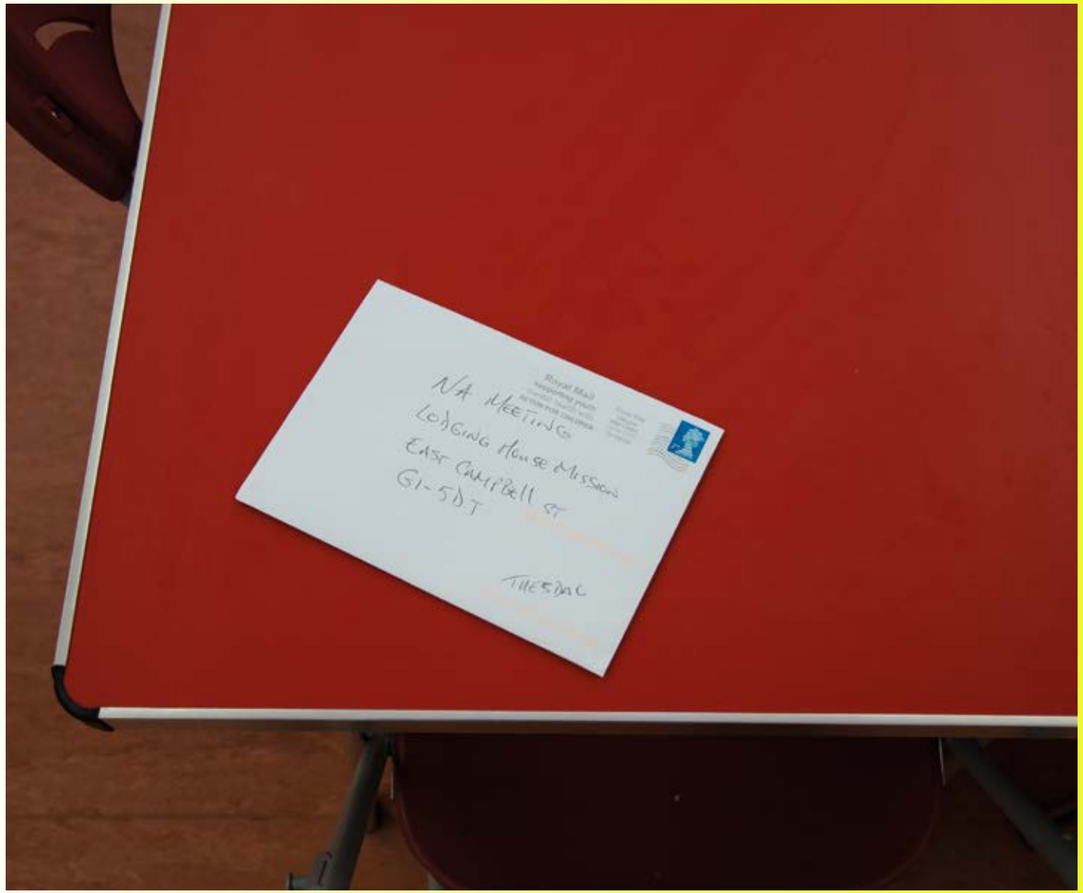
This at least in part reflects the fact that specialist refuge providers will not accept women with active addictions and chaotic lifestyles in some areas. Whilst this policy stance is understandable, given the imperative to keep refuges feeling safe for all of their residents, it does indicate the need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

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.



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.

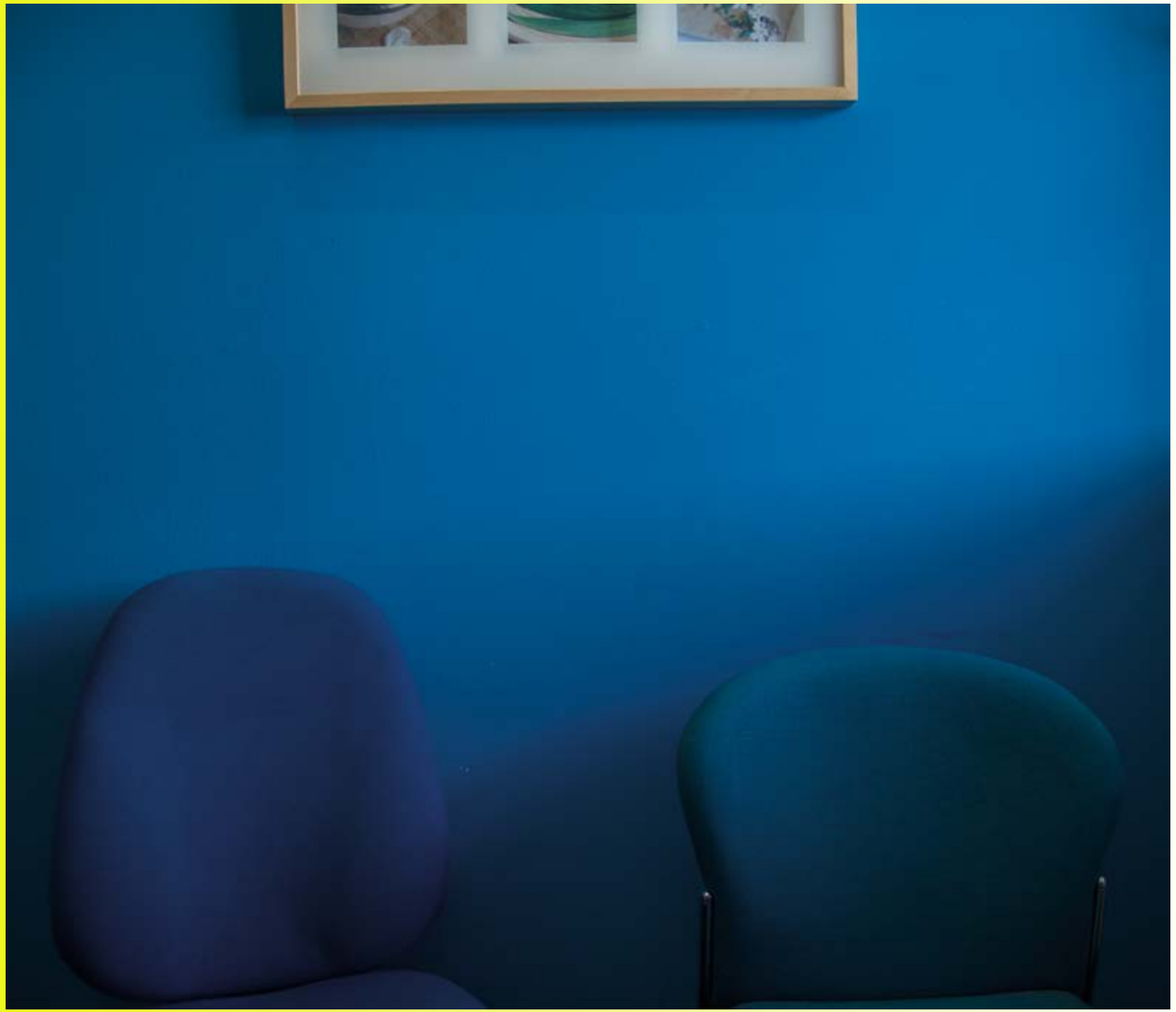
Crisis-focused systems that can't cope with the effects of trauma

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.

“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.”

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.

Acknowledgements

We owe a great debt of gratitude to the many experts and officials across Scotland who assisted our work by participating in multiple project advisory group meetings and/or by facilitating our access to key datasets.

Local statutory and voluntary services in six (anonymous) areas across Scotland gave generously of their time to enable us to assess the reality of the situation 'on the ground'. Above all, we would like to thank all of the people with direct experience of severe and multiple disadvantage who participated in the Lived Experience Reference Groups or in-depth interviews in local areas. We hope this report helps to convey your experience in a way that brings about much-needed change across Scotland.

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.

Designed by Studio Rollmo

Photography by Michael Thomas Jones

With support from:
Clydesdale Community Initiatives

Cyrenians

Glasgow Homelessness Network

Printed by Seacourt

Download the full report:
lankellychase.org.uk/connected