

Manifesto for Change

Changing systems for people facing
multiple disadvantage



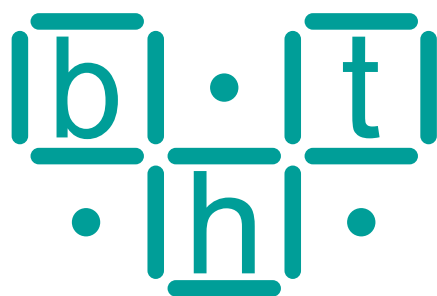
FULFILLING LIVES

South East Partnership



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This report was compiled by staff and volunteers of the Fulfilling Lives South East partnership, which is led by Brighton Housing Trust (BHT), with the support of delivery partners Equinox and Oasis Project.

We would particularly like to thank all the contributors with lived experience who shared their stories and expertise, local organisations who have collaborated with us to date, and the project's funders; the National Lottery Community Fund.

Fulfilling Lives – Manifesto for Change

This report, our Manifesto for Change, highlights the six key themes that have arisen from the work of the South East Fulfilling Lives Project, and sets out our commitments under each of these themes. These will be the focus of our work for the remainder of the project and achieving them is a main component of the project's planned legacy.

The South East Fulfilling Lives Project started in 2014 and is funded until July 2022 by the National Lottery Community Fund. The Project is one of 12 projects across England funded to (i) provide intensive support for people experiencing multiple disadvantage (ii) involve people with lived experience of multiple disadvantage at all levels (iii) challenge and change systems that negatively affect people facing multiple disadvantage.

The South East Project operates in Brighton & Hove, Eastbourne and Hastings and works on two levels: an immediate level – directly with people who are most in need right now; and on a lasting level – changing systems to enable people experiencing multiple disadvantage to receive the support they need at the right time.

The work of the project is informed and directed by people with lived experience – working in staff teams, identifying and researching needs and solutions, being involved at a strategic governance level, and providing support and aspiration to peers.

We are using the learning from the programme to (i) inform providers, policy-makers and commissioners (ii) evidence the need for systems and services that are more welcoming, responsive, flexible and coordinated for those with the most complex needs (iii) promote ways of achieving this.

The project is made up of four teams:

Frontline Delivery teams

Working directly with clients, providing assertive, specialist, personalised interventions. This work is used to identify and highlight gaps and barriers within current services and to showcase best practice and innovative ways of working.

Learning and Impact team

Exploring, promoting and evidencing best practice, including that modelled by the delivery teams, and sharing this through co-produced resources, training, events, and publications.

Service User Engagement team

Acting as champions for maximising co-production in all project activities and ensuring the genuine involvement of those with lived experience of multiple disadvantage at all levels within the project. The team consists of volunteers and paid staff with lived experience who gather feedback and insight into the gaps and barriers experienced by those with the most complex needs.

These teams have provided the evidence-base to inform and support the project's wider systems change work, which is led by the:

Systems Change team

Leading and coordinating the work on the six key themes of this report which the project has identified as the priority areas for people experiencing multiple disadvantage. The team works directly with local partners and stakeholders to achieve real change and improvements in local services and systems.

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01 Health Inequalities

Introduction

Restricted access to healthcare is a strong and consistent theme in our casework. Client case studies evidence a stark and disturbing picture of the very real health inequalities experienced by people with multiple and complex needs.

Client data shows that 84% (43 of a total 51) of current clients have a physical health problem or problems. Many have a combination of long-term chronic conditions such as liver cirrhosis, hepatitis C, diabetes and circulatory diseases. The female clients we work with have more complex and chronic conditions compared to men. A number of factors contribute to this, including the impact of domestic abuse and violence, as well as the stress on the body from rough sleeping.

The average life expectancy of homeless people is low – for men this is 47 years of age, for women this is 43 years of age. Fulfilling Lives (FL) has worked with 94 clients to date. Ten clients have died, eight of whom were female clients (their average age was 41 years at the time of their death).

What we know from the project's work

There are high levels of repeat attendance at A&E. The table below shows the four highest users of A&E on our caseload to date. Client A attended A&E 19 times between Oct 2017 and Oct 2018. This client has a learning disability alongside other complex physical and mental health problems. These attendances were for pregnancy related complications including a miscarriage, mental health crises and an overdose.

Client	M/F	Area	Number of A&E attendances
1	F	Eastbourne	26
2	F	Eastbourne	25
3	M	Brighton	23
4	F	Hastings	21
Total			95

- 78% of FL clients describe themselves as having a disability. This is compared to 16% of working age adults in the UK¹
- FL clients have a higher prevalence of almost all health conditions than the general homeless population in the UK²
- Hastings has the lowest number of clients registered with a GP, but the highest prevalence of long-term conditions, as well as the highest average number of conditions per client

The East Sussex Homeless Health Needs Audit (2016) identified that access to health services was restricted, with 47% reporting a time in the previous 12 months when they could not be seen by a practitioner for a physical /mental health problem. This is compounded by the difficulty of making appointments by telephone and the lack of drop-in clinics available. Our recent client work suggests this is still the case and we have many examples of restricted access and barriers in provision for clients with complex needs.

¹ This figure is from DWP data 2014

² Figures are from Homeless Link's 2014 report on health inequalities for homeless people

Our casework demonstrates that healthcare services are often unable to meet the needs of clients with multiple and complex needs without significant intervention from support workers.

Healthcare services can be:

- Inflexible
- Punitive for non-attendance of appointments
- Unaware of trauma presentation and needs
- Unaware of substance misuse issues
- Lacking the processes to communicate with agencies who are supporting the client
- Stigmatising in their language and attitude

Access to GP and outpatient appointments

It is unsurprising that this client group, due to the level of their complex needs, frequently miss appointments and lose medication. This commonly results in a punitive response from GPs and hospitals, including removing the 'privilege' of being able to book appointments in advance.

People with multiple co-occurring long-term health conditions usually access a number of designated clinics to manage their health, and are able to do so. The FL client group rarely prioritise their health needs and rely on scarce GP appointments or on A&E to address urgent or emergency care.

Hospital discharge

Case example

S is a female homeless client who had been in hospital for five weeks. She was diagnosed as suffering from endocarditis, with damage to the mitral valve,

two thalamic infarcts and two cysts on the brain. At the beginning of week six, despite her being homeless, it was recommended that she be discharged and that she "go home and gain further weight and return after a month to review her health ahead of a referral for heart surgery".

Stigma

Examples of stigmatising practice witnessed by FL Specialist Workers include:

After he had read she had alcohol related liver disease the consultant said "I will see her at some point, but I have other people to see who are very poorly".

Regarding stronger medication I heard a consultant say, "give her whatever, give her anything". [A client dying from liver disease]

Special Patients Scheme (SPS)

Following a violent or aggressive episode in a health care environment, clients can be put on the Special Patients Scheme (also known as the Violent Patients Scheme) and a number of FL clients have been put on this scheme. We have identified that, due to reviews not taking place, clients can remain on the scheme and have this label despite the event(s) being historic.

J, a client in Hastings, has been on the SPS for over three years without being offered a review. Being on the scheme means that:

- He is unable to access the GP building without a prior appointment
- He can only access the GP building on a Tuesday when security is present
- The surgery will only see him with a keyworker present, not a family member or friend
- Because only one surgery in Hastings accepts people on the SPS he is unable to attend a surgery closer to his accommodation, despite being disabled with a serious leg injury

Our work to date

Health Watch are currently reviewing the Special Patients Scheme following FL highlighting barriers. We have provided anonymised case studies to help evidence the negative impact of the scheme on this client group.

In their casework, FL workers consistently challenge health care services and advocate for greater flexibility and understanding of clients' needs. They have negotiated flexible appointments, have flexed the rigid approach of the Special Patients Scheme to allow appointments to be made on any day of the week, and have represented clients' best interests when they are discharged from hospital. They have challenged stigma and have appealed for dignity for patients who are receiving end of life care.

The FL casework evidences the complexities of clients' needs and the complicated coordination required to ensure services and professionals are in place when needed. What appears to be a straightforward task of accompanying someone to a GP or a hospital appointment requires significant planning, and often many hours of time, factoring in outreaching and preparing someone emotionally to enter a clinical environment.

Our Commitments for Change

We acknowledge that the organisational anthropology of the NHS and its complex governance and management systems brings additional challenges to achieving systems change.

Our commitments relate to key pressure points for clients with MCN within the healthcare system:

1. People with MCN will have improved access to, and coordination of, primary care to better address their needs
2. All clients with MCN who are placed on the SPS will have an annual review in line with current guidelines
3. The triage system in A&E will be able to identify people with MCN and to assess potential risks and the need for follow-up care and support when they are discharged
4. Workers who support clients with MCN will be informed and empowered to use official systems to challenge and escalate unsatisfactory responses and care
5. Hospital discharge protocols for MCN clients will be fit for purpose and consistently implemented

02 Domestic abuse and complex needs

Introduction

Domestic abuse and violence is a very common experience for this client group. In a snapshot in December 2018, 93% of the women on our caseload had experienced domestic abuse (25 out of 27 women) and at the time of the snapshot 13 of the 25 women were currently experiencing domestic abuse. This prevalence has been consistent throughout the lifetime of the project.

Of these 25 women, 76% were homeless (rough sleeping/in temporary accommodation/sofa surfing/in hostels), 96% had both substance misuse and mental health needs when we began working with them, 88% had histories of offending, and 72% had disabilities.

What we know from the project's work

From our work supporting women who experience domestic violence as one of several complex and intersecting needs, we have identified three pressure points in the system when trying to access or navigate services:

Access to appropriate housing options

Women with multiple and complex needs who are experiencing domestic abuse often present for help in the first instance at their Local Authority Housing Options Service. We have found that clients can experience judgemental and stigmatising responses and unsatisfactory outcomes on presenting.

Domestic abuse and complex needs

Women frequently do not receive a service which reflects an understanding of the complexities, dynamics and risk issues of domestic abuse or receive a trauma informed response.

Case example

V is a 34-year old female client who is alcohol dependent and a recovering heroin user in substance misuse treatment. Fulfilling Lives supported V to present at the local authority housing department as she was fleeing domestic violence from the partner she was living with. The initial interaction, with V needing to re-tell her story to several different people, and the physical space of the assessment (open plan and next to a children's play area, which was not confidential and was also triggering for V) was an unpleasant experience for her.

The housing officer suggested out of area refuge accommodation which V considered but decided was not a suitable option for her. Despite V stating that she did not wish to be placed out of area, the housing officer called three more out of area refuges. None of the refuges could offer a suitable placement due to V being in a wheelchair.

The housing officer was only willing to place V in temporary accommodation out of area, citing the risk from her partner as the reason for this. V felt safe in her local area with her network of support and services and she did not want to be isolated. The housing officer was not willing to consider placing V locally and V was left with the option of sleeping rough or returning to her abusive partner from whom she had just fled.

Fulfilling Lives paid for V's accommodation that night. After further advocating and challenging, and a second night in a B&B funded by Fulfilling Lives, the housing department did eventually place V in temporary accommodation in her local area.

At the housing options assessment, women are often presented with a rigid and limited housing offer, usually out of area accommodation or a refuge as their only options. Their wishes are not always considered, and women can experience this as a punitive and re-victimising approach, where their autonomy, choice and opinion are overridden.

Women who turn down this offer can be judged as declining a reasonable offer of accommodation and this can go against them in the overall assessment of their eligibility for the council to have a statutory duty to house them.

We have discovered through our case work that refuges are usually not equipped to accommodate women with multiple and complex needs; referrals are frequently rejected on the grounds of clients' mental health and substance use needs being too high, citing staff cover as not adequate to manage potential risk.

On one occasion when a client was able to access a refuge she was evicted after a short period due to an altercation with another resident; a process which had a detrimental impact on her. She also felt unheard and unsupported during the eviction.

Client Voice: (J) *"I appreciate that I have support needs (which I was extremely honest about during the initial referral), but I was working with multi agencies to address my issues."*

Access to, and initial engagement with, specialist domestic abuse services

The access point for specialist domestic violence support in Brighton and Hove and East Sussex is via The Portal – an online referral and self-referral system. The Portal is also the online contact point for the domestic and sexual abuse helpline.

Accessing services via The Portal is particularly difficult for this client group:

- Clients can call a freephone helpline number (answered by voice message) or email or complete an online form. Messages via all three routes are triaged, and a worker will then attempt two return calls. If they cannot contact the client, the client needs to contact the service again to make another self-referral
- Once through to a worker, the triage system of assessment involves the client having to tell their story more than once to different workers before being allocated a specialist Independent Domestic Violence Advisor (IDVA) caseworker

- Once allocated a specialist IDVA worker, clients need to attend regular appointments at a specific venue

Case example

Client A is a 27-year old woman experiencing medium risk domestic violence. As the only route into specialist services, she was referred to The Portal; however, she was homeless and did not have a reliable phone or a private space to take a call and so she was unable to respond to the return call, and the case was closed.

Multi-Agency Risk Assessment Conference (MARAC)

The MARAC is the multi-agency risk assessment conference for high risk cases of domestic abuse. Representatives from key agencies discuss each case referred and agree actions and safety plans in order to reduce risk and keep individuals safer.

For our client group a referral to MARAC proves to be the only route to access input from specialist domestic abuse agencies as, when a case is heard at MARAC, a referral is automatically made to the IDVA service.

A snapshot of our data in December 2018 showed that 52% of the 25 women on the Fulfilling Lives caseload who were experiencing domestic abuse had recent MARAC referrals.

From the project's experience of supporting clients through MARAC, the current process does not serve to mitigate the risks for women with complex needs and is, therefore, not an effective forum for this client group. There are key functions that are not fulfilled by multi-agency plans:

- Plans do not include clear actions and timeframes - there is often insufficient time during the meetings to cover the full complexity of the case, resulting in plans focussing on making referrals rather than enhanced actions from agencies present

- Plans do not include shared accountability - agencies attending the MARAC are reluctant to take responsibility for Fulfilling Lives clients; responsibility is often left with Fulfilling Lives alone, rather than the client receiving the benefit of a multi-agency package of support
- Plans do not take account of safeguarding issues - the structures rely on the victim being able to seek support and fully engage with safety planning; this is often not the case

Case example

Fulfilling Lives participated in a serious case review in 2018 following the death of client X, a 41-year old woman and high-risk victim of domestic abuse being supported by Fulfilling Lives as well as multiple other agencies. One of the themes arising from the review was a lack of a coordinated strategy between the statutory agencies and those closest to X 'on the ground'. Although her case was heard at MARAC several times in the year preceding her death, she remained homeless and at high risk. There was evidence of multiple 'hand offs' from professionals who felt that X's primary needs fell outside of their remit without evidence of a commitment to work more flexibly and creatively. This included local authority housing teams.

There was a level of good evidence of joint working between some agencies, but there did not seem to be a real sense of coordinated strategy or responsibility between the statutory agencies and those closest to 'on the ground'.

The MARAC process and limited time allocation for case discussion did not allow sufficient time to consider the full complexity of the case and allow for the full range of professionals involved in X's care and support to feed into more robust safety planning.

Our work to date:

Fulfilling Lives has sought opportunities to highlight the issues and identify constructive solutions with stakeholders.

A meeting was facilitated with the national Deputy Manager of Operations of Refuge, along with a Fulfilling Lives client who had recently been evicted from Refuge, to identify learning from her case. This constructive meeting, and subsequent liaison with commissioners, highlighted the need for accommodation options, other than Refuge, for women with multiple and complex needs who are experiencing domestic abuse – for example, dispersed refuge placements or temporary accommodation with floating support.

This need is also borne out by a research project commissioned by Refuge in January 2019 – *Supporting Women with Multiple Needs: The Transforming Responses Project*.

The Fulfilling Lives Women's Specialist Worker in Brighton and RISE have undertaken joint work to bring an IDVA service to women who were not able to engage using the normal referral / self-referral process via The Portal.

Working with two Fulfilling Lives clients who were experiencing domestic violence, the RISE worker worked flexibly and agreed to meet with the clients not only at RISE 's premises but also at the clients' hostels; the Fulfilling Lives Specialist Worker supported the two women to attend these appointments. This enabled both clients to successfully engage with RISE and receive the support they needed. This work has included: safety planning, emotional support, education, information on legal rights, support at court, and a Domestic Violence Protection Order (DVPO) being obtained and served.

This collaborative work contributed to a successful bid by RISE to the National Lottery Community Fund, to fund an assertive outreach worker dedicated to working with clients with multiple and complex needs. Our teams are working closely together, to support clients and to influence commissioning decisions.

In the past few years there has been a significant increase in the number of cases referred to MARAC, resulting in the time allocated to discuss cases being

under pressure. For example, since October 2015 the Eastbourne MARAC has seen a 69% increase in the number of cases referred (latest data captured March 2019). A review of the MARAC process and structure is currently underway and Fulfilling Lives is working with local authority commissioners across Brighton & Hove, Eastbourne and Hastings to support improvements to the current system, in particular to advocate for more effective interventions for women with the most complex needs.

As statutory agencies are not able to work as flexibly as Fulfilling Lives, we are often the lead agency for the project's clients:

- we maintain consistency in assessing and referring clients into MARAC and attend the meetings to represent clients and to advocate for a joined-up approach to safety planning
- we model case-coordination as best practice in this area and advocate for multi-agency involvement with the client's voice at the centre
- we lobby statutory services to fulfil their duties and engage with this client group in a more flexible way

Our commitments for change:

1. Women with MCN who present to the local authority as homeless and experiencing domestic abuse will receive a trauma informed response which is appropriate to their needs, and creative safety planning – including access to appropriate accommodation
2. Women with MCN who are experiencing high risk domestic abuse will be offered one to one support from a specialist domestic abuse service
3. Women with MCN who are heard at MARAC will have a robust multi-agency safety plan (including housing, adult social care, substance misuse, mental health, police, IDVA) that takes account of safeguarding issues and includes shared accountability and clear actions with deadlines
4. The staff in non-specialist services supporting women with MCN will be equipped and trained to better respond to domestic abuse

03 Criminal Justice System – repeat offending

Introduction

Our statistics show that people with multiple and complex needs are overrepresented in the criminal justice system. Of the 94 people we have worked with up to December 2018, 25 clients (27%) have been in prison. This compares to 0.18% of the general population. In our current caseload of 52 clients, 20 people have patterns of repeat offending; all have identified mental health problems and are alcohol and/or drug dependent. This client group are some of the most complex and disadvantaged and remain on our caseload the longest - of these 20 cases (eleven men and nine women) 50% have been on our caseload for three years or more.

These individuals are engaged in repeat cycles of acquisitive crime, such as shoplifting and theft; their offending is often driven by active addiction. They receive short custodial sentences and are regularly released as street homeless where the chaotic nature of their lives leads to breaching license conditions and being recalled to prison after only a short time in the community. Those receiving community sentences frequently breach probation orders, again due to the lack of stability in their lives, resulting in them being recalled to prison. Clients quickly get caught in cyclical offending and the revolving door between prison and the community.

There are few or no steady periods of stability (either in prison or in the community) in which the person can address their addiction, their mental health or their homelessness in order to break the cycle; instead, the cycle exacerbates and perpetuates these problems. Work is focused on immediate crisis and risk-led interventions, rather than on planned or preventative work to support individuals to break the cycle and reduce reoffending.

What we know from the project's work

Homelessness on release from prison

Case example

N is a 32-year old male client with a long history of homelessness, an opiate addiction, a diagnosis of personality disorder and a history of self-harm related to mental health and bereavement issues. He is 'stuck' in the revolving door of prison and community and feels a sense of hopelessness that nothing will change. A week before he was being released, he said: "I've lost hope and don't have a spring in my step even though I'm released next week. I feel like I've been left like a dog on the streets." N was back in custody within a week of being released.

Case example

P is a 31-year old male client who has spent most of his adult life revolving between custody and homelessness. He has mental health problems and is a street drinker. His mental health diagnoses include depression, anxiety and personality disorder. His offending is primarily shoplifting for alcohol and food. After two weeks post-release from HMP Lewes, P said "at least I've got a bed and a TV in prison. I don't normally have accommodation offered to me after prison. I usually return to rough sleep or sofa surf and that's when things feel like they start to go wrong."

Prison release on a Friday

Proportionately more people are released from prison on a Friday, as this also includes those whose scheduled release date falls on that Friday or Saturday or Sunday or Bank Holiday Monday.

Case example

Worker account: H was released from HMP Lewes at 10:30am on Friday morning. Our journey to Hastings Borough Council to make a homeless application took an hour. The assessment and investigation for this also took an hour and then we waited for another hour for a decision. At 2pm H was offered temporary accommodation in Eastbourne, for which he would be required to pay a £25 top-up; H had no benefits in place at this point.

H then had appointments at the Community Substance Misuse Service in East Sussex and at Probation – both appointments had been made for 2pm. As the substance misuse service is nearest to the housing office, we went there first. This assessment took an hour and then we had a further 30-minute wait to see the GP. We had to wait another 45 minutes for the GP to look over the assessment and agree to continue prescribing. It took a further 20 minutes for the prescriptions to be generated and signed. We finally left the substance misuse service at 4:40pm.

H still had to get across town to the Probation office, which closes at 5pm, to fulfil his license requirement or he would be at risk of being recalled to prison. We were able to pay for a taxi, which meant H did attend, but it did not allow adequate time for Probation to complete their assessment and talk through with H how to remain compliant with his licence conditions.

H said: *"I'm shattered, haven't even eaten, how am I meant to get to all these places without you. I feel like I am already being set up to fail."*

H still had to travel to Eastbourne to reach his accommodation and then had to get through the weekend without any services being open for support, no benefits in place (including to pay the required top-up for his accommodation) and no food.

Repeat short sentences allowing little time in the community to build relationships with clients

Case Example

J is a 30-year old male client. He has been in prison seven times in the past three years. He has been in prison for a large proportion of this time with only short periods in the community (between 1 – 8 weeks) before being recalled again. His offences include shoplifting and carrying a bladed article. He is frequently recalled to prison for non-compliance with his licence conditions. He has been released as street homeless five out of six times. He was offered temporary accommodation once, but he was recalled to prison within a week.

Gender specific barriers

Female clients on our caseload who are repeat offenders tend to receive more community-based sentences than male clients, and fewer prison sentences than male clients. The majority of female offenders with complex needs are also victims; this does not, however, result in them receiving better coordinated support. It is widely accepted that women need a dedicated pathway of support that takes account of the multiple trauma experienced and their victim status; this has been well evidenced by the Corston report³ and Corston 10+⁴, but there remains a shortage of trauma-informed, gender-specific interventions for women locally.

The women on our caseload who fit this profile have some of the most complex difficulties of any of the clients working with Fulfilling Lives.

³ Baroness Corston's review, published in March 2007, made 43 recommendations for improving the approaches, services and interventions for women in the criminal justice system and women at risk of offending.

⁴ Corston report 10 Years on, published by Women in Prison, 2017, gave an overview of what progress had been made in the implementation of the Corston recommendations; very little in most cases.

Of the nine women on our current caseload who fit this profile:

- All have mental health diagnoses, including anxiety and depression, personality disorder and bipolar disorder
- All use alcohol and drugs
- Eight have experienced domestic violence
- Only one has not had children - eight clients between them have 20 children, none of whom are in their care
- Three clients are rough sleeping, three are sofa surfing, one is in supported accommodation, one is in temporary accommodation and one has a social housing tenancy

Case example

K is a 34-year old female client who has been supported by Fulfilling Lives since February 2015. K has a long history of poly-substance misuse and she is in active addiction for crack cocaine and heroin. K has a diagnosis of emotionally unstable personality disorder and suffers from depression and anxiety. She has a history of suicidal ideation and attempted overdoses. K has stated that her father sexually abused her as a child, and her behaviour often reflects embedded and unresolved childhood trauma. She has a complex relationship with her family and has often said that she feels alone. K does not have regular contact with her mother, or with her 16-year old daughter who lives with a family member. K's offending is mainly low-level shoplifting and she is also often in breach of her license due to non-engagement with Probation and non-attendance at court. Although K has maintained long-term bed and breakfast accommodation, she also has periods of rough sleeping due to not feeling safe at the accommodation.

K says that she knows the importance of maintaining contact with Probation, but has found the changes in staff, and the changes in the location of where she sees a worker, very difficult. The revolving door of K coming in and out of prison has affected her negatively; K says she is constantly anxious of being

recalled to prison because of the uncertainty this causes, including in relation to her accommodation and to her methadone prescription. K says that whenever she goes to court, she always brings her belongings with her due to feeling that she will be returned to prison. K says that she offends, mainly shoplifting, to finance her substance addiction. K states that she wants stability in her life, but that her substance addiction governs her actions and behaviour.

Our work to date

This is an area of our work where progress to date has been hampered by frequent changes within the criminal justice system, including the restructure, retendering and part privatisation of the National Probation Service in 2015.

The Through the Gate initiative went live on 1st April 2019 in recognition of the need for a better coordinated resource for support on release from custody.

We are making strong links with partners in Probation and are setting up focus groups with KSSCRC (Kent, Surrey and Sussex Community Rehabilitation Company) to identify examples of good practice and to establish joint areas for learning, and to try different approaches for working with clients with multiple and complex needs who are in the Criminal Justice System.

We have been able to secure accommodation on release as 'exceptions', with positive outcomes for clients.

Case example

J was due for release, and during his time in custody the FL Specialist Worker liaised with the local authority and accommodation provider and together they planned for J to move into accommodation immediately on release. The Specialist Worker liaised with the healthcare team at the prison and met J on the day of release and took him to his accommodation. Whilst J still struggles in some areas, he has remained in the accommodation, his engagement with Probation has improved and he has not been recalled to prison to date. He has re-established contact with his family, having not spoken with them for over a year due to feeling ashamed.

Our commitments for change

1. For no clients with multiple and complex needs to be released as street homeless
2. For no clients with multiple and complex needs to be released from prison on a Friday
3. For clients with multiple and complex needs to have a named CRC / Probation worker to coordinate their release and resettlement planning
4. For clients with multiple and complex needs to receive multi-agency case coordination of their support in the community
5. For women with multiple and complex needs to have access to a gender-informed package of support

04 Treatment pathways for coexisting conditions

Introduction

Substance misuse and mental ill health are the most commonly experienced problems for people on the Fulfilling Lives caseload (94% and 96% of the project's caseload respectively). There is a high degree of overlap between the two conditions, with 90% of beneficiaries experiencing both. This is consistent across the national Fulfilling Lives programme. There is a corresponding prevalence of complex trauma amongst beneficiaries; much of this linked to Adverse Childhood Experiences.

Current clinical pathways often require an individual to address their substance use before mental health treatment can be provided. Ongoing substance use can result in an assessment not commencing or even being attempted.

This is despite current NICE (National Institute of Health and Care Excellence) and PHE (Public Health England) best practice guidance being clear that a 'no wrong door' principle should apply, with no one being turned away from services because of co-occurring mental health and substance misuse conditions.

Treatment pathways for coexisting conditions

The substance misuse treatment system is difficult to navigate for people with the most complex needs, in particular when their mental health needs are considerable; many clients have needs that are undiagnosed or untreated. For example, the focus on group work can be a barrier as can the requirements to demonstrate consistent stability and motivation.

We aim to focus the project's work on improving access, engagement and successful outcomes in substance misuse treatment for people with multiple and complex needs by looking at the following two areas of this complex issue:

- Pre-treatment psychological support to address complex trauma so that clients can access substance misuse treatment effectively
- In-treatment support for those with dual needs to engage with, and succeed in, all stages of substance misuse treatment by having their mental health needs adequately supported throughout

What we know from our work

A significant proportion of people are effectively excluded from formal mental health assessment and treatment pathways due to presenting with behaviours resulting from complex trauma coupled with substance use. They are told they must first address their substance use and then return for mental health support; stability and/or abstinence being a prerequisite. Despite this requirement, however, people are often not able to access or succeed in substance misuse treatment precisely because of being stuck in these patterns of behaviour resulting from complex trauma.

People are caught in repeat cycles of mental health crises, often resulting in acute hospital admissions with no clear treatment plan on discharge. Without receiving specialist input to be able to engage with services effectively and appropriately, people are left to repeat this cycle over and over again. Complex trauma is frequently viewed as being social in cause and there are inconsistencies in response from clinical services, many seeing it as outside the scope of clinical work.

The project's casework evidences the need for clinical therapeutic support for complex trauma, to help build psychological resilience and stability, in order to

make access to substance misuse treatment possible. This work is ongoing and is already developing a better understanding of the potential role for 'pre-treatment' services.

Case example

A is a 49-year-old male, with a diagnosis of Mixed Personality Disorder and Post Traumatic Stress Disorder (PTSD). He has a history of depression, anxiety, panic attacks, auditory hallucinations and suicidal ideation. A has a long history of substance misuse, primarily alcohol (up to 2L of vodka daily) and the misuse of painkilling medication which he purchases on the street. He has been on the FL caseload for 21 months and is securely housed. He engages consistently with Probation, intermittently with the community substance misuse service and his GP surgery.

A attended his GP surgery reporting hearing voices and feeling suicidal. The locum GP referred A to the local mental health community triage team for an assessment and medication review. A attended a mental health assessment three weeks later with support from FL. He reported having self-detoxed over the previous two weeks and was currently drinking four units daily.

The assessment began with a long review of A's current substance use and advice around safe detoxing, which was helpful as the mental health nurse had previously been a specialist alcohol nurse. The questions regarding A's mental state felt perfunctory in comparison and took less than 15 minutes.

Four days later A received a copy of a letter addressed to his GP about the mental health assessment. The outcome of the assessment was unclear, stating that A would need to be 'at least three months free from alcohol and other substances for an intervention such as psychological work to be appropriate' and that if A developed coping strategies in this time, 'this would make a psychological intervention more possible (although we can never guarantee that this will be available)'. The letter concluded 'Therefore, at this point in time the team will be referring (clients name) back to your (GP) care'.

It had taken almost a month from GP referral to mental health assessment. A was now required to demonstrate a three month period of substance-

free stability before he could return to have an initial assessment with a psychologist for a 'consultation and up to four sessions to explore A's readiness for treatment'. If this treatment pathway was agreed, A would be added to a 3 – 6 month waiting list for a first appointment. This would mean a 7 – 10 month wait for treatment to begin from the time he went to his GP because he was hearing voices and feeling suicidal.

Our work to date also highlights key barriers for clients with a dual diagnosis in receiving the mental health support they need whilst they are in substance misuse treatment. A snapshot of the FL caseload in December 2018 showed that out of 52 people, 44 (85%) were accessing substance misuse treatment whilst only five (10%) were receiving mental health support.

A lack of available mental health support frequently means that individuals are unable to remain in, or make progress in, their treatment.

A lack of joint care planning between mental health services and community treatment services can mean that people do not feel able to formally reduce their substance use for fear of their mental health symptoms becoming unmanageable or unbearable. People remain, therefore, in dangerous patterns of drug use.

When people do enter formal treatment and start to detox, mental health symptoms often increase or become more apparent as they are no longer being masked by substances. Similarly, mental health problems can reappear or worsen as people move through their treatment programme and are addressing the underlying reasons for their substance use.

Our work to date

South East Fulfilling Lives has seconded a Band 7 Mental Health Nurse (from Sussex Partnership Trust) into a pilot role as a Specialist Psychological Therapist (SPT). Her role is specifically to offer therapeutic interventions to FL clients who would not normally be considered as being stable enough to access therapy.

The aim of this pilot is to explore whether working outside of traditional parameters could lead to better outcomes for clients in terms of access to,

and engagement with, services. The SPT has offered short and longer-term interventions, drawing on a range of therapeutic tools, to support clients to manage overwhelming emotions and reactive responses, develop coping strategies and articulate their needs in new ways. A main aim is for this to improve clients' access to, and engagement with, mainstream services.

The SPT draws from a broad practice base using therapeutic models including; psychodynamic therapy, cognitive behavioural therapy (CBT) and systemic therapy to work with difficulties including loss and grief, social anxiety, managing anger, low self-esteem and complex trauma.

Preliminary research suggests the pilot is improving the wellbeing, welfare and dignity of clients, with individuals seeking positive changes and addressing maladaptive coping mechanisms. The pilot is demonstrating that building a steady, safe base for engagement and working flexibly and responsively to deliver truly bespoke interventions can successfully pave the way for more intensive therapeutic work to be possible.

A frontline support worker works alongside the SPT so that needs including housing, benefits, rehabilitation and health are simultaneously addressed alongside psychological work.

Case example

L is a 36-year-old female who lives in a hostel. L has a diagnosis of PTSD, Bipolar Disorder, and is both alcohol and opiate dependant. L has also experienced long term domestic violence relationships.

Although engaging with the substance misuse service sporadically, L was not able to start on a methadone reduction programme due to her alcohol consumption, and was informed that she may have to have an inpatient detox before starting on methadone. Her anxiety was very high and she was drinking to manage the symptoms of past trauma.

L was keen to access specialist input to help manage her anxiety, which was causing her to drink so heavily, but her substance misuse was a barrier for receiving therapeutic treatment.

Fulfilling Lives supported L to access several sessions of Equine therapy. Even at the first session, L noted a huge change in her thinking. She commented how the horses went away if she cried when she was talking about painful things, so she had tried to talk through the feelings. L also commented that the Equine therapy had helped her to cope differently in the "here and now".

L has had four sessions of Equine therapy to date, and says she feels less anxious and more contained and able to put boundaries in place to look after herself. Her thinking and speech seem less rushed, and her decision-making and concentration have improved. L feels her anxiety is more under control and she is better resourced to tackle every day difficulties. L is able to walk down streets that are busy and stay in buildings to wait for appointments in a way that she was unable to manage previously.

The biggest change has been that since starting Equine therapy L has been able to reduce her alcohol consumption to the point that she no longer requires a hospital inpatient detox, and this has enabled her to start on methadone and make progress in her recovery journey.

A joint academic evaluation of the SPT role (led by the University of Nottingham) is underway and findings will be published in 2020.

Fulfilling Lives has made real progress in reinvigorating collaborative working between mental health and substance misuse services in Hastings. Through taking a constructive and solution-focussed approach and involving teams from the substance misuse service and mental health services in shared training sessions, a Working Together Agreement has been developed. This sets out how services work together to ensure clients have a treatment plan which is informed by the expertise of both mental health and substance misuse services. A monthly operational forum is facilitated by the substance misuse service provider (CGL) with the aim of improving the dual diagnosis pathway for people who are not receiving appropriate support for their substance misuse or their mental health. Cases are referred and presented for shared problem solving and joint planning. On average, 10 cases are updated at each meeting.

This work is overseen by a quarterly Dual Diagnosis Strategic Steering Group which receives updates from Sussex Partnership Foundation Trust (mental health trust) and CGL (substance misuse service provider). Indications are that this work has led to sustained improvements for those with dual needs. Clients are more likely to be joint assessed and treated for both issues simultaneously than they were prior to the Steering Group being established. Both staff teams have an increased understanding of the partners' services, many staff members now know colleagues in the other setting and there is increased joint working and sharing of good practice. This work is now being rolled out in Eastbourne.

Fulfilling Lives have taken on the chairing of the Dual Diagnosis Steering Group in Brighton and Hove at the request of the Clinical Commissioning Group. This group has good attendance and buy-in at a senior level and represents a key influencing opportunity for the project. Work during the last quarter has included mapping the interface meetings and opportunities to provide a joined-up service response for clients with a dual diagnosis, and to review the effectiveness and outcomes of these forums. Case studies are shared at each meeting to highlight ongoing problems. Mental health and substance misuse commissioners attend the forum as well as public health, statutory and non-statutory service providers.

Our commitments for change:

1. For all clients with complex trauma presentations to have access to psychological support to help prepare for accessing formal treatment
2. For mental health support to run in parallel at all stages of substance misuse treatment i.e. access, assessment, community substance misuse services, detox and residential rehab

05 Unsupported Temporary Accommodation

Introduction

The housing shortage is particularly acute in the South East of England. The increasing demand and competition for private rented accommodation, as well as landlords increasingly choosing not to accept tenants on Universal Credit, have contributed to significantly reduced housing options for people with complex needs; there is a crisis of supply.

This crisis of supply, together with growing numbers of people becoming homeless, has resulted in increased pressure on local authorities to source and provide temporary accommodation.

Higher numbers of people with multiple and complex needs are being placed in unsupported temporary accommodation, including out of area placements, and are remaining in this accommodation for longer.

What we know from the project's work

When clients with multiple and complex needs are placed in unsupported temporary accommodation this frequently ends in their placements breaking down, leading to clients returning to homelessness.

The impact of repeat cycles of homelessness can be devastating, leading to life-threatening levels of alcohol and substance misuse, significant fear of being harmed and, in some cases, shocking experiences of sexual and physical assault.

This is evidenced in the project's casework and in the experiences shared by the project's Action Group volunteers.

We have identified this area as a priority in order to address how vulnerable people are placed and supported in Temporary Accommodation and to increase the likelihood of placements being successfully sustained and leading to positive housing outcomes.

The following data is a snapshot of the project's Specialist Workers' caseloads in December 2018 and is indicative of the prevalence of these issues over the lifetime of the project:

Area	Brighton	Eastbourne	Hastings	Total
Caseload - Dec 2018	13	19	18	50
No. of clients the project supported to make a homeless application	10	14	10	34
Percentage of the total project caseload in Dec 18 that this represents	77%	74%	55%	68%
Total no. of homeless applications made to date	14	23	12	49
Total no. of placements accepted (in and out of area)	12	16	7	35
Total no. of placements that broke down	8	10	2	20
No of out of area placements that broke down *	1	1	1	3 (out of 5)
No of in area placements that broke down	7	9	1	17 (out of 30)

*No. who were offered out of area placement	2	3	4	9
*No. who accepted	1	1	3	5

68% of the Fulfilling Lives caseload (Dec 18) had made a homeless application. two clients had made as many as four applications each.

Of the 49 applications made, 35 placements were offered and accepted. Of these, 20 (57%) broke down. One in five placements offered were out of area and only half of these were taken up. Of the 30 offers of in area placements, less than half successfully transitioned to a more permanent placement, whether this be supported housing, a private tenancy or a social housing tenancy.

57% of placements broke down due to behaviour or a failure to comply with the accommodation provider's license agreement and expectations.

20% of homeless applications resulted in no offer, either due to being assessed as non-priority or being found intentionally homeless.

Temporary Accommodation placements

Temporary Accommodation (TA) placements can be unsafe for vulnerable clients:

- The environment can be unsafe
- Staff are not trained to accommodate/work with people with MCN
- The TA provider is often not aware of clients' needs, vulnerabilities or associated risk information or support agencies involved

Case example

J is a female client in her 30s. She describes living at [TA] as a very frightening experience every day, saying the "hallways are dangerous places to be. I am always hiding and sneaking around in order to go unnoticed when I am going to use the toilet or shower. I do not feel safe at all. I am in fear. Sharing toilets and showers with men who walk in naked. There is no safety at night time when the caretaker has left. I see men walking around with weapons. There are fights. Loud parties. I turn my radio up loud to block it all out. Some women do not come out of their rooms. I sleep with a knife behind my door".

Case example

P took an overdose whilst staying in TA. She became unconscious and was treated at the scene by a member of the FL team and Paramedics. When she gained consciousness, P was confused and frightened and became aggressive and threatening. The FL Specialist Worker was able to de-escalate the situation. During the subsequent debrief session we held with the TA provider, they explained that they usually have no information about client risks nor any details of clients' support networks.

Quote from TA Provider: *"We have experienced multiple situations where a TA resident has displayed progressive changes in their behaviour which have ultimately resulted in cancellation of their booking. Examples might include failure to maintain medication, depression or relapses into substance abuse. We are keen to find solutions to reduce the frequent cycles in TA and support progress towards stable living.*

When taking a booking, we are usually not offered any third-party contact details beyond the Housing Officer's. If we had access to a named support worker, we could contact them at the earliest indication that something is not right. This would enable support to be provided at the earliest opportunity and reduce the risk of further deterioration and loss of housing placement."

Out of area placements

FL clients have had to make 'impossible' decisions between receiving the support they need or accepting accommodation out of area. FL clients have often refused out of area placements in order to access their support networks locally; rather than face the isolation of being placed away from support services, they have slept rough.

Case example

J is a female client with long term unmanaged mental health problems who is known to MARAC (Multi-Agency Risk Assessment Conference, where agencies discuss high risk domestic abuse cases) and who needs safe accommodation.

After intensive FL input J engaged with mental health services in Brighton. She was told she was going to be placed out of area. She was then told that the mental health service could not support her out of area. J had to make a choice between receiving mental health support or having a safe place to stay. J reported that she was so desperate to be placed and to have her own space that she considered accepting out of area accommodation. Ultimately, she decided to turn down the placement in order to continue to receive mental health support.

Case example

B is a male with unmanaged HIV who is alcohol dependent. B has been placed out of area and as a result he is unable to access community detox through the community substance misuse service (Pavilions) in Brighton. The client is at high risk of death due to his level of alcohol abuse. This cannot be managed through assertive outreach due to B being placed out of area. Being placed out of area also adds a barrier to possible engagement with the Lawson Unit (specialist HIV treatment centre in Brighton) to explore better management of his HIV.

Case example

K is a young vulnerable female IV drug user with a history of sex working and domestic violence. K has also been a rape victim. She is not in receipt of any benefits and is placed by BHCC out of area in Newhaven. K is unable to access support for her IV drug use, such as the needle exchange. She is not able to access the titration process that is based in Brighton to substitute heroin for a safer dose of methadone. K is unable to access the community substance misuse service (Pavilions) to enable her to work towards detox by attending a regular drop-in to become eligible for detox.

Out of Area Placements



Unable to benefit from outreach services



Support workers unable to effectively monitor wellbeing



Area unfamiliar so difficult to find services and facilities



Financial Problems e.g. travel costs and council tax



Living away from social and personal support networks

Our work to date

- South East Fulfilling Lives has collaborated with temporary accommodation (TA) providers, local authorities and the charity Just Life, to instigate a Temporary Accommodation Forum in Hastings and Eastbourne to improve communication between local authority housing teams, TA providers and support services and to provide a regular opportunity to address problems and explore solutions.
- We have delivered Trauma Awareness training to the main temporary accommodation provider in Eastbourne (there are currently no supported hostels in Eastbourne).
- We are working with the Temporary Accommodation Action Group (TAAG) in Brighton and Hove to develop proposals for improved support provision for people with multiple complex needs who are placed in TA.
- We are working with Brighton and Hove City Council on protocols for MCN clients who are placed out of area to be prioritised for return to area.

Our commitments for change:

1. To establish acceptable minimum standards of training and quality for TA providers, in order for local authorities to use them to provide temporary accommodation for people with MCN
2. To develop a tool for Housing Options teams to identify people with MCN
3. To agree a protocol whereby MCN clients who are being assessed for TA will have an identified lead professional/support worker to coordinate a package of support i.e. for no MCN client to be without a tangible and achievable package of support in place
4. For Housing Options teams to routinely share relevant information with TA providers at the time of placement, including: clients' support agencies and professionals, support needs and associated risks
5. For people with MCN not to be placed out of area unless they have specifically requested it. If, in exceptional circumstances, MCN clients are placed out of area, for them to always be prioritised for a placement back in their local area

06 Repeat removals of children into the care system

Introduction

Every Local Authority in Britain has experience of working with women who have multiple children removed from them and placed into the care system. Many of these women face multiple disadvantages and have complex histories that include; being in the care system themselves, sexual abuse, domestic abuse and violence, substance misuse, learning disabilities and mental health conditions. They are also significantly more likely to require interventions from public services throughout their lives.

After a child has been removed into care, women are often left without support at a time when they are especially vulnerable. Due to the complexity of the issues involved, women often become pregnant again and this damaging cycle is repeated, sometimes multiple times.

Fulfilling Lives is not seeking to challenge decisions to remove children, but to identify and highlight opportunities for more supportive interventions to be considered and for the cycle of repeat removals to be interrupted.

What we know from the Project's work

Our casework provides real insight into the prevalence of this issue - it is common for our client group to have children who are not in their care.

A snapshot of the women on the Fulfilling Lives caseload in December 2018 showed that 14 women had children; none of the children were in their care. The women had a total of 50 children: 19 children had been adopted, one was in foster care and 17 children had Special Guardianship Orders (16 known to be with family members). For 10 children the status of their care placement was unknown.

One client alone had nine children who had been removed from her care.

Data Snapshot

14 women



50 children



Adopted	Living with family	Other care arrangements	Fostercare	Special guardianship order
40,43%	34,04%	21,28%	2,13%	2,13%

Stigma

Women with multiple and complex needs can feel stigmatised and judged by the professionals involved with them. Many women have had negative experiences

of social services in the past, often as children themselves. This can lead to distrust and a lack of openness and unwillingness to engage, which can be interpreted negatively rather than understood, and can perpetuate assumptions and stigmatising practice.

Case example

B is a 28-year-old woman who started working with Fulfilling Lives in 2016. She was heavily pregnant, street homeless and known to a women's service that was supporting her with substance misuse; cannabis and binge drinking.

B has a diagnosis of emotionally unstable personality disorder and a mood disorder with paranoid thoughts. B had been with her current partner for four years and she suffered domestic abuse and violence in this relationship, with repeat referrals to MARAC.

B's presenting concern was that her youngest child had recently been placed for adoption, and she was not able to cope with this process. She presented as being very angry with services and her access to contact with her children had been stopped (four different care orders are in place). B has had more than 25 social workers dealing with these care orders.

B had no contact with her son for over a year. B's anger had been particularly directed towards the social worker who had been involved in the care placement of one of her children and who had been on duty on the day this child was removed. B was threatening to her, and this resulted in the contact arrangements for all her children being stopped.

Awareness and understanding of the process and ability to participate

Women feel disempowered through the process of working with social services, not understanding their rights or having a firm grasp of what is happening at each stage.

The experience of attending child protection conferences and managing contact arrangements has, in particular, been reported to be incredibly difficult

for this client group and women are left feeling that they have no say in what is happening with their children.

Clients report that they didn't receive enough information on their rights or on options for advocacy support at the beginning of their involvement with social services. We have significant feedback from women with lived experience who felt they encountered little or no information, support or advocacy when at risk of losing the care of their child and that they were excluded from the process.

Some women report having little or no understanding of the type of care orders their children have been placed under and they feel lost as to how to participate in the contact they may be entitled to.

Many women report that their views were not represented or incorporated at all; that they were passive recipients of a process that was making permanent decisions about their own lives and those of their children.

Case example

P is a 35-year-old woman with a learning disability. External reports identify her functioning at around the level of a nine to twelve-year-old. P has five children; all of her children have been adopted or are in the care system. P has no contact with her children. P's youngest child was removed from her care at birth; Fulfilling Lives received notification that P had a 4-week window to have a final contact with her child and have the opportunity to say goodbye.

P's mental health at the time meant that she did not meet this deadline. The impact of not being able to see her daughter for a final contact has been substantial and her mental health has significantly declined since missing this contact.

To date, P has declined any support to access contraception despite it being regularly revisited with her. It seems that P wishes to become pregnant again despite the consequences and the debilitating effect of repeat removals on her mental health.

Case example

H is a 24-year-old woman who, from the age of two years, has experienced 96 care placements and has had many adverse childhood experiences including childhood sexual abuse. H has a diagnoses of emotionally unstable personality disorder, depression and severe anxiety and has experienced a serious sexual assault as an adult. She uses cannabis daily, and sometimes binge drinks and uses ketamine.

H began working with Fulfilling Lives when she was eight months pregnant with her first child. Two mother and baby placements broke down (one due to concerns with the foster family itself, the second due to geographical distance). H had few options left for placements or for accommodation due to her complex needs and, as a result of the placement breakdowns, the child was removed within two weeks of H giving birth.

As a care leaver, H was entitled to an enhanced package of support, which is a statutory duty under Section 3 of the Children and Social Work Act 2017. Our work in supporting H included advocating for her to have an allocated Personal Adviser from the Care Leavers Team, to help her to navigate the system, understand what was happening at every stage, and maximise her chances of retaining the care of her child. H, however, never met with a Personal Adviser as both she and we were unaware that one had been allocated to her until months later, due to the Adviser going on long term sick leave and there being no communication with H by the Care Leavers Team.

H was often frustrated by the process; her mental health and wellbeing were a regular concern during this time and there were instances of H self-harming.

Support post removal

At the end of care proceedings, when social services' involvement ends, women frequently feel isolated and unsupported in dealing with the effects of having had their child removed.

Having been housed by the local authority in the latter stages of their pregnancy, women can lose this priority need status once they no longer have the child with them, and so can rapidly become homeless.

Psychiatric assessments are often commissioned as part of court proceedings to evidence mental health problems and concerns around the mother's ability to parent; however, these highly detailed assessments rarely result in onward referrals for support or treatment.

The system set up to protect vulnerable children has unintended consequences of further traumatising vulnerable women. As their support needs are not met at this time, and past trauma is not acknowledged, women frequently return to an extreme level of chaotic and dangerous substance use and risk-taking behaviours.

Case example

L is a 35-year-old woman who has been working with Fulfilling Lives since January 2016. L has a diagnosed mild learning disability. She has suffered from mental health issues throughout her life – these include depression, anxiety and suicidal ideation. L has experienced significant trauma as a result of suffering sexual and physical abuse from her father as a child. She spent long periods of her childhood in foster care.

L's five children have been removed from her care due to safeguarding concerns; all are either in the care system or have been adopted and L does not have any contact with them. L has been the victim of domestic abuse from a long-term relationship with the father of four of her children.

Following the removal of her youngest child at birth last summer, L had a breakdown in her mental health, abandoned her accommodation, disengaged from services and support (including from her sister) and returned to rough sleeping with her abusive ex-partner (the father of her four children). Whilst rough sleeping, L then began to use substances again after a long period of abstinence.

When L was pregnant, her Outcomes Star score was high at 59, as she was engaging well, was focused on her wellbeing and sustaining her temporary accommodation placement. Her latest score is nine; she has struggled mentally and physically since giving birth and this has led to her withdrawing from support and accommodation. This dramatic change in the Outcomes Star score illustrates the opportunities that may have been missed when L was engaged and healthy.

Our work to date

Representatives of our Action Group, who are all people with lived experience, supported by Fulfilling Lives, have met with the Brighton & Hove City Council Quality Assurance Programme team for initial discussions on the opportunity to influence practice within Children and Families Social Services and the importance of access to advocacy for all people engaged with a Children and Families social worker and / or those going through child protection or care proceedings.

The casework with Fulfilling Lives clients experiencing these issues has focused on maintaining stability, safety, and advocating for them to have more autonomy and power in the process.

The focus of the work undertaken by B (case example above) with the project's Psychological Therapist has been on managing anger and impulse control, exploring different ways to express herself and developing her capacity to better regulate her mood and manage her overwhelming feelings of shame.

After several months of engaging in therapeutic work and without any prompting, B called the social worker she was abusive to and apologised and asked about restarting contact arrangements. The social worker remarked on how different B seemed and agreed to meeting with B and Fulfilling Lives to restart contact.

B and the social worker continue to meet regularly and, with support from Fulfilling Lives, B has compiled complaints about a previous foster care placement for one of her children, which has resulted in the placement no longer being used by social services. B has also been able to meet the adoptive parents of her youngest son. The social worker is now informing B of her rights around contact and has become a 'go to' person for B to contact directly when she has queries about care arrangements.

The therapeutic underpinning of the work with B has enabled her to repair the relationship with the social worker, re-establish contact arrangements with her children and have a level of involvement and agency which otherwise she may not have achieved.

Our commitments for change:

1. For women with multiple and complex needs to not suffer stigmatising practice (e.g. from antenatal and post-natal health care providers, courts, police, GP and social services)
2. For all women with multiple and complex needs going through child protection or care proceedings to be offered access to independent advocacy, with the aim of helping women to understand each stage of the process, including what is going to happen next
3. For all women with multiple and complex needs who have a child permanently removed from their care to have access to therapeutic aftercare

Mechanisms for Change

Severe and multiple disadvantage has many and complex causes, which are unique to each person. However, broad factors such as poverty, discrimination and adverse childhood experiences are common characteristics. Focussing on local systems and services, we have found clear examples of services actually perpetuating and exacerbating the very issues and problems that they are meant to address.

Services and systems are made up of, and made by, people; and people can be inspired, educated, trained and convinced to work in a more humane, person-centred and enlightened way. Whether frontline practitioners, staff in public services, senior leaders in organisations, or commissioners, the most inspiring practitioners we meet are those who see the fuller picture and reflect this in their work.

The challenge is how to influence practice positively in order to achieve lasting change. Through our work to date, directly with clients and with services, there are common themes which seem to be part of the solution. To bring about positive change in practice, our project is highlighting two key mechanisms for achieving positive change:

1. Co-production, and service user involvement in designing, delivering and commissioning services

2. Developing trauma informed workforces

By modelling these approaches through the work of the project, developing the evidence base for each, and sharing and promoting their adoption across local services we aim to effect tangible change in service quality, accessibility and outcomes for people with the most complex needs.

Co-production and service user involvement in designing, delivering and commissioning services:

Fundamental to the project's ethos, and a core project principle from the outset, is a belief that the involvement of people with lived experience of complex needs is an essential part of the solution.

The project is actively modelling a variety of ways of involving experts by experience and incorporating their knowledge, assets and skills into all project activities. We use the ladder of engagement as a scale to meaningfully engage people with lived experience; we start with Involvement – discussion, consultation, gathering feedback - and we aspire to Co-production. "Co-production is not just a word, it's not just a concept, it is a meeting of minds coming together to find a shared solution. In practice, it involves people who use services being consulted, included and working together from the start to the end of any project that affects them."⁵

Representation and decision making

People with lived experience are represented in the project at all levels and take part in all decision-making processes including membership of the project's strategic Core Group, equal decision making in all staff recruitment, and establishing the project's systems change priorities and the commitments included in this report.

Volunteering & Employment

When people with lived experience become professionals working in services, they can break down stigma, act as role models for service users - inspiring and offering a peer perspective and reducing barriers to engagement, and they can use their lived experiences and knowledge of services to influence change.

Via our employment programme we are supporting people with lived experience of multiple complex needs to work. During the programme we support the development of personal and professional skills that will enable

⁵ Think Local Act Personal, London 2011, Making it real: Marking progress towards personalised, community-based support

people to sustain their employment on the project and to successfully move on to further employment.

With our volunteering programme we are developing a model of best practice through which volunteering becomes part of, and strengthens, individuals' recovery journeys. Underpinned by an assets-based model, the programme offers individual mentoring support to help people develop personal and professional skills to move on in their recovery, including into employment, training and further volunteering.

Commissioning

One of our key work areas is to bring together commissioners and people with lived experience to increase co-production in the design and commissioning of services. The involvement of service users with lived experience of complex needs should improve accessibility, quality and outcomes. The project champions the peer research model for service user consultation and representation.

Our aspiration is that experts by experience will be involved at all stages of the commissioning cycle; from needs assessment to service design, procurement and monitoring and evaluation for all relevant services in Brighton and Hove, Eastbourne and Hastings.

Trauma informed workforces:

A snapshot of the project's caseload in 2017 revealed that all had experienced complex (multiple) trauma, often starting in childhood and continuing throughout their lives.

People who have experienced complex trauma are likely to have difficulty sustaining stable relationships; they are more likely to lack trust in others and this can negatively impact on relationships, including with people who are there to offer help and support. They are more likely to experience overwhelming emotions, have difficulties controlling fear and anger, and may have other mental health problems such as anxiety, depression or personality disorder. For this reason, they may use maladaptive (unsuitable) self-management techniques, such as using drugs or alcohol or self-harming, as a way of coping.

Through our casework we have evidenced a strong link between the experience of complex trauma and the manifestation of complex needs and challenging behaviours. Clients who have experienced trauma often present with behaviours that many mainstream services are unable to support. Consequently, clients are perceived as disruptive or too high risk to access or remain in accommodation or services and are excluded from the support they need. Whilst it is important not to negate individual responsibility for behaviour, there are clear case examples of situations where rigid or inhumane service responses have resulted in a lack of support being available for the individual.

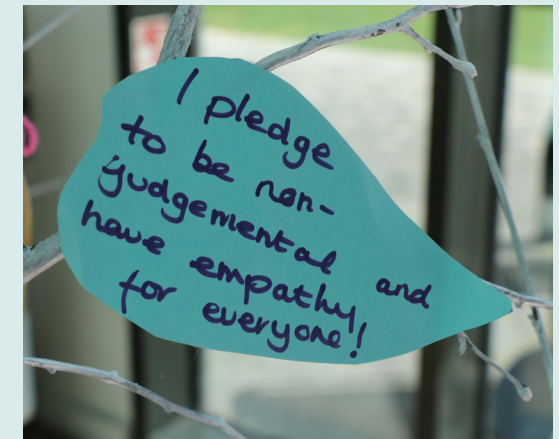
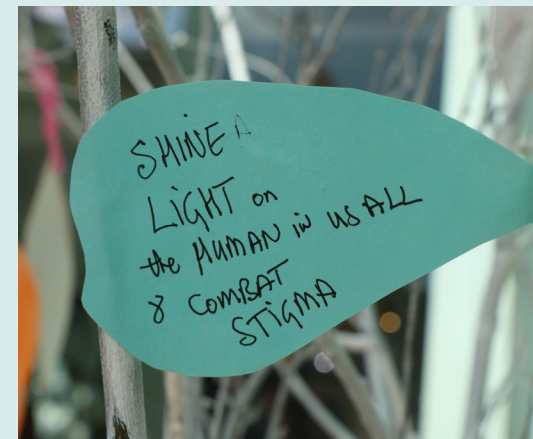
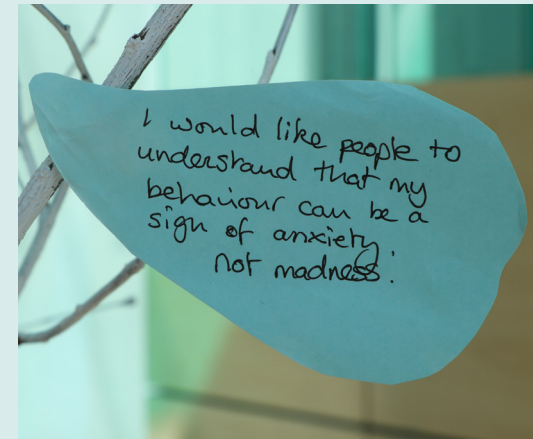
We also have case examples of great practice and flexibility, sometimes because the service culture and processes have built in the ability and support for staff to be flexible, and sometimes because individual workers are prepared to 'go the extra mile' to find a creative, workable solution. However, there are stark inconsistencies in practice, and it is evident that some services and teams are significantly more advanced than others in working in a trauma informed way.

We have identified five tools and approaches that are key to supporting engagement and improving outcomes for those with the most complex presentations:

- effective multi-agency case coordination
- psychologically informed practice and environments
- multi- disciplinary dynamic risk assessment and support planning
- asset based assessments and plans
- trauma responsive practice

Through offering training and support, incorporating knowledge and insight from those with lived experience and creating opportunities for shared learning and practice development, staff across services will develop a greater understanding of the psychological and emotional issues that sit behind presenting behaviours and will be able to offer a more understanding, empathic and flexible service.

If you would like to find out more about the project, please visit www.bht.org.uk/fulfilling-lives



The above photos show messages from Fulfilling Lives South East's pledge tree, which was created by our volunteers for the first ever national Multiple Disadvantage Day on 3rd July 2019. Members of the public heard the real life stories of Fulfilling Lives staff and volunteers with lived experience of multiple disadvantage and wrote messages with pledges on leaves which were added to the tree.

For further information about the campaign or the work of the national Fulfilling Lives programme please visit www.multipledisadvantageday.org



The aim of this report, our Manifesto for Change, is to highlight the six key themes that have arisen from the work of the South East Fulfilling Lives Project, and to set out our commitments for the project's planned legacy.

For further project information please visit www.bht.org.uk/fulfilling-lives

If you would like to discuss working with us on any of the commitments, please contact:

Jo Rogers

Senior Manager – Fulfilling Lives Project, BHT
jo.rogers@bht.org.uk

Nikki Homewood

Director – Advice and Support Services, BHT
nikki.homewood@bht.org.uk