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Severe and Multiple Disadvantage

A review of key texts

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

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

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Introduction

This literature review provides a summary of key texts that address 'severe and multiple disadvantage' (SMD), namely the coincidence of homelessness, drug and alcohol misuse, mental health problems, cycles of violence and abuse, and chronic poverty. It tracks an emerging appreciation of the distinct challenges experienced by people who face SMD, hence not all of the texts are exclusively concerned with this issue. The review highlights attempts to (i) define the issue politically, (ii) provide data on the scope and scale of SMD, and (iii) make recommendations for service delivery and government policy.

The term 'severe and multiple disadvantage' is used advisedly. The existing literature adopts the terms 'complex needs', 'multiple needs' and 'deep, chronic or extreme social exclusion', sometimes interchangeably, in dealing with the same issues. The advantage of employing SMD is that it recognises the social nature of ***disadvantage*** by emphasising its relativity: as the experience of disadvantages that most others don't experience. This avoids the individualising effect of talking about 'needs', which appear to originate from the peculiarities of the person rather than inhering in social relations and requiring social and political solutions.

One health warning is worth noting at the outset. This review should not be read as suggesting that SMD should be the only priority for social policy or that it is not linked to wider patterns of disadvantage and poverty. Clearly, while some of the challenges of SMD are distinct, treating it as a discrete phenomenon carries its own risks. The sole intention of this review is simply to highlight a form of disadvantage that tends to get lost or neglected within broader analysis.

Defining Severe and Multiple Disadvantage Politically

In looking for political acknowledgement of severe and multiple disadvantage, a useful starting point is the work of the Social Exclusion Unit (SEU) set up within the Cabinet Office in the first term of the last Labour government. Its raison d'être was to address the problems which arise "when individuals or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime environments, bad health and family breakdown" (SEU 1997).

The SEU began with an assumption that the core concept of social exclusion was sufficiently comprehensive that it could be used to analyse and generate solutions to the problems faced by most marginalised groups. The SEU coined the phrase 'joined-up solutions to joined-up problems' to characterise a renewed confidence that entrenched social issues would be susceptible to more sophisticated policy making.

The SEUI went on to publish reports on rough sleeping, school exclusion, deprived neighbourhoods, teenage pregnancy, ex-offenders, teenage runaways, mental health, older people and youth in transitions. Each report sought to frame the issue in terms of social exclusion and apply a broad methodology of costing the problem, analysing the systemic barriers and dysfunction, establishing accountability and focusing public agencies on key measures of success.

> *"The SEU coined the phrase 'joined-up solutions to joined-up problems' to characterise a renewed confidence that entrenched social issues would be susceptible to more sophisticated policy making"*

By 2005, 'social exclusion' had become a very broadly (and loosely) applied concept, prompting a speech delivered by Phil Woolas MP on behalf of David Miliband MP, then Minister for Communities and Local Government. The speech highlighted the need to differentiate ***wide*** social exclusion, experienced by a large population including those facing discrimination, living in poor neighbourhoods and those in poverty, as well as long-term workless households, from ***deep*** social exclusion, experienced by those facing multiple combined social problems.

The population facing deep and persistent disadvantages was identified as existing at the intersection of poverty and broader social exclusion: "within the large minority of people who are below one or more of the basic minimum standards, there will be some who face exclusion on multiple counts. Here we get closer to a more recognisable definition of social exclusion reflecting the most disadvantaged in society" (Miliband 2006). The speech also goes on to distinguish geographically ***concentrated*** social exclusion, and notes the lack of academic consensus on the 'area effect'.

> *"Individual agencies do generally focus on improving outcomes for the neediest within their services... but often miss those who have multiple needs but need less help from any one service"*

Miliband notes the perverse consequences of categorising too tightly, but suggests that there is 'common sense' in distinguishing between the following people:

- the person struggling with basic skills "seems definitively socially excluded if they are also long term unemployed"
- the child in poverty "seems more likely to be socially excluded if their housing is poor, and their parent suffering mental illness"
- the homeless person on drugs and without skills or family "is definitively on the edge of society".

Notably this analysis does not suggest a prioritisation of these groups, but rather a differentiated approach. What is implicit but clear is that social exclusion is a phenomenon that happens to individuals as much as groups, and each individual is excluded differently depending on the particular combination of disadvantages which they face. Even within the homeless population, therefore, there will be individuals whose exclusion is much deeper than others.

In 2006, the SEU metamorphosed into the Social Exclusion Task Force (SETF) and published *Reaching Out: An Action Plan on Social Exclusion*. This report builds on the distinction between wide and deep exclusion, and translates Miliband's analysis into a critique of "why even some of our most ambitious programmes aimed at breaking the cycle of deprivation have had only a modest impact to date on the most excluded" (SETF 2006: 20). Specifically, it suggests that deep social exclusion had been insufficiently acknowledged and targeted.

Most significantly, *Reaching Out* contains the first real acknowledgement from Government of the perverse consequences of a group-based approach to social exclusion: "individual agencies do generally focus on improving outcomes for the neediest within their services (for example the most mentally ill or the most prolific offenders) but often miss those who have multiple needs but need less help from any one service. Thus, people may not meet the threshold of any given agency to trigger a fuller intervention – despite the scale of their problems or the harms caused to the communities in which they live" (SETF 2006: 74).

> “Many people are beset by a combination of these factors, interlinking with one another and driving a cycle of deprivation”

Another key innovation of ***Reaching Out*** is that it takes a life course approach to people who face multiple disadvantages. It argues that it is possible to identify people likely to face SMD later in life from a very early age, due to the commonality of early risk factors that they experience and to an inter-generational cycle.

Since the dissolution of the SETF in 2010, the new Coalition government has described similar terrain, largely informed by the work of the Centre for Social Justice and its ***Breakdown Britain*** and ***Breakthrough Britain*** series. A recent policy document by the Department for Work and Pensions, ***Social Justice: transforming lives***, states that “frequently, very low income is a symptom of deeper problems, whether that is family breakdown, educational failure, welfare dependency, debt, drug dependency, or some other relevant factor. Many people are beset by a combination of these factors, interlinking with one another and driving a cycle of deprivation” (DWP 2012: 10).

It blames rigid systems and stifled innovation as key reasons for the failure to reach this group. As with ***Reaching Out***, it adopts a life course approach, but it places greater emphasis on the health and stability of the family unit as being at the heart of the problem and the solution.

There is then some political agreement on the existence and challenge of multiple disadvantage, and the need to find specific and more effective support for this population. This is illustrated in a recently edited collection from the Fabian Society, ***Hardest to Reach: The politics of multiple needs and exclusions***, with contributions from Hilary Armstrong, Iain Duncan Smith MP and David Halpern. As with ***Reaching Out*** and ***Social Justice***, however, these essays do not achieve or maintain a clear focus on what is meant by SMD, with the result that the overall political analysis remains indistinct and entangled in wider preoccupations.

Scope and Scale of Severe and Multiple Disadvantage

A more tightly focused analysis comes from Australia, in particular at the provincial level of the Victoria Department of Human Services, responsible for the planning and funding of health, housing and other community services. A report by the department in 2003, ***Responding to people with multiple and complex needs project***, goes some way towards defining precisely the relevant population and some subsets within it.

Using data from departmental services and the criminal justice system, it identifies a number of clusters within the SMD population according to the range and severity of learning disabilities, mental health problems, self-harming, aggression and substance misuse. Appropriate policies are then analysed in terms of the level and types of outreach and service co-ordination, suitable accommodation and the extent and nature of intervention suitable such as legal advice, counselling or medical help.

Another applied definition of the SMD population comes from McDonagh et al’s (2011) ***Tackling homelessness and exclusion: Understanding complex lives***, which is a round-up of evidence from four primary research projects examining the interaction of homelessness and other factors. The studies highlight significant coincidence of homelessness with three other aspects of SMD – a history of institutional care, substance misuse and street activities such as begging. The extent of multiplicity is evidenced by the fact that nearly half the sample (47%) experienced all four aspects at the same time.

The research papers draw together new evidence on the coexistence of the four aspects, the trigger factors and the median ages of first experience of various crises and life events.

Multiple pathways to and stages of homelessness are also explored and five clusters or types of SMD are examined including combinations of homelessness with mental health issues, victimisation, street drinking, hard drugs and ‘high complexity’. Traumatic experiences in early life are found to be highly prevalent among this population, including abuse and neglect, as well as a significant rate of self-harm and attempted suicide.

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The notion of ‘chaotic lives’ is a further dimension first linked to SMD in ***Reaching Out***. This is amplified in Schneider et al’s (2007) ***Better Outcomes for the Most Excluded***, which acted as a background study for a key action of ***Reaching Out***, the Adults Facing Chronic Exclusion Programme. It approached SMD by examining the intersection of populations with multiple needs and chaotic lives.

Multiple needs is defined as the experience of two or more of the following: mental illness; certain personality disorders; severe alcohol dependence; drug dependence; learning disability and adult neurodevelopmental disorders. Chaotic lives are defined as involving four or more of the following: difficulty dealing with paperwork; difficulty managing money; no formal qualifications; no personal confidant and few friends; unemployed; highly mobile; and on a low income.

Written from a 'bio-psycho-social' perspective, the report draws on psychological and psychiatric viewpoints and attempts to integrate these with a social perspective on SMD. The authors identify the relevant population based on data from national surveys on learning disabilities and from psychiatric morbidity surveys on prisoners, homeless people and the general population living in private households. The prevalence of mental illness among the homeless and prison populations is found to be 42% and 53% respectively, as against 13% for the general population, while severe alcohol dependence is at 22% and 29% compared with 4% for the general population.

The report further develops the statistical base for the coincidence of a number of multiple needs and their intersection with chaotic lives: "People with chaotic lifestyles made up 0.9% of the general population, people with multiple needs made up 3.5% of the population, but the overlap was only 0.2%" (Schneider et al 2007: 19). The report concludes that this overlap is insufficient to justify a specific policy response, and that differentiated responses are probably needed for the largely distinct 'multiple need' and 'chaotic lives' populations. A telling finding of the study, however, is the limitations it discovered in the available data, which was often too patchy and dated to provide a basis for robust analysis. This frustration with data is echoed in ***Social Justice***, along with a commitment to improve data sharing between Government departments.

Service Delivery

The ***Better Outcomes*** report moves on from working definitions of multiple needs and chaotic lives to an assessment of some of the service delivery issues facing providers. Those services found to be most effective include individualised case management; assertive outreach; integrated, multi-disciplinary team working; crisis resolution; day hospital care; engagement with therapeutic communities and residential rehabilitation; individual placement and a support model of vocational rehabilitation.

An examination of service delivery by sector is also provided. Focusing on the NHS, it finds that statutory services and systems can "fail to prevent, [and may] create or sustain chronic exclusion" (Schneider et al 2007: 59). Boundary exclusions, such as the end of age eligibility for specific health and social care services or other fixed and seemingly arbitrary thresholds that govern any resource-limited service, are shown to be particularly problematic when addressing severe and multiple disadvantage.

While pointing to the strengths of voluntary organisations in working across these barriers, the report finds that they are often in the position of last resort, with limited resources and struggling with poor co-ordination with statutory providers. The report calls for further research on the most appropriate service delivery models and on whether multiple disadvantages should be addressed in sequence or in tandem.

One of the first attempts to envision an effective service response is the 2004 Institute for Public Policy Research (IPPR) report ***Meeting Complex Needs: the future of social care***. It sets out to address what it terms the 'inverse care law': "the more complex a person's needs, the more likely they are to fall through the gaps in the services society provides" (Rankin and Regan 2004: 11).

The IPPR report sets out a vision based on four broad principles: the treatment of whole needs; creative and holistic systems rather than standardised provision in problem-centred silos; a single point of entry to services; and user empowerment and involvement in care provision. The authors argue that the aim should be for universal, decentralised and diverse provision of care services, with personalisation as the key means by which a focus on the depth of SMD would be enabled. It further recommends a statutory duty for the NHS and local authorities to collect data and monitor multiple service use.

The authors argue for commissioning of services to become more strategic, with the emphasis shifting from purchasing to needs assessment. Alongside this a cultural change is required to develop more inter-professional training and cross-issue knowledge and information sharing. The report highlights unanimity among interviewees that cultural changes within organisations are preferable to disruptive structural changes to health and social care services.

Meeting Complex Needs concludes that much social exclusion policy is aimed at the easiest to reach and nearest to the labour market, rather than those with the most entrenched disadvantages. It proposes that the capacity of the voluntary sector should be enhanced to enable it to access those at risk of experiencing SMD. More specifically, it calls for the piloting of 24 hour-a-day Connected Care Centres in deprived neighbourhoods.

In many ways, the approach taken in ***Reaching Out*** to service delivery follows that advocated by ***Meeting Complex Needs***. It sets out a new vision for social exclusion delivery in which all service responses are underpinned by five key principles: early intervention; systematically identifying what works; better co-ordination of multiple agencies; personalisation and an emphasis on rights and responsibilities; and measures to identify and tackle poor performance.

This principles-led approach to delivery appears to signal a departure from the siloed limitations of the group-led approach that characterised earlier efforts. Many of these principles are then echoed in ***Social Justice***, especially the focus on early intervention. Added to these, ***Social Justice*** argues for a new focus on social investment mechanisms and a much stronger emphasi on recovery rather than harm minimisation.

> *“The more complex a person’s needs, the more likely they are to fall through the gaps in the services society provides”*

McDonagh et al’s (2011) ***Tackling homelessness and exclusion: Understanding complex lives*** also makes key recommendations. In service provision, the research examines the gap between the perceptions of clients and professionals and the extent to which service delivery takes account of the interrelated nature of needs. The studies emphasise the potential conflict between the work priorities of support staff and the priorities of clients, as well as the inflexibility of interventionist approaches to individual circumstances. Relaxing the stringency of local connection rules for homeless people and personalising budgets were both found to be more effective.

Examples of genuine joint working are found to be very limited, with more evidence that each agency develops and attempts to implement its own holistic plan for the same client. The report makes suggestions for more self-direction by individuals of the types of support they require, with user involvement and co-production of services acting as key tools.

The report finds that homelessness often follows on from contact with non-housing services such as mental health, substance misuse, criminal justice and social services. Despite this, it finds that housing agencies and homeless support services are often expected to take primary responsibility for dealing with this population, even though housing officers have much less support and training than professionals in other sectors.

Necessary changes include earlier identification of and intervention with the key traumas likely to mark transitions into homelessness and SMD. At the other end of the cycle, it argues that men over 30 with substance/alcohol use and anxiety/depression issues are especially neglected and require psychologically informed support to deal adequately with acute mental stress.

As with other studies, this report advocates support that enables professionals to learn from each other, to develop ‘communities of practice’ and to strengthen their co-ordination and ‘personal assistant’ role. It suggests that a key role of the service offered to individuals, who are often isolated and overly dependent on services, is to promote positive social networks and relationships.

Two Revolving Doors Agency papers also deal with the mechanics of achieving effective service delivery. One provides an overview of the types of failures that permeate the field while the other highlights more positive experiences and lessons from over ten years of experience. ***Complex Responses: understanding poor frontline responses to adults with multiple needs*** summarises the relevant literature. It finds that the obstacles to effective service delivery are (i) inter-personal; (ii) organisational and cultural; and (iii) structural.

Inter-personal factors involve both the behaviour of clients facing SMD, the professionals providing services and the relationship between the two. The stigma attached to some disadvantages such as homelessness and mental health issues can result in stereotyping and negative attitudes towards clients. These problems may be compounded by problematic behaviour, such as aggression or distressing behaviour, including self-harm. Traumatic early experiences are found to be common among this population and may account for such behaviours as well as a general distrust of authority. Service providers and professionals are urged to be aware not to reinforce such negative outlooks or low self-esteem.

However, the report also argues that equivalent awareness is needed of difficulties experienced by service providers and the anxieties and frustrations of staff. The range of behaviours frontline workers may face include over-dependency, excessive demands, emotional manipulation and self-destructive conduct. To prevent demoralisation and feelings of inadequacy, staff must be equipped with a framework for multiplicity that prepares and empowers them to deal with the most challenging clients.

> *“Without fundamental change adults with SMD will continue to “be costly to the system, accessing expensive crisis services rather than structured support through mainstream services”*

Several barriers are also identified concerning ***organisational and professional culture***. Divisions between different care and service professions lie at the heart of many of these. Different professional models of care are likely to produce divergent interpretations of SMD, in terms the factor identified as the primary cause or driver of others, as well as the different approaches to the measurement of problems and outcomes.

Workers may often experience a conflict between care and coercion in achieving desired outcomes. The need to balance these imperatives requires adequate guidance and support structures. Finally, service design and delivery may not be suited to the nature of the clients themselves. For example, long and complex forms are given to people with literacy problems and personal identification is often required of people living chaotic lives. Services and care planning must therefore be designed with people facing SMD at the forefront, with user involvement as a key means of identifying and reducing barriers.

Structural factors largely stem from problems with funding and commissioning, in particular the single issue approach, whereby resources are allocated and distributed according to the component problems without adequate links to other disadvantages. More joint needs assessments are recommended, as well as a greater recognition that rigid funding can be a barrier both to joint commissioning and to innovation in service development.

Limited resources can cause problems beyond waiting lists and high case loads. By raising the thresholds required for access to services, adults who face SMD may end up with little or no help because their needs fail to meet the relevant level of severity despite the acute nature of their combined problems. A similar outcome may occur as a result of legal barriers. The report notes that while there is a statutory obligation to house those with ‘priority need’, those who are deemed ‘intentionally homeless’ are likely to be excluded, even though the apparently voluntary loss of accommodation can only truly be understood in the context of wider factors.

The report concludes that without fundamental change adults with SMD will continue to "be costly to the system, accessing expensive crisis services rather than structured support through mainstream services" (Anderson 2011: 28). Breaks and delays in care, difficulty navigating systems and duplication all harm professional-client relationships, discouraging engagement and preventing the high quality frontline services necessary to help this group.

In *Summing Up: Revolving Doors Agency Key Learning 2000-2009*, the experience of the link worker programme and its ability to overcome obstacles to the successful provision of services for people with SMD are detailed. The link worker model emphasises client choice with the chief aim of forming effective relationships between clients and key professionals. Link workers avoided a punitive approach, instead focusing on aiding clients to overcome barriers to services and building a consistent and trusting relationship. The outcome of the link worker model was found to be more appropriate use of healthcare services, more stable accommodation situations and a reduction in re-offending.

> *"The pilots demonstrate that long term, positive outcomes can be secured for this client group, at half the cost per hour of a social worker"*

This evidence is supported by the 2011 report, *Adults Facing Chronic Exclusion Programme: Evaluation Findings*. As noted early, this programme stemmed from a key recommendation in *Reaching Out* concerning adults with multiple needs and chaotic lives. The evaluation took evidence fro twelve models working with different client groups facing various forms of SMD. The single thread through them all was the provision of a 'consistent trusted adult'. The evaluation concluded that "the pilots demonstrate that long term, positive outcomes can be secured for this client group, at half the cost per hour of a social worker" (Catell et al 2011: 8).

An important series of reports from Scotland have also recently strengthened the literature on service delivery. Rosengard et al's (2007) *A Literature Review on Multiple and Complex Needs*, undertaken for the Scottish Executive, looks at four key themes: definitions of multiple and complex needs; awareness of services; barriers to access and service users' experience of services.

The review finds an expansive number of definitions, covering groups facing broader social exclusion than SMD, including those going through key age transitions and people from black and minority ethnic groups, as well as those at the margins of society. In doing so, it emphasises the wide spectrum of interlinked disadvantages and potentially affected populations.

On ***awareness*** of services, the review highlights again the link between unwillingness or inability (due to factors such as low literacy) to access services, the daunting complexity of services and systems and a general incompatibility between service delivery and chaotic lifestyles.

The ***barriers to access*** identified include inflexible access criteria, such as age limits, that hinder continuity of care; service targets that disincentivise work with the seriously disadvantaged; institutional discrimination; and inappropriate services, such an overemphasis on medical responses to the dual diagnosis of mental illness and substance abuse at the cost of other interlinked social problems.

Service users' ***experience of support*** confirms an outlook of service fragmentation (funding, legislation, professional assessment and support systems/agencies), stigmatisation and a problematic medical model. Those at the receiving end of poor service co-ordination may find themselves in territory contested between professionals, meaning that those with a higher number of inter-connected problems may face a greater challenge than those with fewer but of a higher severity.

> *"Key gaps identified are a lack of strategic prioritisation, short time frames and crisis-driven assessment"*

Key gaps identified are a lack of strategic prioritisation, short time frames and crisis-driven assessment. The review points to a range of improvements needed: single access points to ensure service co-ordination and enable ease of access; more pro-active outreach to identify and persevere with the hardest to reach; link workers to negotiate and overcome bureaucratic fragmentation; and increased involvement of users in the design and delivery of services. The report cautions against defining successful outcomes in terms of exit from services, as this may be unrealistic for many in the long term, as well as an over-emphasis on the quantification of targets.

NHS Lothian has built on this analysis with two further papers. Gallimore et al's (2008) ***What do those with multiple and complex needs want from health, social care and voluntary sector services?*** is a literature review undertaken by the Partnerships for Access to Health (PATH) Project "to explore how health, social care, community justice and voluntary sector partners [...] can work together to improve access to services for people with multiple and complex needs" (2008: 4).

The paper finds that SMD service users want simple, quick access to services at the time they are needed; respect from staff; staff behaviour that is culturally sensitive, equal, fair and non-judgemental; and consistent and positive relationships with staff offering long-term support. On a structural level, users express a desire for effective joint working and communication between services; information about the services available, their remit and how to access them; a flexible approach to each client, as what works for one client may not work for another; support with the practicalities of everyday life; peer support; and involvement in decision making.

The report also develops more detailed findings for particular groups: substance misusers, male sex workers, refugees and asylum seekers, people with physical impairments and mental health issues, learning difficulties, and young and old populations. Further research is called for on groups and issues not covered by available literature: lesbian, gay, bisexual and transgender

(LGBT) people with complex needs; literacy; and domestic abuse. In summary, the review makes the important point that often what differentiates SMD is not the nature of demand for services but the barriers to accessing those services.

A follow-up study was conducted by the same authors under the heading *What can service providers do to improve access to services for people with multiple and complex needs?* With a review of 50 existing studies on the "[multiple] interlocking needs that span health and social issues that lead to limited participation with society", the paper aims to summarise the key findings for improving services for this group (Gallimore et al 2009: 6). The main findings are presented under three headings: 'Getting in', 'Getting through' and 'Getting on'.

Measures necessary for 'getting in' include: early intervention before a client reaches a crisis; an immediate response from services and fast referral; a single point of entry into services; flexible access to services, for example at evenings and weekends, combined with open door policies; provision of accurate information on available services; outreach work; link workers; and initiatives to overcome transport and access difficulties in remote and rural areas.

> *"often what differentiates SMD is not the nature of demand for services but the barriers to accessing those services"*

'Getting through' refers to important factors enabling clients to stick with and benefit from support once started. Central to this is a holistic approach to a client's problems. Other key factors include good relationships with staff and the provision of support, advocacy and follow up, for example by using a link worker who will work with a client across a range of mainstream and specialist services.

Finally, 'getting on' means moving beyond service dependence into a lower level of care or full independence. This requires providing aftercare and continuing support, making allowances for relapses and ensuring user empowerment, in particular the use of social care approaches.

Policy

A broader policy outlook is provided by two reports from Making Every Adult Matter (MEAM), a coalition of four umbrella bodies (Clinks, DrugScope, Mind and Homeless Link) set up to address the issues surrounding SMD and promote co-ordinated working.

In From the Margins identifies six priority areas for focus and change:

- *Stigma and discrimination* are at the heart of a cycle of negativity defining people "by their problems, not their needs, rights or potential" and often contribute to the failure to seek help.
- *Recovery and social integration* models differ between the various fields that make up the SMD landscape, so that adequate training is needed to enable professionals to account for common ground and ensure good services.
- *Personalisation and care planning* should target and measure outcomes rather than simply focus on processes.
- An emphasis on *personal rights and responsibilities* is vital to empower service users, maintain public confidence and use resources wisely.
- *Service user involvement* is necessary to make sure services are determined by the experience of those facing the greatest disadvantages, and that delivery deploys methods that users can trust and that are culturally sensitive.
- Finally, *families and communities* are important sources of broader support, and reintegration into these networks should be an important objective of services.

Turning the Tide, written with Revolving Doors Agency, makes a call to action based on damage to individuals, communities, disruption to services, high cost and the obstruction of intended government outcomes. The paper then sets out a vision for the future organisation of care services.

The priority is to establish the political will to deal with SMD, followed by a cross-departmental policy framework to address inter-related issues, combined with local leadership. Central government should define this population and recognise that calculation of their numbers requires data not available from existing or previous measures i.e. estimates which did not account for short-term prisoners, low-level mental health problems and street homelessness.

Access to community care assessments should be available to all and multiple problems should be integrated into eligibility criteria. In order to get past the silo culture, direction from Cabinet level is required to instruct commissioners who must in turn ensure the focus of frontline services. In terms of funding, a number of suggestions are made including pooled local budgets specifically for SMD, allowing local agencies to keep the savings achieved through co-ordinated action, and new sources of funding such as Social Impact Bonds.

Limitations and Further Research

A number of limitations in the existing research and analysis can be identified as possible areas for further study:

i. data on the overall scale and scope of SMD remains very patchy. Most surveys, even of poverty and social exclusion, are household-based and therefore exclude people not typically found in households e.g. people who are homeless, hospitalised or imprisoned.

ii. the long term economic case for improved action still needs to be properly quantified.

iii. strong international comparators are limited and a cross-border analysis of equivalent issues and best practice is necessary.

iv. a more compelling vision is needed of what success looks like, including who should define it. Beyond reviewing data on what people who face SMD want from services, we need a deeper understanding of what people actually want for themselves and their lives. Amartya Sen's capability approach (see Sen 1999), grounded in what people are able and free to be and to do, is highly relevant here.

v. linked to the last point, more work is needed on measures of success, particularly the complex interrelation of 'hard' quantifiable targets and 'soft' or more subjective outcomes.

vi. also vital is a more thorough investigation of how joint and multi-agency working can actually be achieved. This requires an appreciation of generic institutional factors and barriers to co-working, as well as a specific analysis of the agencies and services involved in working with SMD.

vii. as noted by Schneider et al (2007), research is required into the efficacy and practicality of the sequencing of care for those facing SMD. Some evidence for this has been gathered from the analysis of 'housing-first' programmes which do not require significant progress to be made in terms of drug or alcohol treatment before someone becomes eligible for permanent accommodation, thereby reversing the traditional sequencing of problem-solving for recovery paths.

viii. we need to understand far more clearly the most effective balance of responsibility between central and local government in addressing SMD. Pertinent questions might include: how to move from evidence-based interventions to evidence-based systems? How should accountability be established in this division of labour? What is the right balance between the collaboration of separate entities from different sectors working together and the integration and pooling of delivery within the state?

ix. there is a lacuna in analysis of the years between 'early years' and 'adults with complex needs'. That is to say, we seem to know relatively little about the emergence of multiple disadvantage in adolescence as a key stage in development, and the transition from lifestyle being determined by the parental environment to the emergence of self-determination. The unique experiences of this age group, as well as the connection between family life and early environment with behavioural outcomes and disadvantages experienced in later life, make this a vital area.

x. building on this, we also need to address the disconnected understanding of individual adults facing SMD and families and parents experiencing the same issues.

xi. as initially raised in David Miliband's speech, we don't have enough evidence of the relationship between ***deep*** and ***concentrated*** disadvantage, namely whether this is an 'area effect' on SMD. This will almost certainly need to address the relationship between ***wide*** and ***deep*** disadvantage as well.

xii. finally, there is more work to be done on the specific impact of SMD on particular groups, most obviously women, black and ethnic minorities and people with learning disabilities. Do these groups have a significantly different experience of either severe and multiple disadvantage or of the provision of services to meet it?

Conclusion

The texts summarised in this review point towards a definition of severe and multiple disadvantage as the coalescence within a population of serious social problems that often act in a mutually reinforcing manner leading to their further entrenchment. In particular, the clustering of homelessness, drug and alcohol misuse, a history of institutional care, mental health problems, cycles of violence and abuse, offending and victimisation, and chronic poverty are central to the experiences of this population. While severe indicates the extreme nature of some of the social harms, multiple points to an added dimension of difficulty – that their very co-occurrence is a stand-alone factor which makes experience of, and solutions for, SMD different from the component disadvantages experienced individually.

Multiplicity is central to ***defining*** the target population, in particular in differentiating it from a much broader population experiencing social exclusion. It is at the heart of problems for existing ***service delivery*** such as fragmentation and the funding and commissioning of welfare provision in separate silos. Arbitrary and inflexible thresholds designed primarily with severity in mind are key barriers to those facing multiple problems who may not achieve the required level for care. Key to the ***political*** recognition of this vulnerable group, therefore, is an understanding that some people's disadvantage, and the response to it, can only be understood and classified in terms of its multiplicity.

The literature also points to a clear framework for addressing SMD. This encompasses three levels:

i. government/Cabinet direction for inter-departmental co-ordination, defining the population and problem at hand and developing a mandate for action.

ii. at the local level, data management and identification of population size can be tasked to the local authority, as can commissioning structures that address SMD strategically, pooling resources from different services and providing feedback to central government.

iii. at the level of frontline services, professionals must have a clear framework for dealing with SMD providing necessary links and channels for co-ordination with fellow professionals, emotional support, and flexibility to innovate with different sequencing strategies for addressing problems, and empowering users to co-design their own services.

Extrapolating further from the literature reviewed, three key political benefits for further action become obvious:

First, the nature of SMD requires that a number of factors are addressed by a number of services provided by a number of agencies. There is an obvious immediate gain to be made in cost effectiveness by reducing the overlaps in service provision and the constant use of crisis services through instituting mainstream integrated service provision for this population.

Second, the necessary innovation required to tackle the disadvantages of the most marginalised in society provides a welcome opportunity for creativity and the establishment of new best practices in service delivery.

At a time when public service reform features high on the political agenda, the identification of a sclerotic system that fails to deal with some of the most entrenched harms in our society presents a vital opportunity to marry public sector innovation with social justice.

Finally, with the welfare system the subject of much contemporary political debate, the issue of SMD points to a highly salient area where reforms in fundamental purpose, commissioning and service delivery can begin to make it work for those who need it most.

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