LIVERPOOL PARTNERSHIP AND CARE MODEL

Multiple and Complex Needs Service Specification

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Dr Stephen Weatherhead

Consultant Neuropsychologist (NeuroTriage)

Dr Sam Wright

Researcher (Manchester Metropolitan University)

Dr Ryan Young

GP (Liverpool Homeless Team, Brownlow Health)

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1. Executive Summary

Identifying unmet need

Following the 2019 death of a homeless person, a sub-group of the Liverpool City Complex Lives Multi-Disciplinary Team ('City MDT') have been reflecting on how similar deaths could be prevented. Despite being well known to all homeless services and many hours of MDT joint work, it had been impossible to find the accommodation, care and support that this individual required. A review of other complex cases within the MDT caseload identified a further 15 individuals with similar histories, high service use and professional frustration around the absence of suitable housing solutions. This highlights a critical need for an innovative approach in how we manage the most vulnerable individuals in our community who are currently ill catered for.

The current situation in Liverpool

The Liverpool Ladder: Ending Homelessness in Liverpool (August 2020) highlights the growing number of homeless people with complex needs who require input from multiple agencies. Effective multi-agency working is crucial to support the most vulnerable, challenging and complex individuals out of homelessness. The 'City MDT' provides a multi-agency perspective on how to best support the most complex individuals in the city. However, people with multiple and complex needs are often systemically failed due to service design and implementation that are not tailored to their needs. This results in substantial health inequalities, service exclusion and premature mortality. Increasing reliance on temporary accommodation means that individuals are unable to attain the stability they need and may actually be re-traumatised, exacerbating existing health and substance use problems.

Liverpool is currently piloting *Housing First* and other strategies to address acknowledged gaps in provision for people who are homeless. Individuals with multiple needs, a history of chaos and entrenched rough sleeping may be offered access to Housing First initiatives where rapid and permanent re-housing is provided in the community with wraparound support for a period of time. Housing First provides intensive support, but it is not a 24-hour service and therefore requires independent living with support. There also remains a question about how to best support two separate groups; those who require intensive case management, and those who need a model built more around assertive community treatment. This latter group are people with multiple and highly complex needs, leaving them vulnerable to a collapse of tenancy and a return to homelessness.

Such individuals are discussed weekly in the Complex Lives MDT, where professionals are frustrated by the inability to offer effective accommodation and support. Cases are escalated up to senior managers and housing commissioners, but providing suitable accommodation and care remains impossible in the current system. Hence the need for development of a new Tertiary Prevention Model: to compliment the current system which is effective for the majority of homeless individuals.

The target population

There are currently 15 highly vulnerable, challenging, chaotic and complex individuals known to homelessness services in Liverpool city. They all have multiple experiences of childhood adversity; adulthood trauma; chronic health problems; social isolation; financial and housing problems; escalating substance problems and offending behaviours. All of them have diagnoses of both a personality disorder and cognitive impairment: a combination that impairs their social functioning and leaves them unable to engage in traditional therapeutic models of care used in homelessness services. Multiple experiences of harm, adversity and rejection leads to chronic changes to personality and an inability to engage with mainstream services or meet expected recovery timelines.

Their multiple, complex needs require personalised interventions and support. This group of people have become 'stuck' between a network of services that intend to help them. But their multi-dimensional difficulties (including: emotional, cognitive, physical, offending, substance misuse, and relational elements) combine in a complex array of risks. They are both highly vulnerable and also a risk to others. Exclusion from existing provision often occurs as a consequence of service inclusion criteria, and their difficulties with engagement. Most of these individuals are unlikely to ever be able to manage their own tenancy even with high levels of support.

The case for change: Why current service provision misses the mark

This group of people are all well known to a wide range of service providers (Social Services, medical and Mental Health services, addiction services, Local Authority, Housing and Homelessness Providers Police, Probation, and Prisons). They present with exceptionally challenging behaviours that pose disproportionately high costs to all services and lead to:

- Poorly managed physical and mental health conditions, resulting in high usage of acute medical and mental health services;
- Risk-taking behaviour which leads to both significant vulnerability and substantial risks to others;
- Being barred from multiple service providers (including accommodation providers);
- Involvement with criminal justice and frequent short prison sentences;
- Vicarious trauma for staff involved in their care, leading to high rates of absence and staff turnover.

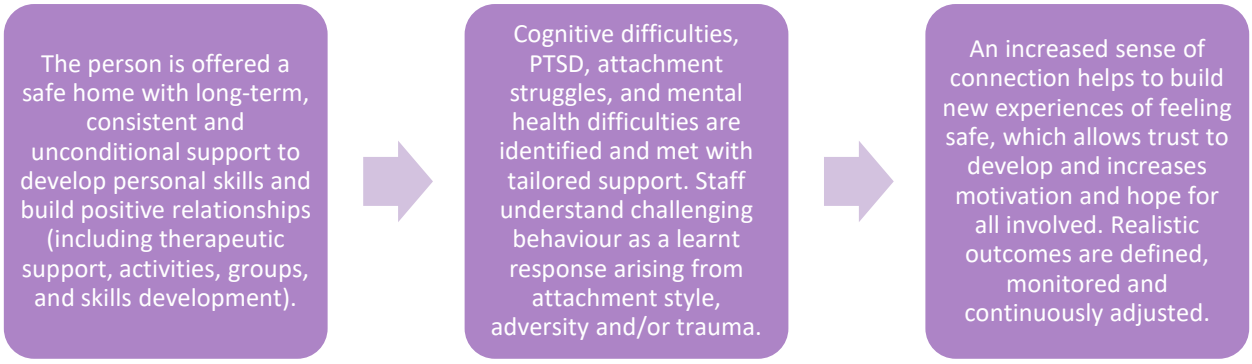
Without a holistic approach, each separate agency is quite likely to underestimate these individuals' support needs – such that none of the services involved see a need to take a leading role in their care. This means they often 'slip through the cracks' and are only partially supported by multiple agencies - with little benefit (and maximum stress) to the person themselves, compounding a chronic history of failure and rejection. Services that focus only a small subset of the complex needs that a person presents with, develop only a limited understanding (or commonly, a misinterpretation) of their difficulties, resulting in provision of inappropriate services.

Being expected to fit into relatively narrow service criteria can result in replication of the rejection many of this group have experienced throughout their lives. When their difficulties are not fully assessed or understood by services, they are offered support that is not tailored to their individual needs and is therefore unhelpful (and can even be harmful). Working in isolation, without understanding the full range of psycho-social difficulties facing these individuals, practitioners can also hold unrealistic expectations about their potential outcomes. Then, when the person's difficulties do not improve, staff and services can feel hopeless and discharge them: leaving the person less likely to be offered (or engage with) this support in the future.

A proposed model for enhanced support

What is needed is a service that is capable of: (1) developing a detailed understanding of each person's difficulties; (2) designing an effective, tailored care plan; and (3) coordinating and monitoring delivery of that care. Promoting a shared understanding between services will make partnership work easier, ensuring delivery of the most appropriate and consistent support. Consequently, the individuals will feel contained and safe, knowing that services are working jointly to support them. This will help them develop trust with practitioners, maximising their motivation to engage and cooperate.

The following diagram summarises key features of this provision:



This proposed new model is intended to provide highly supportive and psychologically informed accommodation for the most vulnerable, complex, chaotic and challenging people in Liverpool city. This service fills a gap where there is currently no provision, complementing the rest of the services across the city, aiming to provide better outcomes for each individual and all the services currently providing inputs across the city. This provision will substantially reduce service demands and costs for an array of services, including:

- Police, Prisons and Probation
- Social Services
- Medical and Mental Health Services (Acute and chronic)
- Addiction Services
- Local Authority, Housing and Homelessness Providers.

In brief, the service design is currently envisaged as follows:

Physical Environment	Psychology Informed Environment	Staffing	Partnership Working
•Three buildings: two male and one female, providing self-contained units for 12 people. •Staffed 24 hours a day to provide support and supervision. •Space will be provided for assessment, therapeutic work and skill development. (Communal spaces will be limited to prevent spaces for 'flash points' between residents.)	• Following assessment and formulation individuals will receive tailored therapeutic psychological input. Forms of therapy to be offered include: •Cognitive Analytical Therapy •Acceptance and Commitment Therapy •Cognitive Behavioural Therapy •Motivational Interviewing •The service will be responsive to moments of crisis or increased need to provide rapid support as required.	•Each person will have a nominated support worker to lead their care: holding 1:1 sessions with them, co-ordinating service input, advocating for them and arranging quarterly MDT reviews. •All staff will receive psychological support and skill development. •Detailed psychological understanding of need, trauma, cognitive impairment and mental health will allow better working between staff, services and the individual.	•All individuals will have a comprehensive multi-disciplinary needs assessment, with input from: Neuropsychology; Occupational Therapy; Social Work; Homelessness Services; physical health; Mental Health; Addiction Services; criminal justice and police. •The support worker will lead care co-ordination: meeting regularly with the individual, liaising with all other specialities and arranging MDT meetings.

This will be an adult service for people aged over 18. The accommodation environment will be neuropsychologically-informed to promote safety for all, thereby reducing the strain on staff members in order to maximise staff job satisfaction and minimise sickness levels and burnout.

The inclusion criteria will ensure that the most vulnerable, complex, chaotic and challenging people in Liverpool will access the service.

Inclusion Criteria:

1. A history of homelessness and exclusion from multiple housing providers
2. Evidence of vulnerability and risk **to** self and others, and **from** others or self-neglect
3. Needs which are present in two or more of the following domains:
    - 3.1. Physical Health
    - 3.2. Mental, emotional or psychological Health
    - 3.3. Poor relational skills
    - 3.4. Social Care
    - 3.5. Criminal Justice
    - 3.6. Drug and Alcohol Addiction

Based on current experience, it is anticipated that most of the identified individuals are unlikely to develop skills to manage their own tenancy or the stability to manage in mainstream hostel accommodation. Therefore, there is no expectation of move on from this service, although a small number may with time, be able to move to less intensively supported accommodation.

Outcomes

Given the level of complexity posed by this group of people, outcomes will take time to be visible (although it is anticipated that reductions in offending, ASB and risk-taking will be seen reasonably quickly). The first year of support would focus on individuals gaining stability across the various physical, health, neuropsychological, and social domains. The second year would focus on enhancing regulation skills and developing an understanding of how the individual can create new ways to relate to others and themselves. In the third year, increased competency will become evident.

At an individual level, outcomes may be measured in terms of reduced access of acute services (as a result of few episodes of unplanned and emergency interventions), stability in accommodation, increased quality of life, the reduced impact of trauma, and (with time) increased levels of physical and mental wellbeing. Capturing qualitative and quantitative monitoring and outcome data will not only inform service development, but would also be disseminated widely to inform future policy and practice.

Although not formally studied it is expected that a similar group will be present in towns and cities across the country. Therefore, there is a need for an effective approach which can be implemented evaluated and if successful replicated country-wide. Liverpool has been at the front of new ways of working with homeless and vulnerable individuals for many years; most recently with the establishment of a highly effective city wide, multi-agency complex lives MDT, the 'Everyone In' campaign which has gone above and beyond government guidance and, the new 'Liverpool Ladders' policy plan which has received widespread support. Given the track record of innovation and excellence and multiagency work being well-established in the city already, Liverpool is seen as the perfect location for this new and innovative approach to caring for the most chaotic and vulnerable in society.

2. The current situation and problem

2.1 Background

Following the death in 2019 of a homeless individual, a group of professionals working in the Liverpool City Complex Lives MDT got together to reflect on what led to the death of the individual and what could be done differently in future to prevent similar deaths.

The individual was well known to all homeless services and had been open to the MDT for many months. Despite substantial hours of joint working, the MDT was unable to find a solution for ongoing accommodation and a place to provide the care and support that the individual required.

When reviewing the case load of the MDT, similarities to 10-15 individuals who remain open to agencies was startling with similar narratives through childhood and adulthood, the same frustration of finding suitable housing solutions and the same high usage of services.

The review of the case and the ongoing frustration for homeless individuals and the agencies that work with them highlighted the need for a fresh and innovative approach to how we manage the most vulnerable currently let down by the system.

This report looks at the current picture of homelessness, current service provision, the characteristics of the individuals who are being discussed and a proposal for the new and innovative model of working.

2.2 Current National and Local Homelessness Context

The current government made a commitment to halve rough sleeping by 2022, aiming to abolish rough sleeping entirely by 2027 (*The Rough Sleeping Strategy, August 2018*). The 'Everyone In' initiative, launched in the early days of the Covid-19 pandemic, reflected this commitment, resulting in the provision of emergency accommodation to protect people living on the streets from contracting the virus. However, the termination of funding for the 'Everyone In' scheme has left local councils across the country with the challenge of figuring out a strategy which supports people to remain off the streets in the long term (*The Liverpool Ladder, August 2020*). While the 'Everyone In' scheme undoubtedly had a positive impact, it has not altered the socioeconomic barriers which were in place before the pandemic began, and which continue to trigger and maintain homelessness. This is compounded by the socioeconomic impact of the virus, which has seen rising numbers of people experiencing homelessness for the first time (*Crisis, 2020*), as well as exacerbating risk factors already faced by the homeless population, such as domestic violence, a particularly common trigger for homelessness among woman and girls (*Homeless Link, 2020; St Mungo's, 2020)*. The government's focus on "rough sleeping" has also left women behind, as rough sleeping figures do not take into consideration the experiences of homeless women, which are more likely to involve squatting, sofa-surfing, and remaining hidden when on the streets in an attempt to avoid violence (*Bretherton & Pleace, 2018*).

Prior to the Covid-19 pandemic, deaths within the homeless population were already on the rise, with 726 deaths in England and Wales recorded in 2018. This figure represents an increase of over a fifth on the previous year and is the largest rise since these figures began in 2013. The highest numbers of deaths among homeless people were recorded in London and the North West of England. It is noteworthy that 2018 also saw a 55% rise in drug related deaths in the homeless population on the previous year, compared to an increase of 16% for the general population (*Office of National Statistics, 2018*). While this figure is stark, it is important to acknowledge that substance abuse does not exist within a vacuum. Rather, is part of a bigger picture of other complex needs and is often predated by socioeconomic risk factors such as adverse childhood experiences and trauma. Indeed, research has demonstrated a well-documented strong association between adverse childhood experiences (e.g. abuse, neglect, witnessing domestic violence) and later life addiction (Hughes et al, 2017). Governmental recommendations reflect this complex picture of interlinking factors, acknowledging the need for an integrated approach to addiction drawing on multiple specialities, including mental health provision, housing, and social care (*Advisory Council on the Misuse of Drugs, 2019*).

The Homelessness Reduction Act (2017) presented one of the highest profile targeted pieces of policy on homelessness we have seen in recent times. It focussed on availability, accessibility and sustainability of housing offered an opportunity for targeted support, particularly for the most vulnerable in society. However, local councils have continued to highlight the gap between policy intention and the reality of a lack affordable housing, leading to an increase in pressure on resources.

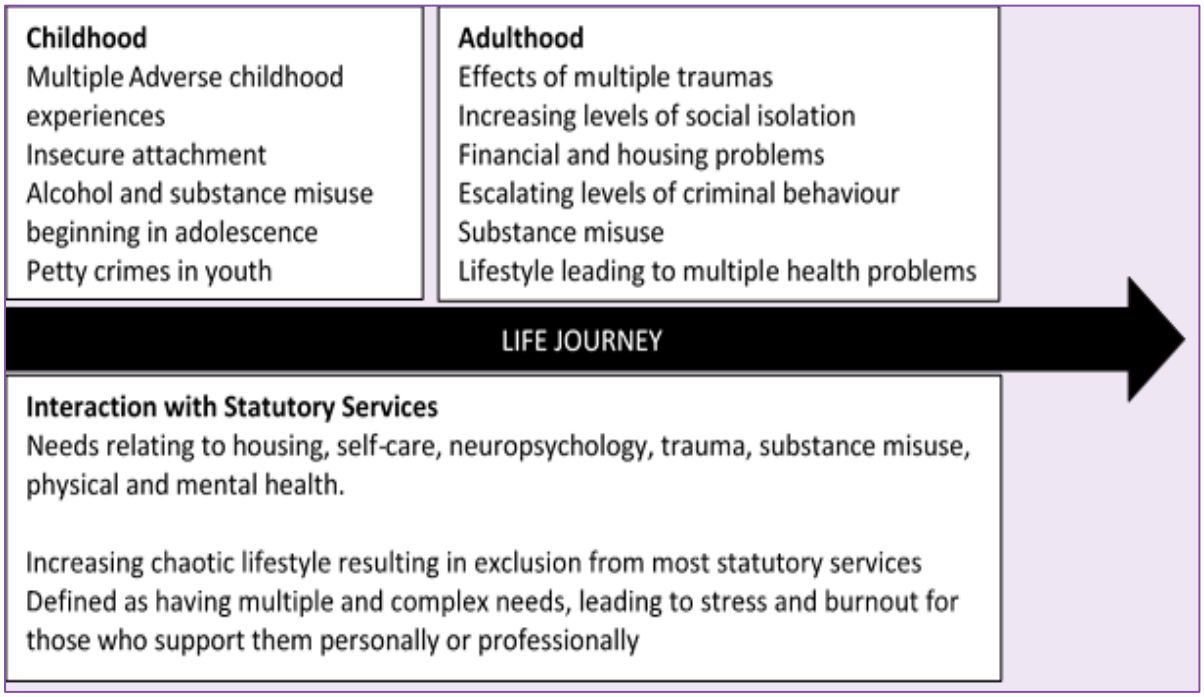
Various initiatives have been developed locally, with Liverpool currently piloting *Housing First* amongst other strategies to address gaps between policy and practice. *The Liverpool Ladder: Ending Homelessness in Liverpool (August 2020)* acknowledges the significant growth of homelessness in Liverpool since the recession of the early 2000's and the introduction of austerity measures. It also highlights the growing number of homeless people who have complex needs, requiring the involvement of multiple agencies. This is mirrored in the increased use of temporary accommodation, settings which by their very nature do not have the resource to support individuals to form long term meaningful relationships and stability. This may actually be experienced as re-traumatising, thereby exacerbating health and substance use problems.

It is now widely accepted that effective multi-agency working is paramount if we are to support the most vulnerable, challenging, and complex individuals out of homelessness and into sustainable home environments. The 'City MDT' is one mechanism for this, by bringing key professionals together on a weekly basis to offer a multi-disciplinary and multi-agency perspective on how to best support the most complex individuals in the city. It is acknowledged that those with multiple and complex needs are often systemically failed due to the design and implementation of services, despite the best intentions of the people who commission and provide those services. Health inequality, service exclusion, and high morbidity rates are observed in this population. Following the death of one of the people who had featured regularly in the city MDT discussions, it was decided to review the patterns and profiles of some of the more complex cases to see if an alternative strategy could be found to meet the needs of this group.

2.3 The Target Population

2.3.1 Characteristics of the Target Population

The working group identified 10-15 individuals who were the most vulnerable, challenging, chaotic and complex currently known to homelessness services in the city. Commonalities were found in their narratives through childhood and adulthood and their engagement with services which are summarised in figure 1.



These individuals are well known to current service providers, as they present with behaviours found to be challenging which leads to:

- Involvement with criminal justice and frequent short prison sentences,
- Risk taking behaviour which leads to significant vulnerability,
- Risk taking behaviour which leads to significant risks to others,
- High usage of acute medical and mental health services,
- Poorly managed physical and mental health conditions resulting in poor morbidity and mortality outcomes,
- Barring from multiple service providers,
- Barring from multiple accommodation providers,
- Disproportionately high costs to all services involved,
- Vicarious trauma for staff involved in their care – especially when provision breaks down.

This population has a history of adverse childhood experiences (often including sexual abuse), insecure attachment and poor educational attainment. This leads to substance misuse at a young age, inability to form healthy relationships, rejection from mainstream work, life and activities, and rejection from statutory services reinforcing feelings of abandonment.

Particularly of note all individuals had diagnoses of both a personality disorder (commonly Emotionally Unstable Personality Disorder) and a cognitive impairment. The combination seems to be synergistically problematic in social functioning and being able to engage in traditional therapeutic models of care used in homelessness services.

All Individuals have needs across multiple domains meaning all were known to:

- Criminal Justice – Police, Prisons and Probation
- Social Services
- Acute Medical and Mental Health Services
- Chronic Medical and Mental Health Services
- Addiction Services
- Local Authority, Housing and Homelessness Providers.

The needs in each separate agency are commonly sub-threshold for any individual service to take over a leading role in their care. This means they often 'slip through the cracks' and are partially supported by multiple agencies with little benefit to the individual compounding a chronic history of failure and rejection.

The chronic timeline of harm, adverse outcomes and rejection leads to chronic changes to personality and inability to integrate with societal expectations. This means that this population is unable to comply with expected timelines of recovery and 'move on' from accommodation. It is highly unlikely these individuals will ever be able to manage their own tenancy even with high levels of support.

2.3.2 Nature of Interaction with Services

Patterns in childhood and adulthood have led to multiple and complex needs, requiring personalised interventions and support. Exclusion from services often occurs as a consequence of service inclusion criteria, and difficulties with engagement:

Every individual does of course have their own personal strengths and difficulties, there are often similarities in the cognitive, physical, social, and mental health profiles of this population. Many come with multiple conditions (diagnosed and undiagnosed) and have become marginalised from mainstream provisions. This population often ends up 'stuck' within and between a network of services that intend to help them. Their difficulties have many components; emotional, cognitive, physical, offending, substance misuse, relational, all combining in a complex array of risks. The population we are considering here are both highly vulnerable and also a risk to others.

It is vital to develop a full and complete understanding of these factors when conducting assessments and interventions. When the person's difficulties are not fully assessed and acknowledged by all services they are offered support that is not tailored to their individual needs and is therefore unhelpful, and can even be harmful. Services can often be focussed on a small subset of the complex needs a person presents with, which can lead to limited understanding, misinterpretations of difficulties, and ultimately a lack of appropriate services.

Being expected to fit into relatively narrow service criteria can result in replication of the rejection many of the people discussed here have experienced throughout their lives. There can also be a pattern of setting unrealistic outcome expectations. Then when the person's difficulties do not improve, staff and services can feel hopeless and discharge them, leaving the person less likely to engage or be offered this support again in the future when / if circumstances change.

A potential route forward is, therefore, to focus on building a non-blaming and compassionate understanding of the person's difficulties, why they have developed and how we can help them. If this understanding is shared between services it will be easier to work together to ensure they are offered the most appropriate support. When all services are consistent in their approach, individuals will be more likely to feel contained and safe, knowing that services are working together to support them. Through being offered the right support and an understanding and compassionate approach the service user is more likely to feel accepted for who they are. This will also help the person to feel able to trust others and services, and to feel motivated and worthy to have their needs met.

All have difficulties with:

- Temporary accommodation
- Drugs and alcohol
- Physical health
- Mental health difficulties
- Offending

This pattern of service interaction can be mapped using a longitudinal psychological formulation (summarised in figure 2[1]) which considers past history, present struggles, interactions with services and potential routes of familiar cycles of complex needs leading to multiple referrals, assessments, relational problems, rejection, re-traumatisation, and repeated patterns of rejection.

[1] Formulation development led by Rebecca Yule

Attachments, ACE's, trauma, social isolation, homelessness

Chronic , unmanaged physical health difficulties/ self neglect

Attempts to gain care have become anti-social, and reinforced through rejection

Substances used to cope

Multiple criminal offences

High risk to self and others

Person with complex difficulties

Emotional dysregulation leading to violence and aggression

Cognitive difficulties: *Impulsivity, memory problems, disinhibited etc*

Mental health difficulties

Little understanding of difficulties and complexity/ misinterpretations of difficulties / lack of appropriate services

- ➔ Mental health V Substance misuse (instead of addressing both)
- ➔ Offences viewed as criminal acts rather than due to cognitive difficulties
- ➔ Mental health difficulties misinterpreted as 'behavioural or manipulative' behaviours?
- ➔ Person is assumed to choose the way they behave and how they cope/survive, when in reality there are no other options available to them
- ➔ Impact of trauma (PTSD) not recognised
- ➔ Cognitive difficulties masked by good verbal skills
- ➔ Person is punished rather than understood
- ➔ Disagreement regarding which services are appropriate/ responsible?
- ➔ High social and healthcare costs

Referrals to services but chaos affects engagement/ declined or discharged due to service criteria / staff burn out.

Person feels more rejected/ unworthy/ hopeless

Repeated prison sentences

Leads to more trauma and reinforces beliefs held by self and others that they are 'bad' and unworthy

Person placed in inappropriate accommodation.

Leads to more trauma

Potential Route Forward

Understand behaviour as a learnt response due to the life experiences/ trauma/ attachment style. Difficult behaviours have previously worked to help the person to get their needs met/ survive/ remain safe. Cognitive difficulties, PTSD, attachment struggles, and mental health difficulties all interact and require individualised support.

→

Containing
Dependable
Caring
Consistent

Safe
Trusting
Worthy

→

Person accepted and welcomed for who they are. It is acknowledged that long-term support is needed. Support is personalised as traditional service models are inadequate. Realistic outcomes defined.

→

The person is offered a home with support, and no conditions for secure tenancy / input. Unconditional support (including therapeutic support, activities, groups, skills development). An increased sense of connection helps to build new experiences of feeling safe and worthy of care. This allows trust to build and increases a sense of motivation and hope for all involved.

2.3.3 Level of Interaction with Services

Medical Services

This population has a high burden of chronic disease which is poorly managed. This is due to a combination of poor engagement with primary care outreach services and difficulty managing risks of treating complex physical health issues when cognitive impairment and poor social functioning limit concordance. AS one might predict, thispopulation account for a disproportionate burden of acute medical service presentations. The population had an average of 33 presentations to A&E over the prior year with the highest being 69 for one individual. In addition to the frequency of presentations, their challenging behaviour creates difficulties for A&E staff; three of the ten individuals have been barred from accessing particular A&E services.

Over the prior year, the presentations to acute medical services accrued an average cost per individual of £17,723.

When admitted to an acute hospital, bed blocking is common without suitable discharge accommodation. There is hope to provide a new 'High Impact Change Model for transfers between hospital and home' in Liverpool, however even with the new model in place successful discharge will not be possible without appropriate accommodation and tailored support.

Mental Health Services

Engagement with mental health services is variable with costly intensive assertive outreach being the only possible way to engage this group. There is a ubiquitous diagnosis of Personality Disorder, the most common being Emotionally Unstable Personality Disorder. It is recognised in psychiatry that Personality Disorders do not respond well to medical treatment and that the mainstay of treatment is psychological intervention. Psychological therapy and mental health services often hold an expectation of stable accommodation and minimal substance misuse in order for an individual to benefit from therapy. However, the approach proposed here is one of creating a holistic, supportive psychological environment, which can provide a 'safe-base' from which to engage in therapy. Liverpool has its own examples of success in implementing psychological support to this group, most notably where psychology is embedded within the accommodation.

As the psychological and mental health needs of this group are not met Individuals will commonly access acute or crisis mental health services when inevitable deterioration occurs, using acute resources which are costly and inadequate to meet their needs.

Drug and Alcohol Services

In this group, treatment of addictions is purely through a harm reduction model, providing Opiate Substitution Therapy and advice around harmful drinking and drug use. Despite the efforts of drug key workers progression to detoxification and rehabilitation will never be possible until basic care needs are met, suitable accommodation is provided and mental health conditions are treated.

Criminal Justice Services

All individuals have prior involvement with criminal justice services. A subset of the population have a sadly predictable pattern of short term prison sentences, release to the community without

adequate care provision followed by a return to criminal activity and further time in prison. This 'revolving door' pattern is witnessed over years with services powerless to break the cycle without adequate accommodation and provision for the individual's care needs.

Housing Services

Over the last year this population had on average four different accommodation placements, the highest being 12 separate placements by the local authority. The shortest placement was less than one day due to challenging behaviour. Despite the 'Everyone In' scheme, rough sleeping events still commonly occurred in this population.

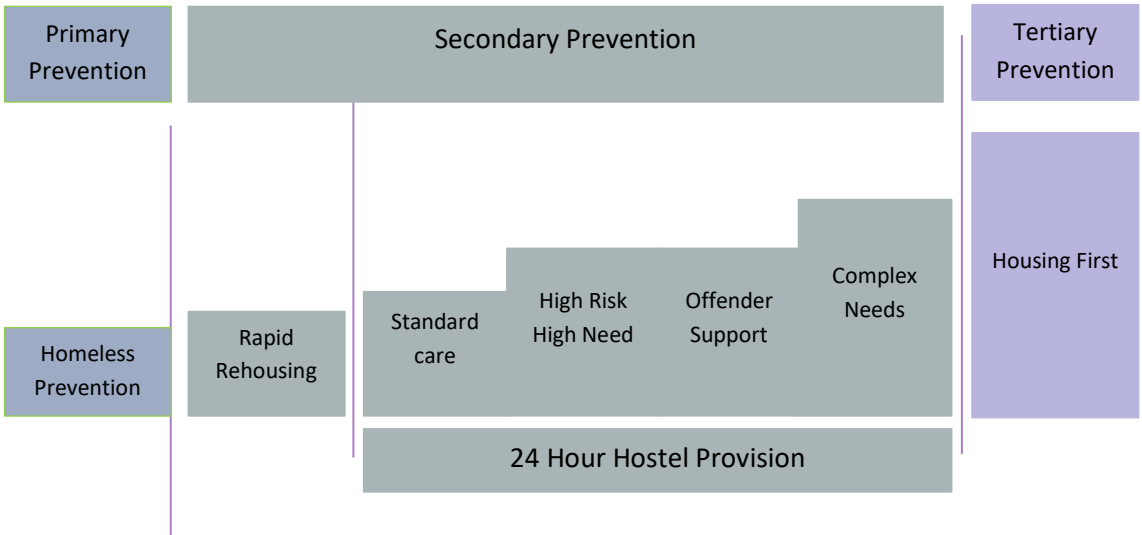
2.3.4 Current Housing Provision

Homeless service provision caters for a wide spectrum of individuals with a wide spectrum of need. Early assessment of need allows appropriate service provision, accommodation and housing support for an individual.

1) Individuals with little or no identified need may be offered simple advice and sign-posting, homelessness prevention advice or offered rapid re-housing.
2) Individuals with identified complex needs may need time in 24 hour supported accommodation with support worker involvement such as homeless hostels or probation hostels. Within hostel provision there is recognition that there is also a variation in need:
    a. Basic hostel provision with 24-hour support available and support worker time.
    b. More intensive support based on "High Risk, High Need", extra time for support from staff
    c. Specialist provision required based on risk to others, such as prior offending history.
    d. Complex needs accommodation within hostels. On top of standard 24-hour support there is extra allocated time for support worker time and access to social care.
3) Individuals with multiple needs, a history of chaos and entrenched rough sleeping may be offered access to Housing First initiatives where rapid and permanent re-housing is provided in the community with wrap around support for a period of time.

Nicholas et al in their paper on homeless prevention splits provision into:

- Primary prevention: homelessness prevention.
- Secondary Prevention: rapid rehousing with little or no support.
- Tertiary Prevention: Permanent rehousing with support such as *Housing First* Initiatives.

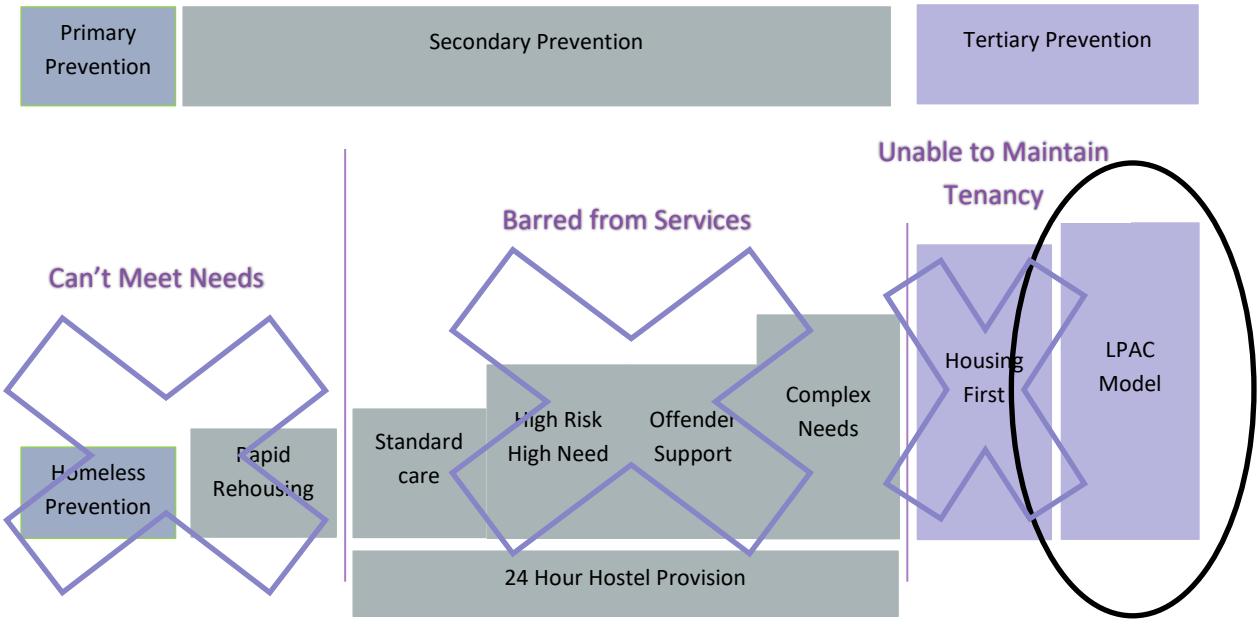


Unfortunately for a group of individuals primary and secondary prevention is not suitable. This is because their needs are not met, they are vulnerable to others in this provision or are a risk to others in this provision. For the population being reviewed, the evidence that secondary prevention is not suitable is borne out by a history of accommodation break downs and barring from almost all hostel accommodation. Individuals currently cycle through placement and breakdown which reinforces feelings of worthlessness, failure and rejection.

Tertiary prevention is provided for those who are unable to access secondary provision or unable to move on from secondary provision. Housing first is the only Tertiary Prevention available in the current system. Housing First provides intensive support but is not a 24 hour service and therefore requires independent living with support. For this group of individuals even an intensive level of community support would lead to collapse of tenancy and a return to homelessness, again propagating negative feelings associated with further accommodation breakdown.

The challenge we see with Housing First as it is currently provided in Liverpool, is that it adheres to an *Intensive Case Management* model of support. Whilst this can be very effective for people who have mental health problems, or other factors that can impact on the ability to maintain a tenancy, it does not meet the level of input required for people with more complex needs. When a person has 'multiple and complex needs' (i.e. a combination of mental health problems, substance misuse, criminal behaviour, and high levels of trauma), an *Assertive Community Treatment* mode is needed. This population need more than case management and support workers. They need regular, assertive treatment interventions that captures all of their physical, psychological, psychiatric, social, and welfare needs. The LPaC model is designed specifically with this population in mind.

These individuals are discussed weekly in the Complex Lives MDT, where professionals are left frustrated by the inability to offer accommodation. Cases are escalated up to senior managers and housing commissioners but providing suitable accommodation and care remains impossible in the current system. Therefore this paper suggests the provision of new a new Tertiary Prevention Model to compliment the current system which is effective for the majority of homeless individuals.



2.3.5 Case Study

Case Example: TO

TO was diagnosed with a learning disability in childhood, and went to a school for children with additional educational needs. His childhood was a difficult one, with household violence being a common experience. He also had a difficult time in school, reporting experiences of bullying and assault from other children. He became socially isolated and vulnerable to bullying and abuse, which became a consistent feature of his life.

After school he had some supported employment, but struggled to maintain it due to being vulnerable to manipulation from others who encouraged him into criminal activity. He lived with his parents until the age of 40, after which things deteriorated significantly, as he could not independently manage the demands of life. In addition to his many arrests and imprisonments, he has also been unable to maintain housing. He has spent four years as a rough sleeper and has difficulties in hostel accommodation.

A cognitive assessment has evidenced significant impairments:

Cognitive Domain	Composite Score	Percentile	Range
Immediate Memory	83	13	Low Average
Delayed Memory	48	<1	Impaired
Working Memory	69	2	Borderline impaired
Attention	60	<1	Impaired
Processing Speed	50	<1	Impaired
Visuospatial Skills	50	<1	Impaired
Perceptual Reasoning	52	<1	Impaired
Language	88	24	Low Average
Verbal Comprehension	63	1	Impaired
General Ability	57	<1	Impaired
Full Scale IQ	52	<1	Impaired

TO has spent a large portion of his recent years in and out of prison, having been detained almost 30 times for crimes such as shoplifting, assault, sexual offences. TO self-defines as bi-sexual, but finds this to be a confusing experience. He regularly goes to a local park for sex, which results in further abuses and criminal behaviour. He has an alcohol addiction, which is likely to exacerbate his cognitive difficulties.

He meets criteria of presenting with multiple and complex needs and has been discussed on numerous occasions at the City Wide MDT.

3. Proposed Model of Change – Liverpool Partnership and Care

3.1 Aims and Objectives

The LPaC model is intended to provide accommodation and support for the most vulnerable, complex, chaotic and challenging in the city. This service fills a gap, complementing the rest of the services across the city. It mirrors the target population and format of the *Assertive Community Treatment* models shown to be successful in regions such as Finland where evaluations have shown positive outcomes with the most complex of individuals who need more than *Intensive Case Management.* The Finnish model includes an MDT of health and social care professionals, as well as 24-hour on-site support. The concept is built on a model of therapeutic community, where support for complex needs is embedded in the psychologically-informed setting and treatment model.

The model will provide accommodation which is non-judgemental, non-punitive, highly supported and psychologically informed. For the individual it is intended that they will have a safe place to call home, have a space to build positive relationships and develop personal skills.

This service will lead to reduced dependence and costs for:

- Criminal Justice – Police, Prisons and Probation
- Social Services
- Acute Medical and Mental Health Services
- Chronic Medical and Mental Health Services
- Addiction Services
- Local Authority, Housing and Homelessness Providers.

3.2 Population Criteria

The characteristics of this population have been described above. Given the history of multiple exclusion from services for this group and the issues of fitting into very narrow inclusion and exclusion criteria, the inclusion criteria has been left broad, while the exclusion criteria has been kept to a minimum.

Inclusion Criteria:

- History of Homelessness
- Exclusion from multiple housing providers
- Evidence of vulnerability and risk to self, others, from others or self-neglect
- Needs which are present in two or more of the following domains:
    - Physical Health
    - Mental, emotional or psychological Health
    - Poor relational skills
    - Social Care
    - Criminal Justice
    - Drug and Alcohol Addiction

Exclusion Criteria:

- Under 18

4. Service Description

4.1 Physical Environment

Accommodation will be provided as a small number of self-contained units within a larger building, envisaged to be around four units per building. The units will be finished and furnished to a high quality to create a feeling of worth, value and pride for individuals and encouragement to maintain a home. Space in buildings will be provided for staff and rooms for assessment and therapeutic work. Communal spaces will be limited to prevent spaces for 'flash points' between residents. Accommodation will need to include spaces for skills development (e.g cooking and other daily living skills) The accommodation will be staffed 24 hours a day to provide support as required and supervision to the individuals.

Separate male and female buildings will be provided. For individuals with gender dysphoria, they will be placed based according to the gender by which they self-identify.

Initially three buildings will be established, two male and one female. This would provide accommodation for 12 individuals.

The vast majority of this population have some form of cognitive deficits due to factors such as brain injury, learning disability / educational issues, physical health problems. These can result in problems with:

- Vision
- Cognition (e.g. memory and attention)
- Hearing
- Physical / mobility

The following is a cursory checklist for supporting the development of a neuropsychologically-friendly environment.

Outside space - Wheelchair accessible - Doorbell / intercoms at an accessible height - Ramps in place of steps - Well lit - Paths, doorways and other entrances contrasting in colour / lighting to other areas - Safe and secure communal area, both sheltered and open - All visitors, regardless of ability, able to access the same entrance	
Office area - Clearly labelled function - Staff photographs, names, and roles easily visible - Reception desk at a height suitable for wheelchairs	
Wayfinding and function	

- Clearly labelled rooms - Colour-coded hallways and rooms, with contrasts between different areas - Rooms with the same function (e.g toilets) have the same colour décor / same doors - Accessible office area enhancing connection - Signage in large print - Good colour contrasts, light against dark (e.g. light yellow / dark blue) - Different textures as a marker between rooms - Plain, not patterned flooring	
Internal space - Light switches, door handles, and handrails at an accessible height and in contrasting colour to other surrounds - Wheelchair accessible doorways, tables, and other furnishing - Seating accessible to people of different heights and physical abilities - Multiple communal areas, range of sizes - Options for light dimming - Accessible lifts between floors - Transparent panels between doors - Suitable number of accessible toilets - Hearing induction loops - Soft furnishings, pictures etc in good condition and regularly updated	
Additional spaces - Counselling / Therapy room - Medical treatment room - Storage spaces - Occupational therapy kitchen area - Workshop space for vocational activities - Recreational activity spaces with a range of activities in good condition and regularly updated	

4.2 Partnership Working

Prior to accessing the service all individuals will have a comprehensive multi-disciplinary needs assessment which will involve input from:

- Neuropsychology
- Occupational Therapy with or without Physiotherapy depending on need
- Social Work
- Homelessness Services/Housing Assessment
- Physical Health
- Mental Health
- Addiction Services
- Probation, criminal justice and police.

This will allow development of a comprehensive understanding of need. These needs will be met by collaborative working and the work of individual specialities in an initial management plan which is then reviewed and modified periodically.

After initial assessment and care plans have been formulated by the Multi-disciplinary Team (MDT), a support worker will take a lead co-ordinating their care, meeting regularly with the individual, liaising with all other specialities involved, and arranging three monthly MDT meetings to ensure needs are being met.

Challenging behaviour will be understood in the context of an individual's narrative and MDT formulation. While boundaries will be present and enforced individuals will not be excluded from the service based on challenging behaviours, rather plans will be put in place to deal with the root cause and to manage risk that occurs.

Individuals will be offered support for addictions through specialised drug and alcohol workers with a focus on dual diagnosis. Opiate substitution therapy will be offered and links to drug and alcohol rehabilitation will be made with the offer of a return to their accommodation. Drug and alcohol use will be tolerated in rooms, but not in communal areas. Prior to opening, discussion will take place with local police to agree a shared understanding of drug use.

Based on current experience there is expected to be a low likelihood that the identified individuals will develop skills to manage their own tenancy or stability to manage in mainstream hostel accommodation. Therefore, there is no expectation of move on from this service, although a small number may develop, with time skills and stability to move to different service provision.

4.3 Staffing

Accommodation will be staffed by support workers with a background in homelessness services, mental health services or drug and alcohol addiction services.

Each individual will have a nominated support worker who will lead their care, have one to one sessions, co-ordinate other services, advocate on their behalf and arrange three monthly MDT reviews.

A staff presence will be on each site 24 hours a day.

All support staff will receive one to one psychological support, with space to reflect on practice, difficult interactions and situations and personal and service improvement. This will be provided through NeuroTriage. This is a key underpinning principle of a true psychologically informed environment. Staff will also be supported by NeuroTriage to enhance their psychological knowledge and skills, to increase the sense of safety and support for all.

The following current services will provide input to a multidisciplinary needs assessment and then ongoing management as needed based on individual need:

- Neuropsychology *(initial assessment and one to work on identified psychological needs)*
- Occupational Therapy with or without Physiotherapy depending on need *(initial assessment, one to one work as needed with identified functional or physical needs)*
- *Social Work (initial assessment)*
- Homelessness Services/Housing Assessment *(initial assessment and ongoing support work as nominated lead support worker)*
- Mental Health *(initial assessment, ongoing support will be provided as appropriate based on need and will be provided as part of usual mental health provision)*

- Addiction Services *(initial assessment, ongoing support will be provided as appropriate based on need and will be provided as part of usual addictions service provision)*
- Physical Health *(initial assessment, ongoing support will be provided as appropriate based on need and will be provided as part of usual general practice provision)*.

It is recognised that individuals may need extra support at times from support workers or other specific specialities. The service will be responsive to moments of crisis or increased need to provide rapid support as required.

4.4 Psychologically Informed Environment – Assessment and Formulation

All individuals on entering the service will undergo psychological assessment and formulation of their past harm, current need and pathways for recovery and development. This will allow a profile to be co-produced with the individual which then can be shared with all other members of the group. A true psychological understanding of need, in the context of trauma, cognitive impairments and mental health diagnoses will allow better working between staff, services and the individual. A truer understanding allows staff to work in a way that avoids future harm, reduces conflict, and allows the individual to feel safe and valued in the new accommodation.

Following assessment and formulation individuals will receive tailored therapeutic psychological input. From past experience the nature of these interventions needs to be flexible and respond to the individual, forms of therapy to be offered include:

- Cognitive Analytical Therapy (CAT)
- Acceptance and Commitment Therapy (ACT)
- Cognitive Behavioural Therapy (CBT)
- Motivational Interviewing (MI).

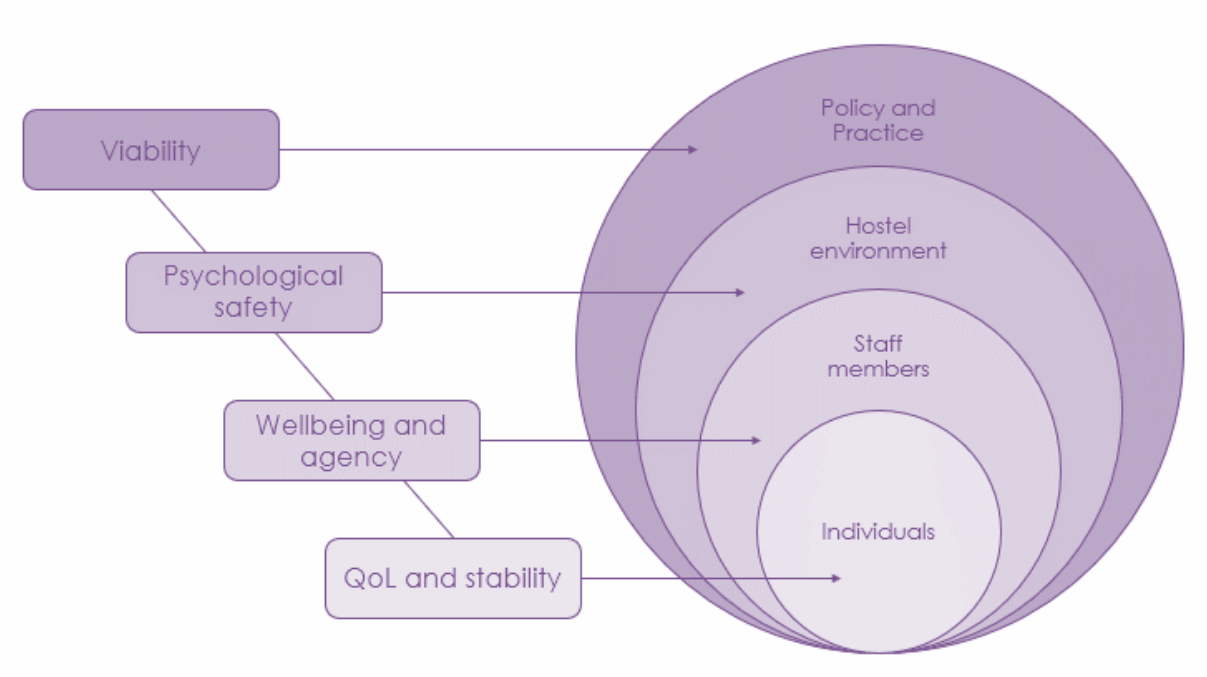
Interventions will be provided when individuals are ready to engage. Psychologists will be available at set times during the week and visible to individuals to allow them to engage on their terms. This is an approach which has proved successful in an alcohol harm reduction service in the Liverpool.

At the beginning of the project all staff will receive training on the central psychological therapeutic models and understanding the client in the context of their trauma and past. This will be supplemented by one to one working or group working as described above.

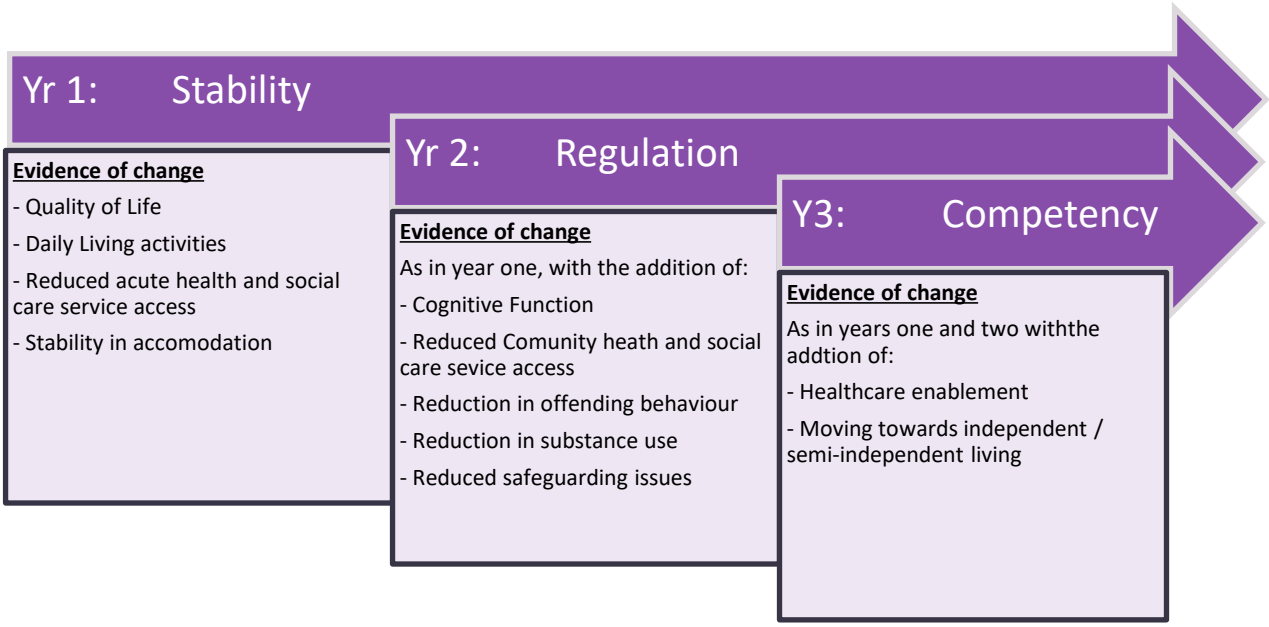
4.5 Outcome Measures

The level of complexity people within this group present with combined with the likelihood that they have experienced a lifetime of struggles means that outcomes have to be taken in context and with the acknowledgement that they will take time to be visible. Traditional models of seeking short-term (3-6 months) change are unrealistic within this group. However, with time and consistency, effective and sustainable change can be achieved at multiple levels.

A range of outcome measures and forms of evidence are required at each of the different levels. These will be different for each person, dependent on their profile, and should incorporate each of the various disciplines involved in the person's care.



The first year would be focussed on gaining stability across the various physical, health, neuropsychological, and social domains. Having set a strong base, the second year would focus on enhancing regulation skills and developing an understanding of how the individual can create new ways to relate to others and themselves. It would be in the third year where one would expect to see evidence of increased competency.



A longitudinal approach is essential in evidencing outcomes with this population, with the acknowledgement that there will be setbacks and steps backwards as well as forwards.

At an individual level, outcomes may be measured in terms of reduced access of acute services (as a result of few episodes of unplanned and emergency interventions), stability in accommodation, increased quality of life, the reduced impact of trauma, and with time increased levels of physical and mental wellbeing. This would reduce the burden on staff members who will be working in a neuropsychologically-informed environment that values their wellbeing, giving them a greater sense of agency. This will reduce staff burnout, lower sickness levels, and increase job satisfaction. The accommodation environment will have an enhanced sense of psychological safety. Capturing qualitative and quantitative data for dissemination across various contexts will help to inform future policy and practice.

Outcome evidence at an individual client level

Outcome Focus	Appraisal tool
Quality of life	Patient Health Quality of Life Questionnaire (SF-12)
Daily living activities	Activities of daily living checklist
Health care access	Number and form of contacts with acute and community health services Mental health service contacts and form
Social care access	Care Act Assessment improvement Cost of social care Social Worker involvement
Accommodation stability	Maintained tenancy Risk of harm to self and others
Cognitive Function	Cognitive screening tools relevant to individual presentation
Healthcare enablement	Patient Activation Measure (PAMS)

In addition to individual client level, evidence should also be gathered at a more systemic level to ensure the work is having a broader impact aimed at sharing ad enhancing knowledge and provision.

As part of the service design the team are working with colleagues in academia to arrange rigorous independent evaluation of the service and outcomes which will then be published in academic literature to guide future effective working and policy.

Domain	Outcome Focus	Appraisal tool
Staffing	Staff wellbeing	Sickness absence rates Self-Agency Reflective Practice Skills
Hostel	Culture	Stakeholder satisfaction Psychological safety Resident Stability
Local and national level	Policy	Model application data reporting Policy guidance Best practice examples Local and national dissemination

5. Key Documents

- The Rough Sleeping Strategy, August 2018
- The Liverpool Ladder, August 2020
- Everyone in
- Crisis, 2020
- (Homeless Link, 2020; St Mungo's, 2020).
- (Bretherton & Pleace, 2018).
- Office of National Statistics, 2018
- Hughes et al, 2017).
- (Advisory Council on the Misuse of Drugs, 2019).
- The Homelessness Reduction Act (2017)
- Homeless Code of Guidance for Local Authorities (MHCLG) 2018 updated 2020.
- The Five Year Forward View for Mental Health (Independent Mental Health Task Force to the NHS in England)
- NHS Outcomes Framework (Department of Health and Social Care) 2021.
- Adult Social Care Outcomes Framework 2019/20 (Department of Health and Social Care) 2020.
- If reoffending is not the only outcome, what are the alternatives? Kevin Wong – HM Inspectorate of Probation. 2019
- (https://www.outcomesstar.org.uk/using-the-star/see-the-stars/homelessness-star/*)*