inpractice
QUARTERLY GOOD PRACTICE BRIEFING

Adfam
Families, drugs and alcohol

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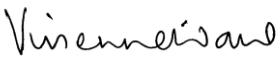
# Families and multiple needs

After the success of our good practice briefings on domestic violence (pdf) and fund-raising (pdf) Adfam felt that the challenge of supporting adults facing multiple needs and exclusions and their families was a topic well worth focusing on.

Adults with multiple or complex needs may be affected by substance use, mental health problems, homelessness, offending, disability or other factors. Each will have unique needs and difficulties as will their families. In this briefing we speak to the experts in the field – both professionals and family member – to find out what works and how help can best be found.

We hope the resources contained in this briefing prove useful for those of us affected by or working with individuals facing multiple needs and exclusions.



**Vivienne Evans, Chief Executive**

**IN PRACTICE**

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CLiNKS DrugScope homeless link mind

MEAM Making Every Adult Matter

# An introduction to multiple needs and exclusions

*Oliver Hilbery is Project Director for Making Every Adult Matter (MEAM), a coalition of national charities focused on policy and practice change for adults facing multiple needs and exclusions.*

Everyone involved in substance misuse services will recognise a group of individuals who face a combination of other problems in their lives, such as homelessness, mental ill health and offending.

Despite the best efforts of many local agencies service provision for this group remains patchy. Differing priorities, funding regimes, organisational cultures and professional barriers can mean that local agencies deal with one but not all of an individual's needs, while others are denied a service altogether.

As a result people can fall through the gaps, becoming reliant on inappropriate and expensive emergency or criminal justice responses and without access to the coordinated interventions that help change lives. As individuals 'recycle' around services the costs mount both for them and for public funds.

In short, individuals who face multiple needs and exclusions

- experience a combination of issues that impact adversely on their lives
- are routinely excluded from effective contact with services they need
- tend to lead chaotic lives that are costly to society.

**How many people are we talking about?**

Because individuals tend to be poorly connected to services there is very little national data available. However estimates suggest that this is a small, non-static group, perhaps numbering around 60,000 at any one time, and found mainly in the prison and homeless populations.

Defining this group locally is probably more appropriate as these individuals are well known to local services, councils and communities. A number of areas have started to use behavioural assessment tools such as the New Directions Team (NDT) Assessment to focus local attention on this group, thereby ensuring that the most disengaged individuals are supported and that there is consistency across work in different local areas.[1]

**Successful interventions**

There is a growing evidence base around what works in supporting individuals facing multiple needs and exclusions. This briefing includes information about a number of services that work with, and for, this most marginalised group. The majority of these interventions focus on engaging individuals, coordinating access to services and ensuring flexible responses from mainstream agencies.

From past and current practice Making Every Adult Matter has identified a set of 'core elements' that are shared by successful interventions. These include:

- **coordination:** a named worker or team to link individuals to existing services and influence local services to be flexible
- **flexibility:** senior level strategic commitment from statutory and voluntary agencies to offer flexible responses for this group
- **consistency:** consistent identification of clients using an agreed methodology i.e. the NDT Assessment (details above)
- **measurement:** commitment to measuring social and economic outcomes.

Alongside these are a number of ways of working, such as a personalised and persistent approach, that are also part of a successful intervention.

[1] The New Directions Team Assessment was developed by the South West London and St. George's Mental Health Trust as part of the Adults Facing Chronic Exclusion programme

MEAM has recently used these 'core elements' to develop, with partners, a series of national pilot services that will operate in three local areas during 2011. Each of these pilots will focus on better coordinating existing services rather than providing a whole new – and costly – intervention, showing that it is possible to achieve better outcomes for this group through stronger coordination of services that local areas already have in place.

**What are the benefits?**

There is also a developing body of evidence relating to the social and economic benefits of more coordinated working. By supporting people to move away from a reliance on expensive emergency and criminal justice interventions multiple needs services can reduce the costs associated with inappropriate and duplicated service use. Of course there are social benefits too – both for the clients of the services and for the communities in which they live.

Collecting and analysing data around both the social and economic benefits is central to developing or sustaining a local intervention. The MEAM pilots are working with Pro Bono Economics and economists from the firm LECG to capture information that will help make this case and a report will be published in early 2012.

**What does government policy say?**

Government policy on multiple needs and exclusions has been developing since the issue was first discussed in *Reaching Out?,* the Labour government's action plan on social exclusion. This recognised that a new approach was needed for adults facing multiple needs and exclusions and put in place 12 pilots to test new approaches - the Adults Facing Chronic Exclusion programme.

A focus on this client group has been maintained by the Liberal Conservative coalition, both through its work on multiple disadvantage and its stated commitment to ensuring that spending reductions are managed in a way that protects the most vulnerable in society. MEAM is working with the new government to examine how a clear message on the importance of tackling multiple needs and exclusions can be conveyed to local areas and the actions that government could take to make it much easier for local areas to put coordinated interventions in place.

**How can I do more?**

Of course there are many barriers to tacking multiple needs and exclusions – national and local – but they can be overcome.

Local agencies and their partners can look at how to better coordinate their responses; review the processes they use to decide who to work with and when; and at how strategic buy-in can be found and maintained. If you are interested in starting a discussion in your local area about better coordination of services for people facing multiple needs and exclusions then the information in this briefing and on the MEAM website should be a helpful starting point, or please get in touch to discuss the issues further.

# What's it like for the family?

When asked to write as a family member of someone with multiple needs I knew my first problem would be how to write everything I wanted down within the word count. My second problem would be coping with the anger and frustration that writing this piece would bring up for me.

Sue H, family member, explains the challenges she faced supporting a son with multiple needs around alcohol use and mental health

Have you ever sat during the night wondering if a person you love is dead, or has perhaps hurt someone else? Have you ever thought it would be far less painful if the person you loved was dead?

Well if you have, you may have been close to someone with multiple needs.

It was life changing: my life stopped for many years and I became sick myself. Where were the people to help when we so needed them? My husband lost a wife, my eldest son lost a mum and we all lost the youngest member of our family. I remember clearly all the times I said 'If only they would listen'.

Full of fear and shame I battled on, but many I got to know along my journey were not so lucky: several in prison for long sentences, one son in prison for murder, several sons dead - families being destroyed and the one common factor I heard was 'if only they listened'. Not feeling heard and not being acknowledged as a person with value can be the biggest frustration when you have a loved one with multiple needs and an enormous factor in family members becoming depressed themselves.

I remember my son saying in court when he was 17 'I have been seeing people all my life and people listen but no-one has heard what I am saying'. His frustrations paralleled ours. It took until he was 28 until one person really heard me and it has been life changing for four people in our family as well as the community. Those years were lost and the problems compounded, with far more trauma than I felt was needed.

Mental health services, alcohol services, the police, ambulances, courts, probation, prison, hospitals – all this was completely new to our family. Our family name was being blackened and all sense of credibility slowly disappearing. It would be many years before I felt we were leaving the stigma behind.

> It would be many years before I felt we were leaving the stigma behind.

The cost it involved was large - financially this would be very interesting to know, but the cost emotionally to us all could never be gauged. This cost as a family will take many years to recover. Recovery for families is not just about when the person gets help; it takes many years and some families will never recover.

The frustration can be massive - going around in circles, being pushed from here to there, waiting for weeks between appointments, unanswered letters, unreturned calls, and all the time being told 'we cannot talk to you – it's confidential'. Imagine hearing the words 'my hands are tied' when you are desperate for help because you can clearly see someone at risk. Who is the person who carries the worry, who is the one that lives every week with this fear, frustration, anger, loss? If workers do not know how to deal with it, how would untrained families? How could I explain to my son the reasons for him not being listened to, the long waits, the merry-go-round of services and staff when I really could not understand it myself?

And then at last – one person listened. He took all my son's previous medical history into account, agreed to see my son and I together, acknowledged all the risk factors but most of all his attitude towards both of us was so different. He acknowledged that perhaps there could be an underlying problem that would contribute to the problems. Oh boy, the relief when someone just sat and listened and looked at past history and recognised that the problems still existed when my son was not drinking. He was willing to look at the whole picture - something that no-one else had really done in many years of distress.

You too could be that person that makes a real difference in your job not only to one person's life but a whole family. See the family as having value and information that may be helpful. We can be a huge support network for that person when you are not around. Don't isolate us if we are supportive people, don't discard us like we know nothing, we have spent far more time with this person than you. Personally I feel there are many issues:

- Attitudes should change: I do realise that not all families play a positive part in recovery but many family members who are trying to help love the person very much and would do anything for them. Some practitioners forget how much influence families can have on encouraging change in the person and what an enormous resource they can be. Families need the support of services and to not be ignored or made to feel bad.
- Families are experts of their own experience: a practitioner may spend one hour a week with a person, but families are often with them the other 167. They may have insight that a practitioner cannot.
- Lack of communication between services: this may sometimes be due to a lack of care coordination or a care co-ordinator in some situations.
- Services are sometimes ineffective in partnership working: many say services are working together and that is of course fantastic, but I still feel there is an unwillingness to do this in some areas.
- Sometimes mental health workers do not feel skilled in working with substance use, whilst substance use workers do not feel skilled enough in working with mental health.

Families may feel they lack the skills to deal with either, but we have no choice. We have the services – it's the connecting, sharing training and a willingness to work together that I know would make a huge difference. It was a journey we will never forget.

We have the services – it's the connecting, sharing training and a willingness to work together that I know would make a huge difference.

# Top tips for a family member

1. **Be persistent and consistent:** keep making the calls and writing the letters. Don't give up - someone will listen eventually. Find out about PALS (Patient advice and liaison service) in your area and seek their advice.
2. **Be safe:** never put your own safety at risk. Have an emergency plan in place to leave the environment if needed. It's far too easy to put the other person's needs before your own safety.
3. **Learn about services:** find out about all the services that are involved with your loved one and what their role is. Learn how services work – they are often confusing to understand. Don't be afraid to ask and never keep quiet for fear of upsetting people.
4. **Advocate for joint working:** problems often arise when agencies don't work together or refuse to take responsibility. Recognise that this is not always because individual workers don't want to help. Advocate for solutions. Ask agencies if they are in contact with the other services involved and if they have held a case-conference. Find out if there is a care coordinator and make contact. Build strong relationships with all the agencies involved.
5. **Be involved:** talk to the person with multiple needs about being involved with their care. If they agree make sure this is recorded in a written statement somewhere and all agencies involved with the person's care are aware of it. Ask if you are included in the person's care plan.
6. **Seek legal help**: learn about legal rights and the responsibilities of agencies involved. There are many help-lines that can provide advice (see contacts page). Be assertive but not aggressive and use your knowledge appropriately for the situation.
7. **Have a crisis plan in place:** ask what happens and who to ring in a crisis. Keep these numbers available at all times and use them if necessary.
8. **Know your rights:** it may be that your loved one does not want you involved and practitioners cannot speak to you about them, but you still have a right to be heard and listened to. If you believe the person is at risk, remind the service that there are exceptions to keeping confidentiality. Tell the service you wish to have what you say recorded.
9. **Keep a record of events:** especially when you feel the situation is deteriorating. This may help uncover patterns leading up to crisis.
10. **Ask about a carer's assessment:** make sure you talk about your own needs as well as what care you can provide. Take care of your own health at all times – tell people if you can't cope.
11. **Find help for yourself:** support groups, carer groups, help-lines, and anyone else you could call in times of distress. Have these numbers available when needed. Build yourself a tool-box of coping strategies and learning from others and don't be afraid to pick up the phone. Do not suffer alone. Do not let yourself disappear and try to keep a balance in life – we need some fun and respite from the situation. Do not feel guilty about taking time out.
12. **Always have hope:** at times it seems unbearable and that things will never improve. Things do change and getting help and support yourself can make a real difference not only to you but also in assisting your loved one to change. It can be a long process, but always have hope.

# Points of view

We interview two people involved with services supporting those with multiple needs – Lee Murphy, Manager of the Life Works project at St. Mungo's and Geraldine Strathdee, Consultant Psychiatrist, Oxleas NHS Foundation Trust, Bromley Complex Needs Service.

**What are the gaps in provision or coordination for people with multiple needs? And what can be done to address these?**

Lee: We are a psychotherapy service for homeless and socially excluded individuals. What generally tends to be available from traditional mental health services for clients is either the short-term Cognitive Behavioural Therapy (CBT) option geared towards low level depression or anxiety or at the other end of the scale a longer term service for which you may have to wait twelve months or more and achieve certain levels of abstinence. The needs of lots of clients fall between these two options – the CBT option is not comprehensive enough and they are excluded from accessing other provision due to lack of formal diagnosis, current substance use, sporadic engagement patterns or failure to use the service in a sustained and linear way.

We offered 25 sessions which people could use like vouchers to book blocks of sessions however and whenever they wished. Some wanted breaks in between sessions, though most preferred to view the provision as a continuous six month period. Of those who attended the first session 70% went on to engage in a meaningful way, attending more than the initial five or six sessions, an excellent engagement rate. The demand for the service is massive - for the two-and-a-half year period we have been running we have had 500 referrals. People want it, use it and get benefit from it. Client's outcomes are measured against the outcomes of similar people using core support services only and their outcomes are more positive on all counts. Significant areas include improved mental wellbeing and relationships but the biggest change is on improved meaningful use of time. A single fifty minute session can have a massive impact on the rest of a person's week, through giving them purpose and meaning.

Geraldine: In South London I run a statutory mental health assertive outreach service that is committed to working with clients facing multiple needs and exclusions. Although a statutory service, we work in close and essential partnership with local agencies, many of them voluntary.

> The main gap in provision is around early recognition and the realisation that some people are at a higher risk than others.

There are two main gaps in provision that we are trying to address. One is around early recognition and the realisation that some people are at a higher risk than others. Children leaving care, for instance, are at a higher risk, as are those with a significant history of mental health or substance use in the family. High risk groups need to be recognised earlier – there is plenty of evidence to suggest that support and help can stop a downward spiral.

The other main gap is outreach in the community – people sometimes have not found services helpful and have not consistently turned up to appointments. More proactive outreach may address this concern. The initial spend on outreach can save money later in reduced interaction with NHS, emergency service, housing, benefits and others. Proactively supporting people is the only way to go – early intervention can save help save costs in the long run.

**What are your working links like with other local agencies and partnerships? And how have you fostered successful partnership arrangements?**

Lee: It is of course essential to have independence in the eyes of the client and clear confidentially so trust can be established but you also need an embedded and trusting relationship with the host referring agency. Clients want to know that services are joined up as they are so used to them not being. There is a fine balance to strike as the clients can

bring problems they are having with the host organisation and its employees which is a challenge, but one on which we would hope to have a positive impact.

All partnerships need clarity and collaboration and are often founded on excellent individual practitioner relationships. Being a voluntary sector agency has a useful dynamic in building trust with clients who have previous negative experience of mental health services. To this end many clients who had previously not worked with statutory services did so after engaging with our service.

Geraldine: Our links are derived from the needs of our patients. We have lots of partnerships – we use as many resources as possible from our local authority's leisure facilities and work with the local employment agency, ASBO team and mental health liaison nurses and GPs.

We also now have a housing specialist in the team and hold at least one housing surgery per week. Clients need a stable financial position, and are very vulnerable and may be targeted by dealers. For the people in the most vulnerable situations we work with appointees from the local authorities who are financial guardians and experts on finance.

**What can a family member do to support their loved one with multiple needs? What challenges do they face?**

Lee: Estrangement from family is very common among homeless people.

> Relationship breakdown is recognised as the single most common factor in causing homelessness…

Relationship breakdown is recognised as the single most common factor in causing homelessness and we therefore don't do much direct work with family members. We do though work with what clients bring regarding their relationships, such as loss, neglect, abuse and bereavement. These are often indicated in early disruptions in people's attachments with significant others and the impact this has on their lives as well as new current relationship difficulties. The work can be helping people think about their situation, working through unresolved feelings, identifying what they want from past, present and future relationships, and sometime re-/connecting with family.

Geraldine: Only a third of our people are still in contact with families. Our deputy charge nurse runs a carers' group for multiple needs and dual diagnosis which has proved very useful and much valued. Families should never give up hope – learning to be kind but tough is hard - it's hard to say 'I love you but I'm not giving you 500 pounds'. Often clients who have supportive families do well, one patient has a brother who goes to the gym every day with him and his mum does a big Sunday lunch every week. This practical and regular support is key.

**What advice would you give those supporting individuals or families affected by multiple needs?**

Lee: Using psychotherapy is for many a huge step and we are constantly surprised by people's bravery in actively engaging. To support this initially a practitioner can help an individual by normalising the use of 'talking' and 'being heard' and asking whether an individual needs anything pre or post session without asking them to break confidentiality.

Geraldine: To get results you have to work in a strong team that wants to do this work as it's hard and you can get despondent. You have to think 'what agency is out there that has the right resources?'.

# Who does what?

People facing multiple needs and exclusions are often in contact with a large number of different statutory and voluntary agencies. It is important for family members to understand the roles of the different agencies and to advocate for joint working when this is not happening (see top tips section).

This brief guide is intended to provide some basic information on who does what. Services may differ locally in their approach to certain issues so this guide is not a replacement for local knowledge and relationship building. It is as accurate as possible, but should not be used as legal advice.

Please note that some of the structures outlined are likely to change in the future as the government implements national changes.

**Criminal justice**

**Police:** The Police protect people and property, deal with emergencies and keep order. There are 43 police forces across the country.

**Courts:** Magistrates Courts deal with minor offences and handle 95% of criminal cases. The Crown Court deals with more major offences.

**Prison:** The Prison Service keeps in custody those committed by the courts. Its duty is to look after them with humanity and help them lead law-abiding and useful lives in custody and after release.

**Probation:** The Probation Service prepares reports for the courts and the Parole Board, and supervises offenders, approximately 70% on community sentences and 30% released on supervision license from prison. It aims to protect the public, reduce re-offending and rehabilitate offenders.

**Criminal justice VCS:** A large number of voluntary services work in the criminal justice system both in prison and the community. These include prison in-reach services, education services and resettlement and rehabilitation services. To learn about the services in your area please see Clink's Working with Offenders Directory.

**Substance misuse**

**Drug and alcohol treatment services:** Drug and alcohol treatment services support individuals towards recovery from substance misuse. They may be provided by statutory or voluntary agencies and often have either a drug or alcohol focus. They are classified on four tiers: (1) non-specific general services, (2) open access services, (3) community services and (4) residential services. To learn more about the services in your area please see DrugScope's Helpfinder database.

**Drug and Alcohol Action Teams (DAATs):** Treatment services in each local area are commissioned and coordinated by Drug and Alcohol Action Team partnerships or DAATs. These bodies are made up of key partners and work together to address local treatment needs.

**Health**

**Primary Care Trusts (PCT):** PCTs are responsible for the provision of health services in local areas. They directly provide some community services; fund doctors (GPs); and commission secondary care (i.e. hospitals and mental health services). The government has announced that PCTs will be abolished by 2013, with their strategic commissioning role passed to groups of doctors (GP consortia).

**Strategic Health Authorities:** Each PCT is overseen by a Strategic Health Authority (SHA) of which there are ten across the country. SHAs oversee the work of PCTs and health services in the region. The government has announced that SHAs will be abolished as part of the NHS changes outlined above.

**Doctors:** Doctors, or General Practitioners (GPs), are the main point of entry to the health system. They provide 'primary' health services for physical and mental health issues and often act as the main point of referral to secondary and specialist services when further treatment and support is required.

**Hospitals:** Hospital services are provided by NHS Hospital Trusts (also known as Acute Trusts) and commissioned by PCTs (above). They provide

'secondary' health services for physical health issues. The term 'secondary' is used because most individuals are referred from 'primary' services, such as GPs or via Accident and Emergency departments.

**Mental Health**

**Doctors:** As above, doctors provide 'primary' services for mental health issues. They may refer individuals to 'secondary' services provided by mental health trusts (see below) or to other services such as counselling provided by their surgeries or elsewhere. They may also prescribe some drug treatments.

**Mental Health Trusts:** Mental Health Trusts (commissioned by PCTs) provide 'secondary' care services for those facing mental health problems. Mental Health Trusts may provide some or all of the following types of service:

- **Hospitals:** Psychiatric hospitals provide hospital-based services for individuals requiring residential treatment. They usually support people experiencing more severe mental health problems or facing periods of crisis. Most hospitals also operate outpatient units. Psychological as well as psychiatric care is provided in hospital settings. Most individuals will be referred to hospital via a Community Mental Health Team (see below). Those detained under the Mental Health Act will also be admitted.
- **Community Mental Health Teams:** CMHTs support individuals with mental health needs in community settings. Services may include psychiatric treatment, counselling, psychotherapy (such as CBT) and family support.
- **Crisis Resolution and Home Treatment Teams:** CMHTs may operate Crisis Resolution and Home Treatment Teams (CRHTs) that support people in crisis and seek alternatives to hospital admission
- **Assertive Outreach Teams:** CMHTs may also operate Assertive Outreach Teams, which work to engage individuals that Trusts find it harder to reach. An Assertive Outreach Team can be a good place to discuss the needs of an individual facing multiple problems
- **Specialist Teams:** Some CMHTs will run specialist assertive outreach services focused on homelessness, substance misuse or multiple needs.

Note: Many Mental Health Trusts restrict access to their services based on the perceived needs of the individuals concerned. Some are unwilling to work with those currently using drugs or alcohol or those whose needs fall below a certain 'threshold'– for example those experiencing low to moderate anxiety or depression or personality disorder.

This is not the case everywhere and the exclusion of people on this basis should always be discussed and where necessary challenged, locally. This is because when combined with other issues such as homelessness, substance misuse or offending, low level mental health needs and personality disorders are often a serious cause for concern.

Determining whether and how to provide a service should be based on a holistic assessment of need conducted in close partnership with other local agencies, such as drug treatment teams, who all share a responsibility to the client and to supporting local mental health services.

Treatment and support for this group can have positive effects and it is often an underlying mental health issue that is driving other negative behaviours. Government guidance recommends that Mental Health Trusts should take the lead in cases of Dual Diagnosis (mental health and substance misuse combined) and that those with personality disorder should no longer be excluded from treatment.

**Voluntary providers:** Many voluntary sector agencies provide support for those experiencing mental ill health. Services may include advice, guidance, day services, resettlement, carers support and housing. For a list of local Mind services please see Mind in your area.

**Social Care**

**Social care:** Social care is provided by social service departments in local areas. They are usually part of the local council, but some areas have combined health and social care teams, which may also

include mental health services. Anyone thought to be in need is entitled to a Community Care Assessment to test their eligibility for services, which may include help in the home (for example with bathing or dressing) or residential support (such as care homes). Access to social care services is restricted by the Fair Access to Care Services (FACS) criteria with many areas providing care only to individuals assessed as having 'critical' or 'severe' needs.

**Adult Safeguarding:** Local authorities have a statutory responsibility to safeguard vulnerable adults (a legal term) from abuse or neglect and will have an Adult Safeguarding Team. This team can undertake safeguarding investigations to address actual or alleged abuse/neglect and put in place appropriate joint action from all local agencies. Such action is justified on the basis of possible 'harm', which includes 'ill treatment… impairment of, or avoidable deterioration in, physical or mental health; and the impairment of physical, intellectual, emotional, social or behavioural development.'[2] Adult safeguarding procedures have been used successfully to support individuals facing multiple needs and exclusions.

**Housing and homelessness**

**Local authority advice and assistance:** All local authorities have a statutory duty to provide advice and assistance on housing to anyone that requests it. Most local authorities will have a housing advice centre or homeless person's unit where this advice can be sought. The advice should be 'up to date' and 'effective' in helping to 'achieve the authority's strategic aim of preventing homelessness.'[3]

**Homelessness duties:** All local authorities also have a duty to provide accommodation to individuals they assess as being homeless and in priority need. This includes people with dependent children and those found to be 'vulnerable' (a legal term) due to various circumstances, such as age or illness. For more information on priority need please see the Shelter website. Everyone has the right to a homelessness assessment and to a written decision from the local authority.

**Temporary accommodation:** Local authorities may place people they have accepted a duty for (see above) in temporary accommodation while a more permanent solution is found. Due to a general lack of housing people can spend a long time in temporary accommodation, which may be provided in social, private or supported housing units.

**Homelessness hostels:** Homelessness hostels provide short-term support for people who are homelessness. They are provided either by local authorities (who may use them as temporary accommodation, above) or by voluntary sector agencies. Most hostels are supported by local authority funding and most can only be accessed through a referral from an outreach team or other agency (such as a day centre or support service). Hostels aim to support people around their needs and prepare them for permanent accommodation (see below).

**Day Centres:** Day centres provide open-access advice and support for homeless people. Many will also offer activities, education, training and facilities such as showers and meals. They may also provide assessments for homelessness accommodation.

**Outreach teams:** Outreach teams engage with homeless people on the street. They provide advice and assessment with the aim of helping people to address their needs and move into accommodation.

**Permanent housing:** There are four main kinds of permanent accommodation – social housing (which is owned by a local authority or housing association (sometimes called a registered social landlord); private rented accommodation supplied by private landlords; accommodation that is owned by individuals (often with the support of a mortgage); and supported housing, which may be provided socially or privately and includes an element of support. **Floating support** services provide help with tenancy sustainment.

To search for all homelessness services in your area including hostels, day centres and outreach teams please see Homeless Link's Homeless UK website.

[2] Dept. of Health and Home Office (2000) No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse, DH & HO, London
[3] Communities and Local Government (2006) Homelessness Code of Guidance for Local Authorities, CLG, London

# Learn more

- ✓ Beyond the Silo is a blog covering mental health, homelessness and substance use. It contains lots of information of interest and relevance to the multiple needs agenda.

- ✓ Clinks is the national charity which supports third sector organisations that work with offenders and their families. It works nationally and locally to lobby for change, build capacity and support networks and partnerships for delivery.

  Its Working with Offenders Directory is an online directory of third sector organisations working with offenders and their families.

- ✓ DrugScope is the national membership organisation for the drugs field and an independent centre of expertise on drugs and drug policy.

  Helpfinder is DrugScope's database of drug treatment services and could be useful in searching for support services.

- ✓ Homeless Link is the national charity representing homeless organisations across the country. Homeless Link also manages Homeless London and Homeless UK, which provide searchable listings of homelessness services across the county.

- ✓ Making Every Adult Matter (MEAM) is a coalition of four national charities – Clinks, DrugScope, Homeless Link and Mind – formed to influence policy and practice change for adults facing multiple needs and exclusions.

- ✓ Mind is the leading mental health charity in England and Wales. It works to create a better life for everyone experiencing mental distress by campaigning for people's rights, challenging poor practice in mental health, and informing and supporting thousands of people on a daily basis.

  Mind has advice and information available online and via the telephone. For details please see Mind's website - for example, information on mental health and drug or alcohol misuse, which is often referred to as dual diagnosis. Mind also publishes a series of short information booklets, which can be viewed here.

  In your area is a directory of Local Mind Associations (LMAs) and allows users to search for these by location.

- ✓ The Economic and Social Research Council has a research programme on multiple exclusion homelessness.