FRONTLINE HOMELESSNESS SERVICES: RESPONDING TO THE CHALLENGE OF COMPLEX NEED

Anton Roberts, Homelessness Researcher at Manchester Metropolitan University

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In Collaboration With

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MEET THE TEAM

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Contributor	**Affiliation**	**Position**	**Background**
Anton Roberts – Report Author	Manchester Metropolitan University	Homelessness Researcher	Anton is a researcher at the Policy Evaluation and Research Group (PERU) at MMU. His PhD research focuses on visible forms of homelessness i.e. street/rough sleeping, and the service difficulties when engaging with this group. He has over a decade of experience working with marginal populations more generally.
Judy Vickers – Research Partner	Lifeshare	Lifeshare's Executive	Judy has worked with Lifeshare since 2005 and is qualified in social work. Judy manages the core operations of the service, as well as the Respite service at the Mosaic Wellbeing Hub and Christmas Project . Judy represents Lifeshare at a strategic level.

KEY OBJECTIVES

1. What are complex needs and how does it overlap with other terms such as multiple deprivation?
2. What are the problems organizations, service users and staff encounter as a result of complex deprivations/needs?
3. What solutions and examples of best practice can we bring to bear to improve the outcomes of society's most vulnerable and improve provision's ability to meet these difficulties?

SUMMARY OF FINDINGS

This service guide combines a variety of sources, at the staff, service and service user level to present a series of detailed recommendations. These represent a series of general approaches that can be utilised by front line services to assist in meeting the challenge of complex need.

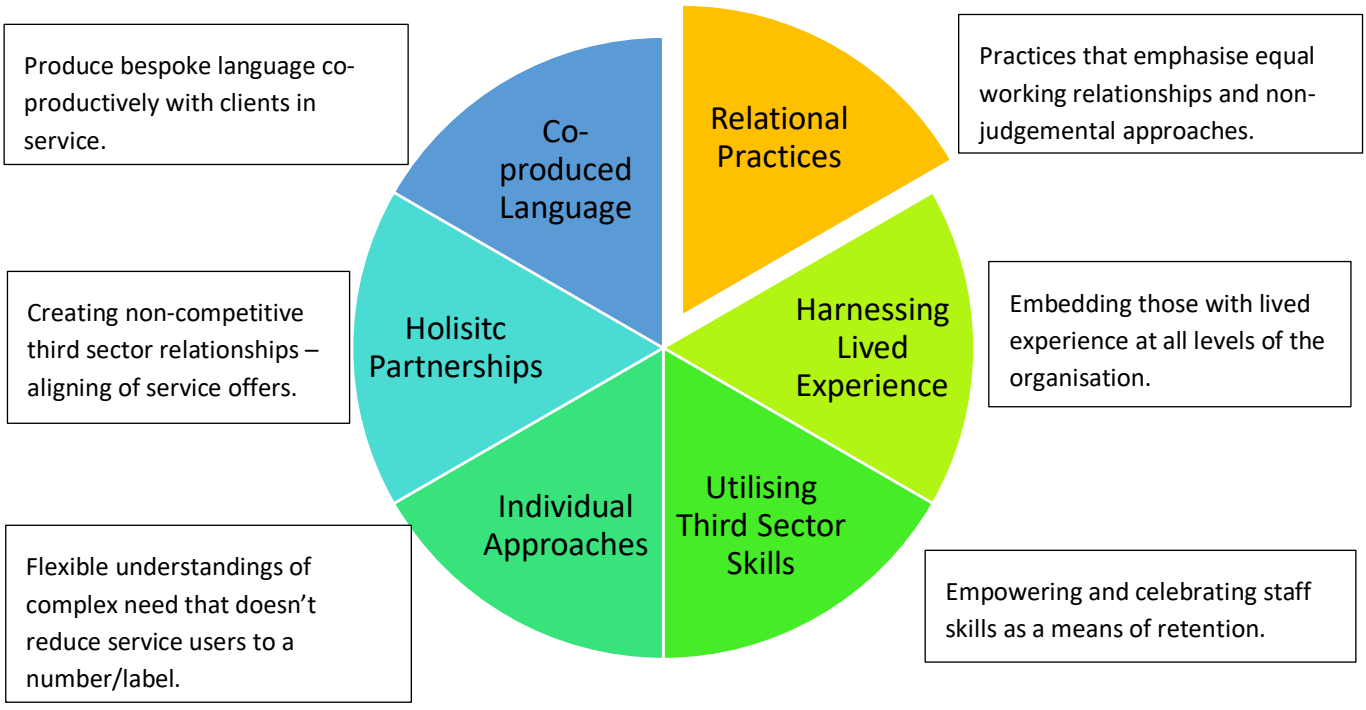


Figure 1. Summary of main themes

INTRODUCTION – A SNAPSHOT OF HOMELESSNESS

Homelessness is a complex social phenomenon and represents one of the biggest challenges to modern society. A common understanding of homelessness is lacking internationally and varies between formal organisations such as governmental bodies and voluntary homelessness services/charities. One of the most common definitions of homelessness looks at it through 3 domains: the legal, physical and the social. Individuals are said to be experiencing homelessness if their dwelling fails to meet their basic needs (physical), if they are socially excluded in some way (social), or they do not have the same legal rights as others e.g. the right of having an occupation (legal) (Amore, Baker & Chapman, 2011). As a population, it represents one of the most diverse, marginal and vulnerable populations that it is possible to work with. Official government figures tend to show a year-on-year increase in the number of people experiencing homelessness. At the level of local authorities, 311,990 homelessness assessments were done in 2022-23 in England alone (GOV, 2023a). This is nearly a 7% increase on the previous year. Typically, at one end of the spectrum of homelessness exists what might be described as the 'hidden homeless', which for a whole host of reasons do not present as services or local authorities, such as those couch surfing with or squatting in unknown locations. No accurate statistics exist for this population, as they are not recorded by any of the usual measures e.g. seeking housing assistance, but it is likely to be considerable.

A significant part of the population for those experiencing homelessness are those that are currently insecurely housed, this means they have not yet presented to their LA. Often, these individuals are enduring dangerous living arrangement such as being a potential victim of domestic violence, or their residence is not fit for human habitation i.e. substandard or extreme overcrowding. At the other end of the spectrum are the more visible forms of homelessness, such as the rough sleeping/street sleeping communities. In this form of homelessness

individuals 'bed down' outside in the open air, such as in stairwells, areas of high foot fall e.g. high streets, or public parks. They are what most people understand as homelessness and suffer a disproportionate level of violence, criminalisation and victimisation due to that increased visibility. Although it can be a diverse group they are more likely to be white, male, and are often referred to as a 'single homelessness', which often entitles them to only the poorest levels of welfare support (Gov, 2018). Official counts on the number of rough sleepers in England, has varied from around 3000 to 4000 (see McVeigh, 2016), with the latest government figures placing it at 3,069 (GOV, 2023b). Although homelessness charities have consistently suggested this number is considerably higher, a report from Crisis (2018) for example, placed the figure of rough sleeping at 11,000 in England alone, on any given night.

At the service level Individuals with extended experiences of rough sleeping represent the most challenging demographic within this group. Not only is statutory assistance reduced (usually assigned in relation to perceived 'priority need' a statutory definition of what is considered vulnerable), but they tend to have the greatest degree of complex need/multiple deprivation as a result of their experiences of rooflessness. Although it should be noted that complex needs and forms of multiple exclusion are not exclusive to any particular form of homelessness. It is not uncommon for instance, for those experiencing hidden homelessness to also avoid services or have experiences of rough sleeping at some point in their journey through homelessness (Crisis, 2011).

WHAT ARE COMPLEX OR MULTIPLE NEEDS?

Surprisingly, despite the long recognition within the sector of an ever-increasing population of those that would be described as 'complex' or 'multiple' need, a fixed definition is hard to find. There is an increasing awareness that purely 'brick and mortar' solutions to homelessness are insufficient to properly address the societal problem of homelessness (Dobson, 2022). As the number and complexity of individuals experiencing forms of homelessness increases year on year, so does the variety of problems and barrier that services, organisations, and statutory bodies attempt to respond to. As other scholars such as Manuel (2016) have pointed out, complex needs are so poorly defined that it routinely goes by a range of other interchangeable terms such as; multiple exclusion homelessness, various forms of 'disadvantage', those with high support needs, and services users with co-morbidity or multiple/dual diagnoses etc.

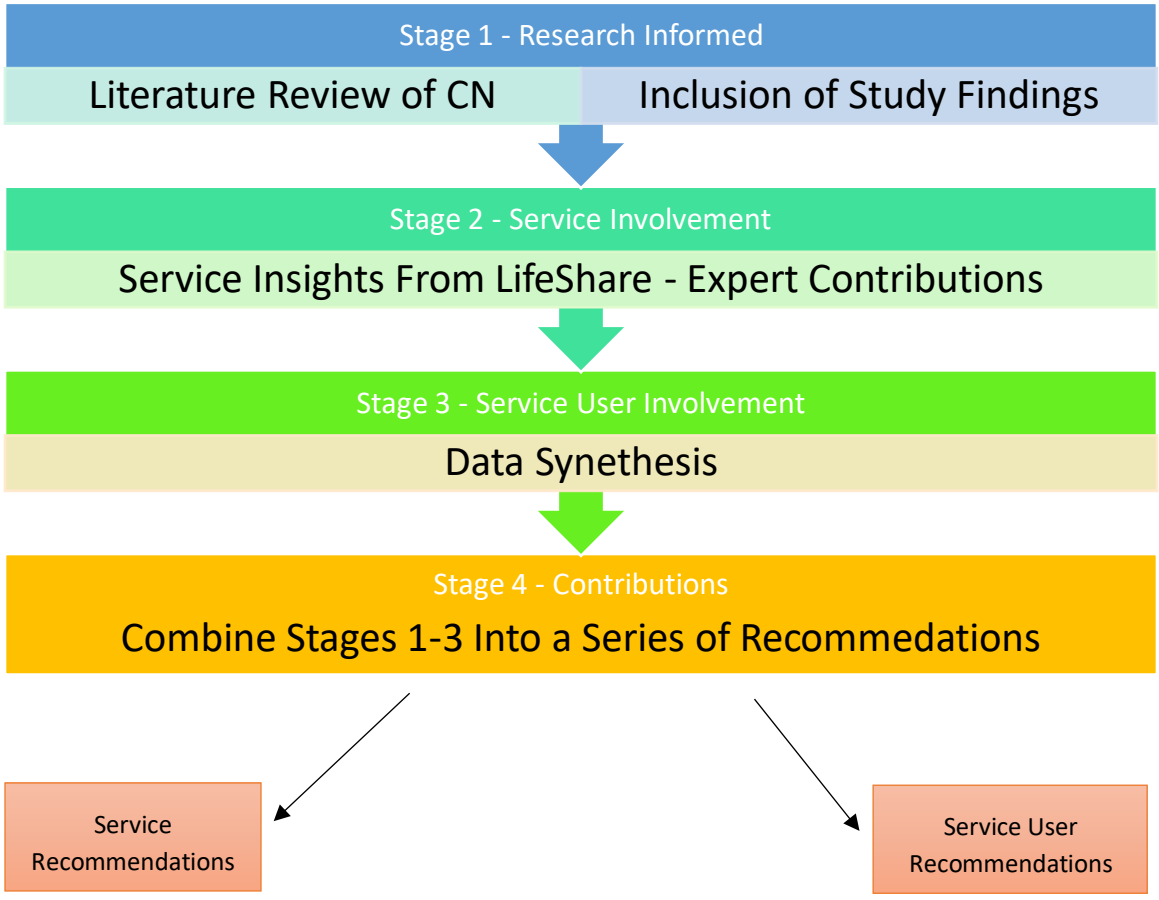
One of the foundational causes of complex needs is prior i.e. ACE's (adverse childhood trauma) or recent experiences of trauma of one form or another, which can result in a whole host of challenges (Radcliff, 2019). This could have occurred as a result of being in an institution, for example, such as a prison or a mental health facility. Another aspect of complexity can be how

experiences of homelessness causes difficulties in their relationships which creates all manner of difficulties at the service level. It's not uncommon for individuals to experience difficulties in forming new and trusting relationships, as to those experiencing rough sleeping, connections with others can carry a great deal of risk. This relational complexity can be difficult when trying to establish a baseline of trust which services and professionals of all types. Although these are only two examples of complex need it serves as a good starting point, for both the challenge of working with such a client base and the need for a practical guide that attempts to wrestle with these ideas.

HOW THE RESEARCH WAS CARRIED OUT

HOW WAS THE RESEARCH CARRIED OUT?

Fig.2. Visual Representation of Research Process



This innovative service guide incorporates several strands of data, insights and lived experiences. Academically it contains a summary, a literature review more generally, around complex and multiple need. This provides the wider background and current definitional understandings. This report also includes many of the preliminary thematic findings from Roberts (2024) doctoral research - an in-depth ethnographic study which took place over a two-year period across multiple homeless provisions across Manchester. This work focused on service users who displayed the most difficult behaviours for services to engage with such as those with concurrent physical and mental health related diagnoses, and those who often presented as 'hard to reach' i.e. resistant to support. This study also included detailed interviews, 15 in total, with both historic and current individuals experiencing rough sleeping, some of which had homelessness histories extending over decades. These two data sources were combined and analysed, and the subsequent themes are presented here both as challenges and recommendations for potential solutions at the service, staff and service levels respectively. Many of the findings of this research were able to speak to the (at times) extreme challenges faced by services, that were attempting to combat a seemingly ever-increasing societal problem of complexity of need in their service users. In addition, there were many examples captured in the data of impressive, novel, and good service practice which were being utilised to combat this ever-changing phenomenon. The intention of this report is to create a resource that is useful to any frontline service or organization that works with marginal populations. However, this body of work represents a shared enterprise to the challenges and solutions to complex need.

As such, alongside the literature review, and the summarised themes from the doctoral research, a co-productively involved homelessness organisation added another layer of insight to this service guide. The result is a resource that does not belong to any one individual or service, with the hope that it is useful to those on the frontline of homeless provision. Participatory methods were employed in two respects, firstly as mentioned above, co-production informed on the data collection directly as Roberts (2024) study was created with individuals experiencing homelessness (not on). The research data itself was co-produced with service users on site at the service to insure it remained as faithful as possible to their voices, with the author already an outspoken advocate for the benefits of coproduction at the government/social policy level (see Roberts, 2022).

RESEARCH PARTNERSHIP

Additionally, the second stage of this project involved working closely with a third sector research partner i.e. a frontline charity that was already working in the homelessness sector. In this case the organization Lifeshare which is a voluntary organisation established to help meet the needs of homeless and vulnerable people in Manchester and Salford. Their first point of contact is with people on the streets, offering practical assistance, support and information. They offer continued assistance that enables people to secure suitable accommodation, support them in maintaining their tenancies, and help them to access initiatives that carry their lives forward. They also fight to combat digital exclusion, a still unrecognised form of marginalisation within homelessness.

At the service level Lifeshare have a long history of working closely with those individuals who they assist, both being advocates for working 'with' not just 'for' service users. Both the researcher and the partner organisation are considered advocates of practices of empowerment and agency. Both authors of this report are also active members in the Manchester Homelessness Partnership (MHP), a voluntary co-productive organisation that joins up charities, services, government organisations and those with lived experiences of homelessness to work on shared solutions to homelessness.

Lifeshare facilitated a series of written contributions and recorded interviews, from members composed of staff, volunteers, and service partners (many with lived experiences of homelessness). At the first level this involved discussions around the definitions of complex need, as it related to their expertise and experiences etc. They reflected on the challenges of

navigating the wider welfare system and how that impacts on service user needs, services and wider complexities of deprivation. Once a full draft of the guide was produced it was circulated with the full list of contributors who then provided further feedback. This final stage not only allowed for an additional element of verification, but taken together it offered a synthesis of academic, service and service user insights, of what complex needs amount to in the day to day, and how in a practical way (and often with few resources) we can respond to this challenge.

HOW THE EXPERTS DEFINE COMPLEX NEED

Throughout the interviews all the contributors were asked to define what they thought complex needs was, they were shown the definitional prompt and the examples from the bulleted list below. This pragmatic definition of complex and multiple needs served as a starting point of discussion.

'Any service user that presents at the point of service with 3 or more of the following needs, may be categorised as experiencing complex/multiple need.'

Although this list is not exhaustive, the literature discusses many needs in connection with complex need (CN) that are often encountered in this population:

- Homelessness itself – difficulties created around everyday survival e.g. not being able to attend medical appointments
- Poor mental health – deterioration often follows experiences of homelessness
- Previous or complex trauma - childhood abuse is common in this group with many being former care leavers
- Illicit substance and/or alcohol misuse
- Housing difficulties – lack of secure/safe accommodation
- Unemployment – often as a result of lacking a fixed abode
- Disabilities – higher rates of a whole range of learning difficulties
- Multimorbidity (suffering from multiple forms of illness simultaneously) e.g. diabetes, psychotic episodes and/or substance misuse
- Relational difficulties - loss of social connections e.g. denied access to children.
- Domestic violence/other Forms of Abuse
- Involvement with criminal justice system – forced to comply with license conditions etc.
- Poverty/economic Instability – debts, or lack of a bank account

- Presenting as 'hard to reach' i.e. chaotic – thus not able to consistently engage with services
- Resistant behaviours i.e. presenting with aggressive 'street survival behaviours' in the service – often leading to service banning.
- Institutional mistrust – suspicion towards professionals due to negative experiences with welfare sector

Although a small selection is included above in the literature summary, our contributors argued that CN's was not a static label. That it interacted, and in some cases, overlapped with terminologies such as multiple deprivations which could be a source of ambiguity to staff and service users. There was realisation that there are too many needs or deprivations to name. There was a shared sense these specialised needs flow together, interacting in complex ways and that any sort of fixed definition had little value. An example might be how growing substance misuse can lead into suffering from forms of depression, anxiety and paranoia to create an almost unique set of needs for that individual and in some cases repeated bouts homelessness. There was however a wider recognition that broader structural factors play a big part of what we see as a need. One point of distinction here were how ideas around wider deprivation could be seen as synonymous with CN which many of the experts resisted - geography could also play a part i.e. more deprivation or CN is assumed within certain areas. *'Complex needs can be a result of a number of factors, not just deprivation' (Service Partner).*

Figure 3. Diagram of example definitions

THE CHALLENGE OF COMPLEX OR 'EXTREME' NEED

As a result of the challenging behaviours that are associated with complex needs, it is not uncommon for practices of exclusion to often emerge, even at the service level e.g. banning, as a result of the challenging presentation you can see in this group. As a result they often only engaging superficially with a wide range of welfare resources e.g. hospital A&E's, using a disproportional amount of time and resources. Not only do such individuals slip through the statutory and service cracks, but they often persist with such needs for extended periods without improvement. These could range from drug rehabilitation units, supported accommodation to homelessness services etc. At a wider level this presents a significant financial and time burden on the welfare system more generally, often with little long-term impact (Dobson, (2022). However at the point of the individual, stuck with an array of complex/multiple needs, they can struggle to access the conventional pathways to homelessness recovery. With services often only focusing on only one aspect of their, at times, extreme need. As a result, such individuals often find themselves missing out on a variety of supportive interventions that they desperately need. As part of a wider process known as 'skimming', services are incentivised to cater to individuals with lower levels of need at the expense of this more complex and challenging cohort.

HEARING FROM THE EXPERTS

There was widespread agreement on the sheer scale and challenge of complex needs and multiple deprivations in the sector, regardless of their role or connection with homelessness. This could take the form of a lack service of some sort, or a lack of supportive relationships in their wider networks. When asked to reflect on the nature of the problem, all understood the multiple ways it is experienced and presented at the point of service. There was differing expectations between clients in what they expected from a service and how to address CN's.

The recognition of the difficulties was universally acknowledged. *'Yeah. there are there's loads of challenges isn't' there? Food to the homelessness, you know, sleeping on the street, getting, you know, mental challenges. Yeah, people get down. People commit suicide because they haven't got nothing else. You haven't got no future have they, you know?' (Service User).*

Often addressing CN's meant going beyond the scope or capability of the services present as this could require a high level of assistance. *'But I think to address these complex needs, we need to take quite a lot of stages back, will bring you to the child and the child's upbringing'. (Service Partner).*

The reality of this level of need can often mean that services are prohibited from effectively addressing CN. Often referral criteria could be exclusionary so that services only allowed for one or two needs e.g. a housing or substance misuse need service - clients that lay outside of this were often 'too' complex to qualify for assistance. This could work in either direction, with clients either being too complex or 'not complex enough'. As illustrated here, *'Yeah, yeah. And dual diagnosis is so difficult to get to get somebody who will deal with mental health and substance at the same time because there's a lot of service will say no, you've got deal with substance first. Then we'll do your mental health' (Lifeshare Staff).*

This is further compounded by the fact that such acute needs do not stop at the end of a normal professionalised workday. A service partner here discussing the frustration at the gaps in homelessness provision. *'You don't stop being homeless at 5pm. 'Why is homelessness a 9 to 5 job? You know, 5 o'clock Friday, all the services shut. Homeless people must just go home somewhere and come back on a Monday Morning' (Service Partner).*

Another challenge reported concerned the behaviour of complex need itself. Due to the difficult ways in which individuals' present at the point of service many behaviours can distract from the reality of their vulnerability e.g. aggression towards staff, which may reflect an inability of a service user to ask for help or regulate their emotions due to the array of traumas they may have experienced while experiencing homelessness. *'Yep. And like I was just saying, these are now learnt behaviours, survival techniques. So, they come into this place, you know, adult, 26, they don't get their own way they bang the door. Yeah. The reason we do this is because that's what helped them survive when they were a child' (Service Partner).* Reflecting here, the importance of understanding the wider context of the individual and their behaviour, as the essential element in meeting the client's needs. These contextual factors can extend across the whole life of the client, *'so it could be a multitude of events, what's led to the complex needs that are traumatic triggers from the past. A lot of those child experiences we know now categorically through research' (Service Partner).*

IS THE LABEL OF COMPLEX NEED USEFUL?

This was a difficult question for all of our experts to answer, as so many factors impacted its usefulness such as the existing rapport of the staff using the term and their level of shared lived experience with the individual accessing the service. At the level of the client, when using the services it was often referenced that some service users might feel these types of labels disempowered them, particularly if they were unsure of the meaning of the term. As *'CN can be seen as a barrier, as people to avoid, or they are excluded from services for being 'too complex' (Service Partner).* However, in pragmatic terms it clearly provided value, at least professionally when working with other organisations it granted a rapid and practical means of categorising individuals which could be used in the moment to leverage support and advocate on the client's behalf. As we see here, *'Complex needs is a useful label as it tells workers that the client has multiple barriers that they will need support with' (Service Partner).*

There were real tensions in using such labels as complex needs, that they clearly must be managed carefully by any provision using them. In another illustrative case using such labelling can create difficulties when attempting to create individualised approaches through this categorising of clients. As a volunteer expressed here, using such labels came with an element of hesitation, *'Me, my personality. I don't like giving them a label for (CN) because, OK, they might be complex, but they're humans. They've all got a name. They deserve everything, as much as we've got, you know?' (Lifeshare Volunteer).* There was also concern around the wider implications of using such labelling from the wider public. These concerns went beyond the ethos and reach of services and reflected wider concerns about how labels can be used to reduce an individual's agency. *'Society labels everyone don't they? You got the rich and the poor and that's the way it's. Always going to be. You're never going to get rid of it.' (Service User).* As we can see here this concern was not confined to staff or volunteers.

For many, CN specifically carried an association with deprivation which could be experienced as stigmatising for service users. Once such a label was applied, it could be difficult to remove and created a whole host of other difficulties such as criminalisation. This *'stigma (of complex need) instantly putting the assumption that there's usually a link between deprivation and crime' (Lifeshare Volunteer),* could clearly be legitimately harmful for clients in a range of ways.

IMPORTANCE OF LANGUAGE

One of the strongest themes that came from the data was the crucial importance of the language used, which could be experienced as ambiguous, exclusionary or inclusive depending on its use. Some services users found it very difficult to understand *'I don't know what it (CN) means, so no' (Service User).* As this extract demonstrates there was a real need to develop a

range of linguistic approaches, that would depend on your audience *'I talk to different clients in different ways. I'll talk to one client if I know that he knows I've done a bit of work with him talking about drugs, or you could talk to another one about football. Or there's different ones that you have a different sort of way of talking' (Lifeshare Staff).* For service users using overly formal, academic or 'official' language it can be a reminder of the negative experiences they have had from wider institutions e.g. care sector or instances of criminalisation.

Some made suggestions around using distinct levels or tiers of language, one for clients, and another for other professionals. But all agreed that the words we used, the ways in which we discuss and label client needs, is crucially important. It could provide the language necessary to describe the complexity of their clients but that it seemed less justifiable between a client and practitioner. *'We could change some of the language so say person instead of service user with complex needs and express instead of experiencing CN – 'I think that. It Just makes it more comfortable for them using those words' (Lifeshare Volunteer).*

And again here:

'Well it is because it depends on their needs and some people are more complicated than others, so yeah I do think it's helpful, but maybe not for them (the service user), you could simplify it a bit' (Service Partner).

CASE STUDIES

Although these accounts are fictional, the content of these stories are not. Each of these voices have been carefully curated from the doctoral data and the reflections of the experts through their everyday experienced in this sector. They are accurate and illustrative case studies that demonstrate the types of clients that homelessness provisions encounter every day. They are intended to provide a higher degree of context for the challenges of complex need, and how such complexities can act as a series of barriers for the staff and services within the homelessness space. They represent a snapshot of the sorts of cases that staff and services must find ways to assist with, and how these deprivation/exclusion type factors can negatively interact with each other to become a barrier to assistance. Following each case study will be an example of best practice at the service level that provides illustrations of how provision can work effectively with such a group.

MARKS STORY

Mark is 25 and regularly presents at multiple homelessness services across the city and is well known to all the staff and volunteers. He comes across as very confident and is highly sociable, and physically doesn't appear to be experiencing homelessness at all. To many of the staff they don't understand why he is coming to the services, that his level of need doesn't require their support which is often a cause of tension in the service between staff. Mark rarely shares any personal information about his circumstances and only engages on

a superficial level with staff i.e. food and toiletries and refuses any additional support just saying 'I'm fine mate, I don't need any help from you, just help the other guys yeah?' However unknown to the staff, Mark has been street sleeping for several months and currently has a heroin habit that is becoming increasingly difficult to manage through more legal means i.e. begging. He already has a long history of offending stretching over many years and frequently comes into contact with the police and other enforcement organisations, often being moved along in any location he stops in. As a result, Mark has poor and deteriorating mental health and due to his currently chaotic situation, has difficulties making new relationships. He is not currently in contact with any of his family following a fall out and as consequence is becoming increasingly isolated.

PRACTITIONER REFLECTIVE QUESTIONS

1. What is known about Mark from the other services?
2. How might his circumstances explain his presentation?
3. If Mark is presenting as physically capable and independent, what other ways might he show his need?
4. What do you notice about his relationships with other staff members and service users?
5. In what ways could you build a relationship with Mark beyond the superficial?

EXAMPLE OF GOOD PRACTICE

At the point of contact the service adopts a non-judgment approach that provides a universal level of care with no conditionality i.e. they reject any value judgments around 'he/she does not need this support'. This provides a level of baseline trust with service users so that their accounts will not be questioned, or support revoked. The second stage would be to gather as much information as possible from other third section organisations and statutory bodies, to gain a wider context of Mark's interactions with those services. As the service begins to build a picture of his life and personality, staff use this context/knowledge combined with the general open service approach to begin building rapport with him and meeting the client where he is. If Mark is not yet ready to open up about his difficulties, then how might your service build that connection? This could take the form of shared interests with a staff member, on-site activities or enlisting Mark's help with some of the other service users. Staff should also be trained in the types of presentations they might see at their particular service, along with the wider contexts that explain those behaviours. In Mark's case, his hypermasculine performances of exaggerated independence are a way of protecting himself from the judgment and victimisation of those around him. For Mark while incarcerated asking for help was a legitimate sign of his vulnerability and staff will have to patiently work to overcome those learnt behaviours. Once

this trust is earnt; Mark will begin to drop his guard and disclose his poor mental health and substance misuse (his form of coping) to the service staff. At this stage staff will be able to offer more trauma-informed approaches, signpost effectively and recommend heathier/harm reduction techniques.

FRIDA'S STORY

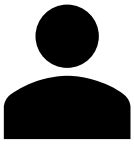
Frida is rarely seen at the point of service, and when she is, she often goes unnoticed – sitting at the back and not drawing any attention to herself. She is 17 years of age and has been alternating between sofa surfing with friends and rough sleeping for 6 months. Her bout of homelessness was necessitated by a relationship breakdown with her family, following allegations of abuse from a family member. Frida has also had prior experiences in the care system following previous instances of relational breakdowns within her family networks. She presents as highly vulnerable to exploitation, and likely struggling with addiction issues, but this has never been confirmed by service staff. Due to her previous involvement with the care sector, she has an allocated social worker, which she never see's due to the combination of the chaotic nature of homelessness and the inflexibility of the wider welfare system to accommodate her needs. Staff have previously highlighted her vulnerability however they have so far been unable to provide any assistance, Frida is often accompanied by another male experiencing homelessness who often 'speaks for her' in conversations around her need such as denying her requirement to make a doctor's appointment or reconnecting with family members. Due to her previous negative interactions with wider institutions, she is also highly hesitant to trust the help offered by staff and is heavily resistant to any form of assistance.

PRACTITIONER REFLECTIVE QUESTIONS

1. Why is Frida going unnoticed at services?
2. What impact do you think her care leaving experience might have on how she interacts with the service?
3. What impacts might these exploitative relationships have on your ability to provide support?
4. Why have previous attempts to provide assistance to her failed?
5. What are the implications of her poor social networks?
6. In what ways might she be more vulnerable than other service users?

EXAMPLE OF GOOD PRACTICE

In this example we see that Frida's presentation is one of social withdrawal, not uncommon for someone of her age and gender. If we take a wider look at her life history, she has spent many years within the care system experiencing many adverse child experience (ACE)'s along the way, this has likely created a resistance to professionals of any kind. It is probable that her core need is around trust/hostility towards staff, but this is not always shown in aggression. In some cases, as in Frida's, it manifests in her extreme avoidance. As a service, it is important to understand why previous work with other professionals has failed. Often in cases such as this, such a presentation results in a consistent 'falling through the cracks' with a true joined up approach often absent from her previous work with other statutory organisations. As an example, a higher level of multi-agency co-operation is required that involves not only the related welfare services, but also the estranged family members. As the heart of working with complex need is understanding how such needs interact with each other in real time. In this case how might her withdrawal, lack of trust and countless previous traumas be seen in her behaviour? For example, this can be seen in her 'choice' and vulnerability to, becoming involved with abusive partners that could be described as coercive and exacerbating her homelessness and isolation.



DAVID'S STORY

David is 56 years old and is well known to services across the city, having an extended history of homelessness stretching over many years and at many formal institutions e.g. prison and mental health hospitals etc. David as a result has moved several times and has no friends or family support in the area. His presentations can be quite erratic at the point of service, at times he is highly gregarious, speaking with multiple staff and service users, other times is silent and socially withdrawn, on some occasions, he is found speaking with himself for extended periods. Although these behaviours are certainly concerning, at the point of service they rarely cause problems for staff or other service users and his deteriorating mental health has largely gone unnoticed. Unknown to the homeless services in the area, David has various underlying health-related conditions that continue to exacerbate his homelessness. He has a diagnosis of paranoid schizophrenia, which can be managed effectively with anti-psychotic medication. However currently, David is not taking his medication consistently, as his allocated temporary accommodation is located many miles out of the city and with other health conditions such as infected leg ulcers etc exacerbating his difficulties, he is often unable to physically make the trip. David has previously attempted to move his

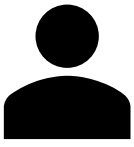
prescription closer, but like many older individuals experiencing homelessness he is mostly illiterate, with potential for undiagnosed learning difficulty, and is unable to fill out the required paperwork.

PRACTITIONER REFLECTIVE QUESTIONS

1. What explains David's apparent erratic behaviour?
2. Is your service in a position to capture/monitor these behaviour changes?
3. How could something as concerning as Davids's presentation go unnoticed in the service?
4. How has David's learning difficulties gone undiagnosed for so long?
5. What other needs may be going unnoticed?

EXAMPLE OF GOOD PRACTICE

David shows signs of serious mental instability with a diagnosis of schizophrenia (unknown to staff) and as a result presents very erratically. In this instance this demonstrates why it's so important that services regularly share client information internally with other staff members to begin creating detailed and nuanced pictures of their guests – this can be done in the form of regular de-briefing at the end each shift where key learnings are circulated to the wider team. The recognition of multiple needs here would lead to a consistent approach in the support that is provided for David – in a less reflective service, David might be receiving various forms (of at times) conflicting support due to his varying presentations. In this example he has a set of needs that singularly could be reasonably managed, however as is common in experiences of homelessness the cumulative impact has caused a real deterioration and snowball effect on David's life. In this instance his mental health needs could be prioritised as the most pressing first i.e. with an immediate mental health crisis referral to adult social services, however it would essential that something was in place upon the completion of such an intervention e.g. supported accommodation and staff home visits to help address his other needs, and assistance securing follow up medical appointments to help manage his set of needs.



YAZ'S STORY

Yaz is Muslim, 25 years and has recently become homeless. Prior to this, they had no experiences of homelessness. This event was precipitated by a large family argument following the news of their gender transition in which the police were involved and there were numerous reports of physical violence directed towards

Yaz, fearing for their own safety fled their family home, informing no one of their location. In addition to now experiencing rough sleeping, Yaz is trans, and it currently transitioning to a trans male, from a cis female. They have reported to many of the homeless related services in the area asking for help, but most do not have the specialized gender/LGBTQ+ informed knowledge required. Due to many complex religious and legal factors mentioned above, Yaz cannot access their family/friend support networks. They report constant thoughts of suicidal ideation but are also resistant to go to A&E, sighting previous examples of discrimination due to their trans identity by health services. At the service level, their complex identity is also a source of difficulty for staff to manage as despite identifying as male this is not recognized by some of the other service users and there are real concerns for her welfare and victimization.

PRACTITIONER REFLECTIVE QUESTIONS

1. In what ways is Yaz vulnerable?
2. If you are unfamiliar with homelessness in the LGBTQ community, who could you reach out to for advice?
3. How might the support Yaz requires differ from some of your other clients?
4. Why do you think Yaz is resistant to go to A+E?
5. What LGBTQ+ provision exists in your area?

EXAMPLE OF GOOD PRACTICE

Cases like Yaz are not as rare as you might think, and this case gives us a great illustration of the levels that exist when thinking about complex needs. Service users bring all these complex factors with them and understanding these are key to providing the support required. Although a 'one solution' is never possible, there are some general recommendations we could explore here. Many cultures stigmatise experiences of homelessness - are there ways of engaging the local Muslim community in positive ways to assist Yaz, such as a community liaison through their local mosque? Service staff can be an essential go-between for such marginalised populations. This is also a demonstration here of how crucial staff knowledge is for the groups they assist. Such an awareness allows staff to contextualise their clients' presentations, many people who identify as trans avoid mainstream health services due to their previous negative experiences with health professionals. As such, such a refusal by a service user is not a statement of not requiring, or indeed wanting assistance. It is an opportunity to help them build more positive relationships with a health service that is both trauma and LGBTQ+ informed. Such a wider awareness of complex need would also allow staff to see the ways in which Yaz is at an increased risk of victimisation e.g. violent reprisals from family members or sexual exploitation from other individuals experiencing homelessness, because of her

needs/presentations. With this contextual knowledge a service should be able to respond accordingly.

INSIGHTS FROM 'THE FIELD'

The following sections represents a thematic summary of the challenges, potential solutions and instances of good practice captured in the ethnographic data mentioned above. As such there was numerous examples of good practice which are noted and collated here for use at other front-line services. This work spanned a 2-year period working closely with multiple homelessness services across Manchester.

CHALLENGES FOR SERVICE STAFF

'I'm noticing a strange sense of tiredness from seeing so much suffering, I can see why some people just switch off' (Fieldnotes).

- *Compassion fatigue* – staff members exposed to such cases of complexity and trauma are at risk of experiencing difficulties in their ability to empathise to the same degree.
- *Vicarious trauma* – much like those on other front-line services staff can be at risk of taking on too much of the adverse experiences of their clients which can have negative implications for their own mental health.
- *De-skilling/burnout* - due to the enormity of the challenges involved in addressing complex need, there is a real risk of staff feeling inadequate and unqualified when compared to the sheer scale of the problem, this can be detrimental to staff performance and well-being.
- *Boundaries* – many relationships with service users of complex need are long term, which can present a challenge as the line between professional, staff, practitioner or even friend can blur.
- *Unpredictability in service user* – there can be great variation in their presentation e.g. calm one moment, but verbally aggressive the next.
- *Skill variation* – many services are reliant on a body of volunteers with a high turnover, which may have no experience with working with clients of complex need.

- *Staff training* - extreme difference in the needs of clients e.g. can range from helping a Service user setting up a new phone, writing a will, to acting as an intermediary in a family conflict. This makes adequate training difficult.

RECOMMENDATIONS FOR SERVICE STAFF

- *Understanding staff limitation* - greater recognition of the level and limitations of the staff skill set present within the homeless provisions, as at times the client base will require an expert practitioner in another field e.g. psychiatrist.
- *Relational focus* – relationship and rapport building are the core component in reaching this population, which should be prioritised before all other assistance.
- *Gender informed practices* – individuals experiencing rough sleeping are often male and can have distinct gender profiles to others i.e. many will conceal their extreme need. Staff should be made aware/trained in the types of gender presentations they will see and the purpose they serve to the service users.
- *Appropriate boundaries* - ensure that the provision is consistent in its relational approach, be explicit state these boundaries to staff and service user e.g. difference between being a 'helper' and 'friend' at the service level.
- *Incorporating trauma informed approaches* – such practice starts at the first point of contact, but it extends to many other areas such as the service environment itself.
- *Reflexivity* - include routine and regular practices of supervision such as staff/volunteer debriefs at the end of every shift for anyone that comes into contact with complex clients.
- *Exceptional circumstances drive extreme behaviours* - staff should be aware of the stark differences in their everyday experiences and attempt, (where possible) to meet clients where they are even, if this is challenging for the service to facilitate.
- Disruptive behaviours such as refusing to co-operate with staff or being confrontational are actually signs of 'tragic adaptations' (Van der Kolk, 2015) which form due to their experiences of homelessness, as such, maintaining a nonjudgmental approach is (challenging) but essential.
- *Pragmatism* – prepare all staff for the difficult reality of the homelessness sector and manage their expectations accordingly.
- *Staff/volunteer development* – easily accessible training opportunities that provide the skills required to cater to this group such as modules of de-escalation, handling sensitive disclosures and basic safeguarding.

CHALLENGES FOR SERVICE USERS

'Today was overwhelming, I was on the 'shop floor' today of the homelessness service, working with the outreach nurse. The level of complex need here was simply profound' (Fieldnotes).

- *Lack of trust* – many individuals experiencing homelessness for extended periods (which is common in this group) and may have difficulty establishing new relationships. They have experienced personal and structural failure many times.
- *Service users 'Not being seen'*- the failure of the staff to not recognise their complexity and individuality and not be seen as just another 'homelessness person' at the point of service.
- *Social exclusions* - extreme deprivation and complex needs often leads to a loss of most if not all of their supportive social networks.
- *Language* – many service users felt that imprecise or over professionalized terminology, particularly in regard to their presenting difficulties, could act as a large barrier to service users getting appropriate support.
- *Mislabelling* - service users can be referred to the incorrect service for their respective needs.
- *Survival behaviours* - they are often excluded/banned from the essential services they need due the presentation of their multiple needs and/or multiple diagnoses.
- '*Too complex'* - Service users may be 'de-prioritised' and support withdrawn due to their high need, due to service focus on throughput.

RECOMMENDATIONS FOR SERVICE USERS

- *Trauma informed care* - at the level of service users this means curating support at an individual level, as opposed to generalised solutions.
- *An intersectional approach* – incorporating other perspectives of care e.g. more gendered and racially informed approaches.
- *Behaviour as communication* - everyone responds differently to adverse experiences and the acknowledgement of these differences is essential when working with this group. Service users may present in multitude of ways from verbally and physically aggressive, socially withdrawn or highly social and nonstereotyped.

- *Flexible ways of working* – open approaches that allow staff to adapt to the ways of working that are most comfortable for each service user individually i.e. what method of help do they prefer? Service users often do not work to the services typical timelines and attempts can be made to meet them halfway.
- *Co-production of delivery* – fostering a shared sense of ownership with service users, providing them with an increased sense of agency in a world that otherwise denies it.
- *The creation of 'safe spaces'* - due to the persistence of prior traumatic experiences many service users will be hypervigilant to potential dangers both real and imagined and can benefit from a protective space.
- *Utlising a whole person approach* – it can be easy to focus on merely the problematic symptoms e.g. a disruptive and violent behaviour, instead of investigating the source/driver of that presentation. Good practice is able to look beyond the presentation.

COMPLEX NEED AT THE SERVICE LEVEL

At the service level complex needs can present in a multitude of ways, there is not one mode in which it can be classified. However, there are sets of common characteristics that are often present at the point of service and can be understood as complex/multiple need. Service users with such multiple forms of disadvantage are often highly chaotic, with a wide range of complex behaviours but what they do all share is that they require a large proportion of staff time and resources. Some examples from the research are include below:

- Aggression towards staff or other service users
- Self-destructive/self-harm presentations
- Other service/organisation involvement – your service may be unaware of essential service user information i.e. work already carried out at other provisions
- Concealment of wider need through distractive elements of their presentation e.g. substance misuse
- Communication difficulties – e.g. poor mental health or requiring a translator
- Unpredictable and often contradictory behaviour – often coined the chaos of homelessness
- Treatment Resistance/poor help seeking – denial of need e.g. '*I don't need anything from you'*
- Use of Violence – presents challenges at point of service around ethics of 'banning' and ensuring staff safety
- Social withdrawal – refusal to engage at any level, often appear invisible in service.

CHALLENGES FOR HOMELESS PROVISION

'Many things at the homelessness service they just can't deal with' (Fieldnotes).

Some examples are included below:

- *Time scales* – often the long terms work necessary in the complex need are not suitable within the current welfare framework.
- *Lack of funding* – due to this problem employed paid support staff are always lacking in services - third sectors organisations are forced to over rely on volunteers with high churn/turnover of this volunteer base, which sadly often lack expertise necessary effectively assist the clientele.
- *Competitive bidding/funding practices* – does not incentivise good practice sharing between services. Acquiring such 'strings attached funding' means services may be required to provide assistance not in line with their personal philosophies (Cloke & Johnsen, 2010).
- *Risk of complex need to service* – when attempting to manage the sheer variety of need/presentations with some blanket service approaches SUs may find it coercive or triggering.
- *Complex and underfunded welfare system* – within this challenging context it is difficult for services to advocate effectively for service users of this demographic.
- *Increasing level of need* – the complexity and number of service users experiencing complex need and for extended periods seems to only be increasing.
- *Lack of expertise* - such extreme need requires staff with a high level of skill e.g. advanced knowledge of welfare sector in order to be effective advocates.
- *Chaotic population* - service users in this group experience chaotic and marginalised lives, regularly disappearing from provision which presents a significant challenge to the service in terms of relationship building and them attending any effective interventions.
- *Service limitations* - service user needs often also include those not normally associated with homelessness e.g. undiagnosed learning difficulties or language barriers which services are rarely equipped to fully address.

RECOMMENDATIONS FOR HOMELESSNESS PROVISION

- *Holistic working* - create more opportunities for co-operative relationships with other volunteer organisations and governmental bodies, that cover the gaps in your own service provision i.e. joined up working practices.
- *Participatory/co-productive involvement* – empower service users in the day to day running of the service centre – also an effective means of meeting the ever changing needs within homelessness sector (see Manchester Homelessness Partnership as an example of good practice).
- *Acknowledging and Embedding Complexity* - moving away from 'one size fits all' approaches and instead recognising the individual differences of the clients and responding accordingly.
- *Creating processes of service improvement* - embedding reflective practices into everyday procedures to fostering share learning across all hierarchical levels.
- *Knowledge creation* - combat the high staff turnover often found within the third sector by creating institutional knowledge within your organisation.
- *Staff Investment* - staff require training in the full range of survival behaviours that will be seen by their clients.
- *Strength-based models* – move away from narratives of deficit, of perspectives of blame and instead emphasising what went well with your clients. Modes of empowerment can be effective tool e.g. the promotion, using and displaying of the skills/insights of your service users.
- *Approaches to risk* – while still recognizing the importance of staff safety it is necessary to still leave challenging service users with routes back into the service, for when they are in a more positive position to engage with the support more effectively.

A NEW APPROACH TO COMPLEX NEED

It may be beyond the scope of this guide (or indeed any guide) to provide an exhaustive list of perfect responses to the monumental challenge of the complexity of need in the third sector. The overall findings of the report however do suggest some more general but fundamental aspects that should be present at any homeless provision, which have been outlined in the table below.

Relational Practices	Ways of working that fosters equal connection between staff and service users and is able to create strong and trusting working relationships. It is crucially important that the human element is not lost in the work being done.	'But you know, it helps massively. I mean, and it's the way they treat you in the especially. They'll just treat you with respect. You know what I mean? They don't treat you like a down and out, like you're a bum or whatever' (Service User)
Harnessing Lived Experience	It is essential to show at all levels of the organisation the importance of lived experience with staff and volunteers, when connecting with service users. It is a grossly underused resource that is key meeting the challenges of extreme need. Lived experience when used correctly i.e. not exploitatively, can be a powerful force within any provision.	'For example, if I speak to somebody who's been in prison because they know if and I tell them I've been in prison, it lowers the barriers for people. So I think it's about relating to people. Even if you can't relate to them, but in some way that if you don't know somebody who's had that issue or problem, you know, somebody who does' (Staff, Lifeshare)
Championing Third Sector Skills	It is important to both recognise and celebrate the various skills of your experienced volunteers and staff, while also recognising the gaps in their knowledge. Which can be mitigated through bespoke service training. Such a combination can be a powerful means of staff/volunteer retention.	'Also depends on different volunteers. Another volunteer might not have had that type of experience before and seen that (challenging presentations from CN), unlike a volunteer like me who's been through a lot. I've actually had the type of experience with those (CN clients) type of people, so I

		would never judge them and I would want to help them'. (Lifeshare Volunteer)
Holistic + Individualist Approaches	CN when used as a blanket category can get become a barrier that doesn't allow for a flexible 'case by case' service ethos. Although the label of CN is sometimes useful, when working with clients directly Individualist approaches allow for the investment in the client over time, thus providing wider wrap around support and fostering trust.	'I'd like us to have a big massive building with a bit of accommodation with drug workers on site, with a needle exchange on site, with different therapies on site. Everything from chiropodists up to CBT therapists and everything in between and being able to do that outreach on the street as well', (Staff Lifeshare)
Holistic Partnerships	The non-competitive interworking of multiple staff, volunteers and outside but related services can be an effective tool to combat CN. At the level of service user this could be reflected in a less complicated experience, where close third sector connections reduce friction for the client at the point of service e.g. close relationships of housing, drug and mental health services. Wherever possible working towards a common goal.	'And I think that's one step forward innit, to helping people (with complex needs), it's about making life less complicated and less stressful for other people'. (Service Partner)
Co-productive Language	As a service, decide together on a language-based approach that works best for your service users, that balances the inclusion of clients with the practical necessity of the work being done.	'I think (the language) it depends on the client. Specifically, and what they do wanna speak with you and the way in which they wanna go through it'. (Lifeshare Volunteer)

Table 1. List of solutions to complex needs

CLOSING THOUGHTS

Complex needs remain one of the biggest drivers of exclusion for those experiencing homelessness at the service level. Any frontline service that works with this incredibly heterogenous population continues to see ever more complex presentations. When this reality is combined with the stark economic situation that many provisions find themselves in, this remains one of the biggest challenges to combat. This guide has attempted to provide a grounding of the term, to capture the voices of those that have experience complex need/homelessness and include the skills/challenges of the professionals that attempt to address it. Alongside, providing a person-centred set of approaches and practical improvements that any service can begin to embed within their provision. This has included reflections of the challenges faced in the third sector but alongside a multitude of recommendations at the staff, service user and service level which we hope will be useful to the range of frontline provisions attempting to meet this ever-changing complexity. These suggestions have ranged from applying reasonable adjustments wherever possible for service users, such as we already used in specialist provisions within the education sector to more inclusionary practices, i.e. improvements to the very language we use.

The challenge of complex needs remains great, and the dangers of not getting this right have never been higher. Although this resource has also touched on the wider structural problems of CN that go beyond the responsibility of individual services e.g. service funding forcing services to de-prioritise clients with higher complexity in light of more 'achievable objectives' or greater throughput i.e. more clients through the door. The question remains as to what level of change can reasonably be made within the sector to create more inclusive services that take account of these differences and complexities while also working within these wider limitations. Or as one articulate and very experienced volunteer commented, '*I think what's happening across the board with the lack of resources and the lack of funding it's (complex needs) becoming a tick box exercise. Yeah, they don't, you know, if they're not high up enough or they have too many needs, they can't take that on*' (Lifeshare Volunteer). However, with the wider criticisms withstanding, the key insight from this work has been the potential for improvement at all levels. Of course, no approach or resource (such as this service guide) will replace the chronic lack of funding that many provisions suffer and continue to operate on. Although progressive changes in our approaches at the service level do have the potential to improve the lack of understanding around CN more generally, which could have wider positive societal implications for this vulnerable group. We hope this resource increases the knowledge of need itself, and allows for the creation of more inclusive, trauma informed spaces and thus better utlise what limited resources do exist in these challenging spaces.

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Name	Role	Affiliation
RL	Service Partner	Coffee4Craig
Rosalinda	Service Volunteer with Lived Experience	Expert by Lived Experience
Barry Plumridge (MBACP)	Service Partner	Combat Stress
Julie	Staff	Lifeshare
Ray	Service User	Expert by Lived Experience
Genna Spiteri	Service Partner	Be Well
Trish	Volunteer	Lifeshare
Susan	Volunteer	Lifeshare

*Please note some of the contributors (n-5) did not wish to me named and were therefore omitted from these acknowledgments, but their insights were still included in the following sections.

USEFUL RESOURCES AROUND COMPLEX NEEDS

Adult Social Services – Assessment Toolkit

Greater Manchester - Homelessness Prevention Strategy – Co-produced with the MHP

No Wrong Door – Latest Evaluation Report (2019) – Complex Needs and Barriers to Entry

Revolving Door - Police and Crime Commissioner's Guide to Tackling the Revolving Door of Crisis and Crime (2024)

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Department of Sociology
All Saints, All Saints Building, Manchester M15 6BH
https://www.mmu.ac.uk/

1st Floor, 36-38 Sackville Street Manchester M1 3WA
https://www.lifeshare.org.uk/
Tel - 0161 235 0744