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Complex Responses

**Understanding poor frontline responses
to adults with multiple needs:**

A review of the literature and analysis of contributing factors

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Chapter I

Introduction

Introduction to the research

This report is the result of a large scoping review of the research literature in an attempt to understand the many and complex reasons behind poor frontline service responses to adults with multiple needs, with a particular focus on those in contact with the criminal justice system.

The initiative for undertaking this review came from discussions with Revolving Doors' National Service User Forum. Frequently they reported poor responses to their needs from a wide range of frontline services and there was a concern that positive policy did not always filter down into positive practice on the ground.

This review aims to increase the understanding of the negative experiences frequently had by adults with multiple needs when they are accessing frontline services. In addition, it aims to explore the primary and underlying factors that contribute to this poor service response, considering interpersonal, professional, organisational and structural factors.

The review was undertaken with the hope that through a better understanding of the factors that contribute to this poor service response, those involved in relevant policy-making and the commissioning, design and delivery of services will be able to improve standards of care for a vulnerable population.

What are 'multiple needs' and why do they matter?

Revolving Doors' experience suggests that mainstream frontline services are failing to support a particular group of adults with multiple needs:

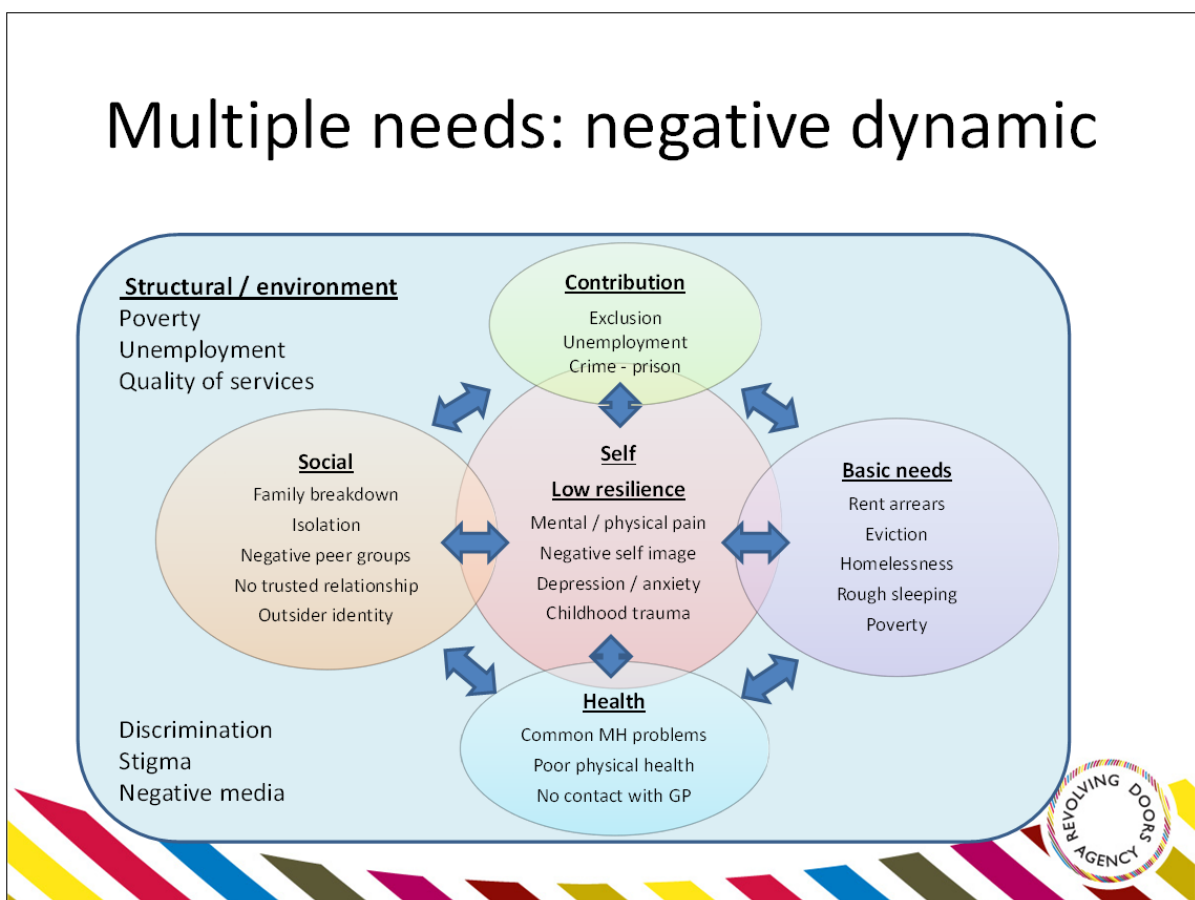
“Our emergency services and criminal justice system are forced to respond because our mainstream services do not. Our health and welfare systems, designed to tackle one problem at a time, or to focus on more serious conditions, are simply not geared up to provide the sort of help people need to avoid or escape this trap. The result is that people are caught in a downward spiral as one problem exacerbates another, causing damage to themselves and communities, generating huge costs to the public purse.” (Revolving Doors Agency, 2010, p.3)

In our publication, *Summing Up* – which reflects on the findings from 16 years' research and practice – Revolving Doors finds clear evidence of the existence of a group of people with multiple unmet interrelated needs, including health, behavioural, practical, emotional and skills-based needs who are both victims as well as perpetrators of crime (Anderson, 2010). The report highlights the sheer multiplicity of need. Almost half of the clients from the Revolving Doors' pioneering Link Worker services needed help from between six and ten services; a further 10% required help from 11 services or more.

The interrelation of these needs is important when conceptualising what is meant by the designation ‘adults with multiple needs’ for the purposes of this research.

The interaction of these needs matters; this is often articulated by emphasising that the sum is greater than the individual parts. Rankin & Regan (2004) use the term ‘complex needs’, however their description of ‘breadth’ of need perfectly captures what is meant here by ‘multiple needs’:

“a framework for understanding multiple interlocking needs that span health and social issues. People with complex needs may have to negotiate a number of different issues in their life, for example learning disability, mental health problems, substance abuse. They may also be living in deprived circumstances and lack access to stable housing or meaningful daily activity... [T]here is no generic complex needs case....People’s complex needs can have breadth (range of need) and/or depth (severity of need). It is valuable shorthand to describe multiple interlocking problems where the total represents more than the sum.” (Rankin & Regan, 2004, p.i)



By the very fact of their multiple problems, adults with multiple needs come into regular contact with a multitude of different services and agencies. These include – but are not limited to – primary and secondary health services, social services, the police, the prison service and probation, solicitors, drug treatment agencies, the job centre, Pathways to Employment, educational training and colleges, street outreach workers, homeless hostels, domestic violence projects, counselling, and agencies such as the Citizens Advice Bureau (Anderson, 2010; Braithwaite & Revolving Doors’ National Service User Forum, 2009).

Nevertheless research suggests that such adults may not engage well with services. A comprehensive literature review commissioned by the Scottish Executive into the experiences of people with multiple needs identified problems relating to **poor awareness** of appropriate services, **difficulties accessing** these services and **poor experiences** of these services following access (Rosengard et al. 2007). Similarly, Revolving Doors' own research suggests that the needs of this group remain unmet due to repeated experiences of service rejection, a failure to access services and a range of systemic barriers that impede access or are detrimental to care (Anderson, 2010). The result is that service users feel dissatisfied and unsupported and all too often the criminal justice system acts as a safety net (Revolving Doors, 2010).

The prevalence of multiple needs in the general adult population is unknown. Rankin & Regan (2004) highlight that this is partly due to inadequate data collection and sharing of data between agencies, but is also partly due to inherent difficulties in the term itself since it describes the result of an individual-specific interaction between health and social care needs. Revolving Doors also highlights the difficulties of identifying a group that are, in part, defined by their poor engagement with services (Anderson, 2010). Nevertheless, Rankin & Regan find *"clear evidence to suggest that complex needs is a significant issue that affects hundreds of thousands of people"* (p.ii).

What is clear is that the presence of multiple needs is concentrated in populations that present a concern to the public, such as offender and homeless populations. Homeless services surveyed by Homeless Link were asked to approximate the percentage of their clients who had multiple needs. In the 2011 survey, the average was 49% for day centres, 44% for direct access hostels and 36% for second stage accommodation (Homeless Link, 2011). Our review of literature into short-sentence prisoners shows high levels of social care need across a broad range of need areas (Anderson, 2011). This is particularly true for women offenders, with research from the Fawcett society suggesting that *"a key characteristic of women offenders is the likely presence of multiple presenting problems"* (Gelsthorpe & Sharpe, 2007, p.17).

It is also clear that there is a significant financial impact of failing to provide an effective service to this group of adults. Their repeated use of crisis services, such as A&E and the police, is simply not an efficient use of public money. Early findings from our Financial Analysis Model suggest that investment in prison and community based services for adults with multiple needs in contact with the criminal justice system could save over three billion pounds to the public purse over three years (Revolving Doors Agency, 2011). This is one of the reasons it is so important that we improve frontline responses for this group.

Chapter 2

Methodology

This report was designed as a 'scoping exercise' of the contributing factors of a poor frontline service response to adults with multiple needs. The report specifically focused on negative experiences and does not claim to be a rigorous review of all the literature into the experience of services of adults with multiple needs.

Starting with a number of key pieces (Keene, 2001; Rosengard et al. 2007), recommended reading, meetings with experts in the field and previous Revolving Doors' research, themes were identified which were revised throughout the research process. Further literature was identified through database searches (including CSA Social Sciences, the Cochrane library, Medline, PubMed, Social Policy Digest, Social Services Citation Index and SCOPUS) and a search of the Bodleian library collection. Searches were conducted using search terms related to multiple needs (such as complex needs and multiple problems), the combination of search terms from different need areas or services (such as homeless* and mental health) and search terms related to identified themes (such as stigma and organisational culture). Research was included on all relevant services: housing and homelessness services; substance misuse services; services offering support around welfare benefits and employment, training and education; health services; criminal justice services. However, the search yielded particularly high numbers of articles on healthcare services. Preference was given to research conducted in the United Kingdom, although other research was considered where relevant.

Literature was considered which discussed the experiences of groups who were likely to have multiple needs (such as substance misusers) even where 'multiple needs' were not mentioned explicitly. Additionally, literature was identified that explored the experience of those who had a diagnosis of 'personality disorder', a diagnosis disproportionately experienced by clients of Revolving Doors' Link Worker services (Finn *et al*, 2000), as well as by prisoner (Singleton *et al*, 1998) and homeless populations (National Mental Health Development Unit, 2010).

Much of the literature on multiple needs referred to the experiences of those with multiple medical diagnoses, usually including severe physical or learning disability. While some of the issues that affect these groups will be relevant, articles which focused specifically on these diagnoses were excluded because these very severe needs were not prominent in previous Revolving Doors' research regarding those in contact with the criminal justice system (Anderson, 2010). That said, while severe learning disability might be less common, the Prison Reform Trust still found that between 20 and 30% of offenders have learning difficulties or learning disabilities that interfere with their ability to cope within the criminal justice system (Loucks, 2007).

The aim of this review is to provide a general overview of the experience of adults with multiple interrelated needs. However, it was immediately clear from the literature reviewed that the needs of particular groups are often inadequately met by services and that this may exacerbate the impact of having multiple needs. Rankin & Regan (2004) highlighted a number of such groups, including young people in transition, older people,

women and black and minority ethnic communities who “*stand out because services have traditionally been ill-prepared to meet their needs or because they are more likely to experience multiple inter-locking problems*” (p.21). Other minority groups, such as gay, lesbian, bisexual and transgender people, did not appear specifically in the literature; however membership of this group is also likely to impact on how they engage with services and whether services are seen to meet their needs.

Despite the clear impact that membership of such a group has on interaction with services, an analysis of the experience of individual minority groups is outside the scope of this review. Literature that specifically considered how membership of such a group impacts on the experience of frontline services was excluded. The experience of minority groups is an important area for further research.

The first draft of this report was reviewed by a range of experts in the field, both from research and practice, who provided detailed comment. A further review of the themes and a further search of the literature were conducted following this feedback.

Chapter 3

Service users' experience of front-line services

When reviewing the literature, the first task was to establish exactly what are the negative experiences frequently had by adults with multiple needs when they are accessing frontline services. A number of themes emerged from the literature regarding service users' experiences. These included poor relationships with staff, failure to involve the service user in care planning, delay in receiving help, problems navigating complex systems, refusal of and exclusion from service, poor continuity of care and a fragmented service response.

An existing literature review on multiple and complex needs undertaken on behalf of the Scottish Executive (Rosengard et al. 2007) proved a particularly valuable source of information for this introductory stage of the research and is referenced throughout this chapter.

1. Poor relationship with staff

Professional-client relationships were frequently poor. Adults with multiple needs complained of unhelpful, insensitive and other negative staff attitudes and were sensitive to staff who came across as uncaring or judgmental (Hanley-Santos & Burnett, 2010; Howerton et al. 2007; Keene, 2001; St Mungo's & Revolving Doors Agency, 2010). Relationships could be characterised by distrust, particularly of authority figures (Howerton et al. 2007).

Adults with multiple needs often perceived stigma and discrimination or felt that they were being stereotyped (Bhui et al. 2006; Rosengard et al. 2007). Examples of this include being targeted for stop and search by the police due to their ethnicity or their choice of dress (Braithwaite & Revolving Doors' National Service User Forum, 2009), the perceived stigma in the attitudes of benefits officials as a result of their long claims' history and problem drug use (Bauld et al. 2010) and the impression that general practitioners took mental and physical health problems less seriously following the disclosure of drug use (Braithwaite & Revolving Doors' National Service User Forum, 2009). Negative staff attitudes often led to poor experiences with services and disengagement.

2. Failure to involve service user in care planning

Clients and professionals often differed in their views on how to proceed (Keene, 2001) and Rosengard et al. (2007) reported a failure to involve service users in care planning. Poor communication between professionals and their clients appeared to be a consistent problem. Service users repeatedly complained that services failed to listen to them (for example, Hanley-Santos & Burnett, 2010). Additionally, in two studies into the experiences of patients with a diagnosis of borderline personality disorder, patients described being given little or no information about their condition (Horn et al. 2007; Stalker et al. 2005). Consequently, the care that clients received was often very different to the care that they expected or wanted (Keene, 2001).

3. Delay in receiving help

A repeated theme in the literature was a failure to respond quickly when help was requested: in times of crisis, at transition points, out of hours, or when motivation is high, for example to address substance misuse (Bhui et al. 2006; Gallimore et al. 2008). Access to services could be delayed by long waiting lists (Devaney, 2008; Rosengard et al. 2007), and applications for services such as benefits claims could take considerable time and were often beset by a number of problems such as lost or incorrectly completed forms and breaks in payment (Anderson, 2010; Bauld et al. 2010; Bhui et al. 2006).

Following a period in prison, adults with multiple needs report being released homeless, without any benefits in place and with only a prison discharge grant that is inadequate to meet their needs (Braithwaite & Revolving Doors' National Service User Forum, 2009), a finding supported by other research (Hopwood Road et al. 2007). Service users emphasised that they needed support immediately if they were not to return to old habits (Gallimore et al. 2008).

4. Problems navigating systems

Rosengard et al (2007) found that the availability of information about services could be limited, and was often not presented in a form that made it accessible for those with literacy problems, a first language other than English or an impairment which impacts upon the ability to read or comprehend information; low levels of literacy in particular are found among adults with multiple needs in contact with the criminal justice system (Anderson, 2010). Research conducted by Braithwaite & Revolving Door's National Service User Forum (2009) also identified a lack of information about services as a problem. Poor signposting to appropriate services by other agencies was repeatedly identified as a significant issue.

These problems are exacerbated by complex systems which are daunting to those attempting to navigate them; wrought with complex rules, forms and the overuse of technology (for example, Rosengard et al. 2007). Notably, although there were reports of negative attitudes among benefits agency staff; complaints about benefits services were predominantly focused on the system itself (Bauld et al. 2010; Bhui et al. 2006; Braithwaite & Revolving Doors' National Service User Forum, 2009).

5. Refusal of or exclusion from service

People with multiple needs were often refused a service altogether as they failed to meet service criteria (for example around age or diagnosis) or thresholds for support (Keene, 2001; Rosengard et al. 2007). Even where access to services was initially granted, adults with multiple needs often experienced exclusion from these services, for unacceptable behaviour or failing to adhere to service rules.

The inflexibility of services was considered a particular problem. Adults with multiple needs frequently found themselves the wrong side of rigid exclusion criteria. Additionally, service users complained of strict or immovable appointment times with penalties for failure to attend promptly such as withdrawal of benefits, 'breach' of probation or refusal of a service (Braithwaite & Revolving Doors' National Service User Forum, 2009; Bauld et al. 2010; Hanley-Santos & Burnett, 2010). What is more, appointment times at different

services could often clash with one other so that a mandatory appointment with the Jobcentre prevented attendance at drug treatment or education.

Support often appeared time-limited (such as Supporting People Services or age-restricted services) or support was withdrawn, or service users de-prioritised, if they failed to make progress (Gallimore et al. 2008; Keene, 2001).

Poor awareness of other services and signposting between services, as well as gaps in service provision, mean that when support is refused by one agency it is not always clear who, if anyone, will fill the gap.

6. Poor continuity of care

Service users experienced poor continuity of care, for example as a result of (often multiple) staff changes (Gallimore et al. 2008). Particular problems were observed at transition points, notably from children's to adult's services or across the prison - community boundary. Rosengard et al. (2007) observed '*an abundance of examples [in the literature] of problematic assessment, support planning and provision in the context of transitions*' (p.38) that delayed access to services and affected people's rights.

The transition from children's to adult's mental health services has received particular criticism in terms of poor continuity of care for those reaching the age of 18, including in some cases a withdrawal of support altogether at the threshold. Additionally, the lack of clarity over which service should respond to 16 and 17 year olds can leave them without a service altogether (National CAMHS Review, 2008; Social Exclusion Unit, 2005).

7. A fragmented service response

Service users experienced a fragmented service response; where multiple agencies were involved, clients found that care was poorly co-ordinated and services failed to talk to one another (Keene, 2001; Rosengard et al, 2007).

In Revolving Doors' *Unfamiliar Territory* report, service users expressed frustration at the assumptions that they might not want their information shared with other agencies that might be able to help them. Often, they were happy for this information to be shared as long as the purposes of sharing information were clearly explained to them (Herlitz & Jones, 2009).

This failure to communicate effectively with other agencies so as to coordinate care meant that service users were subject to the stress of repeated assessments but often these assessments and resulting care plans failed to identify the 'depth', 'breadth' and interconnectedness of need (Keene, 2001; Rankin & Regan, 2004; Rosengard et al, 2007).

Chapter 4

Contributing factors and barriers to change

The introductory stage of the research outlined service user experiences categorised by confusion, delay, refusal and exclusion from services, a lack of coordination and continuity, poor relationships and poor communication with staff. Only once this poor experience with frontline services was understood was it possible to explore the literature for contributing factors and the barriers to change.

The literature suggested multiple factors that contribute to this poor frontline service response to adults with multiple needs. These factors are sub-divided into inter-personal factors (relating to staff and service users); professional and organisational factors; and structural factors. Many factors are also systemic in that they relate to the way that organisations work together; these are threaded through the discussion. Although factors may be categorised in this manner, the relationship between them is dynamic. Understanding all of these contributing factors, and how they interlink, is likely to be crucial to the success of any interventions aimed at improving this front line response.

Inter-personal factors

1. Stigma

Service user perceptions of negative staff attitudes were supported by research with professionals. A small scale study that interviewed general practitioners to identify the barriers to providing primary healthcare for the homeless identified the negative attitudes of general practitioners as the major barrier (Lester & Bradley, 2001). Some general practitioners interviewed for the study “*appeared to view homeless patients as difficult, untrustworthy timewasters*”. In another study of general practices, responses from partners suggested “*[homeless] patients were sometimes perceived as unwelcome, troublesome, dirty, smelly and off-putting to other patients in the waiting room.*” (Wood et al, 1997, p.296). Both studies suggested such patients were seen as ‘manipulative’ and ‘demanding’.

Similarly, studies focusing on patients with a diagnosis of personality disorder found that these patients were often the subject of particularly negative judgments; staff working with this group described how other professionals used words such as ‘attention-seeking’, ‘manipulative’ and ‘demanding’ (Stalker et al, 2005).

Although client behaviour may play a role in eliciting such attitudes, there was significant evidence of stigmatisation of service users. The negative attitudes and discriminatory responses are presented here as inter-personal factors but much of the stigma which prompts such attitudes and responses is cultural and societal and cannot just be attributed to individual staff.

Link & Phelan’s (2001) five interrelated components of stigma are: labelling; stereotyping; separation of us and them; status loss and discrimination; and power differences. Medical professionals held more negative views about patients with a previous diagnosis of personality disorder, irrespective of what the medical professional’s own diagnosis was of

their current condition (Lewis & Appleby, 1988). This suggests that the negative attitudes were not features of the condition itself but of the label.

Language and labelling are important components of stigma, helping to mark out the group as apart from us; “*incumbents are thought to ‘be’ the thing they are labelled*” (Link & Phelan, 2001, as cited in Lloyd, 2010). This separation is likely to be particularly pertinent for adults with multiple needs who are the bearers of multiple labels; ‘offender’; ‘drug user’; ‘mentally ill’; ‘personality disordered’.

Factors that are thought to play a role in the level of discrimination experienced by the label bearer include perceived dangerousness and perceived control over their behaviour (Lloyd, 2010; Young Minds, 2010). Again, the adult with multiple needs may be the bearer of many labels with dangerous connotations, not least ‘offender’ but also unfortunately ‘mentally ill’.

Lessons from attribution theory suggest that people more readily understand people’s behaviour in terms of behavioural as opposed to situational factors; in other words, “*blame is put on the person rather than on the context in which a person finds themselves*” (Young Minds, 2010, p.8). Personality disordered patients were perceived to be more in control of their behaviour (less ‘ill’); the more control the patient was perceived to have, the less sympathy the professional had for that individual (Lewis & Appleby, 1988; Markham & Trower, 2003). Similar conclusions were reached in studies of professionals working with patients who self-harmed (Huband & Tantam, 2000) or misused substances (Weiner, 1980). Lloyd (2010) suggests that “*blame and responsibility lie at the heart of debates about the stigmatisation of drug users.*” (p.18)

Key learning points:

- Adults with multiple needs are often the subject of multiple stigmas by professionals associated with their multiple labels.
- Perceived dangerousness and control over behaviour both have an impact on the level of stigma and discrimination experienced and so may provide a target for intervention.

2. Client histories and resulting behaviour

Difficult or problematic client behaviour is undoubtedly a factor in eliciting negative responses from professionals and engendering a problematic professional-client relationship. Some adults with multiple needs may exhibit violent or aggressive behaviour. Alternatively, they may engage in behaviours, such as self-harm, which are distressing to staff. For example, reception staff working with personality disordered patients complained of hearing descriptions of self-harm and being subject to verbal abuse (Crawford et al.

2009) and other research has suggested negative attitudes among health professionals to patients who self-harm (Huband & Tantam, 2000; McAllister et al. 2002).

Histories of adults with multiple needs are often characterised by neglect, abuse and other trauma (Anderson, 2010; Dean et al. 2003) which can have a lasting impact on inter-personal relationships. Interviewees suffering from a personality disorder, who had almost universally been subject to childhood abuse, expressed a difficulty forming trusting relationships with anyone, including professionals (Stalker et al. 2005).

Research into the effects of prolonged trauma in childhood has shown how such experiences prevent the person from forming either a secure, stable sense of self or stable representations of other people in their mind (Herman, 1997). Consequently relationships are often intense and unstable, swaying dramatically from perceptions of the person as their 'rescuer' to their 'abandoner' when they fail to meet unfeasibly high expectations.

As Maguire et al (2006) explain; *“Early abusive experiences can result in difficult thought processes and rumination and concomitant intolerable emotions. The easiest method of altering these in the short-term at least is to take some form of substance...This is more likely to happen when skills in regulating emotion have not been learnt in childhood...Where more adaptive interpersonal skills have not been learnt, more destructive ones which have been successful to some extent (e.g. aggression) are used.”* (p.125)

In doctors' waiting rooms O'Shea et al. (2003) describe how the combination of a long wait and anxiety about the consultation can lead to frustration, abusive verbal behaviour and even violence.

Adults with multiple needs may repeatedly refuse to respond to support that is offered. Scanlon & Adlam (2008) describe a group of people who simply 'refuse to play the game' as they feel both internally empty and externally isolated from society; *“The homeless, the dangerous and the disordered, often traumatised by experiences of intrusion or abandonment in which the attachment figures were themselves the source of danger, have been unable to develop the capacity to understand and process their own distress...In this state of mind, such people seek to avoid 'being inside' anything, while all the time being held in the grip of a contradictory and equally strong wish to be known and inside the minds of others.”* (p.31)

Theories from psychoanalysis suggest that clients can unconsciously project aspects of previous relationships onto the professional-client relationship; so-called “transference” (Hughes & Kerr, 2000). Within this mental projection, the professional will fulfil some predetermined role (an omnipotent parent; an uncaring staff member); their behaviour will be interpreted by the client accordingly, resulting in inappropriate feelings and behaviours by the client towards that professional such as complete dependency or anger.

Client histories and subsequent inter-personal difficulties may also heighten sensitivity to (inaccurate or accurate) perceptions of rejection from staff or services, resulting again in either a depressive or angry response (Maguire et al, 2006). Repeated rejection from services continues a cycle of rejection initiated in childhood. Services must be particularly careful not to reinforce this cycle, particularly when the nature of client behaviour elicits rejecting responses (National Institute for Mental Health in England (NIMHE), 2003).

Troubled histories may elicit a wide distrust of ‘the system’ and particularly negative responses to authority figures (Dean, 2003; Howerton et al. 2007). For example, adults who spent periods in care as children may blame statutory services for being taken into care in the first place or for poor experiences while in care (Communities and Local Government, 2010; Dean, 2003). Such anti-authoritarianism could also be understood as a strategy to sustain their sense of ontological identity in the face of a service environment that can promote dependency and a profound sense of disempowerment (Dean, 2003). In this way, certain client behaviours may be understood as a reaction to the poor communication with and low involvement of clients in determining care.

Problematic behaviour such as a failure to adhere with treatment may also be a reaction to stigmatising attitudes (Corrigan, 2004). The publicly stigmatised may internalise this stigma engendering feelings of low self-esteem, self-efficacy and confidence (Corrigan, 2004). Regarding adults with multiple needs participating in welfare-to-work programmes, Dean et al. (2003) highlight the “*corrosive culture of self-blame to which they were subject*” (p.19) which “*makes the solutions to their problems and the satisfaction of their needs seem less, rather than more, attainable.*” (p.25)

Key learning points:

- Early traumatic experiences have a profound effect on client’s sense of secure identity and inter-personal and emotional regulation skills.
- Aggressive behaviour, substance misuse and self-harm may be the consequent responses to intolerable emotions and problems developing secure, stable attachments to other people.

3. Staff anxieties and frustrations

Client behaviour may provoke anxious or frustrated responses in staff, or reinforce their existing anxieties and frustrations. Qualitative research with staff working with patients who self-harm in Sweden found that staff felt burdened by feelings, notably concern for the clients’ safety and feeling over-whelmed with frustration (Wilstrand et al. 2007). Staff also expressed a sense of abandonment by co-workers and management.

According to psychoanalytic theory, “countertransference” is the thoughts and feelings that are generated by the professional in response to the client’s transference and consequent behaviours (Hughes & Kerr, 2000). In his seminal paper, Groves (1978) describes countertransference as the ‘*unconscious and conscious unbidden and unwanted hostile and sexual feelings toward the patient – feelings that were seen to impede the treatment and to reflect poorly on the analyst*’ (p.884). He describes a number of groups of heavily dependent patients which he claims evoke hostile feelings in almost all physicians and which can result in their receiving inadequate care.

He categorises such patients within four groups. **Dependent clingers** present with a seemingly bottomless need and appear to perceive the physician as inexhaustible, engendering feelings of weariness and aversion. **Entitled demanders** also present with seemingly bottomless need but are aggressively demanding in seeking to have their needs met, engendering feelings of fear in the physician and a wish to counter-attack. **Manipulative help-rejecters** seek to retain the physician-patient relationship through the continual presentation with new symptoms and pessimism about the effects of all help. These patients engender feelings of guilt and inadequacy. Finally, **self-destructive deniers** appear to glory in their own destruction, so engendering all these negative feelings along with malice and a wish that the patient will “die and get it over with”.

Groves explained that although these feelings were common, care must be taken to avoid acting upon them. Rather than repressing these feelings he suggested that they must be accepted and reflected upon.

Although the conceptualisation of these four groups is derived from psychoanalytic concepts, research has highlighted groups of patients where the doctor-patient relationship is often perceived as difficult by the professional. For example, the National Institute for Mental Health in England’s description of the behaviour of patients with personality disorder echoes the behaviours that Groves describes: “*They may feel that no help is ever good enough, they may be hostile or demanding. They can, at times, sabotage all attempts at help.*” (NIMHE, 2003, p.11)

This point is made by Strous et al (2006) in their consideration of the Groves paper. They cite research into factors of both the patient and the professional that are linked to a problematic relationship; for example, Haas et al. (2005) found patient factors to include psychiatric disorders, unrecognized personality disorders and subclinical behaviour traits, while physician factors include overwork, poor communication skills, low level of experience and discomfort with uncertainty. Strous et al (2006) emphasise that “*negative experiences...stem from the interaction between the patient and professional rather than result from doctor or patient as individuals.*” (p.392)

Many general practitioners interviewed for Lester & Bradley (2001) perceived homeless patients to be highly demanding in terms of prescription requests. Some perceived a concerning power imbalance in their relationship, sometimes finding themselves ‘giving in’ to these demands in a way that they felt compromised their professional role. Even general practitioners who were positively disposed to working with homeless people acknowledged that they could come across as demanding, for example over the need for an immediate appointment. However in contrast to negatively disposed general practitioners, they considered that this reflected their clients’ powerlessness and was often associated with an inability to access the system in the usual way.

Adults with multiple needs often fail to progress within services. Negative attitudes towards patients appeared to be inversely linked to treatment optimism, although the causal direction is unclear (Markham & Trower, 2003; McAllister et al. 2002; Richmond & Foster, 2003). Lester & Bradley (2001) describe how negatively disposed GPs ‘*had few expectations of success in either medical or social terms*’ (p.9) with one ‘*describ[ing] his discomfort in terms of feeling helpless and hopeless when faced with a homeless patient.*’ (p.8).

When clients relapse, staff may take this an indication of their personal ineffectiveness (Maguire et al, 2006). They should be encouraged to voice these concerns and helped to develop alternative understandings of the reasons for this relapse. The National Institute of Mental Health in England highlights a lack of knowledge and skills among practitioners working with clients who have a personality disorder: “Staff currently have no explanatory framework for the challenging behaviours which may be exhibited by people with disorders or the skills to address these behaviours effectively.” (NIMHE 2003, p.7) Job satisfaction is likely to rest at least partly on ‘successful outcomes’, however, Keene (2001) has argued that professional ‘notions of success and failure may be counter-productive for this group’ (p.92).

Finally, staff anxieties played a role in impeding effective inter-professional working. Robinson & Cottrell (2005) observed that concerns among professional staff over threats to specialist identities, status and power were all identified as problems within multi-agency teams.

Key learning points:

- Client behaviour can precipitate or exacerbate staff anxieties and frustrations such as feelings of inadequacy regarding ability to treat, or concerns over a power imbalance.
- Professionals need to be equipped with a framework that explains problematic client behaviours and their reactive emotions, as well as having the skills and management support to address these.

Organisational and professional factors

1. Organisational and Professional Culture

Organisational culture is a complex concept and has been characterised in different ways by academics. However, as Hinshelwood & Skogstad (2000) suggest, it is “an elusive term, difficult to define and yet an important concept when thinking about the dynamics of an organisation.” (p.8) In their introduction to culture, People & Culture (2009) suggest that it can broadly be understood as a collection of opinions, attitudes, beliefs, assumptions, values and behaviours shared by the majority of those within an organisation and sustained by organisational practices. That said, sub-cultures can exist within organisations, particularly those related to level within the organisation (management or frontline), function and discipline.

People & Culture outline a number of characteristics of an organisation which collectively reflect that organisation’s culture: observed behavioural regularities (including common language), norms or standards of behaviour, dominant values (both implicit and explicit), philosophy, rules (written and unwritten) and the climate or atmosphere of an organisation. As such, the culture of the organisation will have strong implications for the

experience that a service user has when they attempt to access support from that organisation.

Organisational attitude to risk has been highlighted as important in work with adults with multiple needs, particularly with an offending history. The evaluation of the Adults facing Chronic Exclusion (ACE) pilots noted that the pilots were able to work with some of these clients because of an organisational culture that was simply willing to tolerate a greater level of risk than that of other local services (Cattell et al. 2009). The evaluation identifies the question of *'whether one can appropriately engage with this group without being prepared to take on risk'* (p.36) as an area for further investigation. However, it emphasised that the benefits of a less risk-averse approach *'must be balanced against the nature of the possible harm'* and in one case a client of one of the services had been involved in a highly serious incident.

The compatibility of cultures and sub-cultures is also likely to have a strong impact on how well multi-professional teams and different organisations are able to work together. In a review of the evidence on inter-agency collaboration in offender health and social care, Williams (2009) found that:

"The most commonly cited barriers relate to professional values and their underpinning philosophies. These barriers are particularly challenging in joint working with offenders as the agencies required to work together differ significantly in ethos, philosophy and in some cases the definition of 'partnership' to which they subscribe." (Williams, 2009, p.578)

Williams observed that the disjuncture in cultural emphasis on care and control also has an impact on the willingness of agencies to share information with each other, due to concerns as to how that information will be used.

Psychoanalytic discussions on culture focus on its unconscious aspects: unconscious assumptions, attitudes and beliefs. Psychoanalysis suggests that unconscious and conscious anxieties in individuals results in the development of psychological defence mechanisms. Hinshelwood & Skogstad (2000) extend the psychoanalytic anxiety-defence model to social systems. Work-related tasks in different work settings generate specific anxieties regarding that task. Collating observational studies on a number of healthcare institutions, Hinshelwood & Skogstad suggest that in general healthcare settings there is a collective anxiety regarding death, and associated anxieties regarding responsibility and guilt. In mental health care institutions the more specific fear is one of madness. In addition, individuals attracted to certain professions may bring with them similar anxieties, for example, Hinshelwood & Skogstad suggest that *"An important aspect of being a carer may be a deep-seated fear of helplessness and loss of control and an attraction to omnipotent expectations of one's capacity to cure"* (p.14); expectations that cannot possibly be lived up to.

Hinshelwood & Skogstad argue that social systems can help alleviate the collective yet unconscious anxieties of the individuals within it by supporting their defence mechanisms; for example, through risk-averse practices, or routines that enable staff to remain emotionally distant from patients. Such defensive systems often have negative consequences for quality of care.

Scanlon & Adlam (2008) suggest that clients who are perpetually ‘unhoused’, without a secure place in society, or a secure sense of self, generate related states of ‘unhousedness’ and incohesion in staff and organisations that work with them. This may result in isolation of the individual worker from colleagues. Alternatively, it may result in the isolation of the organisation and the associated development of a “gang-like state of mind” (p.32), with a severe impact on the workers’ ability to work effectively with other agencies:

“In our experience, there is a concentration of such staff within some specialist teams, where widespread hostility towards mainstream statutory services coupled with a problematic identification with the (oppressed) client group, often involves a flight into a spuriously gratifying war on authority as a reaction against those other agencies that are perceived as having been oppressive and excluding. A resultant ‘none shall be turned away’ attitude can then give rise to a highly politicised ‘rights’ culture, with a correspondingly diminished sense of professional role and responsibility in which the mantra becomes that clients must be given everything they demand – even as they violate the rights of others.” (p.32)

This will impede inter-agency cooperation and is likely to result in a more fragmented service response. In particular, it may be one reason why working relationships can on occasion be poor across the voluntary-statutory sector divide. The evaluation of the Adults facing Chronic Exclusion (ACE) pilots observed that while trying to advocate for better services for their clients ‘unconstructive relationships can be developed with statutory services and pilots “can be seen to be criticising”.’ (Cattell et al. 2009, p.44) The evaluation noted that adversarial approaches had less success in resolving conflicting opinions than approaches which took a ‘softer’ approach that attempted to understand the other organisation’s stance.

Key learning points:

- Organisational culture has an important impact on the ability and willingness of organisations to work both directly with adults with multiple needs and with each other.
- Such culture can sustain a system where collectively-held but unspoken anxieties about the work, lead to problematic organisational practices, both defensive and aggressive.

2. Professional Models of Care

Keene (2001) suggests that a major factor in the poor service response to adults with multiple and complex needs is that clients define their problems differently to professionals and single-agency professional services. Consequently clients and professionals differ in their aims, priorities and expectations for their care and their understanding of what constitutes a successful outcome.

Professional models of care interpret all a client's problems within a single frame of reference (e.g. medical, social or harm reduction) which informs both assessment and intervention. Professionals often have a poor understanding of how different needs interact; other co-occurring needs and the wider context of problems appear to receive little attention in training. For example, neither homelessness nor substance misuse appeared to be addressed adequately in pre-qualification medical training (Lester & Bradley, 2001; Richmond & Foster, 2003).

Intervention by a professional usually addresses a single need only. Where multiple needs are identified, professional models usually define these needs in terms of a 'primary cause' (for example, 'drug use is the cause of depression') and offer interventions targeted at this 'primary cause' (drug use). Access to services are restricted to those clients whose 'primary cause' is identified as falling within their remit and is considered severe enough in isolation to warrant intervention.

However, this interpretation and resulting interventions may not reflect the client's understanding of their own problems (Dean et al, 2003; Keene, 2001). Clients do not experience their problems in isolation but as a complex network of issues that interact with each other and culminate in their day-to-day lived experience. Clients may want help targeted at another need area (for example, depression) or, more likely, want a comprehensive package of help that targets all need areas. Clients may come across as not wanting help – as 'demanding timewasters' – simply because they do not want the help being offered.

A user of one service for young adult offenders contrasts the care received from this service compared to other services; in the Transition to Adulthood pilot project, they "*give you the help that you want and not the help that they think you need.*" (Service user of T2A pilot, Hanley-Santos & Burnett, 2010, p.60). Similarly, examples of general practitioners who had positive relationships and experiences with their clients showed a willingness to extend their remit, in terms of meeting social or practical needs (Bhui et al. 2006; Lester & Bradley, 2001).

Professional models of care are also change-oriented (Keene, 2001). In other words, success is defined as a change in behaviour in response to an intervention (for example, cessation of drug use) and clients are expected to 'progress' through services. But clients may not feel able to make the changes that services require from them. To use a swimming analogy, they may want help just to tread water and keep afloat; they do not yet want help to swim.

Consequently, clients are often refused the support that they feel they need because services consider them 'unmotivated', and if support is given this can be withdrawn if they do not make progress: "*The main message is very clearly sent, that inappropriate service use is not acceptable. Either you use services properly and are motivated [to change] or we will not go on providing them.*" (Professional, interviewed for Keene, 2001, p.86)

Service users in the literature described the stress of feeling pressured to change. For example, the pressure applied by the benefits agency to return to work in unrealistic timescales (Bauld et al. 2010; Dean et al, 2003). As well as being a result of professional change models, these are also a consequence of funder expectations.

Ironically, within this change-oriented professional model, support is also withdrawn if clients *do* make progress. If they have progressed sufficiently in one needs area, support is withdrawn despite the fact that other needs may remain unmet. For example, a drug worker might consider a client to have been a 'success' on the basis that heroin use has ceased, despite the fact that the client is drinking heavily and suffers from depression: *"People think you're alright – 'oh, you're doing marvellous!' – but that person's got everything to deal with then."* (Dual diagnosis interviewee, Revolving Doors' focus group, Middlesbrough).

Keene (2001) demonstrated that professional models of care can also create barriers to relationships between different professionals. Different professional models provide different frames of reference in which to interpret problems. In multi-agency teams and in other teams which contain a number of differently trained professionals (such as a mental health team consisting of psychiatrists, psychologists, occupational therapists and nurses) these 'plurality of perspectives' co-exist and have to be reconciled (Davies et al. 2006; Robinson & Cottrell, 2005).

At the very least, different frames of reference can create significant communication barriers between types of professional, but in some cases these interpretations and subsequent approaches to care can conflict with each other with professionals holding quite different views about how care should proceed (Keene, 2001). In addition, the single frame of reference provided by professional models of care, and instilled in professional training, often means that professionals have a very limited understanding and appreciation of the roles and responsibilities of professionals in other agencies. The results are difficulties in inter-professional working and resultant poorer client care.

Key learning points:

- Professional models of care interpret client problems within a single frame of reference, identifying a primary cause at which change-oriented interventions can be targeted.
- This interpretation is at odds with the client's experience; consequently, professionals and clients often differ in their definitions of the problem, the solution and in what constitutes success.
- Inter-professional working is also impeded, due to conflicting views regarding care and a poor understanding of each other's roles and responsibilities.

3. Professional Role Conflict

In some cases there are tensions within the professional role itself that can lead to dissatisfaction among clients of services. This appears to be particularly the case for 'compulsory' services where a role has both a supporting and monitoring function, but where there is, or is perceived to be, an imbalance between the two functions. Notable examples include children's social services and the probation service.

Families with complex needs who were involved with children's social services were described as disengaging when support was not forthcoming as they perceived professionals to be overseeing them as opposed to offering assistance (Devaney, 2008). Similarly, many of the criticisms targeted at the probation service focused on the lack of support offered (Hanley-Santos & Burnett, 2010). Offenders were seen to have the poorest relationship with their lead professional of all the socially excluded groups covered by Public Service Agreement 16 and probation officers confirmed offender's perceptions that they were more concerned with monitoring than offering support to meet accommodation needs (Communities & Local Government, 2010).

It is worth noting that although this role tension exists for prison officers as well, this group did not appear to be singled out for criticism in the same way (Liebling & Price, 2001). It is possible that within a prison environment a monitoring role is both expected and accepted in a way that it would not be within the community. Nevertheless the dual-aspect role of care and control has implications for the mutual development of trust: for example, prisoners are also often acutely aware of the power that officers have to include information within reports (Liebling & Price, 2001), a barrier which is likely to exist for relationships with probation officers as well.

Problems of role conflict are exacerbated by a lack of accessible information that makes clients aware of what they can expect from services and gives them a clear understanding of professional roles and remits (Keene, 2001; Rosengard et al. 2007).

Key learning points:

- Problems arise where professional roles contain both a caring and a control component particularly where the client perceives an imbalance in the two functions.
- These problems are exacerbated if the client does not have a clear understanding of that professional role and of what they can expect from the service.

4. Service design and operation

Support services need to be designed in a way that facilitates engagement. However, there are a number of aspects of the infrastructure of services that makes it harder to provide an adequate service for clients with multiple needs. In some cases these are general features of services, although there are often specific elements of the infrastructure of individual services that are detrimental to the quality of care.

The use of technology in place of face-to-face human contact was one example of this, for example the use of telephone help lines for benefit enquiries; “*everything’s been rerouted through the phones and there’s no more personal interaction.*” (Bauld et al. 2010) The use of the internet to bid for Choice Based Lettings was also identified as a barrier to housing for socially excluded adults, who were often unable to access or use computers (Communities and Local Government, 2010). This issue is likely to recur if government proposals to make increased use of this technology for benefit applications come to fruition (Department for Work and Pensions, 2010).

Technology can also impede inter-agency working; incompatible IT systems (Keene, 2001), other record-keeping practices and distinct information sharing procedures (Robinson & Cottrell, 2005) are all barriers to information sharing and good communication between agencies. Keene (2001) argues that the poverty of accurate inter-agency data has consequences that extend beyond the poor experience of any single service user; the lack of such data prevents a strategic approach to service planning for multiple needs and the informed development of multi-agency working.

Another problem for adults with multiple needs, who may have low levels of literacy and in some cases have a learning disability (Anderson, 2010), is the use of lengthy and complex application forms by services, particularly for benefits applications (Bauld et al, 2010; Bhui et al, 2006; Rosengard et al. 2007). Additionally, the insistence by services that clients present with the appropriate identification can be a barrier for those who have transient lifestyles, find it hard to retain paperwork and often do not have bank accounts, driving licences or passports which provide multiple forms of identification (Pratt & Jones, 2009).

Factors such as high staff turnover which prevent the development of a high quality trusting relationship and disrupt continuity of care can also be detrimental to the experience of people with multiple needs (Communities and Local Government, 2010; Devaney, 2008; Gallimore et al. 2008; Rosengard et al. 2007; Stalker et al. 2005). Continuity of care was also a major problem for the prison service where complex shift patterns mean that prisoners will see a number of different officers over the course of just a few weeks and may not see their ‘personal officer’ for a number of days (Liebling & Price, 2001).

Inflexible systems, such as rigid appointment systems and office-hour opening only, have also been identified as a major barrier to the successful engagement of adults with multiple needs (Dean, 2003; Jeal & Salisbury, 2004; Rosengard et al. 2007). Rather than attributing the barrier to the organisation itself, it is frequently attributed to the ‘chaotic lifestyles’ of many of these individuals. Although this may be true, chaotic lifestyles often accompany high levels of need and the incompatibility of the organisational structure and the clients it wishes to engage needs to be addressed. For this reason, the ‘assertive community treatment’ (ACT) model was developed in secondary mental health for ‘hard to engage’ clients. Assertive community treatment teams have lower team and individual caseloads

than their traditional counterparts, they work extended hours, are not office-based and continue to try and engage clients repeatedly whether or not the client responds (Killaspy et al. 2006). A randomised evaluation of these services found that fewer clients were lost to follow-up and a greater level of client satisfaction was observed, although it did not find any improvement of social or clinical outcomes among those treated with the ACT approach.

One final point on service design is that particular barriers were observed for services that operate within prisons. The repeated transfer of prisoners between institutions that interrupts continuity of care by prison-based support services (Communities & Local Government, 2010). It affects their ability to undertake education and behaviour courses and can interrupt efforts to secure post-release accommodation (Hopwood Road et al. 2007). This is particularly problematic when transfer to another prison occurs close to a prisoner's release date. This issue is related to the systemic factor of overcrowded prisons, themselves a result of resource constraints and sentencing policy.

Key learning points:

- Service design can deter engagement, through the overuse of technologies, inflexible or complex systems and organisational features that disrupt continuity of care.
- Incompatible technologies and information systems are also a barrier to inter-agency working.
- Particular barriers exist for services that operate within prisons.

Structural factors

I. Funding and commissioning arrangements

Rankin & Regan (2004) highlight the considerable impact that ineffective commissioning has for those with multiple and complex needs: *“The commissioning process has four elements: assessment, planning, contracting and monitoring. However these functions are rarely fulfilled.”* (p.iv) They argue that; *“Too often commissioners are engaged in purchasing rather than strategic commissioning for need. Commissioners do not spend sufficient time mapping need and communicating with providers about how best to meet that need.”* (p.46) Commissioning for adults with multiple needs may also require a willingness to commission preventative services, to avoid escalation of need, which may be in tension with needs to commission reactive services (Clinical Effectiveness Support Unit, CESU, 2007).

Many of the problems identified at individual and organisational levels are replicated at the planning and commissioning level. Commissioners focus on those with high levels of need in one need area (CESU, 2007). They adopt a single-issue approach to understanding people's problems and the solutions to these problems, and are unwilling to commission

for 'whole needs' (Rankin & Regan, 2004). As Keene (2001) emphasises; *"professionals (like planners) assess predefined needs in their specialised populations, using criteria and priorities which are pertinent to their specialisms. They do this in isolation from each other."* (p.7).

The previous government made considerable attempts to improve commissioning practice; for example, through the establishment of the Academy for Justice Commissioning to promote excellence in commissioning criminal justice services (Academy for Justice Commissioning, 2010) and through their World Class Commissioning campaign in health (Department of Health, 2007). They promoted joint-commissioning and the use of pooled budgets, and introduced the Joint Strategic Needs Assessment and the infrastructure of strategic partnerships to facilitate their use.

Nevertheless, these moves appear to have only had partial success for some socially excluded groups (HM Government, 2010). Good information is vital for successful commissioning, but such groups often failed to show up in Joint Strategic Needs Assessments (Social Exclusion Task Force, 2010). Due to the very fact that adults with multiple needs are often excluded from or poorly engaged with services – as well as the sheer complexity of their problems –both patterns and levels of their need can remain unrecognised unless commissioners expend considerable effort and creativity in identifying this need. Research by the Cabinet Office (Social Exclusion Task Force, 2010) suggests that there remains significant untapped opportunity to collaborate with patients, the public and academics to improve understanding of local need.

Funding arrangements pose a number of problems. Different sectors often operate on different boundaries and have different traditions in commissioning. They may operate on different funding cycles and may use different funding mechanisms, for example block contracts versus spot purchasing (Rankin & Regan, 2004). There is no generic funding stream for this group and there are problems combining multiple funding streams from distinct service budgets (Robinson & Cottrell, 2005; CESU, 2007) – which may include both central and local funding. These discreet streams can reinforce a fragmented approach to multiple needs (Rankin & Regan, 2004; Rosengard et al. 2007).

Rankin & Regan (2004) also emphasise the importance of diversity of provision so that commissioners have sufficient choice to ensure that services are provided effectively. However, they highlight significant problems for voluntary sector services: *"the lack of a stable source of funding, the absence of standard form of contract with health and local authorities, and 'sudden death' service contracts of between one to three years which inhibit service development and increase bureaucratic costs."* (p.44)

Similarly, following perceived problems in the implementation and delivery of a 'mixed economy' model of service provision (the 'From Dependency 2 Work' programme) McSweeney & Hough (2006) suggest that a key issue *'is for government to find ways of contracting with providers – whether from the voluntary or private sector – that fosters trust and the sense of a shared enterprise'* which might include *'a commitment to long-term contracts; a preparedness to take account of qualitative as well as quantitative performance indicators; the tolerance of risk in innovation; and the avoidance of disincentives to partnership work.'* (p.121) They highlight that funding arrangements that encourage competition rather than collaboration between services and lead to mutual distrust are particularly problematic for voluntary services who are often struggling to keep their heads above water.

Such problems for the voluntary sector as well as other funding-related issues are likely to be particularly problematic in a climate of severe spending cuts. As early as 2007, the Clinical Effectiveness Support Unit reported “evidence to suggest that big funders such as the NHS – who may in the past been able to contribute – have significant financial difficulties themselves.” (p.30/1) As the financial situation has deteriorated further, there is a danger that services will retract back, avoiding joint commissioning and focusing only on core functions.

Key learning points:

- Many of the problems observed at the organisational level, such as a single-issue approach to need, are replicated at the commissioning level.
- Moves towards improved joint needs assessment and commissioning have only had partial success; greater effort and creativity must be expended in identifying need of excluded groups.
- Funding arrangements create barriers both to joint commissioning and to innovation in service development.

2. Limited resources

The problem of limited resources permeates the system. All services have to determine who has access to limited staff-time i.e. who gets a service and how much time do they get. Many services also determine access to other practical or financial resources, such as social housing (CLG, 2010) or detoxification places (Gallimore et al. 2008); they are ‘gate-keepers’. So-called statutory services have the additional burden that they are legally obliged to provide a service to certain individuals, often irrespective of their capacity to do so.

Consequently, clients are often refused services that they believe they need because high thresholds are placed for access to services. High service thresholds form a barrier to access for adults with multiple needs, since thresholds are often construed in terms of ‘depth’, but not ‘breadth’ of need (Rankin & Regan, 2004). Keene (2001) argues that a multi-agency ‘tariff’ is required which assesses cumulative need and determines access to services.

Even where clients are accepted for a service, limited resources can lead to long waiting lists when immediate help is required (Rosengard et al, 2007; Gallimore et al, 2008). The quality of care may also be damaged, since high caseloads or heavy caseloads (caseloads containing a high proportion of high-need clients) limit the time available to professionals to spend with clients. The Department of Communities and Local Government (2010) identified high caseloads as a detrimental factor to the ability of lead professionals to help

socially excluded adults into settled accommodation; probation staff faced particularly high caseloads.

In contrast, voluntary services specifically targeted at multiple needs clients often prioritised lower caseloads in order to maximise time spent with clients and develop a more nuanced understanding of their needs (Cattell et al. 2009). However, a lack of appropriate services elsewhere in the system may place an increased demand on this type of service and the ability to maintain low caseloads may be jeopardised.

Although the problem of limited resources is a systemic one, it has a profound impact on the organisations and the people within them. Rungay & Munro (2001) discuss the impact that these resource limitations might have on staff and staff attitudes. It is *“the classic dilemma of Lipsky’s (1980) ‘street-level bureaucrat’, who enters a profession aspiring to alleviate suffering, only to find that he or she is required to ration inadequate resources in a world which is overpopulated by potential claimants.”* (Rungay & Munro, 2001, p.362).

Their discussion revolves around the frequent finding in ‘Inquiries After Homicide’ committed by patients with previous contact with mental health services that *“professionals appear to have ignored their distress or rejected their requests for assistance.”* (p. 358) Rungay and Munro suggest a theoretical framework in which *“apparently insensitive behaviour stems from the deployment of rationalizations for denying care to mentally ill individuals, in situations in which professionals experience powerlessness to intervene effectively.”* (p.357) They suggest that *“many of these strategies will exploit the characteristics of those individuals whose personal attributes and behaviour make them the least attractive candidates for the receipt of help.”* (p. 362)

Conversely, Griffiths (2001), who studied the resource allocation process in two different Community Mental Health Teams, argues that inter-personal and organisational factors have a mediating effect on the impact of limited resources. He argues that *“resource allocation decisions are not just a matter of supply and demand, but also reflect human service workers’ subjective understandings of the priorities and pressures affecting them. Rationing decisions, like ethical judgements more generally, have ‘tacit components’ arising from the unspoken context of professional norms, local knowledge, and assumptions about the constraints affecting routine work.”* (p.696)

Another key issue for adults with multiple needs is the lack of strategic prioritisation of this group. The evaluation of Revolving Doors’ National Development Programme described how *“it was evident that the police, the courts and local criminal justice services were often frustrated by the lack of appropriate services to support this group. In some areas attempts had been made to begin to address the needs of the group, however a key problem had been finding funds to support initiatives. This was because the target group was not identified as a national, regional and local priority and addressing their issues did not directly address national or local targets.”* (Kenny & King, 2010 p.5)

Following a number of high profile murders by mentally-disordered offenders, there has arguably been a shift in our approach to mental health care; *“a concern about the welfare of the many has been replaced by a fear of the risk posed by the few”* (Boyle et al. 2009). Adults with multiple needs may engage in low-level offending and only have common mental health problems. Despite having a detrimental impact on individuals’ lives, such problems may not be considered serious in terms of a risk of harm to others. High risk individuals

are prioritised with the result that limited resources may be channelled away from other adults with multiple needs.

Key learning points:

- The problem of limited resources permeates the system, resulting in high service thresholds, lack of appropriate services, long waiting lists, high staff caseloads and the strategic prioritisation of other high risk groups over many adults with multiple needs.
- Professionals who are gate-keeping limited resources may have to rationalise the necessary denial of care to groups who nonetheless have significant need.

3. Legal barriers

The legislative framework in which services operate governs how statutory services distribute their limited resources, by mandating that a service is provided to certain individuals while allowing for the denial of a service to others. In the context of limited resources, those to whom statutory services are not legally obliged to provide support, often find themselves without.

Notably among this legislation are the provisions of the Housing Act 1996. Local authorities have a duty to provide accommodation to those presenting as homeless who are 'in priority need' but are not 'intentionally homeless' (Communities and Local Government, 2006). These concepts can act to exclude those with multiple needs.

Although both mental illness and imprisonment can render someone 'in priority need', it is not automatic. In addition, the person must demonstrate that they are 'vulnerable' as a result of their illness or their imprisonment, a subjective concept that is determined by the local authority and relevant case law (Communities and Local Government, 2006). Research into the settled accommodation outcomes for socially excluded adults found that, of all the PSA 16 groups, offenders were the most likely to be advised to make their own arrangements or seek private rented accommodation (Communities & Local Government, 2010).

Even if a client is found to be 'in priority need', accommodation can be denied if he or she is also found to be 'intentionally homeless', i.e. "*he or she deliberately does or fails to do anything in consequence of which the person ceases to occupy accommodation (or the likely result of which is that he or she will be forced to leave accommodation)*" that was both available and reasonable for that person to continue to occupy (Communities and Local Government, 2006 p.96). Although the guidance makes it clear that there can be no blanket policy as to what constitutes intentionality, anti-social behaviour and offending that leads to imprisonment are both factors which can render a person 'intentionally homeless'. This

was seen to cause problems for the resettlement of care leavers (CLG, 2010) and prisoners (Hopwood Road et al. 2007). This rule gives legal validation to the psychological practice observed among staff of denying help to those perceived to be more 'in control' of their behaviour.

A legal barrier that affects prisoners, even short-sentence prisoners, is the eligibility rules for benefit, in particular the '13-week housing benefit rule'. This limits the payment of housing benefit to sentenced prisoners to a maximum of thirteen weeks, often resulting in rent arrears and eviction (Anderson, 2010). Additionally the legal framework determines at what age some statutory services are withdrawn, for example financial support from social services for former looked after children.

Other problems that relate to the legislative context in which services operate include poor information sharing between agencies. Concerns about adhering to the Data Protection Act 1998, the common law duty of medical confidentiality and professional codes of ethics can create considerable concerns for professionals and agencies. Robinson & Cottrell (2005) identify information sharing issues as '*one of the key procedural "fault lines" along which differences between professions arise in multi-agency teams*', highlighting that '*a particular issue is the value placed upon and the interpretation of confidentiality.*' (p.555) For example, they suggest that medical confidentiality can restrict access to medical databases, even in multi-agency teams.

Although legal restrictions do block the sharing of certain information, it is often the lack of understanding among professionals of this legislation and consequently about what information can be shared which causes problems (Herlitz & Jones, 2009). These problems are exacerbated by a lack of clear protocols regarding information sharing and confidentiality (Rosengard et al. 2007; St Mungo's & Revolving Doors Agency, 2010).

Key learning points:

- Legislation determines how statutory agencies distribute their limited resources, in terms of who benefits and the age and circumstances under which they are withdrawn. Adults with multiple needs often find themselves excluded from services by this legislation.
- Legislation is also a barrier to information sharing between agencies, although poor understanding of how this legislation should be applied is in some cases a greater issue.

Chapter 5

Improving the frontline response to adults with multiple needs

Adults with multiple needs often brush contact with a wide range of services across health, welfare and criminal justice. Some will be well known to these services. However, too often they will be 'famous faces' for all the wrong reasons. They will fail to engage, fail to make progress and be a source of considerable frustration for those professionals working within these frontline services. They will also be costly to the system, accessing expensive crisis services rather than structured support within mainstream services. The research considered has helped us understand the experience of these adults with multiple needs as they attempt to access support, shining a light on why they so often fail to engage.

Throughout the research considered, it was clear that adults with multiple needs wanted consistent, positive and high quality relationships with staff, in which trust and respect were key factors (Gallimore et al, 2008; Howerton et al, 2007; Revolving Doors Agency, 2010). Conversely, they reported poor professional-client relationships, characterised by negative staff attitudes and low trust among clients. Clients wanted to be listened to and to have a say in their own care, but once again, far too often, this did not happen. The result was a significant mismatch with the client's expectations.

Breaks in continuity of care, particularly at transition points, damaged professional-client relationships and often left the client without a service altogether. Delays in receiving help meant that motivation dissipated or clients were lost to services. In other cases, services denied care altogether because adults with multiple needs were not considered to have sufficient depth of need, while the damaging implications of the breadth of their need were ignored.

Systems were complicated, information was often limited and advice frequently unhelpful or inaccurate. The system appeared fragmented, so that adults with multiple support needs were expected to go to different services to receive different aspects of their care, the result being significant duplication combined with gaps in support.

Given all this, it is perhaps unsurprising that adults with multiple needs fail to engage with or progress within support services. Only by improving the quality of the interaction that adults with multiple needs have with services at the frontline can we hope to see them make positive changes. In turn, improvement can only be achieved through an understanding of the multiple underlying factors that lead to such a poor frontline service response.

This review has explored such factors. It has been seen that this poor frontline service response is the result of a *combination* of inter-personal, organisational, professional, systemic and structural factors (see appendix I for overview).

It is the interlocking nature of these factors that produces the end result. The poor quality of the staff-client relationship is, as would be expected, largely a result of inter-personal factors. Nevertheless, this relationship is also significantly impacted by such structural factors as limited resources or legislative frameworks that determine when care is denied

withdrawn. It was seen that limited resources increase caseloads, limit the time spent with clients and, arguably, force professionals to develop rationalisations for denying a service to those quite clearly in need. Conversely, it has been argued that the organisational response to limited resources depends partly on subjective factors such as how people perceive their own role.

It has been apparent that silo structures are clearly a significant issue. There are problems combining distinct funding streams originating from different government and local funding sources. Professional training equips different professionals with distinct models of care and only a limited understanding of other services. Services are artificially divided into services for adults with a learning disability, adults with a mental health problem and adults with a substance misuse problem (CESU, 2007).

That said it is arguable that silo structures were less of a problem than silo thinking at every level. Although the infrastructure of partnerships has been developed significantly under New Labour, traditional silo structures have left a legacy of silo thinking in which needs are artificially segregated. This point was emphasised by Rankin and Regan (2004) who suggested that *“further structural change should not be a priority. The current range of partnership flexibilities and integrated models of working offers an adequate structural framework to meet complex needs. Central priorities need to shift to supporting cultural change that leads to a unified culture of health and social care, and towards developing new models of delivery and new professional roles.”* (Rankin & Regan, 2004, p.5)

Both professionals and commissioners considered problems and their own remit within a single frame of reference only. This interpretation is in direct conflict with the personal experience of adults with multiple needs, as well as the interpretation of many other professionals.

Conflicting organisational cultures were highlighted as a particular barrier to inter-professional working. It was argued that this was a particular problem when agencies with a predominantly caring role were asked to work closely with agencies whose role was predominantly control-focused. (In fact, this conflict between care and control could be seen in individual professional roles, as well as between agencies). In addition, particular organisational cultures could pose direct problems for work with adults with multiple needs. For example, risk-averse cultures could result in clients with challenging behaviours being excluded from services altogether.

Particular emphasis in this review was placed on the considerable challenges and anxieties provoked in work with clients with a traumatic history and/or a personality disorder. Professionals need to be better equipped to understand and respond productively to problematic behaviour and significant work has been and is ongoing in this area from the Department of Health (see for example, NIMHE, 2003). Nevertheless, it was also clear that stigmatising responses to labels, rather than behaviour, was also part of the problem and this must be challenged.

Too often, clients with multiple needs are held to be responsible for failing to engage with services; they are considered too chaotic, too troublesome. However, services specifically targeted at and designed for this group report some notable successes in their work (for example, Cattell et al, 2009). However, problems are particularly acute in mainstream services, where clients with multiple needs may form only a very small proportion of their

client group, or in services that are swamped by high risk, 'depth of need', clients who have to take priority. This is where a particular challenge lies in improving the frontline service response to clients with multiple needs. Nevertheless, it is hoped that the learning from this review may go some way to helping those involved in the delivery, design and commissioning of these services.

Chapter 6

Summary of key learning points

Inter-personal factors

- Adults with multiple needs are often the subject of multiple stigmas by professionals associated with their multiple labels
- Perceived dangerousness and control over behaviour both have an impact on the level of stigma and discrimination experienced and so may provide a target for intervention
- Early traumatic experiences have a profound effect on client's sense of secure identity and inter-personal and emotional regulation skills
- Aggressive behaviour, substance misuse and self-harm may be the consequent responses to intolerable emotions and problems developing secure, stable attachments to other people
- Client behaviour can precipitate or exacerbate staff anxieties and frustrations such as feelings of inadequacy regarding ability to treat, or concerns over a power imbalance
- Professionals need to be equipped with a framework that explains problematic client behaviours and their reactive emotions, as well as the skills and management support to address these.

Professional and Organisational factors

- Organisational culture has an important impact on the ability and willingness of organisations to work both directly with adults with multiple needs and with each other
- Such culture can sustain a system where collectively-held but unspoken anxieties about the work, lead to problematic organisational practices, both defensive and aggressive
- Professional models of care interpret client problems within a single frame of reference, identifying a primary cause at which change-oriented interventions can be targeted
- This interpretation is at odds with the client's experience; consequently, professionals and clients often differ in their definitions of the problem, the solution and in what constitutes success
- Inter-professional working is also impeded, due to conflicting views regarding care and a poor understanding of each other's roles and responsibilities
- Problems arise where professional roles contain both a caring and a control component particularly where the client perceives an imbalance in the two functions
- These problems are exacerbated if the client does not have a clear understanding of that professional role and of what they can expect from the service
- Service design can deter engagement, through the overuse of technologies, inflexible or complex systems and organisational features that disrupt continuity of care
- Incompatible technologies and information systems are also a barrier to inter-agency working
- Particular barriers exist for services that operate within prisons.

Structural factors

- Many of the problems observed at the organisational level, such as a single-issue approach to need, are replicated at the commissioning level
- Moves towards improved joint needs assessment and commissioning have only had partial success; greater effort and creativity must be expended in identifying need of excluded groups
- Funding arrangements create barriers both to joint commissioning and to innovation in service development
- The problem of limited resources permeates the system, resulting in high service thresholds, long waiting lists, high staff caseloads and the strategic prioritisation of other high risk groups over many adults with multiple needs
- Professionals who are gate-keeping limited resources may have to rationalise the necessary denial of care to groups who nonetheless have significant need
- Legislation determines how statutory agencies distribute their limited resources, in terms of who benefits and the age and circumstances under which they are withdrawn. Adults with multiple needs often find themselves excluded from services by this legislation
- Legislation is also a barrier to information sharing between agencies, although poor understanding of how this legislation should be applied is in some cases a greater issue.

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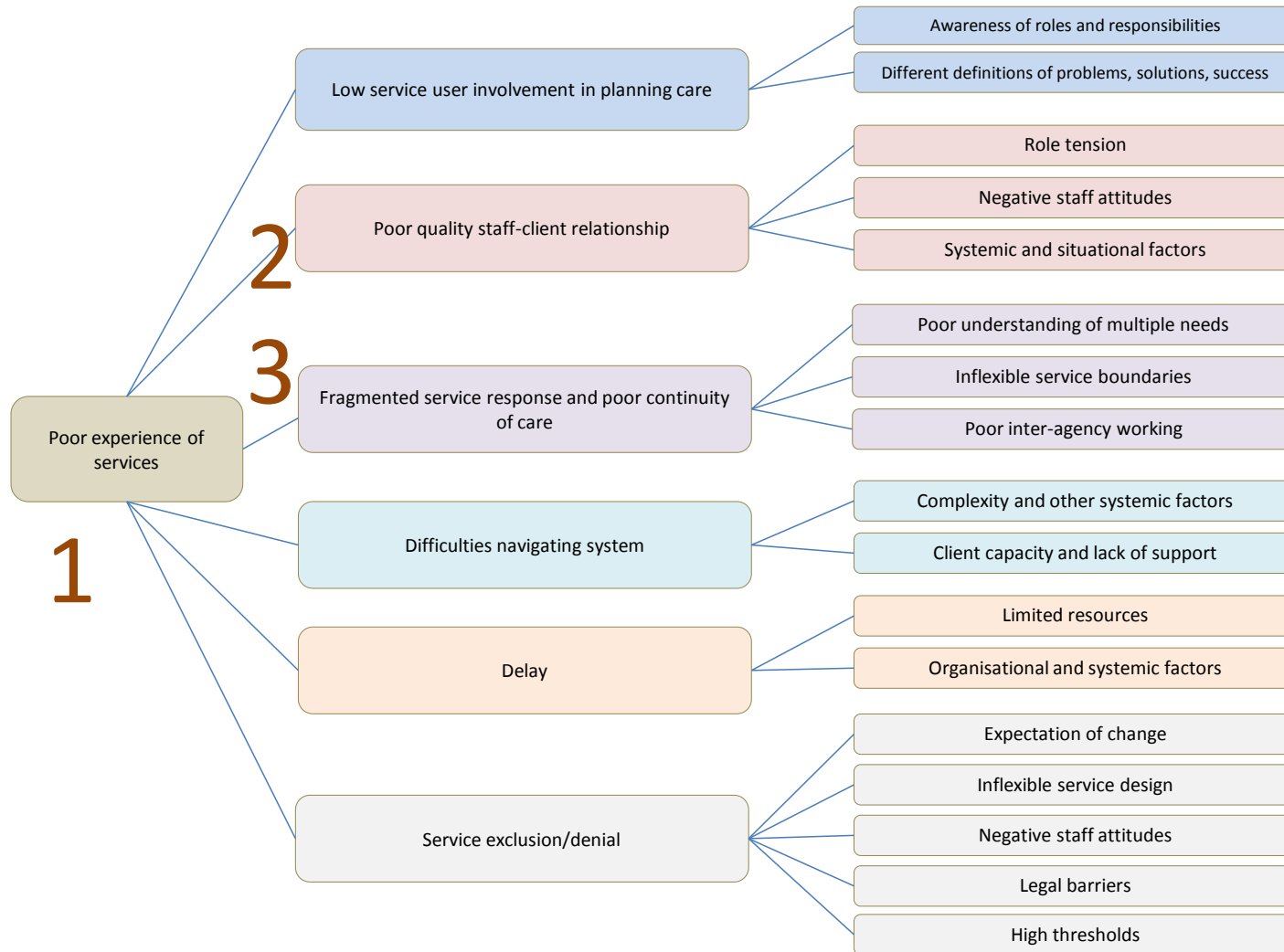
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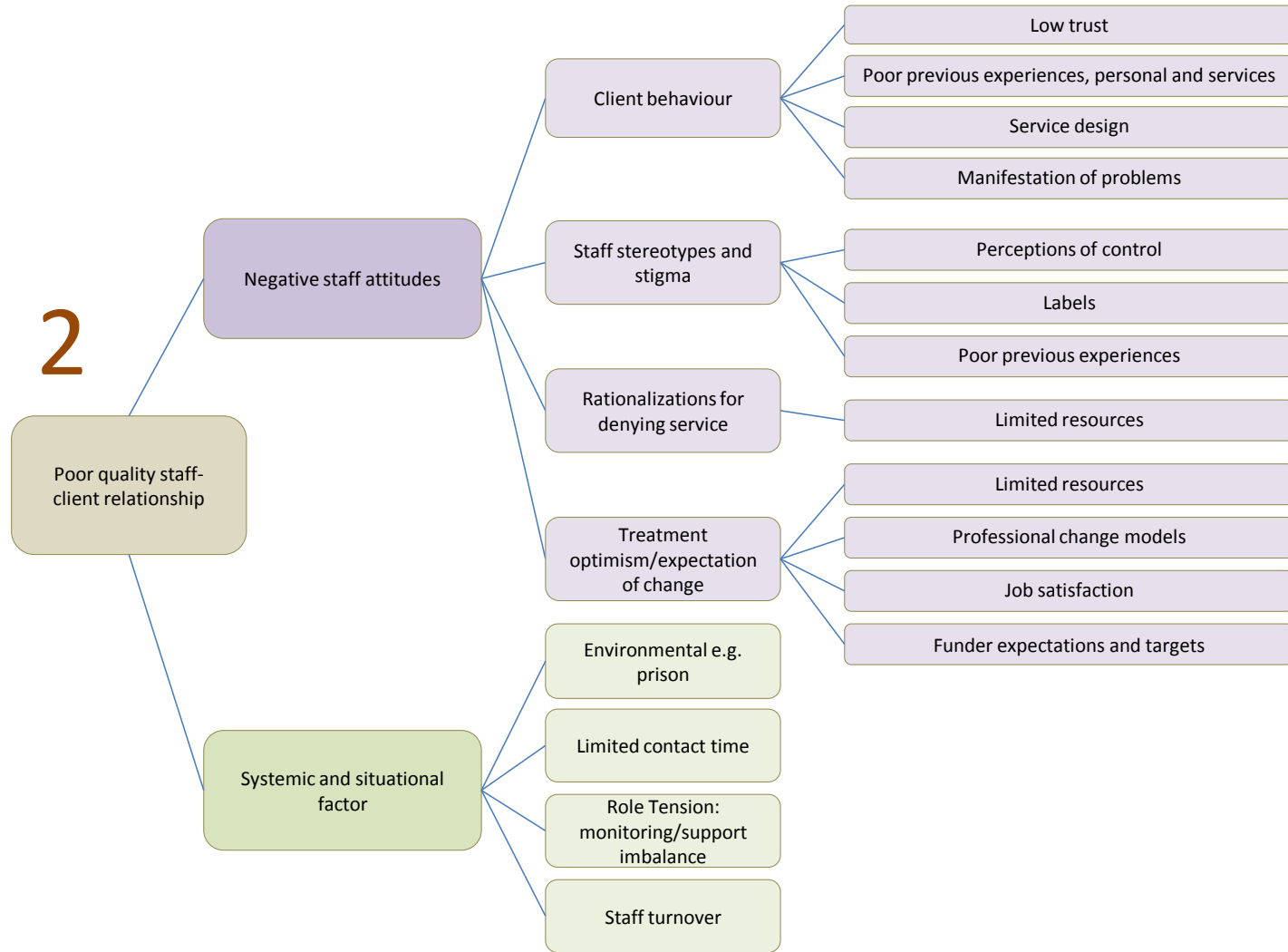
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Appendix I – Overview of contributing factors to poor frontline response



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3

