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Abstract

This paper interrogates pathways into multiple exclusion homelessness (MEH) in the UK and, informed by a critical realist theoretical framework, explores the potential causal processes underlying these pathways. Drawing on an innovative multistage quantitative survey, it identifies five experiential clusters within the MEH population, based on the extent and complexity of experiences of homelessness, substance misuse, institutional care, street culture activities and adverse life events. It demonstrates that the most complex forms of MEH are associated with childhood trauma. It also reveals that the temporal sequencing of MEH-relevant experiences is remarkably consistent, with substance misuse and mental health problems tending to occur early in individual pathways, and homelessness and a range of adverse life events typically occurring later. The strong inference is that these later-occurring events are largely consequences rather than originating causes of MEH, which has important implications for the conceptualisation of, and policy responses to, deep exclusion.

Introduction

There has been a concern in the UK for some time about the need for a more sophisticated understanding of 'deep social exclusion' in order to inform better responses to people with 'multiple and complex needs' (Fitzpatrick, 2007). This reflects growing policy awareness in both the UK (Clinks *et al.*, 2009) and elsewhere in the developed world (Culhane, 2008; Del Casino and Jocoy, 2008) that this multiple needs group may be relatively small in overall size, but is very costly to society as a whole because of the chaotic lives led by many of those within it. The specific role of homelessness within these broader patterns has long been of particular interest, not least because of a suspicion that it may have been given undue prominence in policy debates because of a tendency to treat it more sympathetically than other manifestations of deep exclusion (Philips, 2000).

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This article interrogates the nature and causes of multiple exclusion homelessness (MEH) in the UK, drawing on a multistage quantitative study in seven cities. The study employed the following definition of MEH

> People have experienced MEH if they have been '*homeless*' (including experience of temporary/unsuitable accommodation as well as sleeping rough) *and* have also experienced one or more of the following other 'domains' of deep social exclusion: '*institutional care*' (prison, local authority care, mental health hospitals or wards); '*substance misuse*' (drug, alcohol, solvent or gas misuse); or participation in '*street culture activities*' (begging, street drinking, 'survival' shoplifting or sex work).

In an earlier paper, we demonstrated the very high degree of overlap between experience of homelessness and these other domains of deep exclusion (Fitzpatrick *et al*., 2011). Here we take a more dynamic approach by examining individuals' personal pathways into and through MEH, and explore the potential causal processes underlying these pathways. The next section of the paper prepares the context for the analysis by reviewing current international evidence on homelessness pathways, and on the causes of homelessness, anchoring this discussion within a critical realist theoretical framework. The following section describes the methodology used, before the results of the analysis are presented. The implications of our findings for conceptual understandings of the more extreme forms of social exclusion, and for policy and practice, are reflected upon towards the end of the paper.

Homelessness Pathways

Pathways analysis—which charts the progress over time of an individual or household through both housed and homeless situations—has been proposed as an improvement on the cross-sectional emphasis in much homelessness research (Clapham, 2005). It has been argued that a principal strength of this perspective is that homeless episodes, including episodes of more hidden forms of homelessness (Robinson, 2012), can be "related both to each other and to the housing circumstances both before and after" (Fitzpatrick and Clapham, 1999, p. 174). While notions of a homelessness/housing career or trajectory have sometimes been used to capture a similar conceptual approach (Piliaven *et al*., 1993; Clatts *et al*., 2005; Kertesz *et al*., 2005), the more neutral expression 'pathway' is now generally preferred as it avoids the linear implications of the other terms, which can sometimes appear to imply an inevitable downward spiral (Clapham, 2005; Meert and Bourgeois, 2005; Martijn and Sharpe, 2006; Maycock and O'Sullivan, 2007; Pillinger, 2007; Fowler *et al*., 2009; van Laere *et al*., 2009). This paper pushes forward the pathways approach to the study of homelessness in three novel ways.

First, while there has been extensive quantitative research conducted on pathways through and out of shelter accommodation in the US (Kuhn and Culhane, 1998; Shinn *et al*., 1998; Culhane *et al*., 2007), most analyses of routes *into* homelessness and multiple exclusion undertaken to date have been qualitative in nature (Anderson and Tulloch, 2000; May, 2000; DeVerteuil, 2003; Clapham, 2005; Tyler, 2006; Padgett *et al*., 2006; Maycock and O'Sullivan, 2007; McNaughton, 2008; Ravenhill, 2008), notwithstanding a number of quantitative studies (again mainly in the US) which have focused on the specific chronological relationship between homelessness and substance misuse and/or other health problems (for example, Clatts *et al*., 2005; Martijn and Sharpe, 2006; Philippott *et al*.,

2007). While qualitative research is well suited to providing in-depth, nuanced information about the nature of individual experiences and perceptions, it is not designed to address research questions that require quantification—such as the frequency with which particular combinations or sequences of experiences are found in the homeless population. Robust statistical studies are also required to test the generalisability of qualitative insights, which are typically based on data derived from purposive rather than representative samples.

Secondly, while a key potential strength of the pathways approach is that it encourages a holistic analytical perspective, integrating consideration of a range of aspects of people's lives, in practice homelessness has tended to be interrogated primarily as part of a set of broader housing experiences (Clapham, 2005). Our study, in contrast, does not privilege the housing dimension of people's life courses, but instead locates their homelessness experiences in the context of their experiences of other domains of deep social exclusion. This is appropriate given the study's emphasis on the more extreme manifestations of homelessness, wherein it is linked to multiple and complex forms of social exclusion and need (Fitzpatrick, 2007), rather than where it arises primarily as a result of structural housing market failures (Shinn *et al.*, 1998; Pleace *et al.*, 2008).

Thirdly, pathways analysis is usually approached from a social constructionist perspective, focusing primarily on the meanings which people attach to their homeless and other housing experiences (Clapham, 2005). In contrast, this current analysis is primarily concerned with explaining the causation of MEH pathways. In so doing, it is informed by a critical realist ontology (Sayer, 2000). Realist explanations of the social world are both contingent (given the open nature of social systems) and complex (allowing for multiple, and multidirectional, causal mechanisms). Thus for a critical realist, there is unlikely to be a single trigger for MEH or similar phenomena, with constellations of inter-related causal factors likely to 'explain' MEH in any particular case (Williams, 2001). The key challenge is to identify common patterns that can be explained by the qualitative nature of recurring antecedents—i.e. what it is about these factors that could tend to cause MEH or particular manifestations of MEH (Lawson, 2006).

This is a radical departure from traditional explanations of homelessness which have tended to fall into two broad (and mutually exclusive) categories: individual and structural (Neale, 1997). In the UK, an individualistic focus on the ill health, substance dependencies and dysfunctional family backgrounds of homeless people in the 1960s and 1970s was increasingly supplanted by more structural accounts in the 1980s which foregrounded the role of housing market failures. These wholly structural accounts began to lose credibility in the 1990s as research repeatedly identified high levels of health and social support needs amongst single homeless people, particularly those sleeping rough (Fitzpatrick and Christian, 2006). As a result, researchers started again to take account of individual factors in their explanations of who became homeless, but continued to assert the overall primacy of structural factors such as poverty, unemployment and housing shortages with respect to its overall extent (Pleace, 2000). This new orthodoxy provided a more practically adequate explanation of homelessness than prior analyses, but was unsatisfactory at a deeper conceptual level, not least because it tended to imply a positivistic notion of social causation dependent on both necessity (i.e. homelessness cannot occur unless the 'cause' is present) and sufficiency (i.e. the 'cause' inevitably leads to

homelessness) (for example, Randall and Brown, 1999).

Fitzpatrick (2005) has argued that critical realist ontology can help to overcome these limitations of orthodox explanations of homelessness by introducing a layered social reality which enables account to be taken of a broader and more differentiated range of potential causal factors (see also Williams, 2001; McNaughton, 2009). She hypothesised that the causes of homelessness can operate on at least four levels—economic, housing, interpersonal and individual—which interact with each other through a series of complex feedback loops. Crucially, no one of these levels is assumed *a priori* to be more fundamental than any other. This theoretical approach therefore allows for economic or housing structures to be all-important in some cases of homelessness (probably the majority), and for interpersonal or individual factors to be far more significant in others (probably the minority) (Fitzpatrick *et al*., 2009).

More specifically, it allows for the possibility that the balance of underlying causal factors may vary between different homeless groups (and also between countries—see Shinn, 2007; Stephens *et al*., 2010). For example, there can be little doubt that high levels of youth unemployment and social security cuts played a major role in driving up the numbers of homeless young people in the UK in the late 1980s (Fitzpatrick, 2000), whereas for older people it is plausible that, as Crane *et al*. (2005) argue, personal crises such as bereavement may be more important than any aspect of the structural context. Likewise, a major survey of homeless families in England has suggested that this form of homelessness is far less strongly associated with individual support needs than appears to be the case with street homelessness, single homelessness or youth homelessness (Pleace *et al*., 2008). International comparative evidence has consistently demonstrated that, across the developed world, that proportion of the homeless population which sleeps rough and/or uses low threshold services tends to be dominated by single men with complex support needs, associated in particular with drug and/or alcohol problems, and physical and mental health issues (Fitzpatrick and Stephens, 2007; Philippott *et al*., 2007; Toro, 2007). It is this particular (proportionately small but highly vulnerable) subgroup within the homeless population with which the MEH study and this paper are concerned.

Methodology

A key challenge in conducting this research was that there was no pre-existing sample frame from which to draw a statistically representative sample of people experiencing MEH in the UK. Thus, an innovative, multistage research design was developed by the research team and implemented in the following urban locations where existing information (such as data on housing support services) suggested that people experiencing MEH were concentrated: Belfast; Birmingham; Bristol; Cardiff; Glasgow; and Westminster (London). Prior to the main phase fieldwork, a half size 'dress rehearsal' pilot was conducted in Leeds. As no substantive changes were required in research design following the pilot, the Leeds data were incorporated into the main dataset. The main phase fieldwork was conducted between February and May 2010 and comprised the following four stages in each location.

First, with the assistance of local voluntary-sector partners, all agencies in these locations offering low threshold support services to people experiencing deep social exclusion were identified. We focused on low threshold services (such as

street outreach, drop-in services, day centres, direct access accommodation, church-based soup runs, etc.) as these make relatively few 'demands' on service users and might therefore be expected to reach the most excluded groups. The sample frame included not only homelessness services, but also services targeted at other relevant groups, such as people with substance misuse problems, ex-offenders and individuals involved in street-based sex work. From this sample frame, six services were randomly selected in each location. This means that, together with the three services that participated in Leeds, a total of 39 low threshold services were directly involved in the study.

The second stage of fieldwork involved a census questionnaire survey undertaken with the users of these low threshold services over a two-week time window. This short paper questionnaire asked 14 yes/no questions to capture experience of the four domains of deep exclusion specified in the MEH definition given earlier. While the questionnaire was designed for self-completion, interviewers from the research team and staff from the relevant service were on hand to provide assistance and the questionnaire was translated into four other languages. In total, 1286 census survey questionnaires were returned, representing a response rate of 52 per cent (based on a best estimate of the number of unique users of the sampled services over the census period).

Thirdly, extended interviews were conducted with users of low threshold services who had experienced MEH. A structured questionnaire was designed to generate detailed information on the characteristics and life experiences of these service users. Interviews were conducted face-to-face, recorded via computer-assisted personal interviewing (CAPI) technology, and lasted 46 minutes on average. Particularly sensitive questions were asked in a self-completion section. Interpreting services were made available for those whose first language was not English. In total, 452 extended interviews were achieved, with a response rate of 51 per cent.

Fourthly, feedback seminars were conducted in all seven case study locations (attended by approximately 120 local policy-makers and practitioners) in addition to a national launch event (attended by almost 100 policy-makers, practitioners and service users). Feedback received at these events has informed the interpretation of findings offered in this paper.

This paper draws on data from the extended interview survey with MEH service users. The following sections of the paper explore: first, the overall prevalence and complexity of MEH-relevant experiences amongst these service users; secondly, specific clusters of experience within the MEH population; and thirdly, the temporal sequencing of MEH experiences both within these clusters and across the whole MEH population. A composite weight has been applied throughout the analysis to correct for both disproportionate sampling and non-response bias.

The Prevalence and Complexity of MEH Experiences

In accordance with previous research (Jones and Pleace, 2010), MEH service users were predominantly male (78 per cent) and were concentrated in the middle age ranges (approximately half of MEH service users were 30–49 years old). Table 1 presents the overall prevalence of MEH-relevant experiences amongst these interviewees. Some of the 28 experiences investigated were selected as specific indicators of the domains of MEH identified earlier (i.e. homelessness, substance misuse, institutional care and

Table 1. MEH-relevant experiences

	Percentage
Homelessness	
Stayed at a hostel, foyer, refuge, night shelter or B&B hotel	84
Stayed with friends or relatives because had no home of own ('sofa-surfed')	77
Slept rough	77
Applied to the council as homeless	72
Substance misuse	
Had a period in life when had six or more alcoholic drinks on a daily basis	63
Used hard drugs	44
Injected drugs	27
Abused solvents, gas or glue	23
Institutional care	
Went to prison	46
Admitted to hospital because of a mental health issue	29
Left local authority care	16
Street culture activities	
Involved in street drinking	53
Shoplifted because needed things like food, drugs, alcohol or money for somewhere to stay	38
Begged (that is, asked passers-by for money in the street or another public place)	32
Had sex or engaged in sex act in exchange for money, food, drugs or somewhere to stay[a]	10
Adverse life events	
Divorced or separated from a long-term partner	44
Thrown out by parents/carers	36
Evicted from a rented property	25
Made redundant	23
A long-term partner died	10
Home was repossessed	6
Experienced bankruptcy	6
Extreme exclusion/distress	
Had a period in life when very anxious or depressed	79
Were a victim of violent crime (including domestic violence)	43
Attempted suicide[a]	38
Deliberately self-harmed[a]	30
Charged with a violent criminal offence[a]	27
Victim of sexual assault as an adult[a]	14
Base	452

[a]Asked in self-completion section.

street culture activities), whereas others are adverse life events that qualitative research has indicated may trigger homelessness and related forms of exclusion (for example, Fitzpatrick *et al.*, 2000; Crane *et al.*, 2005; McNaughton, 2008; Fitzpatrick *et al.*, 2009; Jones and Pleace, 2010). A number of indicators of extreme exclusion or distress are also included.

As Table 1 indicates, all of the specified forms of homelessness were reported by very high proportions of service users (around three-quarters or more). The most common form of substance misuse reported

(by almost two-thirds of respondents) was alcohol problems, but experience of hard drug[1] use was also noted by approaching half of service users. Prison was by far the most common form of institutional care experienced, although the level of admission to hospital with a mental health issue was also strikingly high. Over half of service users had been involved in street drinking, and survival shoplifting and begging were also common forms of street culture activity (survival sex work much less so). The most widely reported adverse life events were breakdowns in relationships with parents or partners. Experience of anxiety and depression was extremely widespread and almost four in ten service users reported having attempted suicide at least once, with approaching one-third having engaged in deliberate self-harm. Being a victim of violent crime was reported by a large minority of respondents and one-quarter admitted to having themselves been charged with a violent criminal offence.

As the initial stage of multivariate analysis, regression modelling was used to explore predictors of complexity within the MEH population, as measured by the number of these MEH-relevant experiences reported by individual respondents. This is a continuous variable and was modelled using OLS regression. As our MEH sample was far from being a general population sample, this regression analysis did not seek to predict the likelihood of a member of the general public experiencing MEH. Rather, it investigated: amongst members of the MEH population, which factors had an independent effect in predicting the most complex experiences of MEH? The explanatory variables used in the regression modelling included a range of demographic and other key characteristics (including age, gender, ethnicity, migration status, city and type of service recruited from). The modelling was also designed to investigate the significance of: structural factors (for example, childhood poverty and adult labour market experiences); and, individual and interpersonal factors (childhood trauma in particular).

As can be seen from Table 2, female service users had fewer MEH experiences than male service users, other things being equal. However, age had a more profound impact: younger people (under 20) and older people (over 50) had a lower number of experiences when other factors were held constant, with the greatest complexity found in the middle years (20–49). Younger people clearly have had less 'opportunity' to encounter MEH-relevant experiences, but this does not work in reverse for older people and so suggests that there is a cohort effect operating which renders this current 'middle-aged' MEH population especially vulnerable.

While ethnicity had little impact on complexity, migration status was a key explanatory factor: those who had migrated to the UK as adults had fewer MEH-relevant experiences, other things being equal, and A10 migrants from central and eastern Europe had fewer than other migrants (although this latter finding is marginally insignificant). Being recruited in Westminster was also associated with a lowered level of complexity. Recruitment via a homelessness service rather than another type of service was likewise associated with lower complexity, when other factors were held constant. As most of these other services were drugs services, this finding is consistent with the interrelationship between extreme complexity and hard drug use that emerged from cluster analysis (see later).

With respect to childhood variables, being brought up mainly by one biological parent increased the number of MEH-relevant experiences, but there was a larger negative association with parents having never married or lived together, suggesting

Table 2. OLS regression for complexity measured by number of experiences (out of 28, mean value 10.7)

Variable description[a]	*Coefficient B*	*S.E.*	*Significance*	*Mean*
(Constant)	10.099	0.808	0.000	
Demographics				
Female	−1.526	0.396	0.000	0.223
under 20 years	−2.362	0.795	0.003	0.047
50–59 years	−1.616	0.479	0.001	0.146
60–69 years	−1.747	0.782	0.026	0.048
70 years and over	−2.768	1.357	0.042	0.014
Have children	1.500	0.329	0.000	0.524
Migrated to UK as adult	−1.923	0.568	0.001	0.165
A10 migrant	−0.928	0.701	0.186	0.084
Features of childhood				
Brought up by one biological parent	2.427	0.556	0.000	0.094
Parents never married/lived together	−3.250	0.815	0.000	0.039
A parent died during childhood	−1.424	0.786	0.071	0.043
Sometimes not enough to eat at home	1.051	0.497	0.035	0.147
One+ adult in paid work all/most of time	1.411	0.421	0.001	0.722
Poor relationship with parents (including ran away)	0.666	0.407	0.102	0.464
Physically abused at home or neglected	0.991	0.463	0.033	0.271
Homeless during childhood	1.886	0.489	0.000	0.139
Parents had problems (for example, substance abuse, mental health or domestic violence)	1.366	0.394	0.001	0.406
Years in care	0.147	0.050	0.004	1.120
Education and employment				
No qualifications	−0.461	0.344	0.181	0.398
Poor experience of school (truanted, excluded, bullied)	1.197	0.389	0.002	0.644
Had steady long-term jobs	−1.232	0.401	0.002	0.337
Been on UK benefits most of adult life	1.224	0.425	0.004	0.374
Location				
Leeds	0.894	0.690	0.196	0.102
Glasgow	−0.599	0.514	0.245	0.241
Westminster	−1.355	0.489	0.006	0.330
Belfast	−1.084	0.733	0.140	0.058
Birmingham	−0.983	0.632	0.121	0.102
Recruited via homelessness agency	−2.208	0.428	0.000	0.781

(continued)

Table 2. (Continued)

Model summary				
Model	*R*	R^2	Adjusted R^2	S.E. estimate
	0.744	0.554	0.525	3.192
ANOVA				
	Sums of Squares	Degrees of freedom	Mean square	F
Regression	5357	28	191.315	18.776
Residual	4310	423	10.190	Sig F
Total	9667	451		0.000

[a]Other variables tested but excluded from the model included: being White British; having ever sought asylum in UK; having no permission to live in the UK; having lived with both biological parents for most of childhood; parents having divorced or separated during childhood; experiencing sexual abuse as a child; having dyslexia; having been in the armed forces; having ever been in care as a child; and having stayed in a children's home. Age 30–39 was the default age band and age band dummies for 20–29 and 40–49 were excluded from the model. Bristol was the default location and the Cardiff dummy was excluded from the model.

that family breakdown may be more influential than family structure (although note that both of these experiences affected small numbers). Perhaps more interestingly, there were consistent positive associations between the number of MEH-relevant experiences reported and a range of indicators of childhood deprivation and trauma: reporting that there was sometimes not enough to eat at home; physical abuse or neglect; and, most especially, experiencing homelessness in childhood. In addition, having had parents with problems such as domestic violence, substance misuse or mental health issues significantly increased complexity.

Poor school experiences (such as truanting, exclusion, being bullied) were very common (affecting nearly two-thirds) and significantly increased complexity. Interestingly, in view of the mantra from successive UK governments about work being the best route out of poverty (DWP, 2012), being brought up in a household with at least one adult in paid work actually increased the likelihood of a greater level of complexity, other things being equal (see also Ray *et al.*, 2010). However, for individuals' own labour market experiences, the effects were more in line with expectations: the level of complexity was reduced for those who had been in steady work for most of their adult life, but increased for those who reported being on benefits for most of their adult life.

Clustering of MEH Experiences

We next turned our attention to exploring whether there were particular sub-groups—or clusters—within the MEH population with similar sets of experiences. The cluster analysis was performed using the SPSS two-step cluster procedure, designed to handle a combination of continuous and categorical variables. This uses a hierarchical agglomerative clustering procedure which first determines the cluster centres and then assigns cases to clusters based on a log-likelihood distance measure.

Successive tests were made with different predetermined numbers of clusters and the

five cluster solution was chosen as giving the most coherent profiles in terms of our qualitative understanding of likely sub-groups and patterns of experience. This clustering solution was derived from a variable set including six continuous variables (overall number of MEH-relevant experiences; number of experiences within the domains of institutional care, substance misuse, street culture activities and adverse life events/extreme distress; and age), together with the 28 individual experiences as binary variables.

The clusters generally move from relatively simpler cases with fewer MEH-relevant experiences (cluster 1 especially, but also cluster 2) to more complex cases (clusters 3 and 5 especially) (Table 3). The pattern of experiences found within each cluster and their key demographic and other characteristics are described next (see McDonagh, 2011, for qualitative case study illustrations of these five clusters).

Cluster 1: Mainly Homelessness

This cluster accounted for nearly one-quarter of MEH service users and cases in this cluster were least complex overall (5 experiences on average). These experiences naturally included the various forms of homelessness, although not at quite as high a level as for the MEH population as whole, with between 50 per cent and 60 per cent experiencing each of hostels or other temporary accommodation, rough sleeping and sofa-surfing (but only one-third had applied to the council as homeless). Cluster 1 cases were less likely than the MEH population as a whole to report experiences within the other MEH domains, particularly substance abuse and street culture activities. This group was overwhelmingly male (84 per cent) and mainly aged over 35. Significantly, a disproportionate number of cluster 1 cases had migrated to the UK as adults (35 per cent) and over half (53 per cent) were located in Westminster.

Cluster 2: Homelessness and Mental Health

This cluster accounted for over one-quarter of the MEH population and its members displayed moderate complexity (9 experiences on average). They reported the full range of homelessness experiences at a higher rate than members of cluster 1; cluster 2 members also had a somewhat higher incidence of experiences in the institutional care and substance misuse domains (although not street culture activities), with a noticeably higher incidence of adverse life events. A key feature of cluster 2 cases was experience associated with mental health problems: 86 per cent reported experience of anxiety or depression and 51 per cent had attempted suicide. Notably, cluster 2 was disproportionately female (39 per cent).

Cluster 3: Homelessness, Mental Health and Victimisation

This was a smaller group (9 per cent of the MEH Population), which may be viewed as a much more complex and severe version of cluster 2 (15 experiences on average). Mental ill health was a defining characteristic: experience of anxiety or depression was reported by 100 per cent, suicide attempts by 91 per cent, being admitted to hospital with a mental health problem by 89 per cent and 75 per cent had self-harmed. Very high levels of all forms of homelessness were overlaid by a strong theme of victimisation: 71 per cent had been a victim of violent crime and two-fifths (40 per cent) had been a victim of sexual assault as an adult. There were also high levels of institutional care experience amongst this group: nearly half (48 per cent) had been in local

Table 3. Frequency of experiences by cluster

Experience	*Cluster number*					*Total*
	1	*2*	*3*	*4*	*5*	
Stayed with friends/relatives ('sofa-surfed')	0.58	0.77	0.83	0.79	0.92	0.77
Stayed in hostel or other temporary accommodation	0.60	0.88	0.95	0.93	0.93	0.84
Applied to council as homeless	0.33	0.78	0.89	0.89	0.86	0.72
Prison	0.25	0.23	0.61	0.63	0.77	0.46
Victim of violent crime	0.09	0.47	0.71	0.47	0.56	0.42
Very anxious or depressed	0.43	0.86	1.00	0.88	0.95	0.79
Admitted to hospital with mental health issue	0.02	0.29	0.89	0.24	0.37	0.29
Used hard drugs	0.21	0.31	0.45	0.11	1.00	0.44
Injected drugs	0.07	0.11	0.04	0.04	0.83	0.27
Abused solvents, gas or glue	0.02	0.06	0.31	0.14	0.62	0.23
Problematic alcohol use	0.31	0.51	0.76	0.96	0.81	0.62
Divorced or separated	0.34	0.32	0.56	0.65	0.52	0.44
Bereaved	0.04	0.17	0.10	0.10	0.07	0.10
Made redundant	0.18	0.28	0.21	0.24	0.22	0.23
Slept rough	0.55	0.69	0.90	0.98	0.90	0.77
Street drinking	0.26	0.25	0.78	1.00	0.76	0.53
Begged	0.15	0.05	0.42	0.56	0.60	0.32
Survival shoplifting	0.08	0.14	0.38	0.47	0.89	0.38
Bankrupt	0.02	0.10	0.00	0.04	0.08	0.06
Evicted	0.10	0.16	0.39	0.30	0.39	0.25
Home repossessed	0.02	0.09	0.08	0.02	0.08	0.06
Thrown out by parents/carers	0.10	0.33	0.73	0.31	0.51	0.35
Local authority care as child	0.06	0.20	0.48	0.02	0.18	0.16
Survival sex work	0.06	0.06	0.16	0.00	0.21	0.10
Charged with a violent criminal offence	0.02	0.22	0.36	0.27	0.51	0.27
Victim of sexual assault as adult	0.03	0.21	0.40	0.00	0.16	0.14
Attempted suicide	0.00	0.51	0.91	0.10	0.56	0.38
Self-harmed	0.03	0.35	0.75	0.06	0.47	0.30
Number of experiences	4.96	9.42	15.06	11.23	15.75	10.70
	1	2	3	4	5	Combined
N unweighted	104	117	49	63	119	452
Percentage of unweighted cases	23.0	25.9	10.8	13.9	26.3	100.0
Percentage of weighted cases	23.8	28.3	8.6	14.1	25.2	100.0

Note: Margins of error exceed +/-10 per cent on some of the point estimates for the smaller clusters.

authority care as a child and a majority (61 per cent) had been in prison. In addition, there was a particularly high incidence of certain adverse life events in cluster 3, especially being thrown out by parents or carers (73 per cent). This group was rather younger than the MEH population average.

Cluster 4: Homelessness and Street Drinking

This was also a small group (14 per cent of the MEH population) and comprised a moderately complex set of cases (11 experiences on average). The defining experience

of this group was street drinking (100 per cent), with extremely high levels of problematic alcohol use (96 per cent) and rough sleeping (98 per cent) also reported. Other indicators of street culture activities were also common: 56 per cent had begged and 47 per cent had engaged in survival shoplifting. Experience of anxiety and depression was high within this group (88 per cent), but with comparatively lower rates of attempted suicide and self-harm. Some adverse life events had a significant incidence, particularly divorce/separation (65 per cent). Members of this group tended to be older (84 per cent were over 35 years old), male (98 per cent) and were disproportionately located in Glasgow.

Cluster 5: Homelessness, Hard Drugs and High Complexity

This was another large group (accounting for one-quarter of the whole sample) and was the most complex (16 experiences on average). The defining experience was universal use of hard drugs (100 per cent), with very high prevalence of substance misuse and street culture domain experiences also. Problematic alcohol use was reported by four-fifths (81 per cent), three-quarters had been involved in street drinking and survival shoplifting was experienced by 89 per cent. Although involvement in survival sex work was relatively uncommon across the whole sample (10 per cent), 21 per cent of this group reported this experience (almost all of them women). Involvement in all homelessness experiences was around the 90 per cent mark. Anxiety/depression was almost universal (95 per cent) and attempted suicide and self-harm were also high (56 per cent and 47 per cent respectively). There was very widespread experience of prison (77 per cent), with a strong theme of violence as both victim (56 per cent) and perpetrator (51 per cent). Other adverse life events were likewise common, with relatively high proportions having been evicted from rented property (39 per cent) or thrown out by parents or carers (51 per cent). Cluster 5 tended to be in the middle age range (20–49 years); most were in their 30s.

Sequencing of MEH Experiences

Having explored the overall prevalence, complexity and clustering of MEH experiences, the next and final step in the analysis comprised an interrogation of the sequencing of these experiences. We started this process by examining the median age of *first* occurrence of each MEH-relevant experience, as reported by affected individuals (see Table 4).[2]

As Table 4 indicates, leaving home or care, and first experience of substance misuse, tended to occur in relevant individuals' mid-to-late teens, as did survival sex work (for the minority who reported this experience). There was then a clutch of experiences that, on average, first occurred in respondents' very early 20s: sofa-surfing, survival shoplifting, being a victim of violent crime, prison, anxiety and depression, and injecting drug use. With the exception of sofa-surfing, homelessness experiences tended to be reported as having first happened to MEH service users in their mid-to-late 20s. This was also the case with begging, being admitted to hospital with a mental health problem and adverse life events including redundancy, eviction and bankruptcy. Divorce, repossession and (especially) death of a partner tended to happen at a higher median age.

The order in which experiences occurred was then examined more rigorously by focusing on the actual sequential ranking of experiences within individual MEH cases.[3] The mean sequential ranking used here controls for variations in the number of MEH-relevant experiences reported by

Table 4. MEH-relevant experiences and median age of first occurrence

Experience	*Percentage*	*Median age*
1. Abused solvents, gas or glue	23	15
2. Left local authority care	16	17
3. Thrown out by parents/carers	36	17
4. Had sex or engaged in sex act in exchange for money, drugs, etc.	10	17
5. Involved in street drinking	53	18
6. Used hard drugs	44	19
7. Had a period in life when had six or more alcoholic drinks on a daily basis	63	20
8. Stayed with friends or relatives because had no home of own	77	20
9. Shoplifted because needed things like food, drugs, alcohol or money for somewhere to stay	38	20
10. Were a victim of violent crime (including domestic violence)	43	20
11. Went to prison	46	21
12. Had a period in life when very anxious or depressed	79	22
13. Injected drugs	27	22
14. Slept rough	77	26
15. Admitted to hospital because of a mental health issue	29	26
16. Made redundant	23	26
17. Applied to the council as homeless	72	27
18. Stayed at a hostel, foyer, refuge, night shelter or B&B hotel	84	28
19. Begged (that is, asked passers-by for money in the street or another public place)	32	28
20. Evicted from a rented property	25	28
21. Experienced bankruptcy	6	29
22. Divorced or separated	44	32
23. Home was repossessed	6	34
24. A long-term partner died	10	43
Base	452	—

service users. As Table 5 indicates, the rank order pattern identified broadly reflects that suggested by the median age analysis. Thus, across all MEH service users, the experiences which happened earliest in individuals' pathways (if they happened at all) were: abusing solvents, glue or gas; being thrown out by parents or carers; using hard drugs; and developing a problematic relationship with alcohol and/or street drinking. This implies that these factors, when they apply, may often be contributory factors in the commencement of an MEH pathway.

There was then a group of experiences that, if they occurred at all, tended to do so in the early–middle part of individual MEH sequences: becoming anxious or depressed; engagement in survival shoplifting; being the victim of a violent crime; sofa-surfing; and spending time in prison. These experiences seem indicative of deepening problems which bring people closer to extreme forms of exclusion and street lifestyles. Also featuring in this early–middle ranked set of experiences was one adverse life event, that being redundancy.

Next, there was a set of experiences which typically occurred in the middle–late phase of individual MEH sequences and seemed to confirm a transition to street lifestyles:

Table 5. Sequential order of experiences by cluster, ranked by average order for whole sample (mean order)

Experience	*Whole sample frequency*	*Mean standardised order*					
			Cluster				
		All	*1*	*2*	*3*	*4*	*5*
Abused solvents, gas or glue	0.23	2.14	2.95	3.04	3.54	1.95	1.58
Thrown out by parents/carers	0.35	3.04	2.97	3.24	2.62	3.17	3.01
Used hard drugs	0.44	3.78	3.49	3.68	3.98	3.66	3.88
Involved in street drinking	0.53	3.94	4.00	3.85	4.94	3.71	3.78
Problematic alcohol use	0.62	3.97	4.30	3.81	3.98	3.71	4.07
Very anxious or depressed	0.79	4.19	3.70	4.60	4.00	4.46	3.97
Survival shoplifting	0.38	4.21	3.40	4.09	4.12	4.65	4.29
Victim of violent crime	0.42	4.43	3.81	4.24	4.74	5.30	4.32
Stayed with friends/relatives ('sofa-surfed')	0.77	4.49	4.93	4.61	4.15	4.78	4.10
Prison	0.46	4.58	4.56	4.05	5.37	4.68	4.70
Made redundant	0.23	4.82	5.06	3.91	6.34	4.61	5.12
Slept rough	0.77	5.12	5.36	5.10	5.61	4.85	4.96
Injected drugs	0.27	5.28	4.20	4.62	3.42	4.98	5.79
Bankrupt	0.06	5.84	2.37	7.58	4.15	4.73	5.90
Begged	0.32	5.85	5.33	5.50	7.33	5.21	6.26
Admitted to hospital with mental health issue	0.29	5.94	5.96	5.83	6.42	5.31	6.14
Divorced or separated	0.44	5.94	5.43	5.59	7.02	4.63	7.21
Bereaved	0.10	6.13	6.29	6.48	4.84	7.60	5.28
Stayed in hostel or other temporary accommodation	0.84	6.32	6.59	6.30	5.95	6.87	6.00
Applied to council as homeless	0.72	6.39	6.44	6.18	6.50	6.91	6.26
Home repossessed	0.06	6.75	7.70	5.95	3.43	6.91	8.50
Evicted	0.25	6.86	6.39	7.55	5.58	6.59	7.22

sleeping rough; begging; and injecting drug use. Being admitted to hospital with a mental health issue also tended to first occur in this phase of MEH sequences, as did two of the specified adverse life events: bankruptcy and divorce.

Finally, there was a set of experiences which tended to happen late in individual MEH sequences. These included the more 'official' forms of homelessness (applying to the council as homeless, and staying in hostels or other temporary accommodation) and the remaining adverse life events (being evicted or repossessed, and the death of spouse or partner). The strong implication here is that these later-occurring events were not part of the initial set of originating causes for MEH, but are often outcomes of a sequence of events which are more likely to have started with combinations of the kinds of factors noted in the early and middle stages of these sequences.

Table 5 also shows that sequencing within individual clusters tended to mirror this overall temporal pattern, with most variations in sequencing between clusters either very minor or anomalous results associated with infrequent experiences within that particular cluster.[4] In other words, *if* an event occurred to an individual MEH service user, it tended to occur at approximately the same point in their MEH sequence regardless of

which cluster they were in, even though the chances of it having happened at all often varied significantly between clusters.

Discussion

This paper has presented the first statistically robust analysis of pathways into homelessness and associated forms of severe and multiple disadvantage in the UK. The aim of this analysis was to deepen understanding of the causation of one of the most extreme, and visible, forms of social exclusion found in the UK and elsewhere in the developed world (Toro, 2007). While, as realists would insist, statistical associations and temporal sequences ('empirical regularities') cannot in themselves establish causation (Sayer, 2000), they can suggest strong inferences about likely causal relationships when underpinned by a meaningful qualitative rationale—(i.e. "a theoretical reason for accepting that the relation is a causal one" (Pickvance, 2001, p.10). Our explanatory multivariate analysis is limited by the absence of a general population baseline, but some very striking findings emerged on the factors associated with the most complex forms of MEH. Certainly childhood trauma and deprivation are significant predictors of extreme exclusion within the MEH population, including physical abuse or neglect, violence between parents, parental substance misuse or mental health problems, serious problems at school, being underfed as a child and, especially, childhood homelessness. The inclusion of these factors in the regression modelling was informed by the wealth of existing qualitative research on homelessness (see Jones and Pleace, 2010, for a recent summary) and they are indicative of the complex interrelationship between structural, interpersonal and individual causal factors in this area (Fitzpatrick, 2005). Childhood hunger, for example, can be a manifestation of (extreme) poverty or parental neglect, or both. Individual and family issues, such as parental mental health and/or substance misuse problems, are often, although not invariably, rooted in the pressures associated with poverty and other forms of structural disadvantage (McNaughton, 2009), illustrating the multilayered (as well as multidirectional) nature of causation in this field (Sayer, 2000).

Drawing on our realist analytical framework, we would argue that, for most people who experience MEH, some combination of the (inter-related) factors set out in the previous paragraph, will, by the end of their childhood, have significantly increased the 'weighted possibility' of their experiencing MEH as adults (Williams, 2001). A plausible answer to the key realist question—What is it about these factors that could tend to cause MEH? (Lawson, 2006)—would be that the distress that these childhood traumas generate may seriously undermine an individual's health and coping mechanisms in early adulthood (Maguire *et al.*, 2009). This is consistent with the study's finding that substance misuse and mental health issues typically occur early in MEH pathways. Homelessness, street lifestyles and adverse life events then seem to follow, suggesting that these experiences are largely consequences of deep exclusion rather than originating causes.

All of these later onset MEH-relevant experiences will, of course, then have their own emergent causal tendencies (Sayer, 2000), which will often reinforce vulnerability and deep exclusion. There can be little doubt, for instance, about the bi-directional causal relationship between drug problems and homelessness (Pleace, 2008), with homelessness frequently exacerbating substance misuse as people 'self-medicate' to cope with very difficult circumstances. However, that does not detract from the

central finding that the temporal sequencing identified strongly implies that substance misuse is *predominantly* an antecedent rather than a consequence of homelessness (see also Philippot *et al*., 2007), albeit that substance misuse is in turn likely to be one (crucial) link in a chain of interacting causal factors which stretch back to childhood trauma and deprivations of various kinds (Maguire *et al*., 2009).

A wide range of policy and practice implications arise from this analysis (see McDonagh, 2011; Fitzpatrick, Bramley and Johnsen, 2012, for detailed discussion). Certainly, our evidence strongly supports the contentions of Clinks *et al*. (2009) and others about the very high degree of intersection between deeply socially excluded groups and the need to co-ordinate responses across all aspects of their lives, rather than view them through a series of separate professional lenses (see also Cornes *et al*., 2011; Fitzpatrick *et al*., 2011).

With respect to specific sub-groups of people facing MEH, it is quite clear that the profile and experiences of migrants to the UK differ in fundamental ways from those of the indigenous MEH population, and that they require bespoke services tailored to their specific needs (see also McDonagh, 2011; Fitzpatrick, Johnsen and Bramley, 2012). At the other end of the complexity spectrum, while service innovations—and public sympathy—often focus on younger and older homeless people, and on women who are homeless, our evidence would indicate that there is a 'forgotten middle' of men in their 30s who often face the most extreme forms of MEH, usually associated with hard drug use (see McDonagh, 2011). They too require high-quality services focusing on their specific needs.

The generally lower level of support needs apparent amongst respondents in Westminster has particular policy resonance because of the tendency to extrapolate the detailed data available on rough sleeping in central London to the rest of the country (see also Fitzpatrick *et al*., 2011). Our study would indicate that this is inappropriate and may lead to underestimation of the prevalence of support needs in the rough sleeping population elsewhere. Westminster has by far the largest street homeless population in the UK and the 'Westminster effect' detected is most likely to be explained by a particularly strong in-flow of new rough sleepers in this particular location, who tend to report a lower level of support needs than the more entrenched rough sleepers who are (proportionately) more dominant elsewhere (Broadway, 2011). Interestingly, while we systematically tested for place effects throughout the analysis, aside from this important Westminster effect, geographical locality had relatively little impact on the nature or patterns of MEH: respondents' pathways *into* MEH were remarkably consistent in each of the provincial cities examined.[5]

However, perhaps the most significant policy implication of this research relates to homelessness prevention. Given that visible forms of homelessness—including applying to the council as homeless and staying in hostels or other forms of homeless accommodation—are typically rather late signs of MEH, it is clear that the current preventative focus in the UK on the provision of housing options services at the point of homelessness applications to local authorities (for example, DCLG, 2006) is too delayed a response for this group. Preventative interventions should focus on earlier signs of distress wherever possible, with schools, drugs and alcohol services, and the criminal justice system, likely to come into contact with people vulnerable to MEH well before housing and homelessness agencies do, thus having a crucial role to play in prevention efforts. The

forthcoming national strategy on the prevention of homelessness in England is being reshaped in light of this evidence.[6]

Conclusions

This paper has sought to deepen understanding of the causal processes underlying extreme forms of social disadvantage in the UK via a statistical interrogation of pathways into homelessness and inter-related forms of deep social exclusion. Given our critical realist theoretical standpoint, we were not expecting to find a single trigger—i.e. a necessary or sufficient condition—for MEH or particular forms of MEH. Rather, we were seeking to identify those recurring constellations of factors that appear to increase the weighted possibility of particular MEH pathways and to offer qualitative rationales for suggested causal links. In this regard, the relationship between childhood deprivations and trauma and the more complex end of the MEH spectrum is striking. Sequencing analysis revealed that substance misuse and mental health issues tended to arise early in MEH pathways, consistent with the argument that childhood trauma can undermine coping mechanisms in young adulthood, with potentially long-term consequences for health, wellbeing and social functioning. Homelessness, street lifestyles and adverse life events typically occur later in these pathways, strongly implying that these experiences are more likely to be consequences than originating generative causes of deep exclusion. These insights are relevant not only to policy planning in this area, but also to conceptual interrogations of the generation, manifestation and implications of one of the most visible, and disruptive, dimensions of severe and multiple disadvantage in the UK and other developed economies.

At the same time, it is important to emphasise that the findings presented in this paper relate only to the most extreme manifestations of social exclusion and homelessness, and there are good grounds for thinking that family homelessness, for example, represents a qualitatively different phenomenon requiring separate causal analysis (Williams, 2001; Fitzpatrick, 2005). Moreover, these data are confined to seven UK cities and cannot be assumed to be generalisable to the whole of the UK, albeit that the relatively minor variations identified across these cities (apart from Westminster in London) suggests that many of the findings may be capable of extrapolation to other urban locations in the UK. Similarly, while these are UK-only data, street populations with similar demographic profiles are found across the developed world (Fitzpatrick and Stephens, 2007; Philippot *et al.,* 2007; Toro, 2007), so one can hypothesise that similar MEH pathways may well occur in other countries. Rigorous comparative studies of this kind may be a fruitful avenue for future research on extreme forms of social exclusion across the developed world.

Notes

1. A list of hard drugs was not specified in this question because drugs markets differ across the UK, as do 'street names' for drugs, and any attempt to be comprehensive would have led to a question that was far too long and complex. We did, however, ask a follow-up question on definitions of hard drugs and this confirmed that virtually all respondents understood this term (as intended) to denote drugs such as heroin, cocaine and crack cocaine, and did not include 'recreational' drugs such as cannabis or ecstasy.
2. No data are available on the age of first occurrence for the following experiences: being charged with a violent criminal offence; being a victim of sexual assault as an adult; having attempted suicide; and having engaged in deliberate self-harm. This is

because these experiences were asked about in the self-completion section of the questionnaire where, in the interests of brevity, this information was not sought (except with regard to survival sex work).

3. Leaving care and engagement in survival sex work—while included in the age-based analysis—cannot be included in this rank order analysis as they were asked about in different parts of the questionnaire.
4. Although this is less true of cluster 3, the smallest cluster, where the sequencing was not as closely in line with that of the overall sample than was the case in the other clusters.
5. That said, individuals' experiences 'on the ground' and routes *out* of MEH will inevitably be shaped by what Cloke *et al*. (2010) refer to as homelessness 'scenes' at the local level in the UK, defined by a complex amalgam of factors such as the variable accessibility and quality of support services, nature of street drug markets, policing of street culture activities and so on (see also DeVerteuil *et al*., 2009).
6. Minutes of Meeting, Ministerial Working Group on Preventing and Tackling Homelessness, 28 February 2012 (http://www.communities.gov.uk/housing/homelessness/homelessnessworkinggroup/).

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