

Multiple needs: meeting the challenge

Opportunity Nottingham year four
(midway) report, 2014-2022



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Foreword

Until Opportunity Nottingham came along, I had been bouncing around the system for far too long. The classic cycle: in and out of prison, homeless, too much chaos and temptation in the hostel and so on. When you are stuck in this cycle, all you think about is surviving to the end of the day. But now I am in a better place. My Personal Development Coordinator helped me the most, but other stuff too like being an Expert Citizen, that's really made a big difference. So I can speak from personal experience that all the things written about in this report really do work. And it's great the report describes how they work, so that these ideas can be picked up by other organisations. Because there are a lot more people like I was out there, and to help them we need more of what is written about in this report - not less.

Being an Opportunity Nottingham Expert Citizen has opened doors that I didn't even know were there. Whether it's the Nottingham Playhouse workshops, the Mental Health Awareness Week's events I am going to, or the 'Meet and Eat' sessions with the Expert Citizen Group. Actually I think these have benefitted me more than anything else - I've learned new skills, I don't feel isolated because I can meet with other people who have been through the same experiences, and I have gained a lot of confidence. We need much more of this kind of social activity to be available and Opportunity Nottingham should push this as hard as they can in the next few years.

People talk about system change. I don't know about that, but I do know when you come out of prison and you're homeless - you are in an impossible situation. It feels like a pit you can't climb out of. In this report you see the cost of this. The human cost but also you see the money cost to the government. That opened my eyes. It's crazy. If I met a senior politician I'd say... *"You label me as having multiple needs, as being chaotic, but it seems you're the one with the biggest problem. Because the system which the government end up paying for - that didn't help me but made things worse - now that's what is really chaotic"*. Hopefully this report can contribute to changing this.



Mark

Opportunity Nottingham Expert Citizen



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“ Beneficiaries who made greater progress had been more willing to engage with their Personal Development Coordinators. ”



Pete
Opportunity Nottingham Expert Citizen

Executive summary

This report is an account of the work of Opportunity Nottingham (ON) as it reaches the midway point of its eight-year programme. It builds on the 2016 report *Changing lives, changing systems*, moving beyond the initial concern with basic effectiveness, and towards an exploration of the ways in which ON has gone further in the pursuit of its goals, and has met some of the challenges it has encountered on the way. The report is therefore divided into three parts:

Part I - The Beneficiary challenge

Part I focuses on the challenge of working with Beneficiaries. By the end of March 2018, 343 Beneficiaries had engaged with ON, 73% of the 470 originally envisaged for the life of the project. Of the 343, 149 were actively engaged, 35 had left because they no longer needed support, and a further 65 had disengaged. These proportions are comparable with those reported on other Big Lottery funded Fulfilling Lives projects across the UK. Since 2016, the proportion of Beneficiaries registering progress in their Outcomes Star scores has increased from 63% to 73%. A comparison between Beneficiaries currently engaged at the end of 2017 with those who had disengaged up to that point, showed that those continuing to engage had made greater progress during their involvement with ON than those who had disengaged, even though their need levels were similar at the point of joining the project. A more detailed comparison between those five Beneficiaries who had made greatest progress since 2016 and the five who had made least, revealed no particularly distinguishing aspects of the multiple and complex needs of either group, but Beneficiaries who made greater progress had been more willing to engage with their Personal Development Coordinators (PDCs), and had been motivated by recovered relationships and the desire and opportunity to give something back, for example, through becoming an Expert Citizen. However, those who had made least progress were often struggling to recover from the trauma of bad relationships such as childhood abuse or more recent intimidation.

Analysis of the cost-effectiveness of ON reveals that the average cost of each Beneficiary in public service consumption declined rapidly during the first two years of operation, from nearly £8,000 per quarter to around £4,000.

This figure has remained fairly constant since 2016. A more focused analysis of the 40 Beneficiaries who left the project

by the end of June 2018 (no longer needing support), revealed an average cost saving of £12,185 per Beneficiary during their time of engagement. However, this analysis is based on a limited set of 18 items. A more extensive analysis based on a broader set of 52 items against a random sample of 20 Beneficiaries shows that cost savings in, for instance, criminal justice and emergency health care costs, are partly offset by increased costs in social care services. Moreover, it was found that

“ The PDC role has continued to combine direct support with brokering access to services, but this has since been supplemented by some specialisation according to the different multiple and complex needs with which they have particular experience. ”

overall savings were only achieved for the seven who left the programme because they no longer needed support.

With regard to factors that make for success, as in 2016, the work of the PDCs has been paramount. Focus Groups with the PDCs confirmed that ten distinguishing characteristics continue to guide their work. The PDC role has continued to combine direct support with brokering access to services, but this has since been supplemented by some specialisation according to the different multiple and complex needs with which they have particular experience; and by reflecting system change in the role through promoting knowledge and expertise in multiple and complex needs amongst services with which they have contact. Developing expertise is especially apparent in the motivation of the PDCs through a subtle blend of positive reinforcement and assertiveness that is increasingly emphasising a strength-based approach. Further skills in crisis management and knowing the system are also evident, and the result has been a greater acceptance of the unique role of PDCs in the wider practice community beyond ON. Morale and resilience have continued to be key issues for PDCs, sustained among other things through informal team solidarity, knowing the limits of toleration regarding Beneficiary behaviour, and using appropriate coping techniques when Beneficiaries disengage or worse.

“ The benefits of peer mentoring include; improved wellbeing, reduced relapse, improved self-esteem, better engagement with services overall, access to more positive social networks and shared activities, combatting isolation. ”

Evidence is presented of two other factors that are increasingly making for success at ON. The first is the Peer Mentoring scheme, which commenced in 2017 under the management of a Peer Mentor Coordinator. Early evidence shows that average Outcomes Star scores for the eight Beneficiaries who have had a Peer Mentor over a significant period have improved by 34, which is comparable with the best achievements for Beneficiaries overall. The benefits of peer mentoring include; improved wellbeing, reduced relapse, improved self-esteem, better engagement with services overall, access to more positive social networks and shared activities, combatting isolation, and the benefits of sharing experiences with someone who also has lived experience.

The second development which has been in operation since the start of the project is the Expert Citizen Group. Expert Citizens are a group of Beneficiaries who have made progress on the ON project, to a point where they are able to come together to inform and support its development, and help to ensure that the voice of lived experience is an integral part of system change. 21 Beneficiaries have participated in this group to date, with many more showing an interest. They have been involved in a wide range of activities including training practitioners where the user perspective has been particularly important, and in giving evidence in policy-making forums. The Expert Citizen Group has not only been a vehicle for enabling Beneficiaries to feel valued, but is playing an increasingly important role in the system change agenda.

One further aspect of the project's work with Beneficiaries has been its focus on under-represented groups, of which members of BME communities are a prime example. Specialist work has been commissioned through AWAAZ. Their success in overcoming barriers to engagement encountered by people with complex needs from BME communities is evident in their increased representation in the Beneficiary population from 19% to 28% since 2016. AWAAZ employs Assertive Community Outreach Workers from different BME communities to reflect an awareness of different cultures, and to help overcome the stigma around mental health and multiple and complex needs in many BME cultures. They provide a safe place free of the potential racism that can be experienced in many

settings. Above all, there is an asset-based approach that addresses the whole person, letting Beneficiaries lead and not focusing on primary needs.

Part II - The system challenge

Part II is devoted entirely to system change, an increasingly important aspect of the project's endeavours. This report recognises that success in system change must be seen less in the work of ON, and more in the transformation of the system itself, especially those parts most relevant to the multiple and complex needs that are the project's primary concern; homelessness, offending, mental ill health and substance misuse. However, the first chapter relates to the narrative around the evolving system change plan, based on a review of the results of the original plan from 2015. The aims of the first plan were; to improve access to services, promote unified assessment and data sharing, work towards Beneficiary-led, person-centred services and support, enable Beneficiaries to experience a joined-up support pathway, promote recovery and sustain changes in commissioning, funding and policy. The review found that the actions introduced to pursue these goals were only partly achieved, and did not take account of the changing national context.

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Organisations across Nottingham City who work either directly or indirectly with people facing multiple and complex needs, are being asked to take on the Opportunity Nottingham System Change Challenge. More information can be found at www.opportunitynottingham.co.uk. The five challenges are outlined below:

- 1 **The system works as one**
- 2 **Services are welcoming**
- 3 **The system is service user led or informed**
- 4 **We build resilience in our service users and workforce**
- 5 **We acknowledge and respond to multiple and complex needs.**

One of the original system change goals – the joined-up support pathway – has been subject to more focused evaluation of how far ON has been able to foster inter-agency collaboration in the field of multiple and complex needs. An external evaluation of collaboration at commissioning level identified numerous barriers, and concluded that ON's primary value lay as a catalyst in connecting agencies and people with a shared interest in multiple and complex needs through; involvement in the Partnership Board, maximising the sharing of knowledge and experience through the Practice Development Unit (PDU), being 'at the table' in inter-agency forums where commissioning is discussed, and setting an example in its own holistic, outcome-based commissioning practices, informed by the lived experience of Beneficiaries.

The next four sections are devoted to understanding system failures applicable to each of the four multiple and complex needs and the way they might be overcome. Findings in the first section

“ With 13 Beneficiaries who found tenancies following persistent rough sleeping, an opening NDT score of 31 declined to 21, and an initial Outcomes Star score of 30 increased to 54, giving powerful endorsement to the Housing First model of working with persistent rough sleepers. ”

show that if Beneficiaries are persistent rough sleepers, they are more likely to have all four multiple and complex needs, and make slower progress with their ON engagement than Beneficiaries generally, as measured by NDT and Outcomes Star scores. In response, ON has introduced a Multiple Needs Tenancy Support Team (MNTS) to provide wrap-around support to Beneficiaries with tenancies that they are at risk of losing. With 13 Beneficiaries who found tenancies following persistent rough sleeping, an opening NDT score of 31 declined to 21, and an initial Outcomes Star score of 30 increased to 54, giving powerful endorsement to the Housing First model of working with persistent rough sleepers.

Secondly, Beneficiaries who spend time in prison during their engagement with ON are also shown to make slower progress. Interviews with nine Beneficiaries showed that prison made existing mental health and drug problems worse, and exposed them to bullying and self-harm. They also testified to poor preparation for release, and frequent discharge to rough sleeping. However, Beneficiaries who were already engaged with a PDC at the time of sentence testified to the benefits in better support through the sentence, more effective preparation for release and better management of rehabilitation. However, without someone acting in the role of a PDC, the key ingredients of pre-arranged accommodation and welfare benefit claims are frequently absent.

“ Interviews with nine Beneficiaries showed that prison made existing mental health and drug problems worse, and exposed them to bullying and self-harm. ”

Thirdly, there is a summary of research published elsewhere that shows the difficulties that homeless people encounter in securing access to mental health services, along with a review of the Primary Care Mental Health Service as one response to this problem. Once again, Outcomes Star data showed the advantages Beneficiaries have gained by access to the Primary Care Mental Health Service (PCMHS). Nottingham City Clinical Commissioning Group is currently undertaking a review of mental health services in the City and unfortunately is planning to cease operation of the PCMHS in early 2019.

Fourthly, there is detail on the findings from research into the impact of ‘New Psychoactive Substances (NPS)’ on Beneficiary progress and comment on the response of the drug treatment system. The impact is once again revealed in higher NDT and lower Outcomes Star scores where Beneficiaries admit to regular use of NPS, because of its effect on chaotic behaviour, memory and overall consciousness. There is some evidence of good practice in providing support for NPS users by drug treatment services, but this needs to be supplemented by better staff training in the peculiarities of NPS use, better use of trauma informed approaches and joint working with mental health services.

The legacy challenge

At the midpoint of the project's delivery, ON is starting to think about what it will leave behind. By way of a conclusion, two examples of institutions that testify to some of the things that the project hopes to bequeath to the overcoming of multiple and complex needs are considered. In the Practice Development Unit (PDU), there has been an attempt to crystallise the learning from four years spent grappling with multiple and complex needs into a programme of workshops, action learning sets and communities of practice, by which a new way of working can change the way that frontline staff provide services that acknowledge people's multiple and complex needs. In the Wellbeing Hub, there is an attempt to realise one of the key goals of system change in concrete: the bringing together of a range of multiple and complex needs services under a single roof.

The Wellbeing Hub was only launched earlier this year, and so evaluation would be premature. However, the Practice Development Unit (PDU) has been reviewed after its first year of operation through surveys and interviews with people who have attended events. At least three quarters testified to an improved understanding, especially of the way other agencies operate. Of greater relevance to system change, more than half were planning to share their learning with other frontline colleagues, and some were willing to change the way they work, for instance, through introducing The Pledge (See Appendices i.) or making their service more 'psychologically informed'.

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The Wellbeing Hub, Nottingham



Introduction

This report is an account of the work of Opportunity Nottingham (ON) as it reaches the midway point of its eight-year delivery plan. It is both retrospective in appraising what has been achieved in the first four years, building on what was reported in the year two evaluation, *Changing lives, changing systems (2016)*. The report is also prospective, addressing the challenges that remain, and looking forward to consider the legacy that the project will leave for people facing multiple and complex needs.

Like the 2016 report, this report is a collective endeavour, pulling together the work of the External Evaluation Team from Nottingham Trent University and the Evaluation and Learning Team from ON, and drawing on the insights of Personal Development Coordinators (PDCs), Beneficiary Ambassadors, Peer Researchers and above all, Beneficiaries (service users) themselves. However, in seeking to explore the impact of ON in the context of the wider welfare system, this report draws on evidence from elsewhere, from other agencies and service providers engaged in transforming the lives of Beneficiaries.

Opportunity Nottingham and its evaluation

ON began work in July 2014 as one of 12 UK projects commissioned to deliver the Big Lottery's National Programme, 'Fulfilling Lives: Supporting People with Multiple and Complex Needs'. People with multiple and complex needs face homelessness, substance misuse, mental ill-health and offending, in a cumulative and mutually reinforcing bind from which they struggle to escape. Over the four years in which it has been operating, ON has sought to transform both the lives of people locked into this cycle, and the system that has failed to liberate them. Specifically, it has sought;

- To empower people with multiple and complex needs, and to support and enable them to take control of their lives
- To change frontline services and make them more effective by listening to what Beneficiaries want and need – making services better coordinated and integrated, more person-centred, responsive and realistic in relation to targets and timescales
- To deliver change at strategic and commissioning level by working with strategic leaders and using the learning, outcomes and impacts of the project to change the system's 'DNA'.

The *Changing lives, changing systems* report was mainly concerned with giving an account of what ON had achieved in its first two years, mainly in the lives of the Beneficiaries who had engaged with the project. Evidence was drawn from a number of sources including;

- Secondary analysis of data collected by PDCs and returned quarterly to the National Evaluation Team based at CFE in Leicester. This data included a profile of Beneficiary characteristics and service use, together with the results of periodic New Directions Team (NDT) and Outcomes Star assessments undertaken by PDCs

¹ South West London and St. George's Mental Health NHS Trust (2008), The New Directions Team Assessment (Chaos Index). Available at <http://www.meam.org.uk/wp-content/uploads/2010/05/NDT-Assessment-process-summary-April-2008.pdf>

- In-depth interviews with Beneficiaries for insights into their lives before encountering ON and their experiences of engaging with their PDC
- Focus Groups with PDCs and their Team Leaders on what informs their work with Beneficiaries and how they meet the challenges of this work
- Some cost-benefit analysis of the changing cost of services used by Beneficiaries since engaging with ON – using the Fulfilling Lives Newcastle and Gateshead Cost Calculator.

In addition to gauging the effectiveness of direct work with Beneficiaries, *Changing lives, changing systems* reported on two further aims of the evaluation: the empowerment of Beneficiaries through their involvement in the evaluation as Peer Researchers; and ON's achievements in the pursuit of system change. The report gave an account of the recruitment and training of the first team of Peer Researchers, and their involvement in the design of interview schedules and the conduct of interviews with Beneficiaries jointly with another member of the ON Evaluation Team. It went on to explain how Peer Researchers had become an integral part of the evaluation through membership of a steering group and presentation at workshops. The report was also able to draw on secondary analysis of interviews with stakeholders to explore how far ON had pursued its system change plan.

The next two years and the structure of this report

Although many of these evaluation activities have continued for the subsequent two years, the focus of work and of this report has moved beyond the initial concern with basic effectiveness towards the ways in which ON has gone further in the pursuit of its goals, and has met some of the challenges it has encountered on the way. The report is therefore divided into three parts. Part I focuses on the challenge of working with Beneficiaries; after presenting an update on Beneficiary outcomes since 2016, attention moves more precisely to what works for whom and why. For instance; there is analysis of the impact of length of engagement on Beneficiary achievements, a fuller analysis of the changing cost of service use by Beneficiaries, an evaluation of peer mentoring, a review of the work of the Expert Citizens and their contribution to Beneficiary empowerment, and a review of work with BME Beneficiaries in an effort to ensure that ON's work is genuinely inclusive.

Part II directs attention towards the challenges posed by the wider welfare system. There is an account of the thinking that underpins the new system change plan, followed by a review of evidence that explores the potential for collaboration at the level of commissioning. There is then separate consideration given to the challenges posed by the different parts of the system that relate to aspects of the four complex needs, notably rough sleeping, prison, mental health and New Psychoactive Substances (NPS), using evidence gleaned from people with multiple and complex needs, who may or may not meet the ON threshold. The barriers to Beneficiary progress posed by these systemic obstacles are explored, and potential solutions considered. Part III then gives space to a brief consideration of two potential institutional legacies: the Practice Development Unit (PDU) and the Wellbeing Hub.

² Triangle Consulting (n.d.), Homelessness Star: The Outcomes Star for people with housing and other needs. Available at <http://www.outcomesstar.org.uk/using-the-star/see-the-stars/homelessness-star/>

³ <https://jscalc.io/calc/X5z7IMVE3Tf16A1f>

“ People say they know how you are feeling, but they only see the outside not the inside, so they don't understand the pain. ”

Jacquie Opportunity Nottingham Expert Citizen



Part I: The Beneficiary challenge

The first part of this report will be devoted to a review of what ON has achieved through its work with Beneficiaries, building on what was reported in the year two report *Changing lives, changing systems* in 2016.



1.1 Making progress: the benefits of engagement

Changing lives, changing systems began with a profile of Beneficiaries and evidence of progress since engagement, and this report will do the same, using data from NDT and Outcomes Star Assessments, and other data recorded by PDCs for quarterly returns to the National Evaluation Team at CFE Leicester (although it should be noted that figures for the last two years only cover seven quarters). As before, comparisons will be drawn with the profile of Beneficiaries across all 12 Fulfilling Lives Projects⁴. However, the profile at the end of Q2 2016 recorded in *Changing lives, changing systems*, will also be compared with the profile of Beneficiaries engaged up to the end of Q1 2018, to give a sense of the changing Beneficiary population during the life of ON. The account will then move on to a more focused analysis regarding the benefits of engagement.

A profile of Beneficiaries

By the end of March 2018, 343 Beneficiaries had engaged with ON, 73% of the 470 originally envisaged for the life of the project. ON has recruited the fourth highest number of Beneficiaries when compared with Fulfilling Lives projects nationally, where recruitment ranges from 89 to 702⁵. Table 1 (on page 14) compares the destinations of Beneficiaries during the first two years with those of the second two years, to the end of March 2018. The third and fourth columns compare some of the totals as percentages for the full four years with national figures. These figures are taken from a national dashboard

for the overall programme, but those for Nottingham are taken directly from PDC acquired data.

“ By the end of March 2018, 343 Beneficiaries had engaged with ON, 73% of the 470 originally envisaged for the life of the project. ”

Similar numbers of Beneficiaries were engaged at the end of each period, and similar

numbers disengaged within the two timeframes. However, fewer died or moved away in the last two years. Compared with national figures, the higher than average proportions who have disengaged, died or moved from the area noted in the 2016 report have persisted, though the differences are now much less, suggesting that those joining the project since Q3 2016 have probably followed the national pattern more closely.

⁴ The Fulfilling Lives National Dashboard has been used for this purpose - <https://public.tableau.com/profile/cfe2218#!/vizhome/FulfillingLives2018Q1/1UserGuide>

⁵ This latter figure for WY-FI West Yorkshire – Finding Independence is a bit of an outlier; the highest after that is Liverpool Waves of Hope at 384.

Table 1: Beneficiary destinations

DESTINATION	NUMBER OF BENEFICIARIES AT Q2 2016	NUMBER OF BENEFICIARIES Q3 2016 - Q1 2018	TOTAL % NOTTINGHAM	TOTAL % NATIONAL
Still engaged with the project at end of period	147	149		
Moved to other support (not funded through ON)	1	1		
No longer requires support	13	22	10	11
Client disengaged from project	35	30	19	15
Prison	1	1		
Hospital	1	0		
Deceased	14	8	6.4	4.1
Moved out of area	23	9	9.3	5.2
Other	2	1		
Excluded from the project	0	0		

Table 2 records the changing characteristics of Beneficiaries recruited in the two periods and compares these with Beneficiaries nationally.⁶

Table 2: Further Beneficiary characteristics (%)

BENEFICIARY CHARACTERISTICS	RECRUITED 2014-16	RECRUITED 2016-18	NATIONAL
Women	24	32	33
Black & Minority Ethnic Groups	19	28	17
Disabled	25	40	42
Aged: Under 25	25	40	
Aged: 25-54	54	56	
Aged: Over 55	5	6	

Changes that are worth noting include the higher proportion of women recruited to ON since 2016, a proportion close to the national average and representing the success of measures to recruit more women to the project. A similar point can be made about proportions recorded as disabled, which are far higher than the 18% in the wider population of Nottingham. The increased proportion of Beneficiaries from Black and Minority Ethnic Groups (BME) has moved closer to the 35% for Nottingham as a whole and represents the success of efforts by AWAAZ to develop a more culturally sensitive response to the needs of the BME population, a point taken up more fully in section 1.6.

The benefits of engagement

To be accepted on to the project, Beneficiaries must have three of the four identified multiple and complex needs and reach a minimum score in their initial NDT Assessment. The 2016 report showed a greater proportion of ON Beneficiaries to have all four needs than was the case in Fulfilling Lives projects nationally, and this trend has continued into 2018, with 56% having all four needs, compared with 51% nationally.

The NDT Assessment is designed to build a holistic picture of Beneficiaries' multiple and complex

⁶ The national dashboard gives age groups in different categories, so comparisons are not possible.

needs by means of ten indicators of behaviour and circumstances. Each indicator is scored negatively on a range of 0-4, with two indicators – risk to others and risk from others – counting double, giving a maximum score of 48 for the highest need. Since

“ To be accepted on to the project, Beneficiaries must have three of the four identified multiple and complex needs. ”

the project commenced, the average threshold NDT score for ON Beneficiaries has been 31, which is at the lower end of the range of 30 – 37 recorded by projects nationally. Repeating the NDT Assessment periodically gives an indication of Beneficiary progress as scores decline.

In contrast to the NDT Assessment, the Homelessness Outcomes Star is a way of measuring progress positively. The Outcomes Star uses a set of ten health and social wellbeing criteria arranged in a star, with each criterion having ten rungs of progress. The aim is to reach a score of 10 on each point on the star in order for a total score of 100 to be achieved. Outcomes Stars are completed periodically by PDCs on the basis of their knowledge of Beneficiaries, giving an indication of progress as scores increase.

Table 3 compares the proportions of ON Beneficiaries with at least two Outcomes Star readings where data has changed or remained the same in the two periods. For 2014-16, this amounted to 89 Beneficiaries, and 73 for 2016-18. The table indicates an increased proportion of Beneficiaries who have progressed, on the basis of this analysis.

Table 3: Proportions whose Outcomes Star scores have changed (%)

CHANGES IN OUTCOMES STAR SCORES	2014-16	2016-18
Increased	63	73
Decreased	21	16
Remained the same	16	11

To explore further the benefits of engagement with ON, data was analysed to compare the NDT and Outcomes Star scores of all Beneficiaries engaged with ON at the end of 2017, with the scores of former Beneficiaries who had disengaged from the project. Two new data sheets were created, one to contain the latest NDT and Outcomes Star data for Beneficiaries who were still engaged with the project, and a second for the last available scores of former Beneficiaries who had disengaged.

At the time of the analysis, there were 137 actively engaged Beneficiaries. Beneficiary involvement with ON can end for a variety of reasons. Some may no longer need support or secure it from another project. Others may move away from Nottingham or go into prison or hospital. However, there are some with whom ON simply loses contact. These are the ‘disengaged’, and there have been 57 disengaged since the start of the project. Demographically, both groups were fairly similar, although slightly more females were engaged (32.6%) than disengaged (28.1%). The engaged Beneficiaries were also slightly more likely to be White British (76.0%) than the disengaged (70.2%). Otherwise, no obviously distinguishing features marked those that disengaged.

The latest NDT scores were compared, both overall scores and those for the individual elements of the NDT Assessment. Statistical analysis revealed a significant difference between the NDT scores of engaged and disengaged Beneficiaries, with the former registering a lower mean NDT score (M=24.1) than the latter (M=28.5). These findings suggest that Beneficiaries who disengage from the project have higher support needs at their point of disengagement, than Beneficiaries who remain engaged with the project.

Table 4: NDT scores compared

INDICATOR	ENGAGED BENEFICIARIES	DISENGAGED BENEFICIARIES
Total NDT Score	24.11	28.53
Housing	2.18	2.42
Substance misuse	2.81	3.54
Risk to others	3.28	4.18
Risk from others	3.91	4.21
Unintentional self-harm	2.28	2.68
Intentional self-harm	1.72	1.72
Social effectiveness	1.50	1.81

As indicated in Table 4, a number of differences in the individual elements also proved to be statistically significant.

- *Housing* – a much higher proportion of disengaged Beneficiaries were living in high risk accommodation or housing with high support needs
- *Substance misuse* – two thirds of disengaged Beneficiaries were classed as drug or alcohol dependent, compared with less than half of the engaged group
- *Risk* – disengaged Beneficiaries posed a significantly greater risk to others than engaged Beneficiaries, but there was no significant difference in risk from others
- *Self-harm* – disengaged Beneficiaries were significantly more at risk of unintentional self-harm than engaged Beneficiaries, but this was not the case with intentional self-harm
- *Social effectiveness* – disengaged Beneficiaries were significantly more likely to be lacking in social skills than engaged Beneficiaries.

Outcomes Star scores were available for slightly fewer Beneficiaries – 115 in the engaged group, 45 in the disengaged group. The latest score was used for analysis where there was more than one. As with NDT scores, a significant difference was found in the Outcomes Star scores of engaged Beneficiaries compared with those who had disengaged, with the former having higher scores (M= 42.5) compared to the latter (M=30.5).

Table 5: Outcomes Star scores compared

INDICATOR	ENGAGED BENEFICIARIES	DISENGAGED BENEFICIARIES
Total HOS score	42.45	30.51
Drug and alcohol misuse	4.42	3.07
Managing tenancy and accommodation	4.41	3.27
Offending	5.65	3.73
Motivation and taking responsibility	4.12	2.73
Social networks and relationships	3.74	2.98
Emotional and mental health	3.66	2.91

As with the NDT scores, a number of differences in Outcomes Star scores between engaged and disengaged Beneficiaries proved to be statistically significant, as can be seen from Table 5. No significant difference was found in managing money, physical health, self-care and living skills and meaningful use of time.

Despite similarities in demographic features, it is possible that the differences found in NDT and Outcomes Star scores between engaged and disengaged Beneficiaries could be attributed to the latter simply having more multiple and complex needs from the outset. So, one further stage in the analysis was needed to explore any differences between the two groups in the progress (or otherwise) made while engaged with ON.

An investigation analysed changes in NDT scores of Beneficiaries over their period of engagement with ON. The NDT data of 152 Beneficiaries was analysed, 116 currently engaging with ON and 36 who have disengaged, slightly fewer than the cohorts whose latest NDT scores were analysed above, as Beneficiaries with only one NDT score had to be discarded. Beneficiaries typically undertake an NDT Assessment once every six months. Those who have been involved for the longest period of time tend to have undertaken more NDT Assessments, varying the number of assessments completed by each Beneficiary. To account for this, the first and latest (most recent) NDT Assessments were used in this comparison exercise. This enabled the change in NDT scores over each Beneficiary period of engagement to be identified.

“ Disengaged Beneficiaries posed a significantly greater risk to others than engaged Beneficiaries. ”

The first and latest NDT scores were compared for both engaged and disengaged Beneficiaries. The mean NDT scores for these time points are shown in Table 6. The table shows that mean NDT scores at first assessment are similar for both engaged and disengaged Beneficiaries, and that they fall over time for both groups, but that this decrease is greater for Beneficiaries who are currently engaged. Thus, the latest mean NDT scores are higher for Beneficiaries who have disengaged than with those who are currently engaged.

Table 6: First and latest NDT scores compared

INVOLVEMENT STATUS	MEAN INITIAL NDT SCORE	MEAN LATEST NDT SCORE	MEAN CHANGE IN NDT SCORE
Currently engaged	30.91	22.37	8.54
Disengaged	29.64	26.17	3.47

These findings were confirmed by statistical analysis. The changes over time in mean NDT scores were statistically significant for both engaged and disengaged Beneficiaries, but the difference between the two groups was also significant. However, this finding should be interpreted in light of the highly unequal sample sizes of engaged and disengaged Beneficiaries used within the analyses.

Table 7 (on page 18) breaks down these variations into the constituent components of the NDT Assessment, showing that greater changes could be observed in some measures than others.

Table 7: First and latest NDT scores compared

NDT MEASURE	MEAN AT FIRST NDT ASSESSMENT		MEAN AT LATEST NDT ASSESSMENT		CHANGE IN MEAN NDT SCORES	
	DISENGAGED	ENGAGED	DISENGAGED	ENGAGED	DISENGAGED	ENGAGED
Engagement	2.75	2.69	2.75	1.98	0	-0.71
Intentional self-harm	2.14	2.22	1.94	1.59	-0.20	-0.63
Unintentional self-harm	2.75	2.94	2.42	2.08	-0.33	-0.86
Risk to others	4.53	4.59	3.72	2.95	-0.81	-1.64
Risk from others	4.22	4.95	3.39	3.55	-0.83	-1.40
Stress and anxiety	2.94	3.02	2.64	2.46	-0.30	-0.56
Social effectiveness	1.86	1.84	1.75	1.47	-0.11	-0.37
Substance misuse	3.53	3.60	3.31	2.73	-0.22	-0.87
Impulse control	2.61	2.52	2.33	1.75	-0.32	-0.77
Housing	2.31	2.67	2.19	1.82	-0.12	-0.85

There was a decline in mean NDT scores for all components of the assessment for both engaged and disengaged Beneficiaries, with the exception of ‘levels of engagement’ which remained unchanged for the disengaged group. However, greater decline was discernible for some measures than others, with particularly significant improvements in scores for the two double-weighted measures (risk to and from others), ‘unintentional self-harm’, ‘substance misuse’ and ‘housing’. Moreover, it was on these latter three measures that the most appreciable difference could be detected between progress made by the engaged and disengaged groups, with the former seeing much greater success.

Further investigation analysed changes in Outcomes Star scores of Beneficiaries over their period of involvement with ON. Beneficiaries undertake an assessment once every six months. In order to analyse the change in scores over Beneficiaries’ period of engagement, the first and latest assessments were used. The Outcomes Star data for 125 individuals were analysed. Of these, 30 had disengaged, and 95 were still actively engaged. Many other disengaged individuals had only completed a single Outcomes Star Assessment, making comparison impossible, and explaining why the sample of disengaged Beneficiaries was significantly smaller than the engaged sample.

Table 8 compares the first and latest Outcomes Star scores for both engaged and disengaged Beneficiaries. The table reveals that mean scores for engaged Beneficiaries showed a greater increase (+14.44) than mean scores for those who had disengaged (+1.67). This was confirmed by statistical analysis, which showed the difference to be statistically significant.

Table 8: First and latest Homelessness Outcomes Star scores compared

INVOLVEMENT STATUS	MEAN HOS AT FIRST ASSESSMENT	MEAN HOS AT LATEST ASSESSMENT	CHANGE IN MEAN HOS
Currently engaged	30.97	45.41	+ 14.44
Disengaged	28.20	29.87	+1.67

Table 9 breaks the Homelessness Outcomes Star scores into their 10 individual components.

HOS MEASURE	MEAN AT FIRST NDT ASSESSMENT		MEAN AT LATEST NDT ASSESSMENT		CHANGE IN MEAN NDT SCORES	
	DISENGAGED	ENGAGED	DISENGAGED	ENGAGED	DISENGAGED	ENGAGED
Motivation and taking responsibility	2.63	3.17	2.67	4.41	+0.04	+1.24
Self-care and living skills	3.07	3.29	3.27	4.85	+0.20	+1.56
Managing money	2.57	2.99	2.90	4.79	+0.33	+1.80
Social networks and relationships	2.80	2.72	2.93	4.11	+0.13	+1.39
Drug and alcohol misuse	2.67	2.81	2.77	4.44	+0.10	+1.63
Physical health	3.00	3.31	2.93	4.36	-0.07	+1.05
Emotional and mental health	2.63	2.88	2.93	3.97	+0.30	+1.09
Meaningful use of time	2.33	2.64	2.30	3.95	-0.03	+1.31
Managing tenancy and accommodation	3.20	3.21	3.30	4.68	+0.10	+1.47
Offending	3.41	4.01	3.87	5.97	+0.46	+1.96

What becomes immediately apparent is that improvements for the disengaged are marginal, with mean scores for some elements even having declined (*physical health and meaningful use of time*). However, for the engaged, improvements are substantial, with notable increases in mean scores for *managing money and offending*. No significance should be attached to the particular measures where there have been declines or greater increases; the significant finding is the overall difference that maintained engagement has made to outcome measures. The difference in mean scores at first assessment is slight, so the finding cannot be explained simply by the disengaged having more multiple and complex needs from the outset. The differences can only be attributed to the benefits of continued engagement.

“...the significant finding is the overall difference that maintained engagement has made to outcome measures.”

The purpose of the analysis was to test the benefits of engagement in the starkest way possible, by comparing the latest data for currently engaged Beneficiaries with data for Beneficiaries who had disengaged from the project without explanation. The focus of the analysis was on NDT and Outcomes Star scores for what they reveal about the relative progress made by the two groups. Analysis revealed no significant difference between the two groups at the point of initial engagement. There is no reason to suppose that Beneficiaries disengage because their needs are greater from the outset. Analysis also demonstrated that both groups made significant progress by these two measures during their time of engagement with ON, though there was no way of detecting differences in rate of progress. However, analysis further revealed that those Beneficiaries still currently engaged with ON have achieved a much greater degree of progress than that which had been achieved by disengaged Beneficiaries by their point of disengagement. In other words, continued engagement is worthwhile.



1.2 Successes and failures – a closer analysis

As in the 2016 report, a closer inspection of Beneficiaries who have made the most and least progress has been undertaken, as indicated by NDT and Outcomes Star scores. As before, running records of PDCs have been used to see how far features of Beneficiaries' narratives shed light on the reasons for progress, or the lack of it. The five Beneficiaries who have made greatest progress and the five who have made least, in the two years since 2016 have been considered, to see how far the common features highlighted then have been replicated since.

In 2016, it was found that Beneficiaries who had made the greatest progress

tended to have alcohol problems as a prominent need, but showed willingness to engage with their PDCs, who in turn demonstrated great persistence and flexibility in their support, and a high level of effectiveness in brokering multi-agency collaboration on the Beneficiaries' behalf. The value of Michael Varnam House (a housing service provided by ON lead partner Framework) in the Beneficiary recovery journey was also noted at this time. On the other hand, Beneficiaries who had made least progress tended to have long-standing mental health problems as a prominent issue, which resulted in chronic substance misuse and behavioural problems that attracted criminal sanctions. These Beneficiaries did not engage well with their PDCs or services more widely.

Drawing out common features from this more recent selection of cases is difficult and potentially misleading. The case summaries are presented in Table 10 (on page 21) for consideration, but certain themes are worth noting. Where Beneficiaries made the most progress;

- There was no single complex need that predominated (unlike in 2016)
- There was a clear willingness to engage with their PDC, who in turn worked intensively and flexibly with the Beneficiary at critical junctures
- The recovery of lost relationships often played an important part in their recovery journey
- A desire to give something back, often through becoming an Expert Citizen with ON, provided a strong incentive in many cases.

With Beneficiaries who made least progress (shown in Table 11 on page 22), there were no discernible common features beyond poor engagement with PDCs and other services, and there is even a hint in one case that improved engagement might bear fruit in the near future. In some cases, there is the suggestion that bad relationships, in the form of childhood abuse or bullying later in life, are likely to have lasting consequences.



“ I feel I can get there, you know. ”

Paul
Opportunity Nottingham
Expert Citizen

“ In some cases, there is the suggestion that bad relationships, in the form of childhood abuse or bullying later in life, are likely to have lasting consequences. ”

Table 10: Beneficiaries who have made most progress

NDT CHANGE	OUTCOMES STAR CHANGE	COMMENTS
-12	57	Upon joining the project, the Beneficiary used to spend approximately £40 on crack cocaine per day. She engaged in sex work and shoplifting in order to pay for drugs. She now receives mental health support from a Clinical Psychologist, has engaged well with ON, and has been involved in volunteering with the project. She is very creative and enjoys craft work.
2	57	The Beneficiary has multiple mental health diagnoses which relate to depression, autism and Asperger's. Some family members have criminal convictions and his Asperger's makes it hard to process and understand the family situation. He has issues with managing anger which has led to multiple arrests due to criminal damage. ON helped with emotional support, talking through situations, communicating with his family to help them understand the Beneficiary, and advocating for appropriate accommodation. He has now moved into more suitable supported accommodation, and has reconnected with family members. He has also changed his medication which has moderated his behaviour and the PDC prompts him to take it, but there are still some outbursts of temper. He still has some steps to take as he can struggle with self-care and his home environment.
-29	58	The Beneficiary joined ON shortly after being released from prison for possession and intent to supply. He misused substances such as Mamba and Cannabis. He was sanctioned by the DWP and spent most of his income on drugs, which led to him being served an eviction notice. To begin with, his PDC saw him three times a week and helped him re-engage with the community and build confidence to do things himself. He recently got in touch with his child and is now in regular contact. He practices Buddhism, yoga and attends the gym to abstain from drugs. He is now managing his money and accommodation well. He aspires to be a drug worker once completely abstinent from drugs.
-20	55	Before joining ON, the Beneficiary had a career and family, but his mental health began to decline and he used alcohol to self-medicate. His network consisted of friends who also had issues with alcohol, and would often steal his money, leaving him in debt. Misusing alcohol has impacted on his physical health and he is frequently in hospital. His PDC helps by ensuring that he attends abstinence groups and GP appointments, and that he receives welfare checks at his accommodation. He currently volunteers with ON and gets involved with research and influencing system change. This keeps him busy and offers a positive support network through others with lived experience of complex needs.
-1	57	The Beneficiary had issues with heroin and crack which he used daily. He also drinks six to nine cans of alcohol per week. He tends to experience low mood, and becomes paranoid and violent at times. He has been sectioned under the Mental Health Act numerous times. Following support from ON, he now only occasionally uses drugs and is engaging well with Nottingham Recovery Network. He has also volunteered with ON and has reduced his debt level.

Table 11: Beneficiaries who have made least progress

NDT CHANGE	OUTCOMES STAR CHANGE	COMMENTS
-14	-12	On the face of it, the NDT and Outcomes Star changes provide a conflicting view of the Beneficiary's progress. The NDT score reduced significantly when he moved into his own accommodation, thereby reducing risks from those with whom he was sharing. However, the Outcomes Star score reveals declining motivation. He feels isolated as he is uncomfortable with making friends, and this fuels substance misuse and low mood. His PDC tries to get him involved in various activities, but attendance can be sporadic.
1	-9	This Beneficiary was on the programme for 13 months before disengaging. He has a history of childhood abuse which has affected his lifestyle. To address the trauma, he has used alcohol and other substances. Due to the substance misuse, he has found it difficult to maintain a tenancy, as others would often take advantage of him, bullying him into allowing others to use the tenancy. He lost his tenancy and did not engage with his PDC for nine months. The PDC has tried to engage with him through different activities such as the cinema, but he has been too consumed by other things, mainly drugs.
3	-8	This Beneficiary has a history of substance fuelled psychosis which has led to him receiving a forensic section under the Mental Health Act on several occasions. He is in a cycle of prison, hostel accommodation and rough sleeping. He has a multiple personality disorder, which terrifies him. He believes that alcohol and NPS's give him confidence and make him a better person. He has recently been released from prison and is working with his PDC to set his benefits up again.
-4	-5	This Beneficiary has aspirations to go to college and study music, but this is hindered by substance misuse. He was a persistent rough sleeper and often rejected offers of accommodation due to the extent of his substance misuse. ON did not manage to engage with him during his time with the project, and he did not want support from a PDC.
-1	-1	This Beneficiary joined the project whilst living in Men's Complex Needs accommodation. He was very keen to move into private accommodation and was willing to engage with mental health services which were appropriate to his needs. He developed coping mechanisms to deal with anger, and these were working very well. He has a personality disorder which can effect engagement with services. He does not like to ask others for help, and only reaches out when issues hit a critical point, which often means that supporting him is a long process.



1.3 The costs and benefits of engagement

Saving money has always been implicit in the goals of the Fulfilling Lives Programme. It is based on the belief that people with multiple and complex needs cost public services out of all proportion to their numbers, both in services that they consume and in costs generated elsewhere. There is therefore an expectation that the programme's evaluation has an economic perspective, expressed as money saved by Beneficiaries whose changed lives reduce costs, as their use of services either diminishes or transfers to less expensive areas of public provision. Consequently, routine monitoring gathers data from ON Beneficiaries on their use of services, and measuring tools have

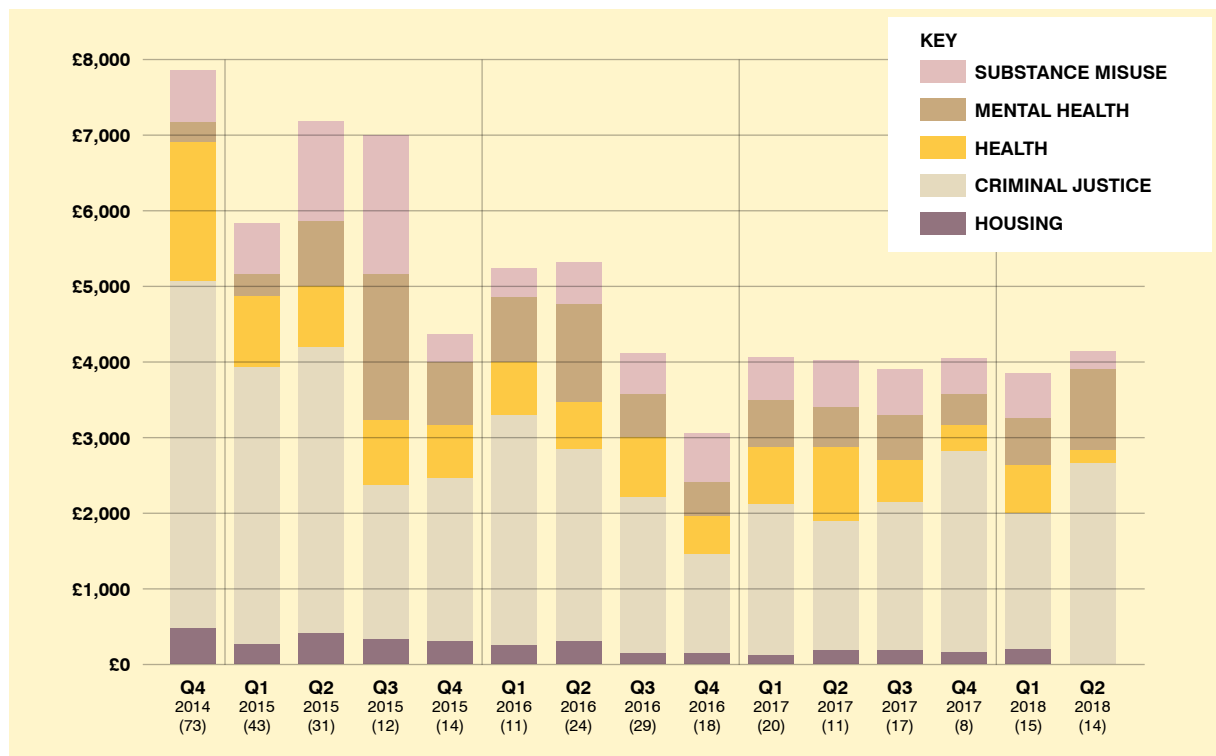
been developed to reflect this consumption in monetary terms.

This section reviews the economic impact of ON at the half way point in the programme. In the 2016 report, a standard dataset consisting of 18 items was used (see Appendices ii.) to gauge the changing use of services of a cohort of Beneficiaries over a 12-month period, between Q1 2015 and Q1 2016. The report noted that costs reduced for nearly all of the 18 items, but statistically significant reductions could be measured for; number of arrests, number of police cautions, number of Magistrate Court appearances, number of hospital in-patient episodes and number of days spent in detox. In other words, many of the most expensive items of public service consumption for which people with complex needs are renowned. However, there was a sense that this analysis was incomplete in the scope of interventions costed. For instance, it did not include any social care or welfare benefit costs and in the housing category it only included evictions from tenancies. To provide a fuller picture this report carries out a more detailed analysis using a 52-item measure (see Appendices ii.)⁷ Presented below are the results of three exercises, and the methodology used for each is explained in turn, with some comments on its limitations.

Changing costs of the Beneficiary population

In the first exercise, analysis was limited to the 18-item calculator, as these are the only items about which regular records of service use are kept. The routinely collected quarterly monitoring data is used to measure use by all Beneficiaries of each of the 18 items in each quarter. The chart in Figure 1 presents the changing average costs per Beneficiary in each quarter since the early months of the project. Figures in brackets indicate the number of new Beneficiaries in each quarter. However, please note that this is not a cohort analysis like the one undertaken in 2016; it simply presents the average quarterly costs of those Beneficiaries who happened to be engaged in each quarter.

Figure 1: Average cost per Beneficiary per quarter



The graph shows large cost reductions in the initial stages of the project. Subsequently there appears to have been a plateauing effect, and so for the past two years, average costs have hovered around the £4,000 level. A possible explanation is that a large number of new Beneficiaries

⁷ As before, we are indebted in our analysis to Fulfilling Lives Newcastle and Gateshead for use of their 'cost calculator' <http://www.fulfillinglives-ng.org.uk/resources/cost-calculator/>, and to New Economy Manchester for their database of unit costs <http://www.neweconomymanchester.com/our-work/research-evaluation-cost-benefit-analysis/cost-benefit-analysis/unit-cost-database>.

were engaged in the early months of the project. Some of these had very high costs on which ON was able to make a relatively swift impact, by stabilising behaviour and supporting Beneficiaries to move from offending patterns to engaging in substance misuse treatment. Thereafter, achieving further change has been more challenging. After stabilisation, the path to individual recovery can sometimes be a long one.

Figure 2 shows aggregated data for both new Beneficiaries joining each quarter and Beneficiaries who have been on the project for anything up to four years. It therefore presents what might be seen as a ‘settled’ cost of around £4,000 per quarter per Beneficiary at the midpoint of the project, as it works with a mixture of new, midpoint and long-term Beneficiaries. Clearly within each of these Beneficiary groups there will be considerable variations. For instance, long-standing Beneficiaries can have periods where costs become marginal, but equally large increases have been recorded and it is likely these can coincide with relapse. The continued engagement of Beneficiaries here is crucial, as this should in the long-term lead to greater cost reductions, but this is not currently reflected in the data.

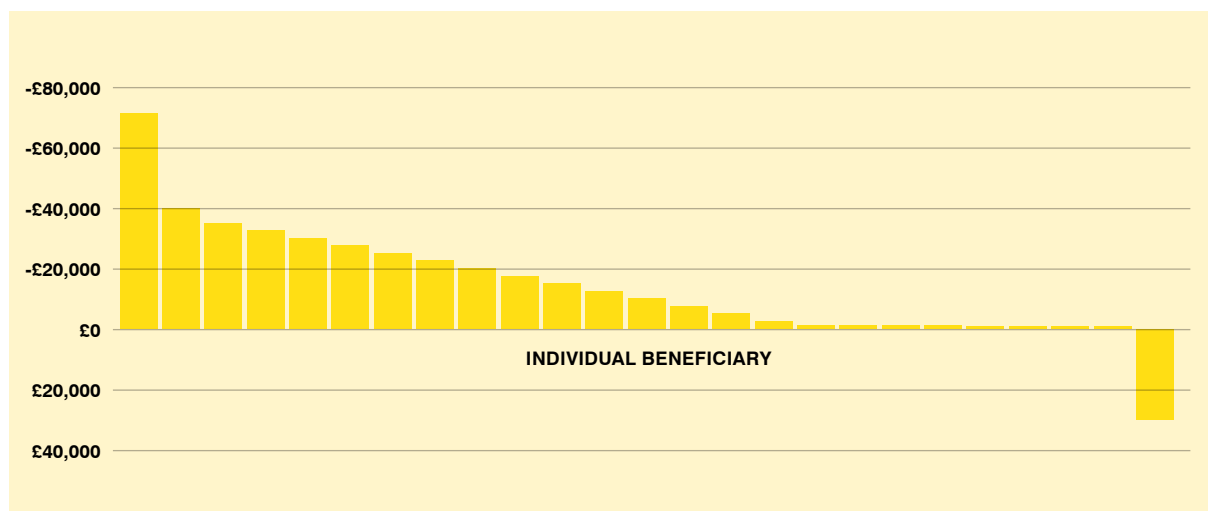
“ Where a positive outcome is achieved the project has so far been able to deliver an average saving of £12,185.54 per Beneficiary. ”

Figure 3 (on page 26) also shows the different costs by sector. The biggest reduction in costs has been the criminal justice sector. The main factor accounting for fluctuation in this area is how many Crown Court proceedings there are, as this is a very expensive item and even one or two cases can distort quarterly data. Similarly, for mental health, community mental health costs which are generally seen as positive are relatively inexpensive (£167). Fluctuation is largely caused by Beneficiaries’ mental health in-patient costs. As with Crown Court proceedings, this is an expensive intervention and even a small number of admissions during a quarter can increase costs.

Savings achieved by positive outcomes

The second analysis was also based on data from the 18-item measure but was a more focused attempt to gauge the cost savings achieved for those Beneficiaries who have left the project with a positive outcome, that is, they disengaged because they no longer needed the support. Whilst Figure 1 shows all Beneficiaries, Figure 2 shows overall costs only for Beneficiaries who have left the project with a positive outcome. Although the proportion who have left with a positive outcome is relatively small at this stage at 40 (23.3% of all leavers to June 2018), the aim was to understand the potential economic impact of the project as the proportion of Beneficiaries who leave positively

Figure 2: Aggregate cost changes for Beneficiaries who have left with a positive outcome



increases.

Figure 4 (on page 27) compares costs during the first six months of engagement with costs incurred during the final six months for 25 Beneficiaries who left with a positive outcome, and each Beneficiary's data is presented separately.

What is immediately apparent is the vast variation in cost changes even between Beneficiaries who have left with a positive outcome, with aggregate changes varying from a saving of £70,000 in one case to a net increase of £30,000 in another. However, what the data does reveal is that where a positive outcome is achieved the project has so far been able to deliver an average saving of £12,185.54 per Beneficiary.



As the data is based on the first cohort that have completed the project when data collection was new, an element of caution should be exercised regarding complete data accuracy. Even so, the data is sufficiently robust to conclude that where a Beneficiary leaves with a positive outcome, it does appear considerable savings are usually made. If these savings were sustained over a number of years, this could add up to many millions of pounds, ultimately well in excess of the costs of the project. Clearly a great deal more work is needed to fully establish that this is the case. However, this analysis does provide a first indication of the potential for ON to deliver system change in its economic dimension.

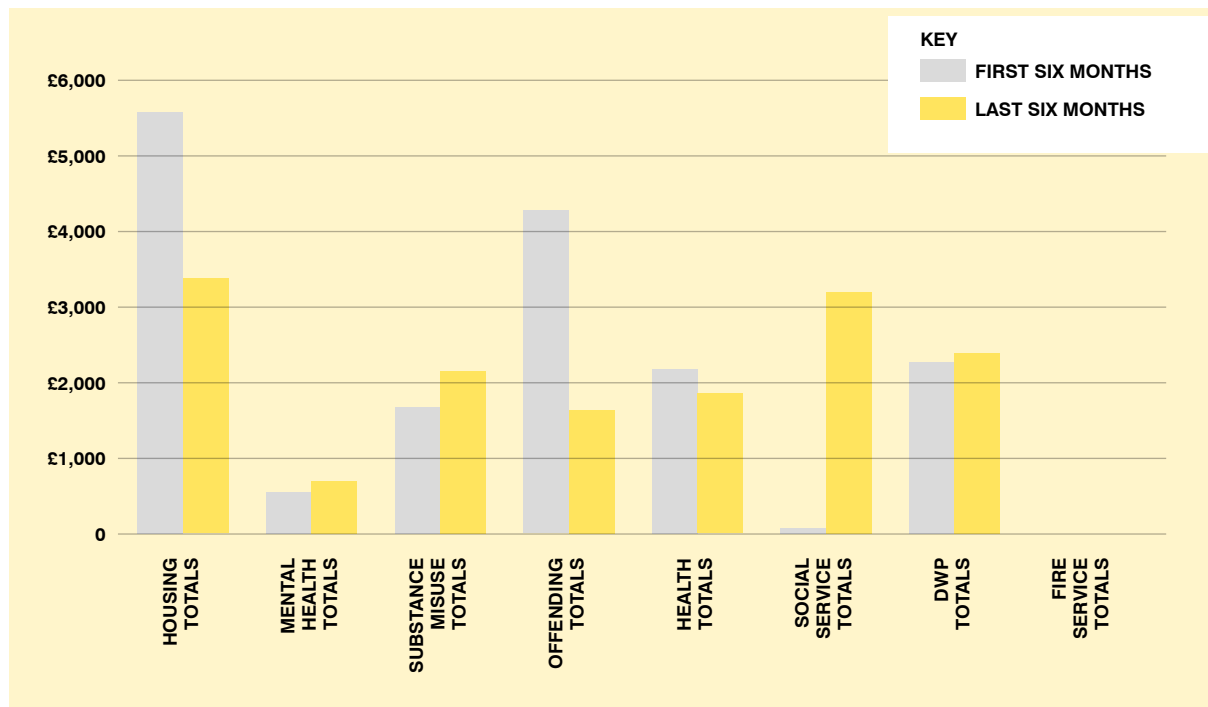
Cost changes using a broader measure

In this third piece of analysis, a different methodology has been applied, using costings from the broader 52-item measure. For this measure, most items are not collected as part of the standard dataset, so a different method of data collection had to be used by examining case notes and logging relevant items. This approach was initially conducted as a pilot to see if enough data could be collected in this way to make it a viable exercise. The main shortcoming of this form of data collection was the variability of PDC notes – some PDCs record more relevant information than others – and the need for consistency is now a focus. Despite this limitation, enough data was collected to enable a judgement to be made about the consumption of each item for costing purposes. However, because collecting data in this way is time consuming, it was not possible to conduct the 52-item data analysis for all Beneficiaries. Instead, a 10% stratified sample was collected by selecting every tenth case in the list of Service User IDs. Data from the first six months of engagement was compared with data for the last six months before disengagement for each Beneficiary. Including only closed cases helps to give the fullest picture of ON's impact at the point where Beneficiaries have completed their engagement journey. For the pilot however, to obtain a reasonably sized sample of 20 cases, if the relevant tenth case was not closed, the nearest Service User ID of a case that was closed was used. However, in future for complete analysis the original chosen case once it is closed will be reviewed. This will enable a truer picture of ON's full economic

impact, as it will include a sample of cases representative of the whole length of the eight years of the project, including cases still open at present where interventions are still therefore occurring.

The below data (Figure 3) shows cost savings broken down by sector.

Figure 3: Average cost per Beneficiary by sector



The chart shows that, as with the 18-item measure, it is in criminal justice where the biggest fall in costs occurs. There are also falls in health and housing costs and this is most likely due to Beneficiaries moving from supported accommodation to their own accommodation or to care homes. Regarding health, there has been a reduction in A&E attendances and hospital in-patient attendances as

Beneficiaries engage better with GPs. There is a relatively small increase in mental health and substance misuse costs and this can be seen as largely positive due to Beneficiaries having better

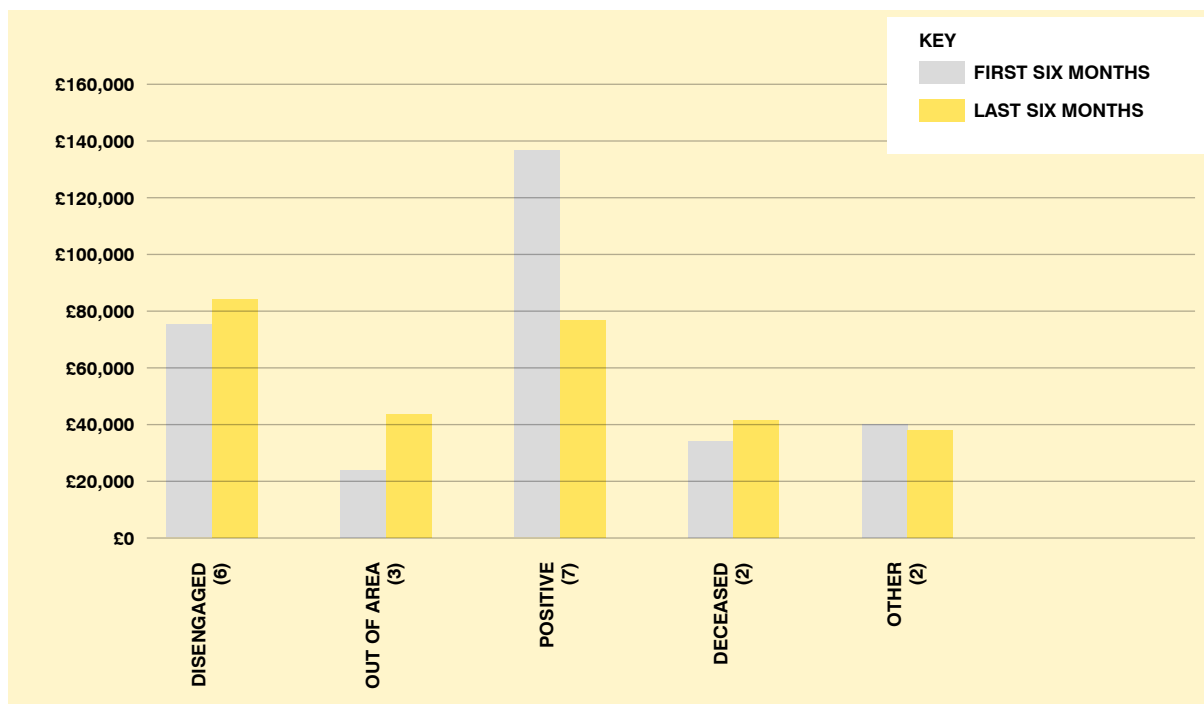
“ The most significant increase is in social care costs. Prior to engagement with ON, virtually no Beneficiaries were in receipt of social care support. ”

engagement with these services. This is something ON actively tries to achieve in most instances. There is very little change in Department for Work and Pensions (DWP) costs and this may be because PDCs are generally able to get Beneficiaries on to their correctly entitled benefits within the first six months of engagement, and so the first six months data will not show any great change.

The most significant increase is in social care costs. Prior to engagement with ON, virtually no Beneficiaries were in receipt of social care support. However, for a small number, obtaining social care intervention has been needed as the only community option available to avoid the severest of consequences. The precise number who will require social care although small has yet to be fully determined, and is part of ongoing work in which ON is engaged around the Care Act 2014. This includes employment of a Social Worker and practice development through the Practice Development Unit (PDU). Despite this being an area of cost increase, further economic analysis could show ON intervention may produce social care savings by reducing the number of Beneficiaries needing social care in the longer term, for instance, through the introduction of Housing First.

The second chart Figure 4 (below), shows how cost savings vary between Beneficiaries according to the outcome of their engagement with ON.

Figure 4: Cost changes by Beneficiary destination



The numbers of Beneficiaries in each outcome category are given in brackets, and care must be taken not to infer too much from such small numbers. However, it is worth noting that the seven Beneficiaries where a positive outcome was achieved were the only ones where cost reductions were achieved. This was not the case for the six Beneficiaries who disengaged. This adds further weight to the conclusion of our analysis of the impact of continued engagement. If ON is to achieve its aims, there should be a focus on increasing the proportion of Beneficiaries leaving with positive outcomes and reducing the proportion who disengage. This should be a priority for both practice development and evaluation, for the remainder of the project.



1.4 Making it happen: the work of the PDCs

In the *Changing lives, changing systems* report, interviews with Beneficiaries highlighted the distinguishing features of the approach adopted by PDCs that were most important in making a difference to their lives.

- Being available at critical moments in the lives of Beneficiaries
- Reaching out to the persistently elusive
- Giving time and space to listen to Beneficiaries' stories
- Being prepared to do what is needed in the interests of recovery
- Showing that you care in meaningful ways
- Standing alongside Beneficiaries as they confront the world of welfare bureaucracy
- Being trustworthy
- Letting Beneficiaries shape their own priorities
- Not giving up on anyone.

These features were then tested in Focus Groups with PDCs, which also went on to explore other issues in the work of PDCs, such as how well their role is understood by other agencies, the challenges they encounter in their work, and what promotes resilience in meeting those challenges.

The PDCs said nothing to dispute the views of Beneficiaries regarding their role, but placed particular emphasis on being available for Beneficiaries, and not giving up on them in the face of set-backs. However, they felt their role lacked clarity in the early days of ON, and it was not well understood by outside agencies, who saw them as support workers rather than coordinators, providing a useful fall-back service at a time when many mainstream services were facing cuts. What gave them strength to manage the emotional demands of PDC work were the support of their Team Leaders, the informal support they gave to each other, workload management that restricted the size of their caseloads, and opportunities for reflection. However, they called for the use of Peer Mentors to undertake more routine support work with Beneficiaries, thereby freeing up their time for more complex work.

The Focus Groups were repeated in 2016 and 2017, with separate groups for those in post at the time of the first Focus Groups in 2015, and those recruited since. By this means, it was hoped to explore how the PDC role has evolved as the project has developed, and whether recent recruits have come with a different perspective on the work. The views of Team Leaders were also gained in separate Focus Groups.



Russell, Personal Development Coordinator

The PDC role and what works

PDCs have become clearer about their role and what is expected of them, as the years have passed by, and this clarity is shared by long-standing PDCs, more recent recruits, and Team Leaders. The role entails a blend of support in building structure into the lives of Beneficiaries, combined with case coordination in brokering access to a range of services. Two enhancements have emerged as the role has evolved. New recruits with specialist training or experience have been assigned to Beneficiaries with particular support needs in, for instance, mental health or drug misuse, and have become a source of advice for other PDCs in those areas. What has also become apparent is the important role PDCs have in promoting

awareness of multiple and complex needs in other services, thereby giving them a role in system change, a point echoed by the Team Leaders.

There is an element of the system change stuff ... in relation to supporting and advocating for those Beneficiaries, to help the services understand our client group a bit better, to try to get them to work a bit better, more flexibly.

Evidence of greater understanding and acceptance of the PDC role among other service providers was mixed. Some still behave as if ON is a housing support service for homeless people, and this conditions their expectations. There is a greater appreciation of the expertise required when supporting those with multiple and complex needs in some quarters, but this contrasts with some continuing resentment in others, something that the long-standing PDCs have experienced.

Some of them are really good and keep you updated, get you involved with everything they are doing. But then you get other individuals where it's a case of well, this is my job; this isn't for you to be doing. They don't update you. I think they really struggle with understanding what we do.

The culture of professional autonomy that prevails in some services still generates resentment at role intrusion where the generic role of PDCs is seen to encroach on fields where specialist expertise has traditionally prevailed. Other participants reported continuing resentment among cash-strapped statutory services towards a generously funded voluntary sector initiative seeking to broker services for its Beneficiaries.

What was believed to work in transforming Beneficiary lives largely echoes the ten keys to effectiveness identified by Beneficiaries. Certain themes came up repeatedly in the focus groups with PDCs, especially those of persistence, commitment and not giving up in the face of repeated set-backs, combined with a willingness to re-engage and give a second chance to Beneficiaries believed to have been lost.

The fact that they are engaging is a massive positive for our team. We will literally try to engage with someone no matter how many times they have missed their appointments. (Long-standing PDCs)

I think it's being persistent with them as well. If they disengage with you for a few weeks, then not giving up, because a lot of other services would have breached them or discharged them, given up on them. But we're like, OK I'll speak to you in a week. They don't get rid of us very easily. (Recently recruited PDCs)

Much importance is attached to being available and flexible in the kinds of support offered, a role more akin to a kind of bounded friendship than a formalised service. This involves building trust through being trustworthy and scrupulously honest.

The Focus Groups gave particular attention to how PDCs motivate their Beneficiaries to pursue avenues of change in their lives, with some discernible differences of emphasis between long-standing and recently recruited PDCs. The former placed a lot of emphasis on positive reinforcement, reminding Beneficiaries of progress made, offsetting this against any experience of failure, and encouraging Beneficiaries to own their goals and expectations.

Start providing that positive reassurance ... So for example if somebody is trying to re-engage with substance misuse services, if you sat with them and get them to make that appointment with them. ... Reiterate the fact that you've done really well making that first step in trying to address the issues. It's that positive reinforcing their goal and making sure they are doing well.

Recently recruited PDCs, along with Team Leaders, concurred with these sentiments, but added a willingness to be assertive if the occasion warranted, and a desire to activate the agency of Beneficiaries by giving a managed level of responsibility.

You do have to be assertive ... We've had these appointments set up and you've missed all of them. So until you go to them nothing will change. Making it very clear, you have to do something, until they realise they are going to get breached ... If you're not going to go then nothing will change. I can't go for you. Me going to this appointment isn't going to help you. You do have to be assertive in that way, analysing the consequences. (Recently recruited PDCs)

What sustains their work

The PDCs were asked what skills and experience they brought to their work. The team reflected the same wide variation in qualifications and experience that was apparent in 2016, but more recently recruited PDCs were more specific about what they believed to be of greatest value. Along with the unconditional listening to which Beneficiaries attach great importance, recently recruited PDCs talked about a knowledge of the system and how to operate it, experience of crisis management and a capacity to juggle priorities, together with a confidence in their instincts to interpret professional boundaries flexibly.

So juggling priorities ... because sometimes a person will take your whole week. Then you've got seven other people chilling in their own chaos that you've got to sort out the week after. It's like preparing for that mentally I guess. I've had so and so all this week so next week is going to be difficult because I've got to catch up on everything else ...

Having an awareness of all the different services in the City as well. A lot of it is linking up and taking people to appointments ...

Having confidence as a worker. Someone might be, 'Well that's how it is', but you are like, 'But that's not quite right' ... Some level of confidence to believe in your own instincts if you think something isn't quite right, and go with it, not brush it under the carpet ...

I think crisis management as well, definitely. You get people ring up who are in a massive crisis and then you've just got to deal with it. I think that's quite difficult.

These are the hall-marks of a maturing project that is learning from accumulated shared experience.

Respondents talked at length about the challenges the work presents, and how resilience is sustained. Each of the PDC Focus Groups raised similar issues. Gaining the trust of an often highly stigmatised group requires patient persistence over long periods, without any expectation of quick results.

It's like trying to be that element of consistency. And like being, ok it didn't work like that this time, let's try it this way. Let them know from the start that it's never a straightforward process. You are never going to walk into a place and we'll sign something and it will all magically fall into place. You have to hack at it and really go at it over time. Then gradually things will start falling into place. (Recently recruited PDCs)

Given the need for flexibility, the defining of boundaries is a regular challenge. Fluctuating moods among Beneficiaries frequently limit what is possible, and there must be limits to toleration in the interests of personal safety. The challenge lies in knowing when to walk away, and in being able to live with the associated sense of failure.

One or two who I work with get quite irate, threaten to do this, that and the other to somebody, tell you quite in graphic details. It takes a while to get used to it. First time I heard it, it was terrible. Second time it was, oh yeah. Third time you go, ok what are you going to do? (Recently recruited PDCs)

Team Leaders also recognised the challenges of sustaining Beneficiary engagement, but for them there was the further need to maintain staff morale. The low rate of staff turnover was evidence that staff morale is high. The long-term PDC group commented on the lack of opportunities for career advancement associated with the role, but the Team Leaders pointed to the developmental opportunities associated with the varied nature of the work and access to further training, which was encouraged.

It [Opportunity Nottingham] opens doors for people to do a variety of things in their professional development, because we have such a wide client group and you can usually draw on an awful lot of experience.

There was also much to promote resilience among PDCs. Both the PDC Focus Groups talked at length about the strong sense of being a team in which members encourage and care for one another and share burdens, as the long-standing PDCs explained.

Everybody works together. It's a great team, it really is. We all back each other up. If we can't find somebody to go out with us, somebody will kind of, if they've got an appointment they will probably make that appointment a little bit later so there are two of us to go out.

They also attach great value to the hands-on approach to management and supervision promoted by the well-informed Team Leaders, with open-door availability and flexible supervision.

And if I can say it, we've got a bloody good management team. If we've got any issues or something, they know us so well, so they know when we come in if we've got issues with something. So we know we can sit and discuss it with them. We can sit and discuss it with colleagues. You know you can get an answer. It's not always the one that you want. But actually that's right.

Team supervision based around the reflective practitioner is a key component. These features were reinforced spontaneously by the Team Leaders themselves when asked about their approach to supervision. They are keen to help PDCs maintain objectivity and to challenge the insecurities that can readily arise from the unpredictability of the work they do.

I think everybody on our team is obviously brilliant to do the job they do. They have their own empathy. I think that insecurity about they are not engaging, not progressing, it's my fault, is borne out of that wanting to help and save people and rescue people. Rather than fear of recriminations from management, we are always very clear, it's not your fault, you're not missing anything ... It's definitely because they want to help so badly.

At a personal level, PDCs talked about the other informal ways they use to safeguard their resilience, especially the ability to compartmentalise their lives, escape from reminders and find ways to distract themselves when away from the work setting. They agreed it's important to accept your limitations and not to be afraid to admit to needing help, for which ready access to external counselling is greatly valued.



1.5 Taking it further: creating opportunities for Beneficiaries

A core aim of ON is to *empower people with multiple and complex needs and to support and enable them to take control of their lives*. Two key points are implicit in this statement and so far, the evaluation has only explored the second by looking at the benefits of engagement and the methods by which PDCs work to transform Beneficiaries' lives. In this chapter, attention turns to the first aim of empowerment. ON has always sought to go beyond simply enabling Beneficiaries to take control of their own lives, challenging though that is; instead, it has strived to find ways to enable Beneficiaries to give something back, to exploit their undoubted gifts and talents to the benefit of each other and the wider community, what in current language is called 'strength-based recovery'.

In the 2016 report, under this overall heading, a chapter is devoted to an account of the use of people with lived experience (not necessarily current Beneficiaries) as Peer Researchers who

have worked alongside the officially appointed programme evaluators in the conduct of the ON evaluation. This work has continued in the years since 2016, most typically in the work with prison leavers described below, and is very much work in progress, especially as peer research moves beyond data gathering to embrace data analysis and presentation. A full account of this work is best left to a future report. Below are two accounts of further initiatives under the broad heading of empowerment: Peer mentoring and the work of the Expert Citizens.

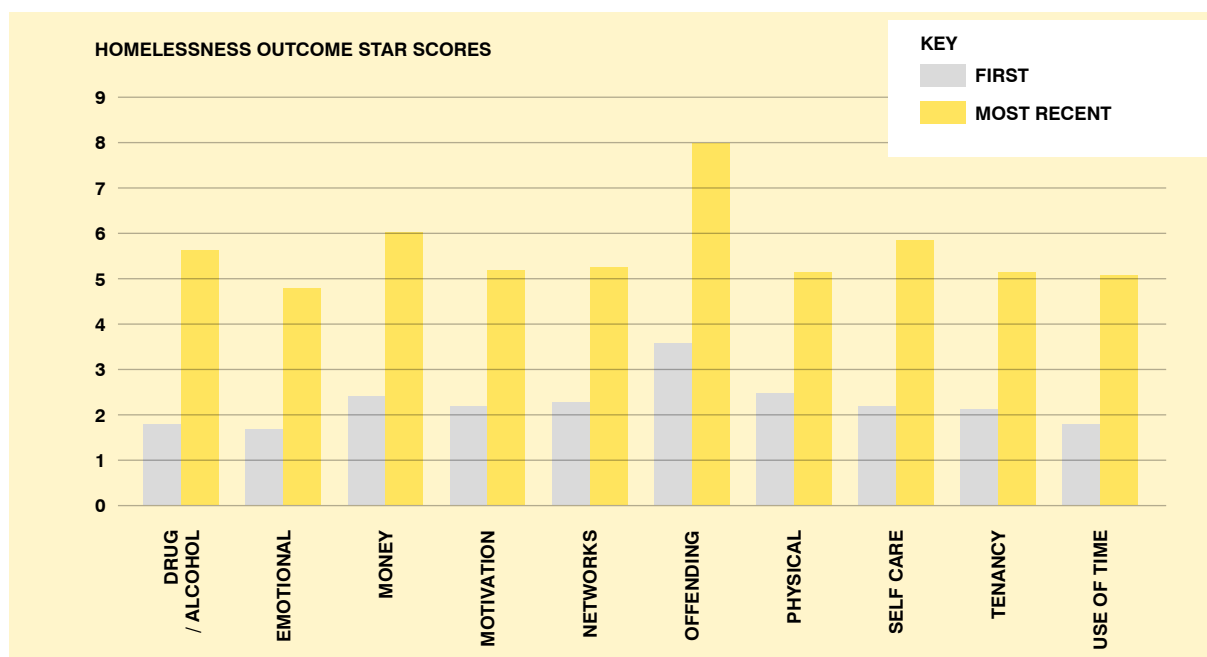
Peer mentoring

Peer mentoring is a support relationship between two people in which someone seeking to manage a challenging experience is supported by someone who has made progress in overcoming it. Peer mentoring is a fairly recent addition to ON’s service portfolio and has involved people with lived experience of multiple and complex needs being carefully matched with Beneficiaries to provide peer support that is additional to support provided by their PDC. The scheme is managed by the Peer Mentor Coordinator.

The scheme was evaluated by a member of the ON Team (Rhianna Walsh) for her Master’s Degree in Social Work at Nottingham Trent University. Rhianna also gained prior experience at ON through a practice placement which generated a valuable level of trust in exploring sensitive issues, especially with Beneficiaries. The evaluation drew on quantitative evidence from an analysis of Outcomes Star data, and qualitative evidence from interviews with the three Beneficiaries with the longest experience of receiving peer mentoring, three Peer Mentors, two PDCs and the Peer Mentor Coordinator.

Figure 5 presents the results of an analysis of Outcomes Star scores for the eight Beneficiaries who had at the time received peer mentoring and compares their first and most recent scores. The chart averages scores for all eight Beneficiaries for each of the ten Outcomes Star indicators. Scores for all ten at least doubled and in some cases trebled, producing an average aggregate increase of roughly 34 (from 22 to 56), comparable with the better Beneficiary achievements during the life of the project. It cannot be said for certain that this is the result of peer mentoring without comparing with the results for a control group of Beneficiaries with similar characteristics and starting points, but it gives an indication of the value of peer mentoring to underpin the qualitative findings.

Figure 5: Outcomes Star scores for recipients of peer mentoring



The interviews were analysed around five themes that encapsulate responses to questions into the motivation and benefits of peer mentoring, the background and characteristics of Beneficiaries and Peer Mentors, and the challenges of peer mentoring.

Positive influences

As one Beneficiary pointed out;

Most people I know are either alcoholics or drug users, you know. This [peer mentoring] is a positive influence. It helps a lot.

As this respondent implied, peer mentoring seems to afford access to more positive social networks, as the Outcomes Star score clearly indicates, but there are other benefits. For another Beneficiary, peer mentoring;

... means additional support, somebody who's there can give a listening ear and some advice, a good influence.

Peer mentoring is also a positive influence on the lives of the Peer Mentors themselves, promoting recovery by mutual aid.

I've got my one [mentee], and it's helping me as much as it's helping him.

Inclusion in the community

Receiving mentoring support plays an important role in combatting social isolation for Beneficiaries, as one explained...

It helped so that I didn't feel isolated as I didn't like going into the community alone. This was a big thing for me, being isolated.

PDCs pointed out that it's much more than this. Peer mentoring is a vehicle for promoting broader community involvement through a range of informal shared activities, once again giving access to a healthier social network.

They [Peer Mentors] take Beneficiaries out, help them to socialise and get active and motivated. Introduce them to things they don't usually do, whether that's because they haven't had the opportunity due to finances or were within the 'wrong crowd'.

The result is improved motivation and better use of time, both of which show considerable improvement in Outcomes Star scores.

Importance of lived experience

The characteristics of a Peer Mentor are also a key factor in its effectiveness. The mentor has to be a 'peer', someone with lived experience, as one Beneficiary insisted.

It does make a big difference ... coz the guy knows what he's talking about then. It's not as though he's just read it out of a book; he has been there himself. It does help a lot.

The Peer Mentor doesn't have to perfectly match the precise pattern of multiple and complex needs experienced by the Beneficiary, but their lived experience complements the professional skills of the PDC, who may or may not have lived experience, providing a level of sharing and identification

not generally possible in the professional context, even offering a role model as a source of encouragement, as one Peer Mentor explained.

You can't sort problems out for them, but you can understand a bit and give a bit of where you've been and that, and if they can see that I've pulled through it ...

Impact of peer mentoring

The impact is evident from the Outcomes Star scores, especially where multiple and complex needs appear to have abated, and this was confirmed by the Beneficiaries.

The last two years with the project has really helped me improve my life basically coz I've not had a drink now for nearly 17 months, so yeah I'm really proud with myself.

Impact is further reflected in improved self-esteem and better engagement with a range of support services. But Beneficiaries are not the only parties to benefit from peer mentoring; the Peer Mentors themselves gain enormously in giving them a sense of purpose.

Mentoring has been a massive thing to me. It has helped me, it has given me a purpose, something to do.

However, this carries a risk, recognising that Peer Mentors are recruited precisely because of their recent history of complex needs. Beneficiaries are as likely to disengage from Peer Mentors as from PDCs, and the effect can be seriously discouraging.

Boundaries

The other main area of risk is in defining the limits of mentoring relationships. The Peer Mentor Coordinator picked up the dilemma that this presents to Peer Mentors in where to draw the line between friendship and professionalism.

I think eventually there could be grey areas, say if they become more like friends but then to keep professional boundaries and the relationship going, I can see why it's quite tough for the volunteers.

On the one hand, as the Peer Mentor Coordinator went on to explain, it was important *"to remind them [Peer Mentors] that it is a professional relationship and keep the boundaries"*, but on the other hand, what were they to do when they encounter a Beneficiary who declares that *"I wanted a friend, which is what I found within my mentor. I love her to bits!"*?

One way in which the scheme has resolved the issue of boundaries is in developing a set of strict protocols governing mentoring practice, including signing in for each mentoring session, documenting the location and time of the meeting, and collecting money and a mobile phone.

Peer Mentors are to phone into the office when they are with a Beneficiary which is then recorded for safeguarding purposes. Which Beneficiaries are put forward for mentoring is dependent on several factors, including who is felt to be ready to work with. Providing Peer

“ Peer mentoring is a vehicle for promoting broader community involvement through a range of informal shared activities, once again giving access to a healthier social network. ”

Mentors with mobile phones allows them to uphold the lone working policy to keep them safe. Mentors are required to bring receipts and change back from activities in which they participate, to ensure nobody is financially exploited. It would be considered unprofessional and crossing boundaries if Peer Mentors or mentees paid with their personal money for one another. Moreover, since Peer Mentors are in recovery themselves, it is important for the scheme to work within their

“ The overall conclusion from this early review of the operation of peer mentoring at ON is undeniably positive. ”

physical and emotional limits in terms of the volume and nature of work undertaken. However, one recommendation that emerges from this research is to extend this protocol into a written contractual agreement between Peer Mentors and the wider ON project.

The overall conclusion from this early review of the operation of peer mentoring at ON is undeniably positive. There are obvious limits to the generalisability of such a small piece

of research, even within a single project, but the richness of the data has provided a sound starting point. What it shows is that, in addition to the more formal role of PDCs, the informal treatment setting of the mentoring relationship can play a crucial part in improving Beneficiaries' wellbeing, reducing relapse and combatting social isolation. This can in turn decrease work load pressure for frontline workers and even assist with transitioning individuals into employment.

Expert Citizens and Beneficiary Ambassadors

The Expert Citizen Group (ECG)

Expert Citizens are a group of Beneficiaries who have made progress on the ON project, to a point where they are able to come together to inform and support its development and help to ensure that the voice of lived experience is an integral part of system change. As of September 2018, 21 Beneficiaries have become members of the Expert Citizen Group (ECG), with a further nine ready to join the group once induction has been completed.



ON Expert Citizens and Beneficiary Ambassadors

To gain understanding of the role of the ECG and the impact it is having both in relation to system change

and in benefitting the Expert Citizens themselves, the Evaluation Team conducted a Focus Group with them. Additionally, Beneficiary Ambassadors were interviewed, and information was compiled about the activities of the Expert Citizens in the past year (July 2017 to June 2018).

To support the development of the project and contribute to system change, Expert Citizens participated in the following tasks:

- Contributing to ON policy and practice development both locally and nationally
- Contributing to ON commissioning, such as tender requirements
- Informing the direction of the project, both delivery and system change

- Participating in and contributing to communications content including films and events
- Supporting training initiatives
- Recruiting ON staff.

Beneficiary Ambassadors

Beneficiary Ambassadors are ON staff with relevant lived experience of the issues that comprise multiple and complex needs. The biggest part of their role is to support Expert Citizens and develop the ECG. Beneficiaries are 'nominated' to join the ECG by their PDCs following discussion with the Beneficiary and Beneficiary Ambassadors. Beneficiary Ambassadors will then provide an induction for each new Expert Citizen, involving both collective activity and individual support and encouragement.

“ The role of an Expert Citizen can be emotionally challenging. Experts Citizens are in demand; policy-makers, commissioners and providers all want to hear their views. ”

The role of an Expert Citizen can be emotionally challenging. Experts Citizens are in demand; policy-makers, commissioners and providers all want to hear their views. However, this can create tensions. Expert Citizens often still feel that the system is at best unhelpful and at worst hostile. To then be asked about it by those who commission and provide the system can stir strong feelings, even anger, built up over many years. Beneficiary Ambassadors play a key role in managing this tension, enabling views to be expressed, but managing it, so that input remains constructive.



Lee, ON Beneficiary Ambassador

Not all Expert Citizens actively participate in the ECG at the same time. ON works with people who are often at the early stages of recovery, and in many cases have periods of time where all or some of their multiple and complex needs may return. Interruption to participation due to relapse will therefore often occur. In ordinary circumstances, the lack of continuity this creates could cause the group to fold, but the support provided by the Beneficiary Ambassadors is crucial in enabling momentum to be maintained. No one is excluded; Expert Citizens can return to the group when they feel ready to do so. The Beneficiary Ambassadors support Expert Citizens through this process, helping to ensure they do not become overloaded before they are ready to take on more challenging tasks which can

be stressful. But equally, the Beneficiary Ambassadors ensure that those Expert Citizens who are able to take on more challenging tasks can do so, and therefore help to prevent boredom which is something many Expert Citizens desperately try to avoid.

The skills, resilience and tenacity of the Beneficiary Ambassadors in supporting the group should not therefore be underestimated. Many of the Expert Citizens would not normally be considered ready or able to participate in involvement and co-productive activities. Whilst ON's approach of not excluding anyone is an admirable aspiration, making it happen can be very challenging. The

Beneficiary Ambassador role can itself be emotionally demanding. As with anyone who works with people who have faced trauma, the availability of reflective practice is something the Beneficiary Ambassadors find important, as well as the mutually supportive team ethos they have developed.

Expert Citizen Group activities

There is no doubt the ECG has been one of the most successful parts of the ON project to date. However, it is difficult to measure the exact extent of the group's impact, particularly as it is part of the system change agenda, which itself is an ongoing process that has not yet been fully evaluated. What follows exemplifies the range of activities in which Expert Citizens have been involved. Starting with their national collaboration as part of the National Expert Citizens Group, moving on to illustrate the workshops in which they have participated and even helped to deliver, the training they have received and further activities that have helped to raise awareness of multiple needs. This indicative list provides evidence of the kind of impact the Expert Citizens are having. The wide range and scale of the activities also help to show the key role played by the Beneficiary Ambassadors in enabling these events to take place and ensuring meaningful Expert Citizen participation in them.

“ There is no doubt the ECG has been one of the most successful parts of the ON project to date. ”

The Expert Citizens have frequently engaged with their peers from the other Fulfilling Lives projects as part of a National Expert Citizens Group (NECG) coordinated by CFE (this contract is currently out to tender) in order to provide a 'user voice' on multiple and complex needs targeted at national policy-makers on, for instance, drug strategy and responses to New Psychoactive Substances (NPS).

Meanwhile, at a local level, they have taken part in workshops to discuss or provide training on;

- Service user involvement for university students
- The ON Communications Strategy
- Women and multiple needs
- Long-term rough sleeping in Nottingham
- Trauma-informed care
- Overdose awareness.

They have also received training on;

- Effective story telling and talking to the media
- Peer Research
- Becoming a Peer Mentor
- Theatre therapy (via Nottingham Playhouse).

They have participated in awareness raising work around multiple and complex needs through;

- A ON short film about stigma
- A Notts TV short film about stigma

- Homeless Link research on homeless couples
- Neon research into mental health challenges
- Community of practice on service user involvement.

This final list has taken the Expert Citizens into the realm of influencing system change through;

- Scoring rough sleeping service tenders
- Contributing to the Institute of Mental Health Consultation on Police Custody
- Meeting the DWP to develop the use of the 'Facts About Me' (FAME) form
- Working with Nottingham Women's Centre on system change issues
- Working with Notts Healthcare Trust to develop trauma-informed approaches to mental health care
- Influencing Framework (ON lead partner) policy on use of mixed hostels
- Recruiting PDCs and a Team Leader to the ON Team.

The following brief evaluation captures some of the thoughts of Expert Citizens expressed in a Focus Group.

Benefits of the Expert Citizen Group (ECG)

The ECG allows members to get involved in various activities in which they would not have been able to participate elsewhere. The group has evolved, linking members to other things and providing a gateway to new opportunities.

Although the Beneficiary Ambassadors did not intend the ECG to become a peer support group, it has almost inevitably taken on this role. Focus Group participants concurred with this.

You see people differently; they will be enjoying themselves and they do not have to discuss their personal life as there is a level of understanding between the group of each other's issues, as they have been through similar obstacles in life.

It is good for individuals to open up to others who understand their situation. They feel safe with the Beneficiary Ambassador Team as they provide support to the group, and they feel as though they are never left alone in a problematic situation.

Members are also able to join in with different things such as Peer Research or drama workshops. As there is such a variety of activities, the Expert Citizens can organise their time, which is highly beneficial as some believe that keeping busy helps with isolation and their anxiety. Some group members agreed that they feel the group is holistic as it helps sustain the mind, body and soul. This is particularly valuable where personal circumstances are difficult, such as trying to recover from substance dependency whilst living in a hostel and surrounded by active users. As one Expert Citizen stated,

I feel like I am human again, the group is an escape from the chaos.

Impact of the Expert Citizen Group (ECG)

Through the group, Expert Citizens feel as though their opinion is being heard. The ECG provides the opportunity to see how services work and gives members a chance to share their own knowledge to help improve these services, for example, through the Facts About Me (FAME) form (see Appendices iii). The group has enabled them to acquire a platform from which wider audiences can hear their voices, a good example is through appearing on Notts TV to talk about the impact of stigma.

There is awareness of system change, although acknowledgement that it isn't necessarily an easy concept to grasp and can sound like 'jargon'. For Expert Citizens, many years' experience of feeling failed by a system that is supposed to help them can lead to understandable cynicism and distrust. One participant stated that;

There are many barriers towards system change ... You can seem to be making progress but then it gets knocked back. The key is perseverance.

In this context another Expert Citizen quite reasonably summed up the feeling of the group when they said, "we can help as long as the systems want to change".

The ECG is very active in Practice Development Unit (PDU) events, where they facilitate training on subjects such as engaging Beneficiaries (service users). The group is also engaged in various activities which promote change and have an impact on different services, for example, a consultation in which they shared their experiences of the treatment of people with mental ill health in police custody, giving feedback on how it could be improved. The DWP also asked for their advice regarding the benefits system and Jobcentres, as a result of which the DWP has become keen to implement the Facts About Me (FAME) form. The group has further influenced the local housing strategy, Crisis, Groundswell, Nottingham City Hospital and the National Drug and Alcohol Strategy. Closer to home, Expert Citizens are aware of their impact on the project, and that their voices are heard when ON makes changes to its working practices. They also value their role in interviewing potential PDCs who will be working with Beneficiaries.

The Expert Citizens are happy for the group to be led by the Beneficiary Ambassadors, as they feel this does not stop them as Expert Citizens having ownership of the group and controlling its direction. The role of Beneficiary Ambassadors in steering the group and providing information on upcoming events is recognised as very useful. There was recognition that;

Without the Beneficiary Ambassadors it would be chaos ... They take people aside if they aren't feeling well and they are always there to support the group.

The future of the Expert Citizen Group (ECG)

Although the Expert Citizens believe that they are having an impact, they feel that in certain cases their contribution can be tokenistic. There is sometimes a sense that they are invited to events, for example consultations, as a 'requirement' and their opinions are not being heard entirely. One Expert Citizen noted that a Nottingham City based service had put The Pledge up in their accommodation, but because the correct processes to authorise this were not followed, it was taken down. (It was subsequently displayed again some time later).

However, the Expert Citizens recognise that they are influencing change within ON and the system, but comment that they don't always get to see the results of their work, and more feedback would be welcomed.

The Focus Group with the ECG resulted in various suggestions as to how the group might operate even more effectively;

- An Expert Citizen and a Beneficiary Ambassador could review the agenda of meetings they attend beforehand, and agree the items so that the Expert Citizens are prepared, especially where there are likely to be requests for input at short or no notice
- In order to involve group members even more, different Expert Citizens could take it in turns to run the group, which would boost confidence
- Some participants said they would like to have more control over the topics discussed by the group, as sometimes it can feel as though they are repeating similar conversations
- The more established Expert Citizens could help to support new members of the group, but to do this they felt they would need more training. This could include how to chair the group and practical ways to support new group members, which would also develop their own skills and confidence.



1.6 Making it inclusive: engaging with BME Beneficiaries

With increasing evidence of patterns of engagement, efforts have been pursued to increase engagement among Beneficiaries with characteristics under-represented in the overall Beneficiary population. Work with BME communities affords a good example. What follows summarises research from two sources. The first is work reported elsewhere⁸ that was undertaken between November 2016 and January 2017 as part of the National Evaluation of the Fulfilling Lives Programme, in which one of the ON Beneficiary Ambassadors and a member of the National Expert Citizens Group (NECG), was involved, and which draws on evidence from Nottingham. The second is work undertaken during summer 2018 by the ON Evaluation and Learning Team.

The NECG research was undertaken by members of the NECG acting as Peer Researchers, with support from CFE Research. Both pieces of research sought to understand why people with complex needs from BME communities are hard to engage, and what works in trying to address this problem. However, the ON researchers had a particular interest in the effectiveness of the AWAAZ⁹ project in Nottingham in reaching and working with people from BME communities who experience complex needs, as they have been commissioned for this purpose by ON.

The NECG researchers drew evidence from ten of the Fulfilling Lives local projects, with a particular focus on work in WY-FI (West Yorkshire), ON (Nottingham), Waves of Hope (Liverpool) and Inspiring Change Manchester. They designed, undertook and analysed interviews with key informants from local projects and drew further evidence from a wider group of NECG members who have lived experience of multiple and complex needs. The ON researchers drew their evidence from AWAAZ's own monitoring data, interviews with staff at AWAAZ and with AWAAZ Beneficiaries, and observations from a day spent shadowing an AWAAZ employee.

The prevalence of multiple and complex needs in BME communities

The NECG researchers began by noting the level of under-representation of BME Beneficiaries compared with BME representation in wider local populations around the country. Of the 12 Fulfilling Lives local projects, only one (Golden Key Bristol) recorded an over-representation of

⁸ National Expert Citizens Group (2017), Engaging Ethnic Minorities with Multiple Needs, Leicester: CFE Research. Available at <http://mcnevaluation.co.uk/wpfb-file/2017-engaging-ethnic-minorities-with-multiple-needs-final-pdf/>

⁹ <http://www.awaaznottingham.org.uk>

“ A high degree of stigma is sometimes experienced by individuals with multiple and complex needs from others in their own communities. There is a fear of being identified as having multiple and complex needs, and if this becomes known in the community then it could bring shame to the individual. ”

BME Beneficiaries, though in six localities the under-representation was less than 5%. It was at its highest where BME proportions in the wider population were highest, such as Lambeth where the BME population was 57%, but BME Beneficiaries only amounted to 33% of the Beneficiary cohort. At the time in Nottingham, when the BME population was 32%, BME Beneficiaries only made up 19%. However, as we have seen from more recent figures, that gap has closed significantly, with BME Beneficiaries now making up 28%, compared with 35% BME in the wider population.

The limitation of these data sources is their tendency to treat the BME population as a single community, whereas anecdotal evidence reveals wide variation in the prevalence of multiple and complex needs in different BME communities. For instance, the *Hard Edges Report*¹⁰ found that, of the population in England with the three co-occurring needs – offending, homelessness and substance misuse – 15% are from BME groups, which is broadly similar to the proportion found in the whole working age population. However, Black African Caribbean people are overrepresented in the multiple and complex needs population and Asian people are underrepresented, comprising only 4% of the multiple and complex needs group, but 8.2% of the overall working age population. Moreover, the National Fulfilling Lives Programme dataset, built from data returned from all 12 local projects, shows even greater differences from the national population than the Hard Edges report, with Asian groups making up only 1.8% of project Beneficiaries, despite most of the projects being in areas with large Asian populations.

Table 12: Distribution of ethnic groups in different populations (%)

ETHNICITY	WORKING AGE POPULATION	COMPLEX NEEDS (HARD EDGES REPORT)	NATIONAL NEEDS (FULFILLING LIVES DATA)
White	85.6	85	88.5
Asian	8.1	4	1.8
Black	3.4	6	4.6
Mixed Ethnicity	1.8	3	4.4

The first task of the NECG researchers was to understand the reasons for low levels of BME engagement, not just within the Fulfilling Lives Programme, but within support services more generally. The research identified three kinds of barriers: barriers in the BME communities themselves; institutionalised barriers from the way support services operate; and practical barriers in securing access.

Barriers arise in BME communities from a lack of trust in services. There are at least three aspects to this mistrust;

¹⁰ Bramley G., Fitzpatrick S., Edwards J., Ford D., Johnsen S., Sosenko F. and Watkins D. (2015), *Hard Edges: Mapping severe and multiple disadvantage*, Lankelly Chase Foundation, available at <https://lankellychase.org.uk/wp-content/uploads/2015/07/Hard-Edges-Mapping-SMD-2015.pdf>

- First, there is the fear among BME communities that they will not be understood or accepted because of culturally based characteristics. This relates to concerns about what might happen if a service is accessed, most prevalent in relation to mental health... “you will be sectioned and they will treat you badly.” Fear can be based on real negative experiences by an individual when accessing services which are then reported across community networks.
- A high degree of stigma is sometimes experienced by individuals with multiple and complex needs from others in their own communities. There is a fear of being identified as having multiple and complex needs, and if this becomes known in the community then it could bring shame to the individual. As a result, multiple and complex needs are not openly discussed and this can lead to a reluctance to acknowledge them. This then further leads to a lack of role models to whom individuals can look up to, particularly in the context of those who have recovered or survived such needs.
- Language can be a barrier arising not just among non-native speakers, but also with English speakers unfamiliar with the terminology used around multiple and complex needs. Stereotyping can be heightened by use of inappropriate language and remarks and judgements that may cause offence from poorly trained staff in agencies.

A number of institutional barriers were also identified. Where Fulfilling Lives projects are reliant on referrals from organisations where BME clients are already under-represented, then that under-representation will only be magnified. Under-representation can be cumulatively reinforcing where, as we have seen, there is a perceived lack of role models among existing Beneficiaries and staff. However, in addition, there is a perceived lack of cultural sensitivity and respect towards BME communities that is essential to fostering trust. Practical obstacles to engagement were more prevalent among immigrant communities who may lack recourse to public funds.

Engaging with BME communities: the NECG findings

The NECG researchers then moved on to investigating what makes for successful engagement with BME communities, and encouraging those with multiple and complex needs to engage with Fulfilling Lives projects. Just as lack of trust was identified as the primary barrier, so methods that promote trust were discovered to be the most successful. This involves firstly forming strong relationships with BME communities and their representative organisations, and secondly creating pathways that can facilitate access to local projects for individuals from those communities. Roles known as ‘community-based assets’- including BME Champions, Outreach Workers, BME ‘Experts’ in multiple and complex needs – are important in this approach.

These core ideas were further developed in a list of recommendations. They begin with measures to improve the ethnic mix of local projects, with improved BME representation among Board Members, staff, Beneficiaries and volunteers, with all stakeholders receiving appropriate training in issues to do with equality and diversity, and what is called ‘cultural competency’. Outreach and awareness raising (concerning multiple and complex needs) among BME communities and relevant services is also important. Attention needs to be given to language needs through use of interpreters and terminology more commonly recognised among BME communities. Lastly, thought should be given

“ Thought should be given to designating responsibility for engaging with BME communities into the hands of either a BME ‘Champion’ or a commissioned agency from within the BME community. ”

to designating responsibility for engaging with BME communities into the hands of either a BME ‘Champion’ or a commissioned agency from within the BME community.

Four initiatives from local Fulfilling Lives projects were cited as evidence of successful engagement with BME communities. The WY-FI project in West Yorkshire makes heavy use of the BME Champions idea, with a BME Engagement Worker and BME volunteers with lived experience. At Liverpool Waves of Hope, the emphasis is on the use of a culturally specific Outreach Worker who frequents facilities and events specific to BME communities. In Manchester, the main approach is a BME lived experience panel of Beneficiaries who act as role models.

Engaging with BME communities: the AWAAZ findings from Nottingham

The fourth local initiative is the AWAAZ project in Nottingham, which has been further evaluated by ON researchers. AWAAZ is a Nottingham based charity, whose primary role has been to provide mental health support for people from BME communities. Over the years, AWAAZ has put considerable effort into providing information about mental health, building trust and a positive reputation amongst BME communities, as well as informing commissioners and partner agencies about BME mental health issues. The charity has been operating for over 20 years, and has been using a particular approach called Assertive Community Outreach since July 2015.

How successful has AWAAZ been in engaging under-represented BME groups in the multiple and complex needs population? In Nottingham, the Asian population is 15% of the total population, whilst Black African Caribbean people comprise 7%, but Asian people comprise only 4% of ON Beneficiaries. Table 13 shows the ethnicity of Beneficiaries AWAAZ has supported as part of its ON contract.

Table 13: AWAAZ Beneficiaries by ethnic group

	NUMBER OF BENEFICIARIES	%
Black: British, African, Caribbean	33	42
Asian	26	33
White Other	4	5
Other	2	3
Mixed Ethnicity/Dual Heritage	14	18

It shows that AWAAZ has been able to successfully reach people from BME groups in Nottingham, and includes a number of people from Asian communities that is more proportionate to their numbers in the wider population than is the case with the ON Beneficiary population. If the Beneficiaries whom AWAAZ have engaged with are added to those who have engaged with the main ON delivery team, this brings the overall proportion of Beneficiaries from all BME communities to 29% of all ON Beneficiaries. However, when a breakdown of gender by ethnicity was carried out, it was observed that whilst overall 30% of AWAAZ Beneficiaries were women, only three (12%) of the Asian Beneficiaries were women. So it’s possible that, whilst better at reaching Asian men, even a culturally specific service was experiencing challenges in reaching Asian women.

Gaining support from BME communities has been central to underpinning AWAAZ’s work. This can be a lengthy process because communities may not initially be open about the issues AWAAZ works on, such as mental health or substance misuse. To overcome this, AWAAZ has spent a long time building links and rapport with BME communities and raising awareness mainly about mental health but other issues too, such as homelessness and substance misuse. AWAAZ also works on issues which might more readily resonate in specific BME communities, such as raising awareness

about diabetes. This has helped AWAAZ to capture an audience and build rapport within the community so that people feel comfortable opening up to AWAAZ about other issues such as mental health which may be more stigmatised.

AWAAZ needs to work across many communities. Nottingham City has a very diverse population and it is difficult to represent all communities within AWAAZ's workforce. Therefore, the Assertive Outreach Workers take it upon themselves to learn about different cultures within Nottingham, so they can be sensitive to how this might affect engagement with an individual. The diversity of the staff at AWAAZ helps develop inclusivity across the whole project. Each worker is able to utilise their experiences and ethnic backgrounds and share learning amongst the team on a regular basis.

AWAAZ is also aware of barriers that individuals face within the communities with whom they work. For example, there can be stigma surrounding issues with mental ill health within some BME communities. The word 'depression' is more acceptable in some instances, so AWAAZ may use this term rather than mental ill health to increase the likelihood that the individual will talk about their mental health. However, there is also a recognition that some individuals may be confused by what is asked, so the worker will ask questions such as what type of medication is being taken or whether they see a doctor other than their GP and if so where they are based. This allows AWAAZ to receive a fuller picture of an individual's actual needs, things that may have been missed, unless a worker was aware of the barrier.

AWAAZ consider the term 'multiple and complex needs' to be unhelpful in engaging with people from BME communities. Interviewing AWAAZ staff, Beneficiaries and a Community Supporter confirmed that the term can create a barrier as it is not used and so not understood, possibly alienating people from the issues with which AWAAZ is concerned. A Support Worker from AWAAZ stated that the term (multiple and complex needs) itself is also "euro-centric" and can therefore hinder or obscure meaningful understanding for communities. This worker went on to state that;

When networking or engaging with Beneficiaries, I provide clear information as to what this phrase 'multiple and complex needs' collectively means.

In mainstream commissioning and service delivery, services are primarily based around single needs e.g. mental ill health, substance misuse, homelessness and offending. Consequently, an agency can tend to see a set of care needs first and the person second. By contrast when considering an individual and how they might best work with that person, AWAAZ does not base their assessment principally on these defined category needs, but instead gives primacy to the 'whole person', considering their wider health and wellbeing, and letting the person lead on what issues concern them. Whilst it is a method by which mental health and housing needs will be addressed, it can also lead to greater emphasis on physical health issues, acknowledging the

“ AWAAZ consider the term 'multiple and complex needs' to be unhelpful in engaging with people from BME communities. Interviewing AWAAZ staff, Beneficiaries and a Community Supporter confirmed that the term can create a barrier as it is not used and so not understood, possibly alienating people from the issues with which AWAAZ is concerned.”

link between mental and physical health. This approach resonates with strength or asset-based approaches. Such approaches are gaining ground more widely across all agencies who work with people who have multiple and complex needs, but may be particularly relevant for people from BME communities.

AWAAZ will often, with an individual's permission, work with the families of their Beneficiaries as well as the Beneficiary themselves. This can enable the family to better understand the issues the person faces and so help to support them. There is always emphasis on support networks, which will often be the family and community, which in turn can aid recovery.

People from BME communities experience frequent racism. This takes many forms, but one form of racism that is particularly relevant in relation to services they may encounter is the concept of 'institutional racism'. Both staff and Beneficiaries interviewed at AWAAZ have experience of this form of racism. They consider it important not only to understand that this form of discrimination is wrong, but also what it feels like to be a victim. To provide an antidote to this experience, AWAAZ focuses on provision of a safe space where Beneficiaries know staff will understand issues relating to their ethnicity, allowing time for trust to be built. As an AWAAZ Community Outreach Worker pointed out;

AWAAZ understands the voices of those who have experienced institutional racism, health inequality and oppression. It understands the impact of marginalisation, and stigma/ barriers people with multiple and complex needs experience. AWAAZ therefore provides a safe, trusting environment where Beneficiaries feel accepted; not judged or criticised.

“ AWAAZ’s strengths-based approach is successful as a method of working with people from BME communities. The focus on creating a safe space where Beneficiaries know that issues relating to their ethnicity will be understood is a key part of this approach. ”



Angela Kandola. AWAAZ Executive Director

In conclusion, AWAAZ’s strengths-based approach is successful as a method of working with people from BME communities. The focus on creating a safe space where Beneficiaries know that issues relating to their ethnicity will be understood is a key part of this approach. Giving primacy to aspirations and concerns first and seeing the whole person rather than seeing a set of ‘needs to be met’ is a model of working that is gaining traction across all services working with people who have multiple and complex needs. For people from BME communities, however, it is particularly relevant, given the additional barriers they face, and the way wellbeing is perceived culturally.

“ I feel empowered. I feel like I’m living. And I feel proud of what I have achieved so far.”

Sara Opportunity Nottingham Expert Citizen



Part II: The system challenge

In addition to reviewing ON's direct work with Beneficiaries, the 2016 *Changing lives, changing systems* report devoted a chapter to the project's third aim, *delivering change at strategic and commissioning level by working with strategic leaders and using the learning, outcomes and impacts of the programme to change the system's 'DNA'*. In other words... delivering system change. The report summarised early evidence from Beneficiaries and key informants around the pursuit of the six objectives identified in the system change plan. It mainly revealed the barriers associated with service accessibility, information sharing, the pressures experienced by frontline staff in services suffering severe budgetary constraints, and the structural disincentives towards inter-agency cooperation.

“ Since 2016, ON has continued to devote energy and resources towards achieving system change. ”

Since 2016, ON has continued to devote energy and resources towards achieving system change, and this report has appropriately devoted an entire section to this aspect of the projects endeavours. The first chapter relates to the narrative around the evolving system change plan, and this is followed by evidence of the pursuit of one key objective;

inter-agency collaboration. What follows is a recognition that success in system change must be seen less in the work of ON, and more in the transformation of the system itself, especially those parts most relevant to the complex needs that are the project's primary concern – homelessness, offending, mental health issues and substance misuse. In giving each issue separate treatment, it is acknowledged that this contradicts with a key principle of the Fulfilling Lives Programme, namely to treat people holistically, rather than as an accumulated bundle of separate needs. However, justification is made through evidence that shows experiencing any one of these needs acutely or persistently seriously hampers progress for Beneficiaries on the project. The evidence is explored, sometimes drawing on sources outside of the internal evaluation work, and remedies suggested.



2.1 The evolving system change plan

The first ON system change plan contained six change priorities with a total of 64 actions. Progress against these up to the end of 2017 is summarised in Table 14 below.

Table 14: Progress with system change priorities

CHANGE PRIORITIES	TOTAL ACTIONS	COMPLETED	PARTLY COMPLETED	NOT COMPLETED	PROGRESS OVERVIEW
Access to services	12	1	7	4	Limited progress
Unified single assessment and data sharing	7	0	3	4	Very limited progress
Beneficiary-led person-centred services and support, including treatment	19	8	9	1	Moderate progress
A joined-up pathway	7	1	5	1	Limited progress
Recovery	9	4	3	1	Good progress
Sustainability – commissioning, funding and policy	10	2	7	1	Good progress
Total actions	64	16	34	12	

The data in Table 14 shows that overall good progress was made in achieving the actions agreed in the first plan, with only 12 actions not completed. However, almost half the actions were only partly completed, though some are no longer relevant due to changing local and national context. Moreover, the review took account of the impact of austerity measures, which in all likelihood impeded progress. The tendency in times of diminished resources is to restrict access to services and make navigation harder. This has a disproportionate effect on people with multiple and complex needs who already struggle with the system. All those responsible for implementing the revised system change plan will need to work with greater diligence to overcome this tendency.

Of the outstanding actions, very limited progress has been made in relation to *Change priority one: access to services*, although the development of the Wellbeing Hub had the biggest positive impact in relation to opening up access. There has also been an increase in using lived experience to initiate change, though it is widely acknowledged that much more needs to be done in this area. Outstanding areas included *'training for all staff in frontline services to challenge complacency and defensiveness'* and *'reviewing and revising restrictive referral practices'*. Better implementation of The Pledge and Facts about Me (FAME) form, could act as a lever to achieve change here, because full implementation of these will require not just change on the surface at the frontline, but also organisational and cultural change.

For *Change priority two: single assessment and data sharing*, very limited progress has been made. This is because agencies are unwilling to give up their own management information systems or add a further system on top of their own. It is unlikely that this can be overcome and so a non-technical approach should be considered going forward, such as the Golden Ticket (data passport) approach developed by another Fulfilling Lives project, Voices of Stoke.

Much of *Change priority three: Beneficiary-led person-centred services and support, including treatment*, relates to actively implementing The Pledge, including the necessary infrastructure changes. ON will need to step up implementation of The Pledge before good progress can be made in this area.

There has been good progress with the action, *'Actively contribute to the most relevant needs assessments and commissioning reviews of the City Council, CCG and CDP'*. Remaining outstanding however is *'working with Beneficiaries and partners to design and develop a set of*

principles that enable Beneficiaries to move seamlessly between elements of the pathway’.

Change priority five: recovery had the greatest level of achievement and so the review concluded it would not need to be re-prioritised for the reviewed system change plan.

Good progress has also been made with *Change priority six: sustainability – commissioning, funding and policy*. However, because this area has such significance in terms of influencing other areas and in terms of legacy too, the gains made can be used as a platform for further action, such as developing collaborative commissioning and working with the other Fulfilling Lives projects to achieve change at national level.

Two further omissions from the original plan should also be noted. The first was a lack of SMART aims (i.e. omitting the ‘who’s, ‘what’s, ‘when’s and ‘how’s) which contributed to implementation challenges. Secondly, there are several key change agents that have become prominent nationally since the plan was developed. It is therefore understandable that they were omitted, but such is their significance that consideration has been given to their inclusion in the revised plan. These are principally the development of trauma informed care and psychologically informed environments, Housing First and strengths-based approaches. ON is now working on all of these initiatives.

The revised (2018) system change plan acknowledges some of the significant achievements so far that have contributed to system change. These include; influencing commissioning and strategic development, setting up the Practice Development Unit (PDU), developing The Pledge and Facts about Me (FAME) form, and increasing the Beneficiary voice in decision making about the system. The revised plan also addresses the weaknesses in the original plan and takes account of the changing national context. The priority areas in the revised 2018 system change plan therefore are;

- **The system works as one** – focusing on better integrated working across the system at both operational and strategic level
- **Services are welcoming** – through better understanding of people with multiple and complex needs and increased use of psychological tools, so all services in whatever sector they are situated, become welcoming not hostile environments
- **The system is Beneficiary-led or informed** – placing people with lived experience of multiple and complex needs at the heart of decision making so that better outcomes can be achieved
- **Building resilience in Beneficiaries and the workforce** – recognising sustainability is the key to enabling workers to avoid ‘burnout’, and for Beneficiaries to achieve long term positive outcomes rather than just be subject to a tick box approach to independence
- **Multiple and complex needs are recognised and understood** – and therefore embedded as a core element of service provision, with this approach able to continue once the ON project has finished, so there is no return to ‘silo’ working.

To support the implementation of the revised system change plan, there will also be a specific transition and legacy programme. This will include Housing First approaches, and create more opportunities for Beneficiaries through increased access to structured and meaningful activity, volunteering or education, training and employment. The transition and legacy programme will also align ON much more closely with the Wellbeing Hub as a physical centre for system change.

Recognising also that ON cannot achieve system change on its own, the revised system change plan also contains SMART targets for stakeholders, and a key development will be the appointment of a System Change Manager to promote the concept of system change, and manage the implementation of the system change plan.



2.2 Collaboration at every level

The original system change plan sought a joined-up pathway, starting with prevention and early intervention, with a view to achieving;

... a 'single' pathway through key services or a set of parallel pathways that are easy to understand and to access; are based on principles rather than process; allow for a non-linear approach; recognise that human beings are not units and will sometimes stumble and even go backwards; enable easy and safe transition between services at key points; work with Beneficiaries to support and enable them to achieve their personal goals.

The 2016 report revealed significant barriers in the pursuit of this goal, and key informants suggested reasons that are relevant at the levels of both commissioning and frontline service delivery.

Agencies have no interest in collaboration and neither, very often, do professionals. In a competitive commissioning environment where services are being pared to the bone, agencies' interests lie in self-preservation and focusing on the core business. This might involve raising access thresholds that screen out people with multiple and complex needs who experience no need acutely enough to pass the gatekeeper, or it might mean that you 'fudge a referral to get numbers off the books and meet targets'.

What follows cites two sources of evidence to explore this issue in greater depth: a report commissioned by ON and undertaken by the organisation Collaborate into ON's efforts to influence commissioning and patterns of service delivery¹¹; and a pilot study with ON staff to explore their experience of agency collaboration in securing services for Beneficiaries.

Approaches to commissioning and patterns of service delivery

Collaborate undertook interviews and Focus Groups with staff engaged in commissioning and managing services in key agencies in the field of multiple and complex needs, to explore their current experiences of commissioning, how well they think it is working, what the barriers are, and whether there is an appetite for a new approach.

Some things were felt to be working well. ON is gaining credibility among partner organisations, in part for setting an example in its own commissioning that has adopted a holistic, outcome based, rather than service-based approach, and there is evidence that this is being pursued more widely. There is also evidence of greater mutual understanding between commissioners, fostered by better networking to gain insights into each other's priorities and expectations. At delivery level, co-location of services and holistic patterns of delivery were felt to be particularly effective, and the work of PDCs was cited as an example.

Aspirations for change very much reflected a desire to extend the things that are believed to be working well. Participants felt that commissioning should be undertaken in teams and agencies should be willing to share data to facilitate a joint process. There should be service user involvement at every stage in the commissioning cycle, from drawing up tenders, through contract allocation, to the evaluation of performance. Commissioning cycles and priorities should be brought into alignment, to reduce the need for separate conversations. Agencies need to be less self-protective and less inclined to see each other as a potential source of demand for their services. There needs to be greater mutual respect between professionals in the assessments they undertake. Service users should be treated holistically, with services less governed by administrative boundaries.

¹¹ The report 'Opportunity Nottingham: taking stock of our current approach. What next for commissioning?' (2018) is confidential but might be available on request.

There is recognition that these aspirations will require structural changes. One is the way that services are financed, with simplification and pooling of Public Sector budgets, with a new local finance model that supports outcomes-based approaches and longer-term planning. Another lies in the growth of lasting partnerships with shared accountability for delivering jointly agreed outcomes, and much greater trust towards delivery partners to have the flexibility to determine the most appropriate service configurations.

The Collaborate report then moved on to consider how these aspirations might be realised. Nottingham needs to study what works elsewhere. There then needs to be a commitment to a 'one system' approach locally, which will require, among other things, honest conversations between agencies about how risks can be shared, the creation of a City plan with shared goals and priorities, and the development of a hub of shared data. Opportunities should be taken for developing new ways of working presented by recent legislation, such as the Care Act (2015) or the Homelessness Reduction Act (2017).

Barriers to making all this happen reflected some of the frustrations identified two years ago;

- The priority to manage current problems gives an interest in quickly reletting contracts at the expense of imaginative long-term planning
- Competing central and local priorities make consensus hard to achieve
- Mutual agreements at the level of principle are hard to translate into practice
- There is little enthusiasm for shared risk taking in an environment of budgetary pressure, especially where the consequences are not shared evenly
- Data is inconsistently gathered, poorly shared and geared to performance monitoring, making the tracking of service users and outcome attribution difficult.

The report presented some recommendations which reflected the aspirations described above. It is certainly a challenge for a time-limited project to influence change in commissioning practice, but not an impossibility. The report identified ways in which ON could play a role by acting as a change catalyst through;

- Connecting agencies and people with a shared interest in multiple and complex needs, for instance through involvement in the Partnership Board
- Maximising the sharing of knowledge and experience through the Practice Development Unit (PDU)
- Being 'at the table' in inter-agency forums where commissioning is discussed
- Setting an example in its own commissioning practices, in holistic, outcome-based commissioning, informed by the lived experience of Beneficiaries.

Analysing the multiple and complex needs network in Nottingham

To evaluate ON's effectiveness in coordinating an inter-organisational network around multiple needs in Nottingham, one member of the Nottingham Trent University Team (Joe Spours) undertook a pilot study with staff from ON and partner organisations. It was part of a broader theoretically informed PhD study into the inter-organisational network as a political economy, for which ON is being used as a case study. The pilot sought to explore how staff relate in practice, in an attempt to provide a deeper understanding of what contributes to effective collaboration. Interviews were undertaken with managers representing agencies with key interests in the four

multiple and complex needs – covering homelessness, mental health services, criminal justice and drug and alcohol services, and a Focus Group was completed with PDCs from ON.

This is not the place to elaborate on the theoretical framework used in the study, other than to say that it seeks to understand a partnership as a network of interests competing for power and resources, where success is likely to be greatest where equilibrium can be sustained in the four key areas of domain consensus, positive evaluation, ideological consensus and work coordination. Each of these will be explained in turn, with some evidence from the pilot study.

1) *Domain consensus* - agreement between participating organisations on the role and scope of different organisations within the network. Simply, this is agreement between partners on who does what, more likely where there are shared goals, less likely where functions overlap, giving rise to competition. The Partnership Board was identified as a valuable forum for understanding the role and scope of partner organisations, which enables the boundary spanning essential to a holistic response to multiple and complex needs to develop in an unthreatening way. What might undermine domain consensus is the non-participation of partners who may be powerful actors crucial to the network's effectiveness. A further threat to domain consensus occurs at the level of frontline service provision, where PDCs still encounter misunderstanding of their role from staff at partners agencies, seeing them for instance as housing support workers.

2) *Positive evaluation* - respect by members of one organisation for the value of the work of others. The esteem in which ON's work is held among partners agencies provides a powerful incentive to network effectiveness. The result has been the development of a high degree of trust and considerable sense of team membership between partners, at least at the Partnership Board level. However, the corollary has been a dependency on the sustained commitment of particular personalities, giving a vulnerability to the network. The same issue was identified at the frontline level, where effective communication with agencies on behalf of Beneficiaries frequently relies on established relationships of trust between individual staff members. There is also the suggestion that conflicting interests in a competitive commissioning environment generates an element of suspicion between partner agencies that undermines trust. Meanwhile, at the frontline, PDCs reported experiencing professional jealousies when these relative newcomers are perceived to venture into established professional territories.

3) *Ideological consensus* - agreement about tasks and how to carry them out. The need to develop and build ideological consensus around strategies for working with people with multiple and complex needs was keenly recognised by participants. Services created through processes of co-production with service-users, the promotion of innovative practice such as psychologically informed environments, and recovery models, were all commonly referred to as guiding principles across all participant levels. Key to this process was the sense that establishing commonalities in outlook was a dynamic process, one that looks to build levels of equilibrium around common approaches from an identified state of disequilibrium. The use of approaches such as The Pledge (co-produced with service users directing professionals as to how they wish to be treated) as well as the development of joint-learning opportunities, can be seen to evidence this process. While participants recognised that each partner agency has differing objectives and accountability structures, they were generally not viewed as barriers to collaboration. However, once again, this experience was not shared by frontline workers, where PDCs' commitment to co-production with Beneficiaries and person-centred working conflicted with the less flexible approaches of staff in other organisations. PDCs thus found themselves less as brokers and more as advocates in this contested service ecology.

4) *Work coordination* - activities split between organisations to improve the efficiency and effectiveness of the network operations. In the theoretical model, if the other three dimensions are working well, then work coordination is expected to follow. If all partners agree on their

respective roles, and respect each other's work and methods of working, then agreement around the scope of shared activities should result. Communication failure was frequently identified as a barrier to work coordination, and at the level of frontline work, this often occurred where there was no regular contact with another agency with whom shared work with a Beneficiary could be discussed. Incentivising collaboration is also critical to effective frontline working, as exemplified by levels of cooperation in multi-disciplinary meetings around individual Beneficiaries, where the motivation to attend by key staff might be compromised by low priority. On the other hand, strategic staff reported a powerful incentive to attend Partnership Board meetings for what they could learn in the interests of their own effectiveness.



2.3 Persistent rough sleeping

When some Beneficiaries experience one of the four multiple and complex needs more acutely or persistently than other Beneficiaries, two things become evident. Firstly, their progress as measured by the Outcomes Star is hampered. Secondly, they test the capacity of a still fragmented wider system, which as we shall see responds to varying degrees of appropriateness. It is here that the challenge of system change is felt most acutely. The following four chapters use evidence from various sources to examine each of the multiple and complex needs in turn, beginning with the most extreme form of homelessness.

The impact of persistent rough sleeping

Evidence of the impact of persistent rough sleeping on Beneficiary progress is taken from a wider study of this phenomenon in Nottingham¹², sparked by concerns about the rising rough sleeper population nationally. The research sought to uncover the characteristics that distinguish persistent rough sleepers from the wider street homeless population, and any common features in their circumstances that might help to explain persistence. The following definition was adopted:



¹² Bowpitt, G. and Kaur, K. (2018), No way out: A study of persistent rough sleeping in Nottingham, Nottingham: Opportunity Nottingham. Available at <http://www.opportunitynottingham.co.uk/making-a-change/project-findings/>

A persistent rough sleeper is someone who was recorded sleeping rough on at least 10% of nights between 1st April 2016 and 31st March 2017, i.e. 36 nights (the 'sustained'), or who has been seen sleeping rough in at least three out of the six years between 2012 and 2017 (the 'recurrent').

The following data sources were used;

- Quarterly data collected regarding ON Beneficiaries by their PDCs to track changes in personal characteristics and circumstances, use of services and progress against NDT and Outcomes Star scores
- Records compiled monthly by the Street Outreach Team (SOT)¹³ based on information that people they have seen sleeping rough are willing to provide on their characteristics and personal circumstances
- Qualitative reflections and commentary recorded in the above data sets by PDCs and SOT members that provide a narrative of the changing lives of Beneficiaries and those seen rough sleeping
- A focus group with the SOT undertaken during September 2017 to explore the reasons for persistent rough sleeping that members have discovered arising from their daily encounters with rough sleepers.

There were 72 persistent rough sleepers who met the above definition, consisting of seven who were both sustained and recurrent, 33 who were sustained and 32 who were recurrent. Of these;

- 10 were women (14%) and 62 men
- 58 were recorded as of White British ethnicity (81%), most of the others being White (Other)
- 13 were recorded as having a disability (18%).

In addition to data recorded by PDCs regarding ON Beneficiaries, the SOT records support needs other than homelessness among people seen rough sleeping, though definitions might differ from those of ON. Data reveals that persistent rough sleepers register higher levels of all support needs, than either ON Beneficiaries or rough sleepers generally.

- 25 out of the 38 persistent rough sleepers who were ON Beneficiaries had all four multiple and complex needs (66%), the remainder having three. The corresponding figures for the overall Beneficiary population whose needs are known are 53% with four needs, 45% with three and 2% with two
- 67 out of the 72 persistent rough sleepers have problems with substance use (93%)
- 49 are offenders or at risk of offending (68%)
- 37 have mental health problems (51%).

More detailed quantitative analysis was undertaken for the 38 persistent rough sleepers who were ON Beneficiaries. Comparison with the full Beneficiary cohort (302 at 31st March 2017) sheds some light on any distinguishing features of persistent rough sleepers.

- 12 (32%) had spent at least two weeks in prison since engaging with ON, compared with 51 (17%) of the whole Beneficiary cohort

¹³ A team employed by Framework(ON Lead Partner) to monitor and support Nottingham's street homeless population.

- 16 (42%) had experienced at least one eviction from accommodation, compared with 74 (25%) of Beneficiaries overall
- 16 (42%) reported being excluded from a service because of unacceptable behaviour during at least one quarter, compared with 48 (16%) of Beneficiaries overall
- Six (16%) reported being refused a service for failure to meet eligibility criteria in at least one quarter, compared with 18 (6%) of Beneficiaries overall
- With regard to illicit sources of income (family and friends, begging, sex work, illegal activity); only begging showed an appreciable difference, with nine persistent rough sleepers (24%) securing income in this way, compared with 35 (12%) of Beneficiaries in general.

In addition to analysing general characteristics, the NDT and Outcomes Star scores for the 38 ON Beneficiaries were compared. As explained earlier in this report, the NDT index measures behavioural and circumstantial patterns that can be seen in multiple and complex needs, across ten indicators. All but two are scored out of 4, generating a maximum score of 48. A Beneficiary would score 4 for housing if they were rough sleeping or living in high risk, exploitative accommodation.

- The average opening NDT score for ON Beneficiaries in the sustained group was 32.3, significantly higher than the current threshold of 30 for accessing ON.
- For those with at least two NDT measurements, the average score by the end of March 2017 was 28.9. This improvement of 3.4 is somewhat less than what is typically achieved by Beneficiaries who on average achieve an improvement of 4.1 at the second measure, and 6.0 by the third. Moreover, this average obscures considerable diversity from -18 to +15, with a quarter showing worsening NDT scores.
- For housing, the average NDT score was 3.2, higher than the typical opening NDT measure of 2.7, with a quarter of sustained rough sleepers scoring a maximum of 4.

The Homelessness Outcomes Star measures Beneficiary progress in ten aspects of their lives, such as self-care and living skills, and managing tenancy and accommodation. Each assessment generates a score out of 10 for each aspect.

- The average opening Outcomes Star score for ON Beneficiaries in the sustained group was 25.5, slightly less than the average opening score of 28.5
- For those with at least two measurements, the average Outcomes Star score at the end of the survey was 31.9, an improvement of 6.4, which again is somewhat less than the 36.3 average achieved by Beneficiaries generally by the second reading, giving an average improvement of 7.8. Moreover, this average for sustained rough sleepers also obscures considerable diversity from +43 to -20, which bears comparison with the best and worst found among all Beneficiaries
- For managing tenancy and accommodation, the average Outcomes Star for those with at least two readings was 2.4, with nearly half recording a score of 2 or less. This contrasts with an average of 3.7 for all Beneficiaries.

In summary, we can say that, compared with the wider population of ON Beneficiaries, those who are persistent rough sleepers are more likely to; have support needs arising from problematic substance use, mental ill health and offending, to have spent significant time in prison, to have been evicted from accommodation or excluded from or refused services, and to engage in begging as a significant source of income. Furthermore, they are likely to be a group who make less progress in general.

Common themes in persistent rough sleeping

The research then explored common themes found repeatedly in narrative provided by PDCs and SOT members, in order to identify reasons for persistent rough sleeping, especially the role of systemic factors. They are listed below (in no particular order):

- 1) Both rough sleepers themselves and those who work with them are encountering a diminishing range of options when seeking to leave the streets, arising from cuts in public funding and adverse changes in the housing market. Hostels have closed, Housing Benefit availability is more restricted, affordable tenancies are more limited in terms of quantity and quality, and the supply of tenancy support has all but dried up.
- 2) Financial issues loom large in the lives of many rough sleepers. This is particularly true of migrants with no recourse to public funds, but also with many indigenous rough sleepers who encounter restricted access to welfare benefits. Access may also be impeded by debts incurred in previous accommodation. The structures needed to sustain benefit claims may result in a preference for begging which is unreliable as a source of income and may thereby put accommodation at risk, something particularly relevant to the recurrent group.
- 3) The high proportion of persistent rough sleepers who experience prison sentences means that prison discharge frequently precipitates a return to previous chaotic lifestyles, even amongst those who may have had some form of accommodation, or otherwise made progress in recovery, immediately before sentencing. This issue is explored more fully in the next chapter.
- 4) The operation of homelessness legislation may act as a barrier in many cases. For instance, rough sleepers fleeing from another locality may be seen as having no local connection to Nottingham, while others vacating accommodation because of intimidation may be seen as intentionally homeless and single rough sleepers in general may struggle to prove priority need status.¹⁴
- 5) The level of multiple and complex need encountered in the persistent rough sleeper population generates problems in the context of diminishing specialist facilities and tenancy support. The result is unsuitable referral to any available hostel accommodation, or premature referral to move-on accommodation, both of which may break down, resulting in eviction.
- 6) As a result of this and other experiences, rough sleepers may carry a baggage of past evictions and negative risk assessments which leave them barred from many facilities and make them hard to accommodate. Moreover, rough sleepers frequently miss out on mental health or other assessments that might give access to specialised support because of the logistics of conducting assessments with rough sleepers.
- 7) The narratives of many persistent rough sleepers recount an ambivalent relationship with hostel accommodation. There are stories of evictions for rent arrears or inappropriate behaviour. There are stories of abandonment for experiences of intimidation or financial exploitation by other residents. As a result, many refuse offers out of fear of who they might encounter, or of being lured into lifestyles from which they seek to escape.
- 8) Personal relationships may have a toxic effect in the lives of persistent rough sleepers. This sometimes affects women more than men, but not always. It is the case that women are more likely to be trapped in exploitative and abusive relationships which impede solutions to their housing problems. Local authorities are precluded from housing a homeless woman with a partner from whom she is at risk of harm. However, other Beneficiaries (men and women) may

¹⁴ This study was undertaken just prior to the introduction of the Homelessness Reduction Act, 2017.

be impaired by loyalty to a partner with whom they have a positive relationship. Meanwhile, others remain homeless from fear of those with whom they might be located. This might be a hostel or shared accommodation, or the only neighbourhood where they have a local connection.

9) A combination of all the above often results in an overall disillusionment with what is perceived as a hostile system that may end up making the streets attractive. The experience of repeated failure, the sense of there being no alternative, and the effect of growing numbers in generating a mutually supporting community, are generating an inertia in engaging persistent rough sleepers in the pursuit of better options.

Confronting the homelessness system

The report into persistent rough sleeping concluded with a number of pointers to how the system might be challenged to respond more effectively to persistent rough sleeping in Nottingham. These indicators mainly concern institutional responses to homelessness, but are not limited to that sector, given the wide range of factors that have been identified as playing a part in sustaining the problem.

- The Homelessness Reduction Act 2017 was implemented in England in April 2018, with new duties for local authorities to provide advice and relieve homelessness regardless of priority need and intentionality, and an extension of the duty to prevent homelessness. Help includes assessment and a personalised housing plan that will enable an applicant to find suitable accommodation, including securing an immediate safe place for rough sleepers.
- Housing First schemes are being explored by Nottingham City Council with particular relevance to rough sleepers who have a chequered relationship with hostels, effectively by-passing them by accommodating rough sleepers into tenancies straight from the streets, building all necessary support services around them.
- This leads us to a role which ON is already pioneering, reviving tenancy support services through its Multiple Needs Tenancy Support (MNTS) Team which provides wrap-around support to Beneficiaries with tenancies that they are at risk of losing, a vital service in the prevention of rough sleeping. *There is a brief evaluation of this service below.*
- Meanwhile, Nottingham City Council has recently benefitted from funding under the Government's Rough Sleeping Strategy¹⁵ to fund measures to ensure no-one has to sleep rough in Nottingham, measures that include additional emergency shelter for people with varying levels of multiple and complex need, and the strengthening of the vital services of the SOT. Despite the statutory funding source, all these services, it should be noted, are delivered by a network of voluntary and faith-based organisations.
- The above analysis of factors in the persistence of rough sleeping poses challenges to the system that go well beyond homelessness, including mental health support, offender rehabilitation and drug and alcohol treatment. Each will be given separate examination in the following sections.

Limited data suggests considerable success achieved by the MNTS Team, not only in sustaining accommodation, but also in supporting more general progress among Beneficiaries. NDT and Outcomes Star scores are available for a small cohort of 13 persistently homeless Beneficiaries who have secured tenancies that have been supported by the MNTS Team.

NDT scores show a continuing downward trajectory. An initial average score of 31 is comparable to

¹⁵ MHCLG (2018), Rough Sleeping Strategy, Cm 9685. Available at <https://www.gov.uk/government/publications/the-rough-sleeping-strategy>

the average of 32 for persistent rough sleepers generally. This latter figure only fell to 29 during the time frame of the rough sleeper study, and this was the average score for MNTS tenants at the point when they were accepted for support. However, this figure had fallen to 26 by the time of the next assessment after acceptance, and 21 by the time of the latest assessment. We are not necessarily dealing with identical time frames, but this is still a positive indication of effectiveness.

Outcomes Star scores tell a corresponding story, this time with a continuous upward trajectory. MNTS tenants had an average opening score of 30, which is higher than the 25 recorded for persistent rough sleepers generally, suggesting that MNTS Beneficiaries are more likely to make progress from the outset. Even so, progress was much greater. Compared with an average improvement to 32 for the overall persistent rough sleeper cohort, scores for the MNTS tenants had only increased to 34 prior to commencement of MNTS support, but increased to 47 by the time of the next assessment, and 54 by the latest.

This is very much work in progress, and the work of the MNTS team warrants more systematic analysis. Nevertheless, what this limited evidence shows is indicative endorsement for the Housing First response to rough sleeping which relies not on accommodation-based support, but on personalised support delivered to a tenant's own independent accommodation.¹⁶



2.4 Discharge from prison

The impact of a prison sentence on Beneficiaries' journeys has attracted attention. It is well-known that prison has the effect of compounding multiple and complex needs that may have been latent at sentencing. Accommodation is lost, mental health deteriorates, and prison is likely to involve fresh exposure to drugs. Moreover, failure to ensure accommodation on discharge increases the likelihood of reoffending.¹⁷

The Offender Rehabilitation Act (2014) was an attempt to remedy this aspect of system failure by creating machinery to ensure that all prisoners receive the support they need to rebuild their lives after discharge. The evidence suggests this measure is not working as intended, and the purpose of this piece of evaluative research has been to examine the effect of prison on the progress of ON Beneficiaries, and their experience of rehabilitation.

The impact of prison

Service user data was analysed between Q4 2014 and Q3 2017 to measure the impact of prison on Beneficiaries' progress. Across the 12 quarters, 96 Beneficiaries are recorded as having spent time in prison during their contact with ON, but only the 67 Beneficiaries who had a prison stay of 14 days or more (in conjunction with Magistrate's minimal custodial sentence) were included in the analysis. On average, they spent 59 nights in any one quarter¹⁸.

Compared with the overall Beneficiary population, the 67 were disproportionately male (88%) and White British (91%), and they spent longer in prison per quarter than the women. Offending behaviour was recorded as a need for 91% of this population, substance misuse for 87%, mental health for 82% and homelessness for 72%.

The latest NDT score for 65 of the Beneficiaries who had spent 14 days or more in prison during

¹⁶ More systematic research into Housing First can be found in Bretherton, J. and Pleace, N. (2015), *Housing First in England: An evaluation of nine services*, York: University of York.

¹⁷ For evidence on this issue, see Bowpitt, G. (2015), 'New keys for old doors: breaking the vicious circle connecting homelessness and re-offending', in Irving, Z., Fenger, M. and Hudson, J., eds., *Social Policy Review 27*, Bristol: The Policy Press.

¹⁸ Because the CFE data is broken down by quarter, calibrating the average length of sentence is difficult where sentences overlap quarters.

their contact with ON was compared with 139 NDT scores from Beneficiaries who had not spent time in prison. It was found that Beneficiaries who had spent time in prison had significantly higher NDT scores (30.19 ± 8.61) compared with Beneficiaries who had not spent time in prison (24.55 ± 6.69).

The latest Outcomes Star score of 60 of the Beneficiaries who had spent 14 days or more during their contact with ON was compared with 130 scores from Beneficiaries who had not spent time in prison. It was found that Beneficiaries who had spent time in prison had significantly lower Outcomes Star scores (30.4 ± 13.57) compared to Beneficiaries who had not spent time in prison (41.41 ± 18.63).

The analysis only measured the latest NDT and Outcomes Star scores for Beneficiaries within that time period, and initial scores might have been respectively higher or lower than for the overall Beneficiary cohort. However, these findings indicate slower progress among Beneficiaries who have spent time in prison.

The experience of entering and leaving prison

To understand the reasons for the negative effect of prison on Beneficiaries, we interviewed a small sample of Beneficiaries with experience of being in prison since joining ON. Nine were interviewed jointly by a member of the academic team from Nottingham Trent University, and a



“ Strike one, two, three. You out, out, out! ”

Daniel
Opportunity Nottingham
Expert Citizen

Peer Researcher. Interviews explored circumstances at the time of imprisonment, the impact of the prison experience, events at the time of discharge and subsequent support. The Beneficiaries' sense of making progress was explored, the effect of prison and subsequent discharge, and the support of PDCs. We also interviewed a key informant who had recently provided

housing and other support to prisoners before and after release. We were particularly keen to gauge the impact of the Offender Rehabilitation Act on Beneficiaries' resettlement, especially accommodation and support with mental health, drug and alcohol issues. How far has this aspect of the system changed? This research is still very much work in progress and will be the subject of a fuller report in due course, but the following will give a flavour of what is emerging.

Of the nine interviewed, seven were men and two women. Three only encountered their PDCs after leaving prison, but the others joined ON either during their most recent sentence, or between sentences. The duration and seriousness of sentences varied, with length of sentence ranging from a few weeks to many years. Offences ranged from petty theft, fraud and deception to more serious acts of violence, burglary, arson or selling Class A drugs. Although sentences were served in various locations, all of the males served time in either HMP Nottingham or HMP Ranby, while the women served time in HMP Peterborough or HMP Foston Hall.

All nine were high on the scale of multiple and complex needs, if not when first sentenced, then certainly at the start of subsequent sentences. Only three had any kind of secure accommodation and they all reported poor mental health, often made worse by their prison experience. Moreover, all but two reported serious alcohol problems, and a similar number talked of drug issues either before or as a result of being in prison.

Despite this, respondents did not necessarily describe their prison experiences in entirely negative terms, and all but one had something positive to say. For Ian¹⁹, prison was “better than being homeless”, and three respondents were glad of the chance to be occupied in various workshops. Furthermore, John acquired basic literacy skills, Fiona was helped to overcome her cocaine addiction, and two others got the benefit of some medication for their mental health problems.

Nevertheless, these positive experiences were far outweighed by the negative. Experiences of bullying and violence featured prominently in many accounts. Geoff described how, because of an aspect of his identity;

They kept on coming up to me, ‘you’re not coming out your cell today’. Every day, I came out my cell, I got poked in my belly, I’ve been stabbed in my ribs. I got my face smashed up in jail, got my arm broke in jail.

The combination of bullying and the mental health problems that many brought with them resulted in self-harm and suicidal thoughts in at least three cases. The prison response extended no further than patching up, as David explained;

When I started self-harming, they come and seen me, got the nurse and said, he needs stitching, we’ll take him to the hospital and that was it. I didn’t get a mental health worker to talk to me or nothing. ... I had to manage it in there because I never got no support. You have to manage it yourself.

The key informant summed up the challenges of supporting people whom prison affects in such dramatically different ways.

You get some people who just can’t cope with that environment, self-harm, suicide attempt which is very sad. And you get some people again, like you say, prolific offenders, who keep going back there. You’ve got people that started committing crimes in their teens and they are in their 40s now and spent the majority of that time in prison, because they are institutionalised and that’s where they feel safe really. You can work with somebody, you can get them somewhere but if they go out and commit crimes because they want to go back into that environment, then unfortunately that’s their choice isn’t it.

What matters for our purposes, however, were Beneficiaries’ experiences of release. How well were they prepared, and what happened during and immediately after the ending of their sentences? At least five respondents reported receiving no, or totally inadequate preparation, due to instant decision-making by the prison

“ How well were they prepared, and what happened during and immediately after the ending of their sentences? At least five respondents reported receiving no, or totally inadequate preparation, due to instant decision-making by the prison authorities who needed to clear space for another inmate. ”

authorities who needed to clear space for another inmate. David’s experience was typical of many;

All of a sudden, they said, you’re being released, get your stuff ready and that was it. ... It was earlier than I thought ... 9 or 10 o’clock in the morning. They wanted me out. They wanted me out quickly for somebody else coming in or whatever.

¹⁹ All names are fictitious, though the quoted words are those of respondents.

All he had was £47 discharge money. Unsurprisingly, at least four respondents reported being discharged to 'no fixed abode', rough sleeping in other words. Moreover, any attempt to report their homelessness was greeted with the objection that their incarceration in a local prison did not earn them a 'local connection' to the City, as Geoff encountered;

I went down to Housing Aid. Housing Aid refused us, said I had no local connection to the area. ... What do you mean I've got no local connection? ... You've got to be on the road for three days and then we'll try to help you. So, then they seen me on road for three days. They said go back in your sleeping bag, we'll come tomorrow. For a whole month I went to Housing Aid. From the day I got released I ended up at Housing Aid every day. ... I was sleeping rough.

Eric's experience was particularly poignant. He was moved to Nottingham Prison when he was about to be released in 2017 following a conviction for drug dealing, leaving no time to prepare for discharge. On release, he went straight to his Probation Officer, who was unable to help with accommodation at short notice. So, his only option was bed and breakfast where he stayed for two weeks, paying for it by reverting to his former lifestyle. He explained the dilemma;

I have thought about this. Resettlement teams, if you have got to move that close towards the end of your sentence, they should be communicating with each other, what you've already done, who you have already spoken to, and ringing up Nottingham Prison where I was to say, look this guy is moving up, we've phoned these people for applications, can you follow it through. Rather than just, here's £40, probation is going to help you. It don't work like that, it really don't. I'm not saying it made me go and start my old life style again, but it didn't give me any choice. When I'm in for dealing and I get out with no roof over my head what am I going to do, know what I mean? My family didn't want me at the family home and all that stuff. ... I was saying this to the Prison Officers in Wolverhampton, if you move me now, resettlement ain't going to help me get somewhere in Nottingham; there isn't time. He just said, 'that's your problem to deal with in Nottingham.' ... Then they wonder why people keep coming back through the system.

There were some excellent examples of how the system is meant to work. Fiona's hostel bed was kept for her until she had completed an admittedly short sentence.

A hostel that I was in, they kept my room open for me, which really, they are not supposed to. ... But no, they kept my room open for me, tidied it all up. ... They emptied my fridge, scrubbed it all out, refilled it the day before I was due to come out, which I thought was good. I come out of jail went to bed in my own bed.

She was even met at the prison gate on release by her POW Worker (POW is a PEER founded charity supporting the rights of sex workers). Moreover, significantly, she had been recruited to ON before being sentenced, which meant that her PDC visited her in prison. Ian also recounted the benefits of being referred to ON six to eight weeks before the end of his most recent sentence. His PDC arranged everything and met him on the day of his release.

They were brilliant really. Things were in place. When I was first released to be honest it was a little bit up and down. They had tried to make arrangements, but unfortunately that fell through. ... Everything was in place and I was really pleased with it. Unfortunately, I had to go back to prison ... When I came out the second time, everything was fully in place for me. ... Mainly it was support workers from Opportunity Nottingham engaging with the prison services. I would say a lot of it is down to Opportunity Nottingham.

The key informant provided further insights into how the system could work²⁰ and is meant to work, in the light of the Offender Rehabilitation Act and the setting up of Community Rehabilitation

²⁰ There are many similarities to the New Keys project. Bowpitt (2015), 'New keys for old doors'.

Companies, and the obstacles to making it work. She worked part of her time in prison, and part in the community. She would receive referrals in prison from various sources, including the CRC, especially when a prisoner was at risk of being discharged to 'no fixed abode'. She would arrange a meeting with the prisoner, which was entirely voluntary. If accepted, she would discuss housing and other support needs and arrange appointments for the prisoner on discharge. There were limits to what she could do, which may be about timing or sheer volume of work.

That's about being realistic and saying to CRC, I'm not going to be able to work with this person. It may be not enough time prior to release or I've got too many people I'm working with. Because I was only there two days a week. So obviously I was limited to what I could pick up. But I would pick up as many as I could.

What was not possible was meeting the prisoner at the gate at the point of discharge.

That would not have been possible with the timescale and things. Like I say I was working two days in prison, so I did have assessments and things to do in the community as well. That just would not have been possible with one person, like you say, to meet everybody from the prison gates.

Every effort would be made to arrange a manageable sequence of priority appointments on release, and to accompany the prisoner if appropriate, but once again this was not always possible or appropriate.

So as much as possible you would accompany them to those appointments. But again, it's when something is realistic. When you know somebody is vulnerable, you would make sure they were contacted. ... What I would say is, is it possible to do it within these times, because I know they've got probation and I know they've got that. I can meet them at probation and I can accompany them to the appointment. Again, it's on the individual isn't it. And some people don't want you to accompany them for whatever reason. I think some people think, I don't need my hand holding.

Moreover, there is no guarantee of success, even when appointments are attended, and the outcome of failure might be a return to the streets.

Housing Aid should be contacting the Street Outreach Team if they can't find anything available. Unfortunately, you are not always going to get successes. You're not going to get everyone accommodated. There might not be the room, they might not be suitable, they might have been turned down for that service. So, it would be getting in touch with Street Outreach to see what they can provide. I'm not going to pretend that you can get everybody housed.

Furthermore, in keeping with Geoff's testimony, this key informant pointed out that having no local connection to Nottingham was a further barrier to securing accommodation. This person's post recently came to an end, and there is no guarantee that it will be picked up elsewhere. Moreover, her work with each prisoner was time-limited, and she was just one worker for potentially hundreds of released prisoners in any one year. Furthermore, she had no control over accommodation shortages and other barriers to rehousing and had limited hope in the Homelessness Reduction Act 2017.

I think it's going to be very difficult. I think it's going to be a lot of work. ... In all honesty, I don't know how it's going to work with the new Homelessness Reduction Act and the licencing laws²¹. I think it's going to be an awful lot of work and maybe the prison will need to employ further staff to implement it.

²¹ From October, the HRA will require prisons to inform the local authority of anyone likely to be discharged to NFA, and the City Council has recently required private landlords to be licensed, as a way of ensuring minimum standards.

2.5 Mental health needs

In the 2016 report *Changing lives, changing systems*, we noted that one of the characteristics of Beneficiaries who have made least progress is the experience of an enduring mental health problem. Partly in response to this and to perceived problems in collaborating with mental health services during the early stages of the ON project, ON appointed a Mental Health Lead Coordinator to work with staff at Highbury Hospital, to raise ON's profile and to improve the appropriateness of the hospital's services to Beneficiaries.

Since then, a lot more has been learnt about the mental health needs of homeless people in Nottingham through research undertaken by staff at Sheffield Hallam University.²² The purpose of this chapter is not to repeat the findings of work amply reported elsewhere, but to give a brief account of what the research reveals about the effectiveness of the mental health system in Nottingham in responding to the needs of a population from which ON Beneficiaries are drawn, and what might be done to address its shortcomings. The chapter will then move on to present a review of one of the recommended innovations, a Primary Care Mental Health Service (PCMHS), which after a period of operation in 2017 and 2018, is regrettably to be decommissioned.

The mental health system and homeless people

The Sheffield Hallam research was commissioned by the Nottingham City Clinical Commissioning Group in 2016, *"to explore and understand the mental health needs of Nottingham's homeless population to inform how Nottingham City CCG can best work with local partners to better meet these needs"* (CRESR, 2018, p.4). Data was gathered from a survey of 167 people with recent experience of homelessness, in-depth interviews with 37 of those with significant mental health needs, and interviews with 23 stakeholders working at strategic, managerial and frontline levels in services relevant to homelessness and mental health.

Findings revealed that survey respondents suffered quite disproportionately from poor mental health. Three quarters had been told by a doctor they had a mental health condition, and a fifth had been detained under the Mental Health Act. Comparable figures for the general population are about one sixth and less than 0.1%. Moreover, two thirds of those with mental health issues had been diagnosed with a severe condition and three quarters had more than one condition. These conditions had typically been experienced for many years, often triggered by traumatic life events or experiences such as domestic abuse and worsened by homelessness.

There is no way of telling how many of the survey sample with mental health needs would have reached the minimum NDT score to trigger ON involvement, but many would have fitted the profile. The correlation with other support needs is stark, with 60% having spent time in prison, 38% having a drug dependency, 32% having an alcohol dependency and 48% having experienced domestic violence. The relationship between homelessness and mental ill-health is complex, frequently mediated by drugs and alcohol, but the authors conclude that *"homeless people with mental ill-health might be more accurately described as having 'multiple or complex needs' or as a population facing 'multiple exclusion homelessness'"* (CRESR, 2018, p.52).

How well is the system serving this population? There was no sense that we might be looking at a population that has consistently eluded services. Homeless people access a wide range of mental health services, and those surveyed revealed few problems accessing a GP and securing medication. Moreover, wide use is made of housing, drug and alcohol services. The issues seem to arise with the effectiveness of these services, where mental health services are described as frequently sporadic, uneven and inappropriate. Half the sample reported that they had not received the assessment, treatment or support they needed at some point in the previous year. The most

²² Centre for Regional Economic and Social Research (2018), *The mental health needs of Nottingham's homeless population: an exploratory research study*, Sheffield: Sheffield Hallam University, available at <http://shura.shu.ac.uk/21958/1/mental-health-nottinghams-homeless-population.pdf>

common reasons were ignorance of sources of help, inability to secure an appointment, lengthy waiting lists, or exclusion for drug and alcohol use. Sometimes, mental health needs were not acknowledged, or were felt not to meet service thresholds, or conversely were too severe for some treatments. Respondents frequently got 'trapped' in the dual diagnosis dilemma between mental health and drug services.

“ Respondents frequently got 'trapped' in the dual diagnosis dilemma between mental health and drug services. Moreover, the standard process of referral, joining a waiting list and attending an appointment simply does not work for homeless people outside the usual channels of communication. They are in need of instantly accessible services in times of crisis. ”

Moreover, the standard process of referral, joining a waiting list and attending an appointment simply does not work for homeless people outside the usual channels of communication. They are in need of instantly accessible services in times of crisis.

The report went on to highlight some of the more structural factors impeding the effectiveness of services for this population group. The wider political landscape of austerity has resulted in key services being decommissioned, closed or reduced. We have already noted the impact of inadequate housing in the previous chapter. In mental health services, there is evidence that raising access thresholds has been used as a rationing device. All kinds of services find themselves obliged to stick to their 'core business', limiting themselves to contracted targets and statutory responsibilities in the context of diminishing budgets. Populations whose needs are 'complex', i.e. multiple and mutually reinforcing, will be excluded by inappropriate attempts to prioritise and address needs separately and inflexibly. Few services can operate in the holistic way needed.

The report was not without hope and identified some services operating at the time of the research, whose work pointed towards the direction of system change. One was ON. Another was the Primary Care Mental Health Service (PCMHS) which, by placing mental health practitioners in GP surgeries, made specialist services available at an accessible place. This service will be reviewed in the next section regarding the impact it has ON Beneficiaries. Specific GP surgeries were commended for their understanding of the perspective of homeless people. Another positive, was the appointment of a Community Psychiatric Nurse to the Homeless Health Team, a mental health service already well-used by homeless people.

When asked what they were looking for in mental health services, respondents identified many of the characteristics commended in the above paragraph, but criticised their absence from mainstream services. The brokerage role that marks the work of PDCs is vital in mediating access to services which Beneficiaries are often only signposted to, or where specific appointments have to be made. Mental health practitioners need to be located in trusted, familiar places. Appropriate housing is absolutely essential in the process of recovery. As identified in interviews with Beneficiaries, respondents wanted people who had the time to listen to their stories and show they cared. A lot of value was attached to; talking to people with 'lived experience' such as Peer Mentors, to professionals who understand homelessness, and to continuity of support.

The Primary Care Mental Health Service (PCMHS)

The Primary Care Mental Health Service (PCMHS) started operating in January 2017. Unfortunately, it was announced in late 2018 that the service will cease to run in early 2019. Nottingham City

Clinical Commissioning Group is currently undertaking a review of mental health services in the City, of which this decision is an outcome.

Therefore, the proposals in this review are inevitably speculative, indicating what might have happened had the service continued, and also how the service could be made even more effective. The key aim of the PCMHS was to provide mental health care and support to people for whom conventional mental health services are 'hard to reach'. People with multiple and complex needs are therefore one of the PCMHS target groups and ON funded 15% of the service. By August 2018, the ON Team had made 36 referrals to the PCMHS. It should also be noted that over 90% of ON Beneficiaries have a mental health need when they join the project.

Outcomes from referrals varied. Whilst there were successful referrals, some did not progress often due to the complexity of the case. The successful referrals highlight the importance of the PCMHS in providing the 'missing piece of the jigsaw' when connecting services for people with multiple and complex needs. This is clearly illustrated in the case study of Gaynor (see page 68).

For referrals that did not progress, at surface level there were two reasons identified. Firstly, following initial contact, the Beneficiary chose not to accept the service. Secondly, the PCMHS felt in some cases they were not able to work with a referred Beneficiary due to the very significant level of need.

Where referrals did not progress, both ON and the PCMHS worked together to conduct a review, taking an 'action learning' approach to overcoming issues. For the PCMHS, within the context of mental health services, the way the service was intended to operate was very innovative and so it is unsurprising that some challenges occurred. Furthermore, in working with people with multiple and complex needs, the PCMHS was also targeting a group who have traditionally been excluded from mental health services, mainly due to high levels of crisis and substance misuse. For ON, the team had to learn about the PCMHS, as a new type of service, in order to understand what it could and couldn't provide. This presented some initial challenges with referrals.

The action learning approach taken by lead staff within both teams identified a number of issues regarding failed referrals;

Better understanding of multiple and complex needs

For the PCMHS staff, initially some did not always understand the issues connected to people with multiple and complex needs, and that traditional processes concerning accessing treatment would not work, for instance the need to be flexible around appointments and meeting locations. A second issue was the need to be flexible and tolerant around drug and alcohol use. Whilst it is the case that assessing mental health services and working with a patient under the influence of drugs and/or alcohol is very challenging, the traditional approach of exclusion is too restrictive in relation to people who have multiple and complex needs. What was needed was some flexibility and tolerance around this from the PCMHS staff, combined with a good understanding of multiple and complex needs, for instance accepting some 'no shows' and working with Beneficiaries who were under some level of intoxication.

Better understanding of mental health services

Initially, there was an issue with ON staff not fully understanding the role of the PCMHS – both what the service offered, and more notably its limitations. So, whilst the PCMHS staff could also carry out assessments and a range of interventions, they could not provide longer term psychological therapy. The PCMHS could however refer (sometimes also with the support of PDCs) to specific services for this type of therapeutic intervention, opening up access routes that would otherwise be unavailable to people with multiple and complex needs. This role needed clearer communication to ON staff, but so did the fact that the PCMHS could provide support and information to PDCs

regarding Beneficiaries who weren't currently on the PCMHS caseload. For instance, the PCMHS could provide useful advice about how to work with someone and how to maximise chances of a successful referral. Moreover, awareness was needed that referral to a mental health service is not a magic wand solution and that on-going support is usually needed by ON. This was particularly important during initial appointments with the PCMHS as relationships developed, just as the ON Team needs to build relationships with Beneficiaries in the early stages of engagement.

Communication

It was identified early on, that communication between ON and the PCMHS needed to be improved. This was mainly to ensure that both services were fully up to date on progress and challenges relating to each Beneficiary accessing the PCMHS.

Culture change

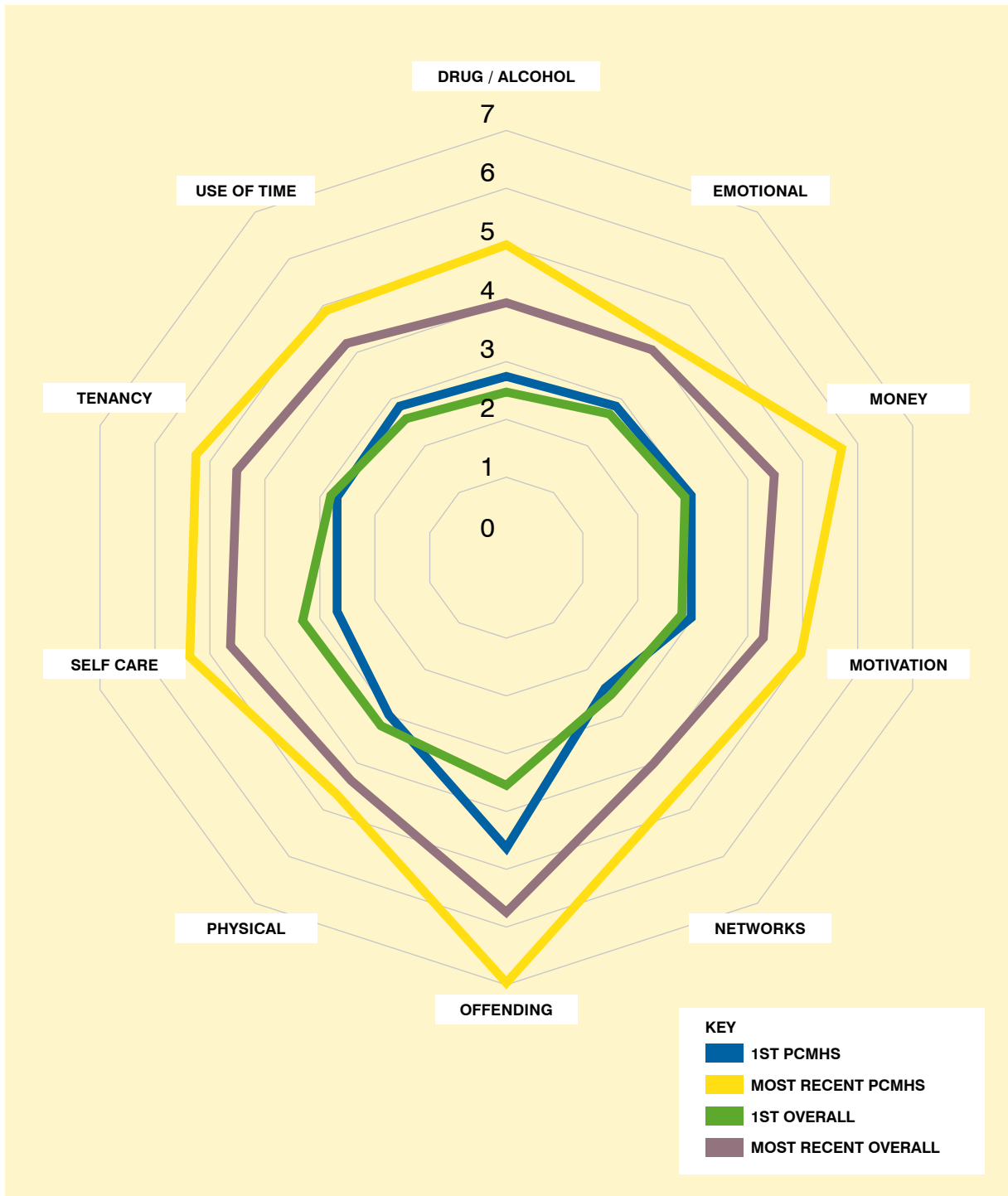
As a statutory mental health service, the PCMHS's way of working was innovative, requiring flexibility, tolerance of uncertainty and understanding of issues faced by people with multiple and complex needs. Some PCMHS staff were not familiar with working in this way, or did not have experience of working with people with multiple and complex needs, particularly if they came from a more mainstream mental health background. Providing such staff with support to adapt to this new way of working was a key element to ensuring the PCMHS was successful. PDCs could have provided more assistance in this area, using their skills and experience to support PCMHS staff to develop their understanding of multiple and complex needs.

To address these issues, a number of measures were proposed (due to the planned closure of the PCMHS in early 2019, the below can no longer be delivered);

- Staff from the PCMHS would spend time with the ON Team. As well as attending team meetings, a duty system was planned whereby PCMHS staff would spend a regular day at the ON Office. This would not only develop their own understanding through spending time in a multiple and complex needs work environment, but also offer a mental health consultancy and referral service to PDCs. A rota system for this would be developed to ensure all PCMHS staff could gain understanding in a multiple and complex needs setting.
- Staff from ON would spend time with the PCMHS, helping to develop their knowledge of the PCMHS's role, but also supporting ON's aim to be a 'trauma informed' service.
- Data sharing would be extended. Initially, when a Beneficiary gave permission, PCMHS staff could access part of their ON record. This greatly assisted the PCMHS in improving their service as they got detailed information about potential patients. It also met ON's aim of ensuring Beneficiaries do not have to keep repeating their story to every service they access. At the time, PCMHS staff had access to ON case records on a 'read only' basis. This was to be changed so that PCMHS staff could make entries on the Beneficiary running notes section in their ON record, facilitating the transfer of important information, and keeping everyone fully informed.
- There would be regular review and learning meetings between ON's mental health lead worker and lead staff at the PCMHS to look at 'what's worked, what hasn't, and develop further innovations in ways of working.'

Evidence of the effectiveness of the PCMHS is limited due to the length of delivery. Figure 6 shows the results of a comparison of changes in Outcomes Star assessments at two points between a cohort of 22 PCMHS Beneficiaries, and a comparable cohort of 91 Beneficiaries who did not access the service. Although scores were higher at the first assessment for the group accessing PCMHS support, they still clearly made more progress overall.

Figure 6: Comparison of Outcomes Star measurements for those who did and did not access the PCMHs



The impact of the PCMHs is also clear within the illustrative case study on page 67. It shows the effectiveness of the work of the PCMHs in improving not only mental health, but also engagement with other services.

The impact of the PCMHS: Gaynor's experience

Gaynor had been engaging with ON since 2014. Whilst this engagement was important in developing a contact point and a meaningful relationship with her PDC, she did not progress in relation to the issues stemming from her multiple and complex needs. Her NDT scores remained in the high 30's and her Homelessness Outcomes Star scores stayed very low.

However, following referral to the PCMHS, important changes occurred that illustrate the vital role the service can play, and chart a way forward for Gaynor. In addition to multiple and complex needs, Gaynor was for a long time subject to a violent relationship, and suffered from a serious eating disorder. Past efforts to refer Gaynor to mental health services for these issues were limited as she was considered unsuitable due to her chronic alcohol consumption. However, following referral to the PCMHS, and over a number of sessions with her worker, she was able to develop 'distress tolerance' techniques. These are psychologically based coping methods to help her deal with the difficulties she faced, which she would otherwise have coped with through excessive alcohol consumption. Her PCMHS worker showed persistence and flexibility in enabling this to happen, for instance, seeing Gaynor whilst she was not entirely sober and not giving up on her, despite some 'no shows'. These are both issues that would normally lead to patient discharge in other mental health services.

As a result of this support from her PCMHS worker, input from Gaynor's alcohol worker became more effective. Her alcohol consumption reduced to the point where her PCMHS worker was hopeful that a successful referral to the secondary care Eating Disorder Team could be made.

Additionally, her PCMHS worker was able to attend the case conference meetings connected to Gaynor's domestic violence and provide vital psychological input into these, specifically communicating that Gaynor's tolerance of the violence stemmed from 'maladapted attachment' and 'abandonment fears'. Two key outcomes stemming from this were firstly, better understanding by the Police who were lacking insight into why Gaynor was having difficulty, in their words, in "taking responsibility" for her actions in continuing to associate with her abusive partner. The second outcome related to housing. Nottingham City Homes (NCH), Gaynor's housing provider, were concerned about anti-social behaviour at the property. Their solution to this was to pursue eviction, but psychological input from Gaynor's PCMHS worker enabled NCH to understand the complexity of Gaynor's circumstances and behaviour.

As a result, there was understanding that other strategies and not eviction could be successfully pursued, if supported by a psychological approach. This enabled the tenancy to be retained rather than condemn Gaynor to a further period of street homelessness.



2.6 New drugs

To complete the multiple needs jigsaw, substance misuse must be considered. In this chapter, consideration is given to work already published.²³ There is a brief summary of this work, highlighting what it has revealed about the effectiveness of the system where substance misuse is

²³ Opportunity Nottingham (2018), New Psychoactive Substances, available at http://www.opportunitynottingham.co.uk/uploadedfiles/documents/30-1519733850-nps_report__opportunity_nottingham__feb_18__final_v1.pdf

concerned. There is also a focus on an aspect of this particular complex need that has presented new challenges regarding Beneficiary progress; New Psychoactive Substances (NPS).

There have been growing concerns throughout Nottingham City about the impact of New Psychoactive Substances (NPS). NPS were previously known as 'legal highs', as these substances



were once sold in shops and online legally. However, in May 2016 the Psychoactive Substances Act came into force, which 'makes it an offence to produce, supply, offer to supply, possess with intent to supply, possess on custodial premises, import or export psychoactive substances; that is, any substance intended for human consumption that is capable of producing a psychoactive effect. The maximum sentence will be 7 years' imprisonment.'²⁴

Although there are many different types of NPS, consideration is given mainly to synthetic cannabinoids such as mamba within this chapter, as these have been the subject of growing concern amongst ON PDCs, and other professionals who work with Beneficiaries in Nottingham City.

The purpose of the research considered within this section, was to provide some evidence around the issue of NPS use, so as to enable services to respond more effectively to those who are using NPS.

What is the prevalence of NPS use? Who uses NPS? Why do some Beneficiaries use NPS and not others? What impact does it have on their lives? What is the impact on health and wellbeing? How can services respond to NPS users? This final question links research to the wider concern with system change, as the link between NPS consumption and other multiple and complex needs, especially the prison experience and mental ill health, has become very evident. How well has the system responded to this significant change in the multiple and complex needs environment?

The research had three main elements. Firstly, PDCs were surveyed. The aim was to obtain their views about the prevalence of NPS use and how it impacts their Beneficiaries. The survey, completed by 16 PDCs, focused on which Beneficiaries were taking NPS, the impact of NPS and their views on how well services are equipped to tackle the problem of NPS use. Noting that some Beneficiaries had used NPS and stopped, there is also an exploration of the reasons for cessation. Secondly, the ON database was used to profile demographic and other characteristics that may make NPS use more likely. Thirdly, qualitative data was gained through holding a Focus Group with nine Beneficiaries with knowledge of NPS, and conducting semi-structured interviews with three Beneficiaries who had used NPS in the past or who were currently using it.

Who uses New Psychoactive Substances (NPS)?

The PDC survey revealed 32 out of 158 currently engaged Beneficiaries used NPS in 2017. A second group of 20 Beneficiaries were considered by PDCs to be very likely to be using NPS. Added to the 32, this amounts to approximately 33% of the current ON caseload. If this proportion

²⁴ Home Office (2016), Psychoactive Substances Act, available at <https://www.gov.uk/government/collections/psychoactive-substances-bill-2015#documents>.

were replicated amongst the group of people with multiple and complex needs across Nottingham City, it would represent around 700 people. A third group of 14 Beneficiaries had previously used NPS but since stopped.

In identifying the characteristics of NPS users among ON Beneficiaries, there should be no suggestion that they represent NPS users generally. Even so, the following features are worth noting for the 32 identified in the survey;

- **Age** – Although evidence elsewhere points to the relative youth of NPS users, the average age of NPS using Beneficiaries at 38 was barely any younger than for Beneficiaries generally at 41.
- **Gender** – Likewise with gender, the 28% of NPS using Beneficiaries who were women was only slightly less than the 35% of all Beneficiaries at the time.
- **Ethnicity** – At 91%, a higher proportion of NPS users were White British than the 73% of Beneficiaries in general.
- **Disability** – Similarly, only a fifth of NPS users recorded a disability, compared with roughly a third of the wider Beneficiary population.
- **Homelessness** – NPS users were slightly more likely (70%) to have been homeless at the start of their engagement with ON than the Beneficiary cohort at the time (56%).

“ However, a further examination of service use data draws out some appreciable differences in NPS users’ engagement with the system. Compared with Beneficiaries generally, they;

- Are arrested at a rate that is three times higher
- Have attendance at community mental health services that is two and a half times higher
- Are two and a half times more likely to visit Accident & Emergency
- Are more likely to engage with drug and alcohol services, averaging 11 contact sessions compared with 4. ”

It cannot be clarified how far NPS use is responsible for these higher rates of service use, but the correlation is worth noting. Of similar interest to the ON evaluation is the impact of NPS use on Beneficiary progress as measured by changes in NDT and Outcomes Star scores. The data in Table 15 shows most recent scores across key areas of the NDT index, with NPS users showing a higher score, indicating greater need and possibly less progress being made since engagement with ON (assuming no difference in scores at first engagement).

Table 15: Most recent NDT scores, September 2017

	SUBSTANCE USE	RISK TO OTHERS	RISK FROM OTHERS	IMPULSE CONTROL	HOUSING
NPS users	3.3	3.8	4.2	2.4	2.5
Non-users	2.8	3.3	3.9	1.9	2.1

Outcomes Star data also shows that NPS users are making less progress overall than those who do not use NPS, again assuming similar starting points. NPS users have higher needs across all ten indicators for their most recent assessments, but especially in relation to offending reduction and management of money.

“ Typically, people were first introduced to what are called ‘synthetic cannabinoids’ in either prison or hostel accommodation. Use in the hostel environment was due to the high level of accessibility, where it is often bartered for tobacco. ”

The reasons for, and impact of NPS use

The interviews revealed further evidence about Beneficiaries’ experience of NPS use, how they came to use it, how it affects their life, and how they came to stop using it. Typically, people were first introduced to what are called ‘synthetic cannabinoids’ in either prison or hostel accommodation. Use in the hostel environment was due to the high level of accessibility, where it is often bartered for tobacco. One Beneficiary was first introduced to mamba at a hostel, having been unaware of it until residing there. Initiation is frequently accidental, people mistaking it for rolling tobacco, and negative experiences can have a powerful deterrent effect. This was certainly the case with some former users.

I picked up dog ends ... I made a roll up, had about three drags and my heart just stopped and I was rushed to Queens Medical Centre

However, there is also an understanding as to why some people use these substances, as one PDC explained.

I can see why people do it though, it’s an absolute mind blocker... if you’re out on the street and you have some of that. It’s six hours later isn’t it?

There is acknowledgment that NPS are used to help ‘pass the time’, especially for those rough sleeping as it helps to distract them from the difficult situation they are in. It is also viewed as having calming effect and helps to induce sleep. Moreover, as with other substances, it can be seen as a form of self-medication, in order to help deal with difficulties, adverse circumstances and past trauma that Beneficiaries have commonly suffered.

However, there is no doubt that NPS has a huge impact on the lives of those who use it. As one PDC stated;

For our Beneficiaries who use NPS, it consumes almost every aspect of their lives, impacting on their mental health, physical health, relationships with support services and accommodation and their finances.

It is extremely difficult to communicate with Beneficiaries who have taken the drug as they go into a 'catatonic state' which means it can lead to them becoming vulnerable and easily exploited. It has also contributed to overdoses and near death experiences. One PDC believed that the death of a Beneficiary may have been partly due to mamba, as the person had smoked it a short while before having a heart attack, and there is a general consensus that NPS causes health issues relating to the heart. Another participant's partner died of a heart attack after having just two drags of mamba.

One of the appeals of mamba is price, currently at about £5 to £10 a gram, and cheaper still if bought in bulk. However, although it may appear to be cheap in small quantities compared to other drugs, the addictiveness of the drug means that people are spending large amounts of money on mamba, £400 a month in one case. This can have implications on other aspects of life such as accommodation. One of the participants stated that they still have rent arrears at a previous accommodation due to mamba and other substance use, while one PDC knew of a Beneficiary who spent all his spare time 'getting money to score'.

Impact on engagement and the system's response

PDCs considered that NPS was a significant barrier to engagement for Beneficiaries. Two main inhibiting factors were apparent, the first one being the drug's effect in increasing chaotic behaviour, reflecting NDT scores (see for instance, Table 13.1 figure for 'impulse control'), even though the effect can be delayed by hours. To reduce risk, PDCs suggested working in pairs with NPS users. The second appears to be impact on memory and consciousness. For example, one Beneficiary stated that *"it is like a mask that comes over; it is like tunnel vision"*. The respondent had every intention to attend support sessions, but drowsiness from mamba led to frequent forgetfulness, impeding access to support. However, it should be noted that, whilst NPS use does present barriers, roughly a third of Beneficiaries use NPS and many do manage to engage, making positive work still possible. NPS use should not therefore be seen as a reason not to work with a Beneficiary, even though NDT and Outcomes Star data suggests progress might be slower.

Working with an NPS user will inevitably involve access to drug and other services, so how well is the system responding to increased NPS use? PDCs felt Substance Dependency Services had responded well in terms of providing useful information about the harm caused by NPS use, with this information available both to PDCs and Beneficiaries. One PDC felt there was good harm reduction advice, while another believed;

Drug and alcohol services are aware and try to promote them as a negative and dangerous substance.

There was however a view amongst some PDCs that whilst information was good, active support by drug services for NPS users could be improved. Because NPS are relatively new compared with substances like heroin, the support is limited in terms of flexibility and understanding of treatment options. PDCs talked about NPS causing engagement issues and that the drug service may be too quick to sign off a Beneficiary because of non-attendance. There is also some uncertainty regarding treatment, as one PDC stated;

Not sure what can be done to support NPS. Heroin/cocaine, go on script and structure is put in place. Unsure of support for NPS!

A number of PDC's felt improved joint working between mental health services and substance misuse services in relation to NPS would be beneficial, due to the connection between these two issues. Overall, half of the PDC respondents would like to have training and refresher courses on NPS to help them develop their understanding of the drugs, with drug services giving clear guidelines and processes that are better connected to mental health services.

Beneficiary views about the response of accommodation services to NPS were mixed. One felt there was hardly any support for NPS in the hostel that they were staying in, even though they felt NPS usage within the hostel was very high. However, two who lived in supported accommodation felt the service was responding very well. One cited monthly meetings to specifically talk about drug and alcohol issues including NPS, which they found very helpful. There were particular benefits from the service taking a less judgemental and supportive approach, rather than a punitive one.

At first, they were giving repercussions like you could get breaches. Now because it's there (the meetings) ... there's been a slight ease off it, with the meetings and being able to talk about it.

This development, which coincided with the service developing a trauma informed approach, appeared to encourage residents to be more open about their problems and so better able to address them.

“ It’s the worst feeling ever to be judged when no-one knows your story. ”

Lee Opportunity Nottingham Expert Citizen



Part III: The legacy challenge

ON has reached the midway point in its eight-year project. From this point onwards, thoughts will increasingly turn to its lasting legacy. This is not only to justify money and time spent on the project; aspirations to effect permanent change were written into the very aims of the Fulfilling Lives Programme from the outset. Much of this report has already borne witness to ON's legacy in the transformed lives of Beneficiaries, and in system change, but there is clearly much still left to achieve in the remaining four years.

In the remainder of this report, the beginnings of ON's institutional legacy is reviewed. Two examples of entities that testify to some of the things that the project hopes to bequeath to the overcoming of multiple and complex needs are given. In the Practice Development Unit (PDU), there has been an attempt to crystallise the learning from four years spent grappling with multiple and complex needs into a programme of workshops, action learning sets and communities of practice, by which a new approach to working can change the way that frontline staff provide services that acknowledge people's multiple and complex needs. In the Wellbeing Hub, there is an attempt to realise one of the key goals of system change in concrete: the bringing together of a range of multiple and complex needs services under a single roof.



3.1 The Practice Development Unit (PDU)

As the 2016 report *Changing lives, changing systems* was being written, a scoping study was being undertaken among practitioners in a range of services used by Beneficiaries in preparation for the setting up of a unit that was to be organisationally separate from ON, so that it could carry many of its achievements far beyond ON's eventual closure. The Practice Development Unit (PDU)²⁵ launched in 2017 as a partnership between ON and Nottingham Community and Voluntary Service (NCVS), with the key aims of;

- Improving the skills and knowledge of professionals working in the field of multiple and complex needs
- Facilitating the sharing of expertise, good practice and resources across sectors
- Promoting and facilitating collaborative learning across sectors
- Creating opportunities for promoting innovation and working practices across the city
- Improving outcomes for Beneficiaries through contributing to system change, and increased coordination and collaborative working between agencies.

The PDU is managed by a Coordinator, who plans a series of learning events for practitioners and managers working in the field of multiple and complex needs in Nottingham City. The Coordinator also sets up Communities of Practice to explore new or contentious issues. The PDU was

²⁵ <https://www.pdunottingham.org/>

independently evaluated after its first nine months of operation (October 2017 – July 2018), and the following observations are based on the outcome of that evaluation²⁶.

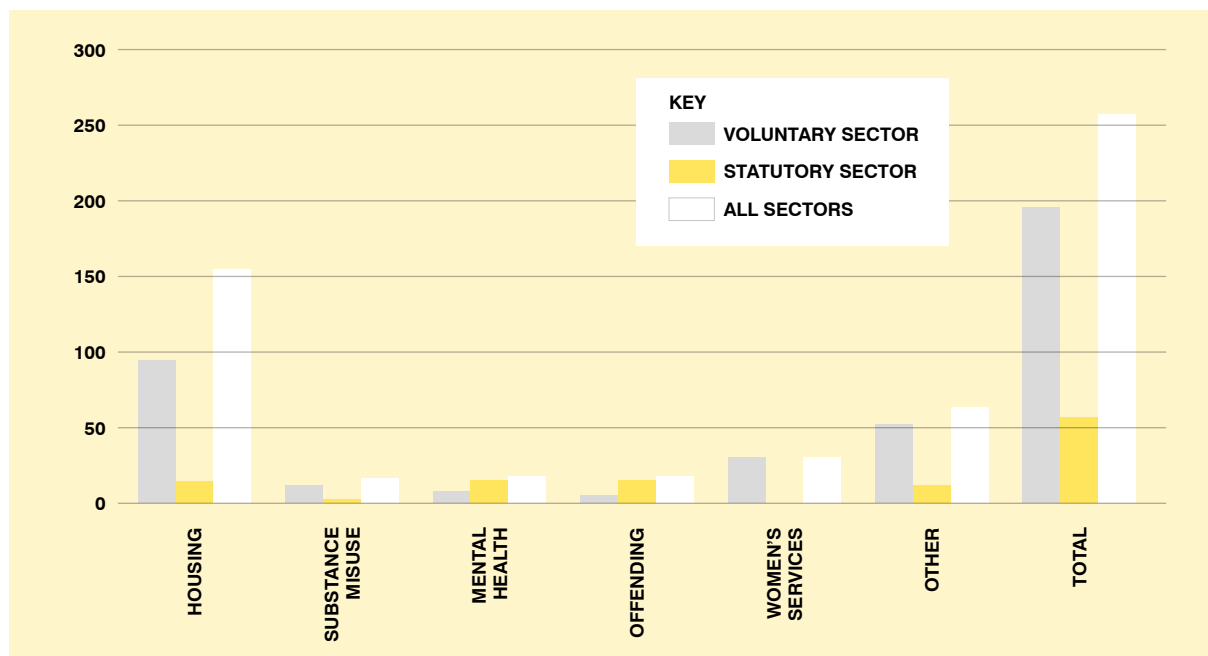
The underlying purpose of the PDU is to spread one of the key elements of system change by ‘spreading the word’ about what ON has learnt regarding how to address multiple and complex needs more effectively. The overall aim of the evaluation was to gauge how far the learning events have done this, and the evaluator undertook surveys and telephone interviews among participants to explore the following;

- Change in understanding, awareness or confidence in addressing an issue
- Change in knowledge
- Sharing and disseminating information
- Links with other organisations and collaboration
- Change in working methods.

The evaluator attended two PDU events and talked informally with participants, and met six ON Expert Citizens to see how far changes claimed by those who have attended learning events are likely to have made a difference to the services experienced by Beneficiaries.

In the period covered by the evaluation, nine events were attended by 211 individuals, generating 252 attendances, mostly (78%) from people working in the voluntary sector. Attendances were further analysed by the Care Sector in which participants work, with housing by far the most prominent (42%). Figure 7 (below) shows the full results.

Figure 7: PDU learning event participants by field of work (n=252)



The great majority of survey respondents felt that, as a result of the event they attended, they had gained at least some greater understanding of the topic (79%), and some additional awareness or confidence in addressing the issues discussed (76%), with nearly all the others believing it confirmed existing understanding or awareness. Many respondents were able to identify new knowledge about the topic, new approaches to their work or greater understanding of how other

²⁶ Fleming, J (2018), The Opportunity Nottingham Practice Development Unit – interim evaluation report, Practical Participation. Copies of the full report can be obtained on request from jennie@practicalparticipation.co.uk

agencies work. The Expert Citizens affirmed the likely benefits of this improved understanding and awareness in the services received by Beneficiaries, pointing to the importance of knowing what is happening in their lives and how it might affect their behaviour, and the value they are likely to derive from exposure to different ways of working.

The real benefit of PDU events lies not only in their impact on those who attend, but also in their willingness to disseminate their learning to those with whom they work. The majority (59%) of respondents who answered this question (n=41) planned to share learning with frontline staff, and six of the seven interviewees had already shared learning with colleagues. There is even greater value where participants meet people from other organisations at learning events and go on to share learning with organisations with whom they are in contact. However, some Voluntary Sector participants regretted that there weren't more attendees from the Statutory Sector because of their impact on what is available to Beneficiaries through the fulfilment of statutory duties of service contracts, and the way they are delivered. The Expert Citizens also attached a lot of importance to mutual awareness among service providers if a full and coherent service is to effectively address Beneficiaries' multiple and complex needs.

Participants particularly appreciated the involvement of Expert Citizens as service users at some of the learning events, but some felt they could have been better prepared in terms of what is appropriate to share at such events, and worried that particular service user experiences became the focus of discussion to the detriment of wider issues. However, Expert Citizens were comfortable with their contribution, recognising that it is important for them to have the chance to share their passions in a setting with service providers. Moreover, they have had training on storytelling and knowing what to share when discussing their journey and experiences.

What really matters is how far participants have changed the way they work as a result of attending PDU events. Many survey respondents said they had already made changes, or were planning to do so, and only a few said they did not intend to change anything. Five people said they had introduced The Pledge in their service, and one had even reviewed the environment of their service considering how far it is 'psychologically informed'. The Expert Citizens considered all of these things would make a significant difference to service users. They commented that things often feel really rushed and there is not the time to build the trust and relationships needed to work well together, so taking more time was crucial. Having created The Pledge, they were pleased to see people finding it useful and committing to it; but they cautioned that people and organisations need to live up to The Pledge and put it in action, not just adopt it. They felt all efforts to involve and gain feedback from services users were positive, as they were the experts in how services were working. All agreed that any steps to make hostels more like homes by, for instance, reducing notices that were '*mainly rules and what you cannot do*', and repairing and replacing utilities in a timely manner, were positive steps.

There were numerous suggestions about topics for future learning events, but the overall impression of the evaluation was positive. The only issue to address is the relative paucity of participants from the Statutory Sector, especially managers and commissioners.



3.2 The Wellbeing Hub

Two of the goals of ON's first system change plan were to achieve 'unified single assessment and data-sharing' and a 'joined-up pathway'. These were felt to be key ingredients in the ambition not only for ON but for the entire welfare system to treat people with multiple and complex needs holistically, recognising the mutually reinforcing nature of such needs. The underlying barrier has always been the structural compartmentalisation of human need on which welfare services are based, with administratively and operationally distinct responses to each category. At a

practical level, people with multiple and complex needs experience this every time they have to go to separate buildings for each of their needs, in each of which they may be subject to different waiting times before they can access services, where they will have to undergo separate complex assessments, only to be rejected by conflicting inclusion criteria.

The Wellbeing Hub²⁷ derives from a vision that one solution to this problem would be to bring all the relevant services under a single roof, where service providers could work together physically, where service users could receive help when needed regardless of the nature of their 'primary need', and where key information could be shared without repeated re-assessment. Such a building would cut across the need for the kind of collaborative machinery implied earlier. Agencies would work together because they could hardly avoid each other!

The Wellbeing Hub was launched early in 2018 and has not yet been subject to evaluation. However, in keeping with its vision, it accommodates a wide range of services on a continuous basis:

- **Wellness in Mind** – mental wellbeing and support
- **Nottingham Recovery Network** – drug and alcohol support/treatment
- **Homelessness Prevention** – advice/support for risk of homelessness
- **Clean Slate** – criminal justice drug and alcohol treatment
- **Opportunity and Change** – employment pathway for people facing complex needs
- **Towards Work** – overcoming barriers to employment and training
- **Better Working Futures** – support for overcoming employment barriers.

And there are other services not yet permanently located there:

- **Trent PTS** – IAPT provider
- **Health Shop** – sexual health, needle exchange, BBV Screening
- **Opportunity Nottingham** – support for people with multiple and complex needs
- **NUH** – HEP C treatment
- **Victim Support** – support for victims of crime
- **Nutritionist** – healthy diet support
- **Women's Aid** – female survivors of sexual abuse.

The Wellbeing Hub is a place not just for ON Beneficiaries, but for everyone confronting multiple and complex needs. The result, it is hoped, will be reductions in homelessness, crime and alcohol related harm, improved mental wellbeing, and increases in sustainable employment and people successfully remaining drug-free.



²⁷ We are indebted to Apollos Clifton-Brown, Service Manager at the Nottingham Recovery Network, for granting access to the presentation on which this brief chapter is based.

Conclusion: what next for Opportunity Nottingham and beyond?

As it reaches its midway point, ON has made some significant achievements. Looking to the future, attention will increasingly turn to how it can 'bottle' those achievements as a lasting bequest to future generations of people whose lives are blighted by multiple and complex needs, and those who seek to support them. This conclusion will pick out key strands in the achievements documented in this report, before posing questions for the remaining four years of ON delivery.

As ON approaches its target number of Beneficiaries with multiple and complex needs recruited to the project, it should be noted that 73% made progress by the standard measures, with increasing numbers leaving the project because they no longer need the intense support. It is clear that progress is greater the longer Beneficiaries remain engaged with their PDCs, and that common components of success lie in restored relationships in Beneficiaries' lives, and in taking opportunities to 'give something back' through activities such as volunteering. Moreover, success can be computed in monetary terms, with an average saving to a limited range of public services of over £12,000 over the whole period of a Beneficiary's engagement, though it is noted that overall savings from a more comprehensive range of services are only achieved with Beneficiaries who leave the project for positive reasons.

When considering the ingredients of success, the PDC role has been pivotal, and is undoubtedly the first product to be 'bottled'. The distinguishing marks identified in the 2016 report *Changing lives, changing systems*, such as persistence and flexibility, have been reaffirmed in the subsequent years. The role is becoming better understood by the PDCs themselves and endorsed by outside agencies, with implications for system change. Also crucial in driving success have been opportunities for Beneficiaries to give something back to ON, and through wider community engagement by becoming Peer Researchers, Peer Mentors or Expert Citizens. Peer research was reported in 2016, but peer mentoring is something new, which has been shown to work equally well for both Beneficiaries and their Peer Mentors. The informal treatment setting of the mentoring relationship can play a crucial part in improving Beneficiaries' wellbeing, reducing relapse and combatting social isolation, while for Peer Mentors, there is improved self-esteem through a sense of being valued for what they can contribute to the lives of other Beneficiaries. Becoming an Expert Citizen takes Beneficiary involvement one stage further by providing opportunities to contribute to ON project strategy and delivery through informing policy and practice development, helping to specify tender requirements, recruiting staff and by sharing the Beneficiary experience in training for other agencies. The Expert Citizen Group is a vehicle to give a voice to Beneficiaries, giving something else to be sustained beyond the life of the project.

Since 2016, ON has been occupied with ensuring that its effectiveness extends to sub-groups in the Beneficiary population that might be described as 'hard to reach'. This has been a challenge to the project itself and to its wider concern with system change, and work with each of the following groups has been evaluated;

- **BME Beneficiaries** were consistently under-represented in the early years of the project, but this has been successfully addressed through commissioning the help of AWAAZ, a charity with a reputation for success in making mental health services more accessible to BME communities. Using 'Assertive Community Outreach', AWAAZ has built links and raised awareness among BME communities, using language with which they are more comfortable, and adopting a 'strength based' approach with people seeking help. The outcome has been an increase in the proportion of BME Beneficiaries from 19% to 28%.
- **Persistent rough sleepers** among Beneficiaries have been consistently impeded by their circumstance in their progress with ON, but there are signs that this issue is being addressed through systemic initiatives at national level through the Homelessness Reduction Act and the Rough Sleeping Strategy; and at local level through the planned adoption of Housing First. One aspect of this latter initiative has been successfully pre-empted by ON's Multiple Needs

Tenancy Support Team (MNTS) who have effected substantial progress through intensive housing support with former rough sleepers to find permanent accommodation.

- **Discharged prisoners** in the Beneficiary population have also found progress impaired if a prison sentence intervenes, in part through systemic failure. Lack of preparation at the point of discharge frequently leaves discharged prisoners with 'no fixed abode' despite the introduction of the Offender Rehabilitation Act. However, having a PDC can mean support during the sentence, preparation for discharge, and accompaniment to pre-arranged appointments after discharge, things that the Offender Rehabilitation Act is supposed to have introduced.
- **Mental ill-health** has been found to be prevalent in the homeless population generally, and among Beneficiaries in particular. The systemic problem lies in making mental health services more accessible, and some advances have been made in this direction through the introduction of the Primary Care Mental Health Service (PCMHS), although this service is to be regrettably decommissioned. The key challenge for mental health services lies in adopting a more tolerant and flexible approach to access for people whose behaviour is often deemed challenging and uncooperative.
- **Use of New Psychoactive Substances** by Beneficiaries has also been shown to limit progress by increasing chaotic behaviour, inhibiting engagement with services. The challenge lies once again in facilitating access to drug dependency services, which in turn need to respond with appropriate information, support and treatment options, applied flexibly in the light of the impact of these substances on people's lives.

Evaluation of working with these more challenging sub-groups has revealed limits to what ON can achieve without substantial impact on the wider system. However, ON has paved the way in showing how one organisation can 'beat to a different drum' in;

- Achieving meaningful Beneficiary inclusion, consultation and co-production
- Changing commissioning, service design and delivery
- Developing learning and best practice.

This report provides ample evidence of meaningful Beneficiary inclusion. In providing training in best practice for staff in other services, the Practice Development Unit (PDU) has begun to 'spread the word' in how to respond effectively to multiple and complex needs. In bringing many components of the system under a single roof, the Wellbeing Hub has promoted collaboration and accessibility.

In the meantime, ON is left with a number of questions as it embarks on the remaining four years of delivery:

- 1 What will happen to Beneficiaries still on the project at the end of year eight?
- 2 What support will be available when ON stops taking referrals?
- 3 How can Nottingham invest in 'what works' at a time of austerity?
- 4 If Nottingham invests in successor support, what will the resulting service look like?



“ In the meantime, ON is left with a number of questions as it embarks on the remaining four years of delivery:

- 1 What will happen to Beneficiaries still on the project at the end of year eight?
- 2 What support will be available when ON stops taking referrals?
- 3 How can Nottingham invest in what works' at a time of austerity?
- 4 If Nottingham invests in successor support, what will the resulting service look like? ”

These questions will need answering and plans putting in place before Opportunity Nottingham closes in June 2022. The support of project partners and Nottingham City-wide organisations working with those facing multiple and complex needs will be essential in delivering this piece of work

Appendices i

The Pledge

Improving the experiences of service-users and frontline staff working in the context of multiple needs.

honesty

What I (the service-user) would like from a service

- Be realistic with me
- Help me to understand what you do
- Guide me through my journey
- Be courteous and compassionate with me
- Involve me when talking to other services.

understanding

How I (the service-user) would like to be treated

- Respect me
- See me as a person; not a problem
- Don't judge me or make assumptions about me
- Please don't rush me
- Listen and hear what I say.

belief

In return I (the service-user) will

- Engage with you to the best of my ability
- Also treat you with respect
- Remember you are human too.



Opportunity Nottingham Beneficiary Ambassadors and Expert Citizens.

Appendices ii

Services costed for cost-effectiveness analysis

Standard 18 service dataset

1. Number of evictions
2. Number of arrests
3. Number of police cautions
4. Number of nights in police custody
5. Number of Magistrate's court proceedings
6. Number of Crown court proceedings
7. Number of convictions
8. Number of nights in prison
9. Number of presentations at A&E
10. Number of outpatient attendances
11. Number of hospital inpatient episodes
12. Number of face to face contacts with CMHT
13. Number of counselling or psychotherapy sessions
14. Number of mental health service outpatient attendances
15. Number of days spent as a mental health service inpatient
16. Number of face to face contacts with drug/alcohol services
17. Number of days spent in inpatient detoxification
18. Number of weeks spent in residential rehabilitation



Fulfilling Lives Newcastle and Gateshead project – 52 item dataset

- | | |
|---|---|
| 1. Hostel | 28. Counselling appointments |
| 2. B&B | 29. CBT appointments |
| 3. Social housing | 30. 999 calls with no ambulance |
| 4. Private rent | 31. Ambulance call outs |
| 5. LA mental health care home | 32. A&E attendances with no admission |
| 6. Voluntary Sector mental health care home | 33. A&E attendance with admission |
| 7. New Housing Benefit claim | 34. Hospital inpatient stays |
| 8. Simple evictions | 35. Hospital outpatient visits |
| 9. Complex evictions | 36. GP visits (Doctor) |
| 10. Homeless application made | 37. GP visits (Nurse) |
| 11. Arrests with no further action | 38. IAPT appointments |
| 12. Arrests with charges | 39. Criminal justice mental health liaison services |
| 13. Police custody | 40. A&E mental health liaison |
| 14. Nights in prison | 41. Residential rehab |
| 15. Magistrate court cases | 42. Inpatient detox |
| 16. Crown court cases | 43. Specialist prescribing services |
| 17. On licence? | 44. Alcohol services outpatient attendances |
| 18. Community order or suspended sentence? | 45. Drug services outpatient attendances |
| 19. Number of fire service call outs | 46. Alcohol service community outreach |
| 20. New prescriptions | 47. Drug service community outreach |
| 21. Mental health inpatient | 48. Attendances at pharmacist |
| 22. Mental health secure unit | 49. Contacts with social worker |
| 23. Mental health outpatient visits | 50. Children in care |
| 24. Contacts with CMHT | 51. Number of weeks child(ren) spent in care |
| 25. Crisis callouts | 52. Benefit amount per week (excluding housing benefit) |
| 26. Mental health assertive outreach | |
| 27. Contacts with EIP | |

We would like to thank all those who have contributed to the content of this report, in particular Opportunity Nottingham Beneficiaries and Expert Citizens.

Opportunity Nottingham is part of an England-wide programme made possible by National Lottery funding from the Big Lottery Fund.

In order to ensure support is in place when Opportunity Nottingham closes, the below questions need to be addressed with partners and Nottingham City-wide organisations before 2022;

- 1 What will happen to people who are still on the project at the end of year eight (June 2022)?
- 2 What support will be available when Opportunity Nottingham stops taking referrals?
- 3 How can Nottingham invest in 'what works' at a time of austerity?
- 4 If Nottingham invests in successor support, what will the service look like?

Meetings will start taking place from late 2018 regarding the above questions.

Project partners and other Nottingham City-wide contacts will be involved. Please email enquiries@opportunitynottingham.co.uk if you or your organisation can support this work.

