LEAD WORKER AND PEER MENTOR

FIELDWORK EVALUATION

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PREPARED BY

emerging horizons

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"*Lives On Hold*" a report on LWPM service

REPORT

Emerging Horizons would like to acknowledge all who took part in providing their time and views for this report. We would like to thank the staff of Birmingham Changing Futures Together (BCFT) and Birmingham Shelter for being supportive throughout the review and enabling access. We would also like to acknowledge a number of clients and staff (former and present) engaged in the LWPM service who gave their time and their views.

PROJECT OVERVIEW

The BCFT programme is funded by Big Lottery's Fulfilling Lives initiative. Each partnership was required to have a single voluntary sector agency leading it and to take responsibility for 'bringing together a range of activities targeting those people with the most entrenched problems within their identified area.' [1] Led by Birmingham Voluntary Service Council (BVSC), the programme will work with service users (SUs) and organisations to shape how services are delivered to vulnerable people with multiple needs. The £10million, 8-year programme has been designed by local partners to improve services for the people using them within the geographical area of the Local Authority boundaries of Birmingham City.

The project focuses on long-term service and system change to support individuals to lead fulfilled lives and to ensure that successful models and approaches pioneered through this project become mainstream. With a strong focus on working in partnership with 'Experts by Experience'[2], the project aims to improve the collaboration and integration of agencies to improve the client journey.

Within BCFT there are several streams of work, and the one which pertains to this report is:

LEAD WORKER AND PEER MENTOR SERVICE (LWPM)

The LWPM service helps individuals with multiple and complex needs (MCN) navigate services and find the right recovery and support package. It is a four and a half year collaboration between Shelter, Sifa Fireside and Birmingham Mind, with staff employed across all three agencies, drawing upon substantial internal skills and resources.

The service is designed to support 'hard to reach' individuals, and the team is made up of 18 highly skilled, empathic frontline staff; Model A, 6 Lead Workers (LWs) who each take responsibility for a small case load of clients, formulating each client's care plan and co-coordinating, reviewing and overseeing a multi-agency care and support package. Model B, 6 LWs are supported by 6 Peer Mentors (PMs), trained Experts by Experience, who have first-

[1] Supporting people with multiple needs Evaluation Report: Year 1 Adamson, Lamb, Moreton, Robinson, Howe CFE 2015

[2] ESOW (Every Step of the Way) is a BCFT user involvement and engagement programme that supports individuals with life experiences of services to become Experts by Experience

hand experience of using services, who bring an added practical and beneficial dimension. Together they provide intensive support to individuals who have previously disengaged with services in Birmingham, and who have at least 3 out of the 4 following complex needs, known collectively as HARM:

- Homelessness
- Addiction and problematic substance misuse
- Risk of reoffending
- Mental ill health

The programme provides a key worker method of provision, using a variety of techniques and approaches to build relationships and develop packages of support. The service recognises that the client group would benefit from long term intensive support, and this support is unlimited in its duration for the individual.

Within this work stream BCFT are measuring the value added of the lived experience, by carrying out a test (Model A/Model B) to ascertain whether the PMs will further enhance the engagement of clients to accept and access support and services to help them achieve a fulfilled life.

REPORT ON THE PROGRAMME

This summary presents key findings of 5 day field research, carried out in March 2017 into the development and utilisation of BCFT LWPM service.

Rationale

The method is a simple one – attempts at assessing engagement were undertaken using a semi-structured interview approach in two populations; primarily the reported engagement of the clients themselves (n=1.5; 2 clients from Model B; one of which completed half of the interview), but also amongst staff (n=10); Service Manager, Team Leader, 5 Lead Workers (3 not matched with a PM, and 2 LWs matched to PMs) and finally 3 PMs.

Staff

10 sample interviews took place and included various roles outlined above. The interviewed staff responded to a request by the Shelter Service Manager. Time in post ranged from 5 months to 26 months. Eight of the staff were employed by Shelter, one by Mind, and one by Sifa Fireside. The interviews focussed on the way in which support is delivered by both LWs and PM as well as aspects of operating on a low case load which enables many of the team to offer a more personalised, holistic service than the larger providers. This more personalised care stemmed from 3 aspects of their approach

- Staff being accessible and flexible
- Continuity and intensive working
- Offering resources such as time, use of office equipment, advocacy etc. across the HARM domains.

A desk review of the Q4 December 2016 Common Data Framework (CDF) Update document, submitted by Shelter containing 191 service Users (SUs) and offering data for 184 (*base level data varies due to informed consent) was used for synthesising information.

Clients

Key reporting around the interventions provided by BCFT came from 2 Model B clients, both were approached opportunistically whilst they were on Shelter premises. Though their views are not necessarily representative of the SUs experience, they are worth acknowledging. They are interesting in terms of representing both sexes, a mean age of 43 (range 42 and 44 years), housing (street homeless and council accommodation), referral route (Midland Heart opposed to a friend introduction), and ethnicity (British Indian and White British). The interview focussed on the relationship and the support, whether their expectations were met and how impactful the service was on their lives.

Throughout the report the direct quotes from all those consulted are used to emphasis/illustrate the findings.

Method

The semi-structured interview was based on contemporary thinking about recovery as a process that takes place over time with a strong relational focus. The qualitative focus was on the subjective experience and needs of the participants and staff alike. This meant that there was attention on strengths of the programme rather than pathologies, seeing potential rather than problems, and on focussed support and engagement.

Reporting

Interviews were taken by an experienced researcher in interview administered approaches to facilitate client and staff perspectives and participation.

APPRECIATING THE CLIENT GROUP

For the purpose of this programme the Big Lottery Fund have defined MCNs clients as someone having two or more of homelessness, mental health problems, substance or alcohol misuse problems and a history of offending. To be accepted onto the LWPM service clients must present with a minimum of 3 of the 4 needs.

The terms associated with “multiple” and “complex” lack consensus, and Rankin and Regan (2004)[3] usefully identify the essence of complex needs as “having both a breadth of multiple needs (more than one) that are interrelated or interconnected, and the depth of need - profound, severe, serious or intense needs”. This definition is useful when considering the clients and it most definitely fits with their presenting needs. The notion of interconnectedness also lends itself to appreciate the need for a holistic approach and this being better suited to support these individuals.

[3] Jennifer Rankin, Sue Regan "*Meeting complex needs in social care", Housing, Care and Support, Vol. 7 Iss: 3* (2004)

Demographics/Presenting Needs

The Lankelly Chase Foundation's 2015 "Hard Edges"[4] report supported by the MEAM coalition ("Mapping Severe and Multiple Disadvantage") offered the first attempt to provide a more comprehensive statistical profile of the MCN client group. The study concluded that "People affected…are predominantly white men, aged 25-44, with long term histories of economic and social marginalisation".

These findings concur with the data set contained in this report; the profile is typical of individuals reflected in the data captured by Shelter, and also the year one evaluation of the aggregated data from all Fulfilling Lives programmes (CFE –"Fulfilling Lives: Supporting people with multiple needs" [5]).

The statistical analysis for this report used cumulative CDF data of 191 BCFT SUs in an attempt to appreciate and understand the nature of the client group, the issues they present with and any inferences we can gain from those who have been involved with the LWPM service since December 2014 (the service launch) to current data reporting of December 2016.

Multiple Complex Needs

All 184 presentations comply with the programme's objectives of clients having a minimum of 3 of the 4 needs.

Almost half, 89 SUs (48%), presented with all four needs, and of these 47 have been allocated a LW, the rest assigned both a LW and PM.

A further 51% presented with three of the four needs. The largest combination of which were those with offending, substance misuse and mental health issues (30% or 56 SUs), whilst the remaining 21% presented with various combinations of three complex needs.

These figures show there is an even prevalence of SUs presenting with 3 or 4 needs.

Substance Misuse and Mental Health

Since September 2015 there has been very little change over time in regard to the type of MCN presented. At the point of engagement into the programme 98% of SUs faced substance misuse issues and 95% faced mental health issues, all of which present with at least 2 other needs.

Homelessness

Of the four needs, only one – homelessness – has been clearly defined for this initiative in the context of all Fulfilling Lives projects:

[4] http://lankellychase.org.uk/wp-content/uploads/2015/07/Hard-Edges-Mapping-SMD-2015.pdf
[5] Fulfilling Lives: *Supporting People with Multiple Needs Evaluation Report Year 1* Adamson et Al 2015

Homeless includes those who are statutorily homeless, sleeping rough, single homeless people living in hostels, shelters or temporary supported accommodation, and hidden homeless households including those living in overcrowded conditions or temporarily sharing with family and friends.

The breakdown of housing needs show that since September 2015 69% (128 SUs) presented as homeless at point of engagement, obviously coupled with 2 or more of the other needs. This is clearly a vulnerable cohort living on the margins of society, at the extreme end of secure housing. This lack of secure, stable accommodation can only exacerbate their other needs. Staff report a return to easier direct access to hostel accommodation after a system change from Birmingham City Council Gateway, and perhaps this will be reflected in the next quarter figures.

Offending

Just under half of the SUs (48%) report risk of offending with the 3 other presenting needs and 86% of the cohort are reported as having offending behaviour in conjunction with at least two other needs. Understandably staff cite police and probation as major sources of referrals.

30% report risk of offending with substance misuse and mental health. 5% report offending with homelessness and substance misuse. It is worth noting that 80% of the total cohort report offending and mental health and 83% report offending and substance misuse.

100% of those with offending behaviour also report 2 or more other needs including mental health and substance misuse and this is higher than the general prison population, estimated at 90%[6], presenting with one or more of the five main psychiatric disorders (psychosis, neurosis, personality disorder, hazardous drinking and drug dependence).

Disability

In addition to MCNs, 43% of clients class themselves as having a long term (likely to last more than 12 months) health problem or disability that affects their ability to carry out day to day activities. This amount has increased by 10% on last year. The figures imply that disabled individuals are disproportionately represented, and this is supported by the Hard Edges report which finds a higher than average occurrence.

It is worth noting that 90% of the current cohort also present with literacy as a problem.

Gender and Age

In terms of the service so far gender representation has remained steady, suggestive that this is a sound depiction of the gender profile of MCN in Birmingham. Female representation has remained consistent and data shows an increase over time of 38 SUs (from 23 to 61). However, the 67% majority are male, rising from 37 to 123 SUs and this confers with

[6] 1 The Bradley Report, *Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system,* April 2009

homelessness more "likely to be a predominantly male phenomenon" (Fitzpatrick et al., 2013) cited in the Hard Edges report.

The biggest proportion of individuals (76%) are classified as "White UK, Irish or Irish Traveller", and of these 50% are male, this is line with the Birmingham Census 2011[7] with 57.9% being "White ethnic". The remaining 22% of the cohort are Black, Asian and Minority Ethnic (BAME) (2% no data), again these figures are consistent with Census data and Fulfilling Lives aggregated demographics.

The largest age group, over a third (35%) are in their 30s, whilst those in their twenties represent 21%. Census information tells us that Birmingham is a youthful city: 45.7% of Birmingham residents are estimated to be under 30. Those clients in their 40s signify a similar number (26%). The outliers are aged under 20 and over 60, accounting for 2%. 82% of all engaged clients fall between the ages of 20 to 58.

Engagement effects

Those SUs allocated both a LW and a PM seem to fair better and average over 7 weeks longer on the programme than those without a PM (CDF December 2016). Both sexes averaged 30 weeks on the programme; males from 1 to 83 weeks, whilst female engagement was shorter ranging from 2 to 67 weeks.

Staff attribute the longer length of stay for those assigned a PM to various factors including; the shared lived experience; the trust gained by the PMs; the LW and PM partnership with the mix of professional and lived practical experience; and the programme itself. All staff unanimously rate the input from the PMs and the positive aspects this brings, and this is not limited to the lived experience. At this juncture it is worth being mindful that the PMs have had experience of at least 2 of the 4 complex needs themselves. It is more suggestive of a way of being with the client, solely for the client. The informality and a level of comfort between the client and the PM staff team can provide hope that things can and will get better.

Staff assert that professionalism can be learned (i.e. the role of a support worker) whereas the lived experience (PM role) can't be taught; it is this intuitive appreciation and understanding of the clients and their innate experience of utilising services for themselves that staff attribute to successful engagement. These different ways of working are summed up in the following comment;

> *"Non-institutionalised culture and way of working. Bring a fresh outlook and are client focussed. They aren't concerned about KPIs and will do what needs to be done for that client. No knowledge of office politics and they are there for the client, not for Shelter."*

[7] https://www.birmingham.gov.uk/directory_record/75397/population_2011

Connectivity

All staff were asked as to their views on client connectivity; whether they thought that they were better connected to service provision. 100% of staff stated that as a direct result of the programme the clients were now better connected. Comments such as handholding to appointments were frequently cited as examples of this better connectivity.

Staff often named ***holistic*** ways of working with the client group, insistent that the service is built around client needs. An example of this can be seen in the comments below;

> *"We offer dynamic, flexible support that is built around the very personal needs of each client. We do not restrict the length of time or how we support each client…we support them."*

> *"We work person centred and ask the client what do they want us to do?"*

Both of the clients interviewed felt respected and care for, and this was a key motivator for them continuing to engage with the programme. They offered the following as an example of ***easier, more streamlined access*** demonstrating the practical support offered;

> *"My biggest thing is anxiety and depression. I have PTSD and I have trouble leaving the house. I want them (Staff) as witnesses as to what is going in my life. I can talk about practical issues. They have supported me with CGL, psychiatrist and docs – Shelter have been very good like that."*

> *"They make appointments for me and then when I can go they will come with me."*

Active clients

Of the 63 current active SUs, 65% (41 SUs) present with all 4 MCNs, whilst the rest of the client group have a combination of 3 needs.

97% present with substance misuse.

94% present with mental health.

89% are at risk of reoffending.

86% consider themselves currently homeless.

68% are 'White UK, Irish or Irish Traveller'.

64% are male (43% representing White ethnic).

41% are in their 30s.

In common with all previous presentations the largest clusters are male, White ethnic and in their 30's, presenting with a heady cocktail of needs.

System change

The two clients remained extremely positive regarding the support they had received, however comments were suggestive that more needs to be done to affect and instil system change, mentioned by both clients;

> *"I could go to appointments alone but I feel like the enemy and that everyone will look down on me and the only person I want to talk to is a PM."*

> "*Easier but still frustrating. BCFT should be challenging other agencies about how they do things. Vulnerable people need advocates and if it is about service change then it should change the way things are done not just be passive witnesses otherwise nothing is going to change."*

The latter negative comment refers to that particular client and the perceived slow rate of change s/he has experienced in their circumstances, compounded by having to come to terms with an identity change as a former professional with a high educational attainment to the conditions s/he finds him/herself in presently.

The comments also chime with staff responses (60%) who are also in agreement about the need for wider system change;

> *"We can advocate on behalf but there needs to be a system change. If we could attend meetings to explain what has happened instead of having to pass onto our TL who relays to Service Manager who relays to BVSC. We are removed from this process and we need to be involved in it."*

Staff assert that some services use the presenting issues as a reason not to fully engage with the client, for example any missed appointments are not necessarily rescheduled to suit/fit with the clients presenting needs, and services seem to disengage. Staff explain that there is a certain amount of time i.e. "a window of opportunity" to act with the client, and this usually goes amiss due to appointments not being available from services when the opportunity arises. Wider partner services are seemingly not yet ***tailored to meet client needs,*** and this is an early indicator of a lack of shared understanding as to what multiple and complex needs are**.**

On a brighter note, PMs advocating on behalf of the client and challenging traditional service protocols has given permission for LWs to do the same, and they too are now employing similar tactics to create system change. This essentially relates to the PMs lack of professional etiquette, that is to say they are willing to assert the rights and needs of the client over their professionalism, even if this means demanding a particular service to meet with clients' needs.

Relationships between Lead Workers and Peer Mentors

"*The anti-PM sentiment",* referring to a perceived lack of professionalism and ***lack of boundaries*** coupled with over ***generous sharing*** etc. seem to have happily diminished and considered as general teething problems of embedding any new stream of work.

It is encouraging to note that career progression for PMs includes external NVQs in conjunction with in-house induction. Some staff say that these opportunities ought to be extended to all staff, furthering the ethos of equality and partnership work between the 2 roles and this would go a long way to strengthen partnership protocols and enhance LW motivation.
There now appears an equal division of responsibilities and the majority of staff report a 50/50 partnership, with the "*Them and Us*" feeling having disappeared. This is due to the organisational and staff learning that has taken place as the programme has evolved. Staff report a "culture shift" and the general mood is echoed in the following sentiment;

> *"Our recruitment has changed to look at our values as well as the experience and co-working, and in 2 years we have developed the role. All PMs have had positive moves and where they have relapsed we have managed this internally, 5 LWs have left or have been managed out. We have had a cultural shift for positive reasons and our recruitment processes now reflect this."*

High staff turnover seems to have impacted positively in terms of the cultural shift. Relapsing PMs have been managed internally rather than going through the HR protocols of the Charity. That said, too many staff to dismiss raised other concerns and some of the more negative comments centred on personality clashes and the perceived favouritism of certain workers;

> *"Personality clashes are abound. There are differences of opinions, if you tell tales to Team Leaders you are treat differently. There are subtle undertones of subversive manipulation."*

This comment may be linked to the PMs who understandably continue to express the difficulty of living, working, socialising and recovering in the same circles. For example, when an incident occurs outside of work there seems to be an expectation to share the information in work. This can create unnecessary pressure and tension within the role, as is highlighted in the following two separate comments;

> *"Staff relapse. Outside connections should not be used to influence decisions. Decisions should be made by management, and not by asking the PMs what is going on. Being abstinent is not a requirement but professional behaviour is. If you are expected to work with MCN then you relapse you should not be exposed. That's not safeguarding."*

> *"Issues between me and other colleagues have been personal as we know each other outside – it is incestuous so I needed to look elsewhere for support."*

Allocation of LW and PMs

There is a unanimous agreement amongst staff that there should be an equal matching of PMs to all LWs, to support and benefit the relationship with the clients and issues regarding how ethical Model A and B are were raised.

> *"If there are 12 LWs we need 12 PMs."*

Comments were very positive regarding the effectiveness of the lived experience. These ranged from observations of the value and benefits of the role; the interaction with the clients, LWs assertions that the role is "pivotal" and "crucial" as the visible recovery provides hope, trust and ***inspiration***. Those LWs without a PM would welcome one.

Adding to the SU experience, acting a bridge between the SU and the programme, the PMs have conversations about their own situations and how they managed to overcome their own difficulties.

It is also encouraging to note that Shelter are managing 2 newly created PM posts for Liaison and Diversion. This is an indicator of the positive perceptions wider partners are beginning to have of the role and its benefits.

Significantly many staff believe that some clients would not have engaged at all after referral had it not been for the input of the PM.

> *"After the referral comes in the initial assessment is critical – lots of the referrals don't get past the initial assessment if there is no PM there."*

This telling comment demonstrates the value of the PMs lived experience, intrinsic awareness of the client, the ease in which they support engagement adds to their way of simply "*being with*" the client.

The two clients also express the added value of the PM relationship. Both reported good relationships, as well as incidences of more personalised support across domains such as talking about issues and attending other service meetings together;

> *"I could go to appointments alone but I feel like the enemy and that everyone will look down on me and I would rather talk to a support worker like the Peer Mentors than anyone else about things."*

> *"I have 4 people in life and one of them (PM) is here."*

When asked what the service did for them, both clients responded positively, illustrated in the following comments;

> *"The support has kept me going. Having someone to talk to and somewhere safe to drop into. They have come out looking for me on the street which proves that someone does care."*

This individual empathic support and ongoing contact has made a difference to their lives and this combination is repeatedly commented upon as vital ingredients for their health and well-being.

Issues regarding the utilisation of PMs have been managed and organisational learning has certainly taken place. PMs are able to share their experience if and when necessary in support of the client, and learning in terms of working protocols has most definitely occurred. It is pleasing to note the 3 PMs interviewed referred to themselves as "professional" which is a positive indicator of identity and organisational value shift.

Outreach

There is a discrepancy with outreach as to whether this still exists. The majority of staff (70%) maintain that active outreach doesn't happen anymore, whilst others say that they go on outreach with other services e.g. Midland Heart and SAFE. Staff state that the majority of SUs come from referrals from other diverse sources e.g. police, probation, hospital, housing options etc.

Referrals from external sources are often incredibly vague and "detective work" takes place to locate the client. Once a referral has been received there appears to be little difference in ***the roles played by both the PM and LW in terms of prior engagement***. The work is autonomously organised and distributed between the two staff.

> *"Referral comes in and we get the same information and contact number. We then make contact and set up the appointment. We share the work and there is no real difference."*

> *"It is diverse who we get referrals from. We work the case and are given autonomy in this."*

Where the roles do differ these largely relate to administration and professional expertise

> *"LWs are the co-ordinators of services, they do referrals and liaise, do paperwork and risk management. PMs have less responsibility and facilitate engagement with client to navigate the services."*

Effective outreach also appears to be hindered by the lack of a "city hub", mentioned by one member of staff, where individual's with presenting needs could possibly drop in and connect with the programme staff. What happens at present is that those who have already engaged with the programme are the ones who use Shelter as a drop in.

Disengagement

100 SUs have had LWs (Model A) and 55% of these have disengaged. 84 SUs have had both a LW/PM (Model B) and 45% (38 SUs) of these have disengaged. Disengagement accounts for 73 clients to date. Female disengagement stands at 55% compared to 48% of males.

Questions could be posed to this client group to ascertain what the contributing factors are and what happens to all clients after they disengage.

The differences in disengagement are not statistically significant when calculating the resource input of staff from Model A as opposed Model B and against a back drop of a larger LW caseload.

The baseline destination viewed by Fulling Lives as a measure of success are those clients of which the programme reports "*no longer required support"* (18 SUs 14%). A further 9 SUs moved to other support, and another 9 SUs (7%) were given custodial sentences. Again it would be useful to consult with these clients as to their reasons for no longer needing assistance to navigate services. Staff assert that what is classed as a success does not incorporate the bigger picture, for example engaged clients dropping in to Shelter for refreshments and change of clothes. Both a client and a staff comment highlight this:

> *"I only use Shelter to get clean clothes, somewhere safe to sit and have a chat."*

> *"The roles (Staff LW and PM) tailor the support to achieve positive outcomes - but these are not funder dictated outcomes - they are what the client will consider a success. For example, a reduction in substance use or accessing a hostel and staying there for a period of time."*

When staff were asked for their views around disengagement responses varied between it being typically reflective of the complex nature of the client group (relapse, custodial sentences, mental health, mistrust of services), navigation of other service protocols e.g. appointments from other services not being readily accessible, inappropriate referrals and the utilisation of "*HOLD"* and "*CLOSE*" (a period of waiting to see if the client re-engages with the service. If the client does not re-engage the client is then closed).

Some staff are of the view that the use of *HOLD* is unhelpful for both the client group and the programme, adding that no real efforts were being made to keep the clients engaged. Some staff alluded to there being a lack of boundaries and consequences for the client, and this coupled with the seemingly embedded culture of accepting disengagement may account for the high disengagement rates. These sentiments are illustrated in the following significant comment;

> *"We were meant to be there consistently and the HOLD and CLOSE is moving us away from that and we are becoming like other services. This strategy can make us choose who we want to work with, and be more selective. After HOLD clients can view us as not being there. Sometimes this can move the client forward, but it has broken the trust. HOLD should be rare and not as common – it is now overused. If you took HOLD/CLOSE away I think the whole team would have to work harder and not used as easy get out clause."*

That said, since December 2014 to date, a total of 17 clients have re-engaged with the service since 2015.

> *"I think working with this very complex group means that there will always be a percentage of disengagement and then re-engagement and this is not reflected in the figures."*

Outcomes

Each project is required to undertake a The Homelessness Outcomes Star (HOS) and New Directions Team (NDT) Assessment with SUs at the outset of their engagement with the project and on six monthly intervals thereafter to track and measure changes in outcomes over time.

Both LW and LW and PM report positive outcomes on the Outcome Star and the NDT Chaos Test. On average, under half of SUs (44%) have had at least 2 of these assessments. Scoring across both measures has improved, on average by 50% demonstrating improved confidence, self-esteem, mental and physical health, housing status and reducing substance misuse and reoffending. The Outcome Star categories with the greatest improvement are 'Offending' and 'Managing tenancy and Accommodation'. This is important as evidence[8] suggests that the use of temporary accommodation prior to being resettled and the duration of stay have a strong influence on tenancy sustainment i.e. those likely to retain their tenancy have experienced long term stays (12 months or more) in temporary or supported housing.

Notably the one Outcome Star Category to worsen is "Social Networks and Relationships" as well as the "Social Effectiveness" score for NDT. Staff have alluded to the pathway's perceived inappropriateness in terms of building positive social networks. The general view is that the work stream "Beyond the Basics"[9] should not come after LW engagement. Rather this should be offered simultaneously to support the client's lifestyle transition. We know from the evidence base that recovery group participation is associated with building and sustaining motivation for sobriety, for creating pro-recovery social networks and for allowing people to learn and copy recovery techniques (Moos, 2007[10]).

In addition to this the pathway of ESOW and NWD are not considered an appropriate route for these clients, with staff deeming it unsuitable for the presenting nature. Gaps in the pathway seem to be immediately after the client has engaged and the adjustment required to become involved in ESOW being seen a step too far.

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[8] Warnes, A. and Crane, M. (2006). Factors in the outcomes of the resettlement of homeless people. Unpublished grant proposal approved for funding, Economic and Social Research Council, London, UK.

[9] Beyond the Basics - *post lead worker engagement which is designed to help clients develop positive peer networks and relationships, access positive and stimulating leisure opportunities and to take up volunteering, training, employment and business/self-employment opportunities.*

[10] Moos, R.H. and Moos, B.S., *Protective resources and long-term recovery from alcohol use disorders. Drug and alcohol dependence,* 86(1), pp.46-54. 2007

However, programme effectiveness is highlighted in the ability to share a client's journey and to co-ordinate, advocate and support the client to navigate other services to maximise health and wellbeing in supporting them to live fulfilling lives.

When asked whether their lives had improved both clients unfortunately reported that there was no real difference in their life experiences;

> *"The support has kept me going. Having someone to talk to. Things haven't really changed for me though. I have some good periods but things haven't really got any better."*

> *"No skills development and no real improvement. There should also be some cultural training for the staff. They have no idea about my culture."*

Client interviews are obviously not statistically significant to accurately demonstrate any positive ***soft outcomes nor any reductions in inappropriate use of emergency services***. When asked what made them continue to engage as they had reported no real change, the replies centred on somewhere to go (Shelter) and the praise which is a motivating factor for both of these clients.

> *"Somewhere to come and I know they will let me sit down."*

> *"I have more strength through motivation."*

Concluding comments

The most common demographic profile are males between 20 and 49 years of age, of a majority White ethnicity. This representation could be due to the fact that these males are the most visible in the city and that females may find alternative services/places of safety so are thus less visible, or they may have differing needs. This begs the question as to whether the system is geared around the most visible clients, who are historically male, leaving a potential for females and other ethnic groups to go undetected and thus be underrepresented. A consideration of how and why people are referred into the programme would shed some light on this. Work could then begin to represent those marginalised from alternative ethnic and gender minorities, fully utilising Fulfilling Lives definitions of homelessness.

It was disappointing that only two clients were interviewed opportunistically. A consideration of past and present clients' reasons for disengaging, or indeed choosing to remain on the programme, would offer insight into just how effective the project is at reaching its intended target.

It would also be useful to hold events with staff, key stakeholders, wider partners and the client group to add further dimensions as to system blockages and change. If the current Fulfilling Lives pathway (LWPM – NWD – Beyond the Basics - ESOW) provision is deemed

inappropriate for the presenting nature of the clients, then perhaps a review/consultation of the expected pathways for these clients would contribute to a move in the right direction.

In brokering this system change LW and PMs could be offered an open forum to voice their concerns rather than having to pass essential information up the chain of command. Some staff feel that their vital perspectives can get lost in translation. This would be useful, particularly when the core aim is that evidence and learning from the programme will promote positive changes in policy and practice, ultimately leading to a changed system that works more effectively for people with MCNs.

Given that 100% of SUs are presenting with 3 or more needs, further investigation as to dual diagnosis services would support assessment to where the reported gap in provision lies. A consideration as to how this void could be addressed to meet presenting needs is considered vital for continued engagement. Attempting system change in the context of funding cuts and the presenting nature of the clients is no mean feat, but it is not impossible. It is testimony to the staff that initial teething problems of introducing PMs who lacked work experience have now, for the most part, been successfully embedded into the service and this most definitely did not come without its challenges.

The high disengagement rates are noticeably and largely dismissed as the "nature of the clients" and the use of HOLD may provide both clients and staff alike concrete reasons to disengage. The use of this strategy could be reviewed as to the reasons used for HOLD, what accounts for a HOLD and how this is utilised within the programme. This is clearly a complex population with ongoing needs around mental health, physical and learning disability and the need for continued support engagement is paramount to the project's success.

The possibility of extending the staff team of PM so that each LW has access to one would promote the benefits of the lived experience for all clients. The clients not only value the support but there is a strong commitment as to the multiple layers of benefit the PM's bring from staff and wider partners too. They are certainly more than a pair of extra hands. The service could perhaps utilise a pool of PMs who offer a diverse range of skills and experiences and match these to the needs of *every* client.

Enabling factors include the dedicated, knowledgeable and personalised holistic 1:1 support from three specialist combined organisations that understand the complexity and the nature of the presenting clients. This and the balancing of good partnerships with external agencies whilst maintaining a distinct BCFT independent status are positive attributes. The low caseloads and the positive mix of the professional and lived experience all contribute to programme effectiveness and the navigation of services on behalf of the client.

There is a vindication and support for the LWPM service in terms of its capacity to enable to sustain engagement and make some progress with complex clients. Given the complexity of the population in terms of mental and physical health, this is an admirable achievement.