LEAD WORKERS AND PEER MENTORS

FIELDWORK EVALUATION

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PREPARED BY

emerging horizons

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EVALUATION

Emerging Horizons would like to acknowledge all who took part in providing their time and views for this evaluation. Emerging Horizons would like to thank the staff of BCFT for being supportive throughout the review and enabling access. We would also like to acknowledge a number of staff from other local service providers who gave their time and their views.

PROJECT OVERVIEW

The Birmingham Changing Futures Together (BCFT) programme is funded by Big Lottery's Fulfilling Lives initiative led by BVSC, and will work with service users 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.

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', 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 fieldwork evaluation is:

LEADS WORKER AND PEER MENTORS SERVICE (LWPM)

Helping individuals with multiple and complex needs navigate services and find the right recovery and support package. The LWPM Service 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 12 skilled, empathic Lead Workers (LW) who each take responsibility for a small case load of clients, supported by 6 Peer Mentors (PM) who have first-hand experience of using services. 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:

- Homelessness
- Addiction and problematic substance misuse

- Risk of reoffending
- Mental ill health

The service provides a key worker approach to support, 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, therefore they have up to 3 years to work with any individual.

Within this service BCFT are measuring the value added of the lived experience, by carrying out a test:

Model A: is a cohort of six Lead Workers

Model B: is a cohort of another 6 Lead Workers who are supported by six peer mentors, who can empathise with the client group they are working with.

The service is testing the assumption that the Peer Mentors will further enhance the engagement of clients to accept and access support and services to help them achieve a Fulfilled Life.

REPORT ON THE LWPM PROGRAMME

This summary presents key findings of 4 day field research, carried out in March 2016, into the development of the Birmingham Changing Futures Together (BCFT) Lead Workers and Peer Mentors (LWPM) Evaluation Fieldwork.

RATIONALE: The method is a simple one – attempts at assessing engagement were undertaken using a semi-structured interview approach in three populations; primarily the reported engagement of the clients themselves (n=6; 3 clients from Model A, 3 from Model B), but also amongst staff (n=11) and wider key partners (n=2) who responded to an interview request.

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. This meant that there was attention on strengths of the programme rather than pathologies, and on focussed support and engagement. The qualitative focus was on the subjective experience and needs of the participants.

REPORTING: Interviews were taken by an experienced researcher in interview administered approaches to facilitate client, staff and wider partner perspectives and participation.

FINDINGS

CLIENTS

Key reporting around the interventions provided by BCFT from 6 male clients, mean age of 42 years, living in a range of accommodation including rehab, hostels and shared housing. 3 clients have a LW only, the remainder having both a LW and a PM. The interview focussed on the relationship and the support, whether client expectations were met and how impactful the service was on their lives.

RELATIONSHIPS

100% of clients reported a good relationship, and when viewed from the perspective of the background of the clients this is incredibly positive. All reported various forms of more personalised support across domains of housing i.e. "*Helped me find a home. I was sofa surfing.*" clinical support and assertive hand-holding, "*they come to appointments with me like the doctors, hospital, court and CRI"* and day to day living support referencing autonomy and accessibility i.e. *"Lets me use the phone. I come 3/4 times a week to use the internet and phone and travel cards…", "offer me a safe place to sit"*.

SERVICE SUPPORT

When asked what the service did for them, all 6 clients responded positively, illustrated in the following comments; *"You don't get fobbed off and she is always in contact." "Talks to me like a human being." "If I don't phone them they will phone me." "I get emotional support to talk."* This individual empathic support and ongoing contact has made a difference to their lives and this combination is repeatedly commented upon by all clients as vital ingredients for their health and well-being. The trajectory of change is very clear. Clients cite examples of now having stable accommodation, resisting engagement in substance misuse or anti-social behaviour and given the complex circumstances of the client group and their cumulative and multiple disadvantage this is a huge testimony to BCFT.

LW/PM support

When considering the distinction in support provided by LWPMs, the clients with both an LW and a PM appear to appreciate the difference and this can be summed up in the following comment, *"He (PM) gives me advice. He tells me "I have done that". He has been to the doctors with me. X has been there and done it, Y is professional and by the book. Two angels have met and I can tell that X has been there."* The assertive linkage to external agencies is also referenced in the following client comment, *"Takes me to meetings – always positive. I have made friends which is not easy because of my bi-polar."* This is critical, as 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 ([i]Moos, 2007). The comments demonstrate the value of the lived experience in instilling hope and connectivity in the client, and there is a clear indication of positive change in the population in spite of the relatively small sample.

In considering what could be improved with the service clients reported that nothing needs to be changed except to provide the city with more support like this to ensure that others receive the same 1:1 professional and personal support. 100% of clients are delighted with what BCFT has offered so far and the findings suggest that those involved in the LWPM programme remain well supported and connected throughout their time.

ONGOING CHALLENGES

Two clients reported communication confusion between other services, for example securing accommodation, but these challenges were qualified by clients reporting that these issues were not the responsibility of the service but more to do with ineffective communication in external agencies such as the bail hostel.

It is pleasing to note that all clients valued the service highly and were able to articulate the positive impact it had had on their lives, as referenced in the following comments.

"I was homeless in Sutton Coldfield. I was begging on the streets. Now I am 3 months in – I have stopped begging, stopped crack and my homelessness has been sorted. I've also got my benefits sorted and had a medical assessment. They come and meet me and come to appointments with me. They have given me food parcels."

"I don't know what I would be doing without them. I was in a bad way. They helped me. I have been sober since October. I got off the gear, I was on 130ml of methadone for 18 years!"

"I was homeless and a street drinker and now I am thinking of volunteering. I've just finished an 8 week woodwork course and now I'm starting a horticultural course."

STAFF

11 sample interviews took place and included various roles; 1 Peer Mentor Co-ordinator, 1 Team Leader, 3 LWs Not Matched, 3 LWs Matched, and 3 PMs. Time in post ranged from 3 months to 15 months. Eight of the staff were employed by Shelter, two by Mind, and one by Sifa Fireside. The interviews focussed on the way in which support is delivered by both LWPM roles and 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 domains of homelessness, addiction, mental health and offending behaviour

FINDINGS

These are closely interwoven with the way in which support is delivered. Staff did not discuss their support as having a distinct PM/LW outcome outside of the personalised experience of support for the client. There was greater articulation of the end result, demonstrated in this comment, *"Flexible in how we support, not one set outcome, we can work holistically. As a former drug worker I'd only worked with drug issues but now I can stay with the client throughout their journey. It is more consistent."* This emphasises the personal journey staff take their client through and is illustrative of the longevity of the support on offer, the flexibility and the professional and personal knowledge that the staff team bring to the service.

In respect of service utilisation comments were mixed. There was an acknowledgment that the service was new and not without teething problems such as the lack of capacity for evening and weekend work; the lack of a personal client budget making it difficult to offer clients refreshments when on outreach and having to continually engage with clients even when the client is intoxicated.

On a more positive note, other comments evidenced in the staff case-studies appearing below, highlight the value and the benefits the LWPM programme brings to the city such as navigating external services on behalf of the client; the amalgamation of the 3 services offers a strong range of experience and knowledge; low caseloads (maximum 8) affording for more flexible, persistent and personal client support and continued work with the client to encourage, initiate and support long term change.

In exploring the role of the LW staff acknowledged professional expertise, this is in contrast to the role of the PM and in accordance with the model, where the asset is considered to be the lived experience.

EFFECTIVENESS OF THE LWPM PROGRAMME

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 mix of the professional and lived experience all contribute to programme effectiveness and the navigation of services on behalf of the client.

LIVED EXPERIENCE

Comments were mixed regarding the effectiveness of the lived experience. These ranged from the perceptions of the value of the role with some LWs asserting it is "*pivotal*" and "crucial", whilst others had not yet witnessed the benefits the role brings, for example *"How can you separate who does what? Data for each client does not relate to who does what. PM shared a similar experience around alcohol but it was a different experience."* and *"We need to understand that the relatable experience is not the other person's experience."* That said, the benefits the role brings, such as visible recovery, are fully realised in the following LWs comment; *"The PMs self-disclosure on addiction made the client sit bolt upright and it gave the client hope. The PM has been clean for 3 years so it gave the client something to think about – the client doesn't know anyone who isn't in addiction."*

CLIENT PROGRESSION

All staff without exception were able to offer concrete examples of client progression through the utilisation of their respective roles. 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 and support them to live fulfilling lives. These examples are evidenced in the following comments.

> ***"First client was street homeless, drinker, anxious. He was nervous and I said "I've been exactly where you are, only I am not doing it today" Homeless, addicted, in and out of trouble. By the end of the day we got him to the doctors and took him on. I remember the anxiety and not engaging with any service. I have played a part."*** Peer Mentor

> ***"First client referred from SIFA. Rough sleeper – alcoholic and street drinker engaging in ASB. LW gained trust over 3 months. Took for coffee. Support built and accommodation was provided away from Moseley. He is engaging in support and values the LW's support and now volunteers in community orchard."*** Lead Worker

> ***"Homeless, begging client who was disinterested. It wasn't until I said I had lived experience then he listened. He is still engaging now – I am adopted and he was. He now has identification. I helped him get ESA. He feels it was me that done it – he doesn't talk to anyone. I know where to find him and we can be flexible."*** Peer Mentor

BARRIERS TO EFFECTIVENESS

Barriers to the programme working as well as it could related to difficulties of maintaining staff/team contact over three bases with three organisations'. These challenges were associated with the different working hours at each organisation; the different case management systems; the lack of key fobs to gain entry into other host organisations and pay scale differentials, as well as some PMs being matched to LW in a different organisation. These are demonstrated in the following staff comments; "*The 3 organisations working as a team. We are all paid differently, different holidays etc. It causes an undercurrent. File sharing is a nightmare. Each organisation has a different individual system that can't be accessed and it is all incompatible. Makes life difficult*." and *"LW is employed by Mind but the PM is employed by Shelter. The case file is in Mind, so paper work and data submission is difficult".*

Other reported ongoing challenges included the matching of the PM to the LW, rather than matching the PM to the client. This brought about challenges for LWs and PMs in terms of being matched or not, having a co-worker present for 5 days a week, managing appropriate disclosure and maintaining boundaries. The matching process was viewed negatively in terms of it not providing an appropriate mix of skills and experience as illustrated in the following comment,

"*PMs should be paired with clients. LW has MH expertise, I have drug abuse but the client may not have this e.g. a sex worker. It would help if PM was matched to client*". It is worth noting that the perceived issue around matching PMs to LWs was mentioned by a staggering 91% of staff.

KEY STAKEHOLDERS

Two external providers offered their perceptions of the service. Comments centred on embedding in a new service and the providers being pleased with those they have so far referred in, citing client progression and timely updates. The role of the service having specialist expertise in complex clients was noted, and the fact that the service offered another layer of support was welcomed by both respondents. It is pleasing to note that both stakeholders would welcome more LWs and PMs.

CONCLUSION

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

The clients not only value the support but there is a strong commitment to the staff. There are also early indications of strong and stable recovery and social capital. However, this is a complex population with ongoing needs around mental health and the need for continued support engagement.

RECOMMENDATIONS

Different approaches could be developed to enable smarter working practices for LWs and PMs e.g. a common system for file sharing and information sharing, a team base, a personal client budget.

The possibility of increasing the staff team, or tapping into existing community supports to allow for longer working hours including evening and weekend work.

Opportunities could be developed to consider matching of clients to PMs, which would assist the lived experience aspect of the model whilst alleviating any pressures of LWs having a matched

PM. 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 the clients.

Career progression for PMs could include external NVQs in conjunction with in-house induction. A change of the PM title would also be welcomed to eradicate confusion with external services, who also use the term Peer Mentor for their service volunteers and thus perceive BCVS PMs as volunteers.

Continued and increased external promotion of the service to assist with joint working partnerships and to aid embedding of the service within the city.

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[i] Moos, R. H. (2007). Theory-based active ingredients of effective treatments for substance use disorders. Drug and Alcohol Dependence, 88(2–3), 109-121.