

FULFILLING LIVES

Newcastle Gateshead

Client journey

Mid-programme evaluation report

Ang Broadbridge, May 2018



**CHANGING
LIVES**

**NATIONAL
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1. Introduction

1.1 About this report

At this stage, the halfway point in the Fulfilling Lives 8-year programme it is important that we look at a snapshot in time to explore what we have learned about our multiple complex needs client group and the system they interact with. This report aims to provide more information in answer to the following questions:

1. Who are the multiple complex needs client group?
2. What has their Fulfilling Lives journey been like so far?

This report is part of a much larger body of evidence that is being produced from the Fulfilling Lives programme; both locally and nationally. Evidence across all twelve Fulfilling Lives programmes is being analysed and reported on by CFE Research. Their evidence is produced independent of the individual projects and looks at common trends and evidence at the national level.

At a local level, we have produced evidence reports for individual systems change pilots and specific aspects of the Fulfilling Lives programme in order to assess impact and, where appropriate, cost effectiveness.

Our system change activity is focussed around three main areas:

- Access to secondary mental health services for people with multiple and complex needs.
- Transitions, including prison release, hospital discharge, access to welfare benefits, and moving towards independent living.
- Workforce development, including psychologically informed environments (PIE), multiple and complex needs training, and reflective practice.

This report exploring our client group journey should be read in conjunction with the aforementioned reports but also and in particular; the New Economics Foundation report we commissioned reviewing our approach to System Change, 'Changing systems for people with multiple and complex needs evaluation of Fulfilling Lives Newcastle and Gateshead' September 2017 (available on our website).

1.2 About Fulfilling Lives Newcastle Gateshead

What is Fulfilling Lives Newcastle Gateshead?

The Fulfilling Lives Programme is seeking to help people with complex needs to better manage their lives, by ensuring that services are more tailored and better connected to each other. The focus of the programme is on those people who often spiral around the system(s), are excluded from the support they need and experience a combination of at least three of the following four problems; homelessness; re-offending; problematic substance misuse and mental ill health. Our goal is to improve and better coordinate services to support people across Newcastle and Gateshead living with multiple and complex needs – to see people for the potential they have, rather than for their problems.

The longevity of the programme and level of funding allows real opportunity to make a serious impact upon the lives of people with complex needs living in and between Newcastle and Gateshead. This means that beyond supporting the individual, one of the main aims of Fulfilling Lives is to learn through the programme, and through that learning evoke a change to the system that will allow us all to work more effectively for people with multiple and complex needs.

Fundamental to this learning is the engagement of service users in the delivery of the programme and finding ways of improvement from a service user perspective.

How it works¹

During the period 2014-18 we offered a combination of Service Navigators to tackle individual need and System Brokers who address systems blockages. The System Broker role was to identify where the current system may prevent service users from transforming their lives and then work with the Service Navigators to evidence the real issues facing our client group.

We also established Experts by Experience, Operational and Strategic reference groups. These groups are committed to understanding and changing the way services respond, are commissioned and are delivered, based on evidence of the real issues.

Our vision

Our hope is that as the system changes it becomes better coordinated and easier to navigate for people with complex needs. The result will be a diminishing demand for Service Navigators and less cost to society.

By removing barriers and blockages to support then the help required to negotiate a complex system will lessen, and this will enable our programme to focus on the provision of a sustainable peer support network reaching those that are the 'hardest to reach'.

¹ It is worth noting that this client journey report sets out findings from the FLNG delivery model within the first four years of the programme 2014 – 2018. It makes reference to roles and a structure operating during that period of time, now obsolete. We have subsequently reviewed the model producing this report that can be found on our website: 'Year 4 Learning Report: Developing the New Model' May 2018, outlining our learning to date and rationale behind changing the model which we implemented April 1st 2018.

1.3 Context

The situation affecting both the support offered and the system surrounding multiple complex needs does not exist in isolation, both in how it interconnects with wider health and social care policies and budget and geographically in Newcastle and Gateshead. Consideration needs to be given to the wider political context and how that may impact on provision and causing a block to change at a local level.

Equally awareness needs to be given to the differences between Newcastle and Gateshead in terms of their local economies, geography and infrastructure. Whilst this programme looks to join working up between the two Local Authorities, and other partners, and whilst some services work across the boundaries, others are deeply constrained by their geographical limits. The idea of a “one size fits all” model may not always be appropriate or may require give and/or take.

Fulfilling Lives in Newcastle and Gateshead exists as one of twelve Big Lottery funded programmes working with multiple complex needs across England. The Making Every Adult Matter (MEAM) coalition is running a number of multiple complex needs programmes. Lankelly Chase and NPC have both recently produced literature around the multiple complex needs client group and system change for that community. This is a client group for whom a greater awareness is being pushed at a national level. Research and evidence beyond this programme will be forthcoming and we should be aware of how this programme relates to other ongoing work and how we can both be influenced, and influence this activity.

2. Understanding the client group

2.1 About this section

The purpose of this section is to help understand who we are talking about when we refer to people with multiple complex needs, what are the issues they are presenting with and are we seeing any trends in the data. In the main this section uses the data for the 100 'active' clients we are currently supporting on the Fulfilling Lives programme; though some of the data refers the wider cohort clients supported to date.

2.2 Support needs

Definition of Multiple Complex Needs

For the purpose of this programme the Big Lottery Fund have defined multiple complex needs as someone having two or more of homelessness, mental health problems, substance or alcohol misuse problems and history of offending. Further definition is also given as to what is meant by homeless in the context of all the Fulfilling Lives projects:

“Homeless includes those who are statutorily homeless, sleep 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.”

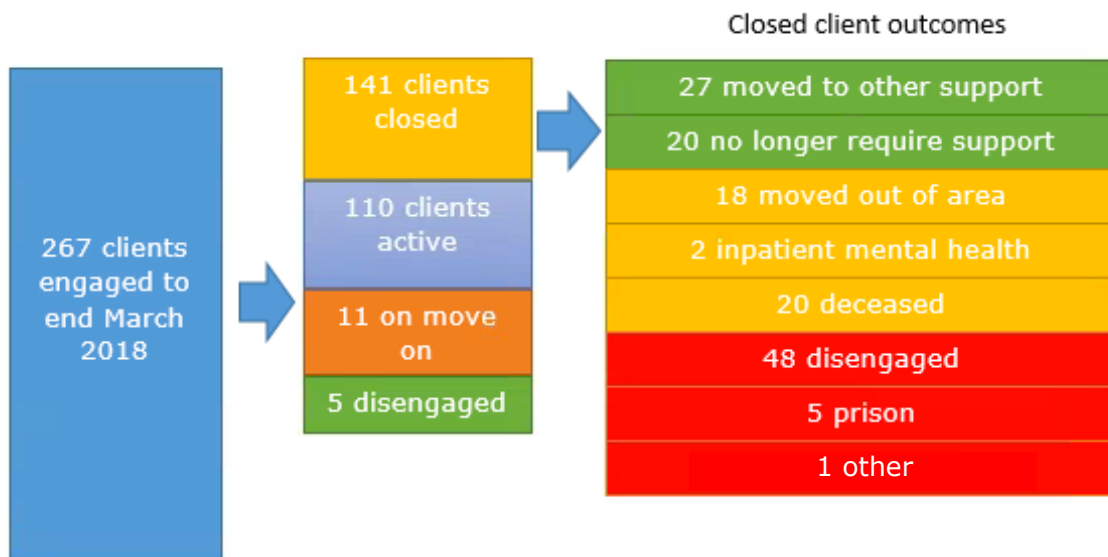
As Lankelly Chase Foundation state, these four categories are *“strongly resonant”* with service providers' definition of multiple complex needs and that there is *“broad consensus [that]... identified this set of experiences as the crucial set of (negative) interactions in their lives.”* (Bramley, G. et al 2015). However it is also important to maintain awareness that these are not the only problems that build up the complexity of someone with multiple complex needs; at its broadest definition multiple complex needs can be considered as *“interconnected needs that span medical and social issues”* (Rankin and Regan 2004).

Whilst the focus of support from this project is around the four main domains, the wider issues and support needs that individuals may have are not forgotten and form an integral part of holistic support offered.

This section looks to examine further what some of these additional support needs are and over the lifetime of the project how they can help develop our understanding of how to best help those with multiple complex needs.

2.3 Client workflow

To date we have engaged with 267 clients, as at end March 2018. We suspended referrals from May 2017 due to our high waiting list. Our client breakdown is:



Key:

Closed – client's involvement with the programme came to an end, see closed client outcomes for reasons for closure.

Active – client actively engaged with the programme.

Move on – client needs less support from programme and is engaging well with other support, or appropriate services are in place around the client; from this phase clients often move to closure, but some do come back into the programme as active clients again.

Disengaged – client is not engaged with the programme, we continue to try to re-engage them and they may be out of contact.

We can separate the client closure categories into positive, neutral and negative outcomes for Fulfilling Lives clients, indicated in the traffic light coding above. The positive outcomes relate to clients either being moved to other support or no longer requiring support. Negative outcomes relate to people disengaging from the programme. The neutral outcomes for the programme are not directly caused by the programme but outcomes arising from wider events including deceased clients and clients moving out the area.

2.4 Client demographics

Client demographics have remained consistent across the life of the programme, and we have engaged with 33% female clients, against 67% male (90 females and 177 males) and there has been no change in the proportion of female: male referrals received either (31%:69%) since the programme started. Of the 416 referrals to the programme 129 were for females (31% of all referrals) and 287 for males (69%).

The age breakdown of all accepted clients again remains consistent with the previous demographic profiles: 10% 18 – 24 years old, 64% 25 – 44 years old, 24% 45 – 64 years old, and 1% over 65.

4% of accepted clients are BAME. Newcastle and Gateshead are predominantly ethnically white areas (90% at the 2011 census), and therefore we would expect to see a low proportion of BAME clients.

4% of accepted clients are LGBT, again this remains consistent with our client profile since the programme's start. This percentage is broadly consistent with population estimates; though sexual orientation is not monitored by the Census so we do not have a local population comparator. Stonewall and LGBT Foundation estimate that between five and seven percent of the UK population are likely to be LGB (there is no official estimate of the transgender population).

These client demographics have remained relatively static. To increase our understanding of our client demographic we undertake additional activities to explore other client profile characteristics including a more detailed drill down into their health needs, who is in their community, what does their support network and their relationships look like. Some of this new data is presented here, and this exploration will be built upon in our future client journey analysis.

2.5 Presenting Needs

At the point of referral into the programme 48% of our accepted clients present with all four needs, 41% present with three out of the four needs, 10% present with two needs and 1% present with one need.

There are a high prevalence of substance misuse, mental health and offending needs in this cohort - 98% of accepted clients have substance misuse problems, 93% have mental health problems and 87% have a history of offending.

Over half of this cohort were homeless on referral (55% of accepted clients). We define homelessness as including rough sleeping, accommodation in hostels, shelters, temporary accommodation and those sofa surfing or staying temporarily with family or friends.

3. Housing

In the year January to December 2017 11% of active clients (14 clients) had at least one episode of rough sleeping, two of these clients are female and 12 male. Eight of these clients were Newcastle clients and six Gateshead clients.

Of interest is the proportion of individuals who are reliant on family or friends for accommodation. Over 35% of active clients had at least one episode of sofa surfing or staying with family or friends in the period, with a slightly higher prevalence of sofa surfing.

This raises concerns around the stress that this is putting on our clients' social support networks who may be acting as informal carers but who may also be unintentionally hiding clients from accessing the support they need.

Reliance on family and friends is not a long term solution to housing issues and there are questions around what assistance, if any, exists for those family and friends who are supporting individuals with multiple complex needs.

As in previous reviews there remains a comparatively large difference between the numbers housed in social housing in Newcastle against in Gateshead. In part this could be explained by the higher number of temporary and supported accommodation units in Newcastle however it does warrant further investigation.

There also appears to be a trend towards more clients accessing supported housing generally, though the numbers of males accessing supported housing appear to be significantly higher than for females. We know that the supported element of supported housing can vary widely and clients can do better in some settings than others, so our client's experiences of different types of supported accommodation also warrants further investigation.

It is important to consider maintaining a choice in supported accommodation options for clients who present with high risk/complex needs. For some clients the stimulation of other relationships in shared accommodation is too difficult and outweighs the benefits of increased social contact therefore, a single tenancy (with intensive floating support) may be a better option. For others the isolation of a single tenancy leads to increased risk-taking behaviour and they therefore benefit more from the containment of staffed accommodation.

Our review of Newcastle Council housing and multiple and complex needs (2017) found that a number of services linked eviction to the clients' needs being too high for them to meet, there may be a need for training for staff around how to work effectively with people who have multiple and complex needs. Creating a Psychologically Informed Environment (PIE) within supported accommodation services is shown to have beneficial effects for both staff and clients. Our workforce development work stream speaks to these issues and our new workforce development offer combines Multiple and Complex Needs Training and PIE with a framework for assessing the workforce's skills in relation to 25 key skills areas for working with people with multiple and complex needs.

4. Offending

4.1 Offending behaviour

Our focus on offending has been particularly focused on client experience of prison release, under our transitions strand of our system change activity. Of the Fulfilling Lives cohort 89% are reported as having offending behaviour and/or engagement with the criminal justice system. This is more common amongst the male clients, with 89% of male service users having offending behaviour, against 76% of females. 100% of those presenting with offending behaviour also have either substance misuse or alcohol problems, or mental health needs. This is significant as it is a higher proportion than the already high percentage across the general prison population which is estimated at over 90%.¹

4.2 Prison subset of clients

The prison subset of clients present with a higher level of need than the average FLNG client. Significantly, there is a 16 percentage point difference between the overall cohort and these specific clients, giving an indication that there is a link between housing or accommodation situation and offending behaviour.

- 100% of this prison subset present with mental health needs.
- Analysis of clients pre and post prison accommodation identifies how transient and unstable their accommodation is.
 - 71% of clients had different accommodation on release than they had prior to custody
 - 44% were released to No Fixed Abode
- The breakdown between the two Local Authorities show relatively similar trends in post release accommodation with 52% (13) of Newcastle prison release being housed in provided accommodation, and 48% (12) in NFA or in less stable accommodation, against 45% (9) and 55% (11) in Gateshead respectively.
- The levels of chaos and crisis increase the more volatile and vulnerable an individual's housing situation. On average on release from prison those released to NFA recorded an average NDTA score of 34-35, against an average of 30-31 for clients in temporary or supported accommodation.
- 42% (21) of these FLNG clients have either re-offended or been recalled into custody during the time they have been engaged with the programme.
- The accommodation that is least likely to result in a client returning to prison is supported accommodation – which is the most stable, holistic and supportive of the accommodations that FLNG clients are released into.

The following findings are based on the experiences of Fulfilling Lives Newcastle Gateshead (FLNG) clients. The data used for these analysis includes all clients who have served a custodial sentence during their time working with FLNG. A total of 50 clients meet this criteria, constituting 21% of our overall accepted caseload to date.

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

The demographic breakdown of these 50 clients:

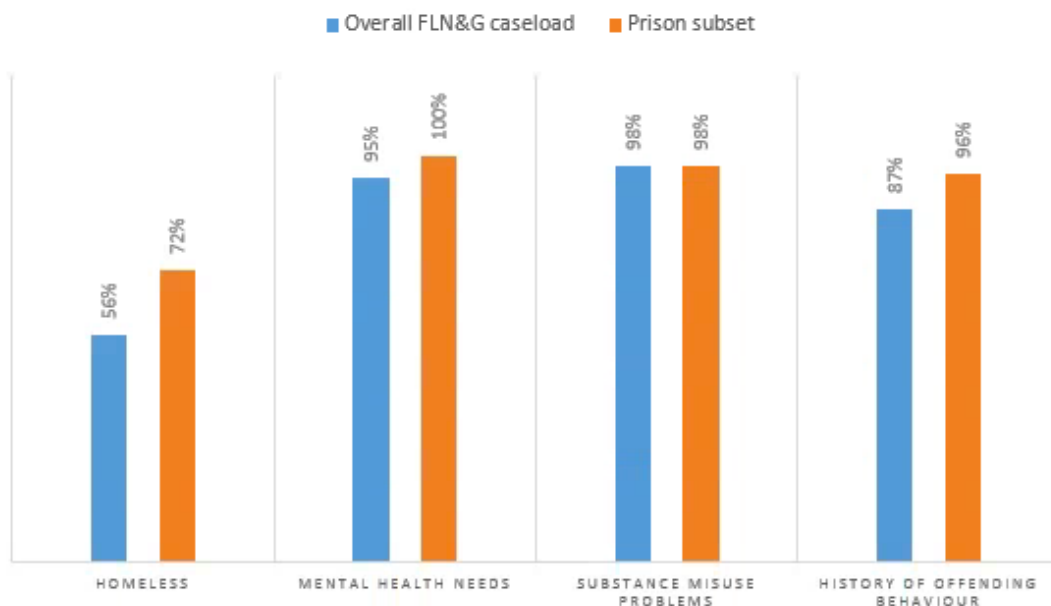
- 32% female (16) and 68% (34) male.
- 86% White British (43), 2% Asian (1), 2% Latin American (1), and 10% did not disclose their ethnicity (5).
- The age breakdown is:

Age range	Percentage	# of clients
20-25	8%	4
25-30	20%	10
30-35	30%	15
35-40	30%	15
40-45	4%	2
45-50	8%	4

- 10% (5) have a physical disability or long term health condition.
- 48% (24) are Newcastle based, and 52% (26) are Gateshead based

The below chart shows a comparison between the support needs, at time of referral, of the overall FLNG caseload and a subset of those clients who have been in custody. This comparison has been done to help understand whether this group of clients are showing any patterns of need that separates them from the overall cohort.

Chart 1.1: Support needs comparison



It is evident from this chart that the prison subset of clients present with a higher level of need than the average FLNG client. This is particularly apparent in relation to housing with a 16 percentage point difference between the overall cohort and these specific clients, giving an indication that there is a link between housing or accommodation situation and offending behaviour. This is supported by the literature which highlights the likelihood of re-offending being significantly higher if homeless (Williams et al, 2012; Homeless Link, 2011). It is also interesting to note the higher proportion of clients presenting with mental health needs in this prison subset of clients, with 100% of clients in this subset with mental health needs.

Table 1.1 Length of sentences

Sentence length	Number of clients	Number repeat sentences
One month or less	20	8
1 - 2 months	10	3
2 - 3 months	6	4
3 - 4 months	6	0
4 - 5 months	2	1
5 - 6 months	2	0
6 - 7 months	2	1
7 - 8 months	1	0
8 - 9 months	1	0
9 - 10 months	0	0
10 - 11 months	1	0
11 - 12 months	1	0
Over 12 months	1	0
Still in custody	28	12

The above table shows the breakdown of the number of clients who have served different custodial sentence lengths. These data are for the number of instances of sentence rather than individual clients and therefore totals more than the 50 clients. It is clear from Table 1.1 that the majority of sentences served by these individuals are short term sentences of under 3 months, with 68% of all completed sentences under 3 months. 87% of completed sentences are 6 months or less. The final column in Table 1.1 shows the number of sentences within each sentence length that are either repeat sentences or individuals who have been recalled.

Accommodation pre-sentence is an important area to understand, particularly given that this group of FLNG clients are more likely to present as homeless than the overall cohort. Table 1.2 shows the housing situation of clients prior to being remanded in custody. It also shows what proportion of clients in each housing situation prior to their conviction went on to either re-offend or be recalled.

Table 1.2: Accommodation prior to custodial sentence

Accommodation prior to remand	Number of clients	Percentage re-offending
Rough Sleeping	3	67%
Sofa Surfing	15	53%
Family or friends	11	73%
Temporary accommodation	9	67%
Supported accommodation	15	40%

Whilst it is evident from these figures that a high proportion of FLNG clients to go on to either re-offend or be recalled, it is also clear that the accommodation that is least likely to result in return to prison is supported accommodation – which is the most stable, holistic and supportive of the accommodations that FLNG clients are released into.

Alan recently moved into supported accommodation after cycling through lengthy periods of rough sleeping and prison; here he describes his current stability and how it impacts on his relationships:

“People I know, they are going back to re-offending, even though they’re like trying to drag us back into that world I’ll just, I’ll even though I say hello to them they’re just me associates, there’s not me pals, like I’m starting to see me kids again, I’m not going to jeopardise me two beautiful children over pinching something, it’s not worth it. This is the first time I’ve been out of jail and not gone to re-offend, since August. I see the police and they’re like what’s happening?! And I’m like anybody can change can’t they?”

Interestingly the findings from the FLNG cohort seem to correlate with the literature when looking at the impact of family or friends. Whilst strong and supportive kinship or social networks are seen as a key element of successful rehabilitation back into the community (Carlisle 1996, Hughes 2010), negative or destructive relationships are seen as being detrimental to an individual’s stability (Hughes 2010, McNeil and Hunter 2015). Difficult relationships between family and or positive social networks are a commonly seen pattern with FLNG clients and may offer explanation as to why those who are released to family or friends are the most likely to re-offend.

Analysis of clients pre and post prison accommodation identifies how transient and unstable their accommodation is. 71% of clients had different accommodation on release than they had prior to custody. It should be noted that not all of these transitions are negative – 20% of these transitions would account for an improved housing situation than prior to release. However 37% are a negative change in accommodation meaning an individual had either temporary accommodation, supported accommodation or their own tenancy prior to custody, and on release were rough sleeping, sofa surfing or with friends or family.

As highlighted in Table 1.2 release from prison FLNG clients are housed in a number of different accommodation scenarios, including being released with no fixed abode. Table 1.2 shows the accommodation that clients have been released to, the average number of days that individuals stay in those accommodation types following release, and the number of different housing situations these individuals go on to have.

Over 40% (21) of these FLNG clients have either re-offended or been recalled into custody during the time they have been engaged with the programme. For the majority (15) of these individuals they have had two custodial sentences whilst engaged, however 3 individuals have returned to prison 3 times, 2 individuals four times and 1 individual 5 times. There is little difference in the re-offending figures dependent on Local Authority with 10 clients in Gateshead and 11 in Newcastle.

What is suggested by this information is that housing alone is not the solution to reducing offending behaviour and reducing levels of chaos in an individual, and instead focus must be drawn to a more holistic approach to prison release.

5. Self-harming and risk of vulnerability

Unsurprisingly this is a client group who present as extremely vulnerable. Almost 90% of all our client population are assessed as being at least at a medium risk of vulnerability with 46% considered to be at a high risk. If looking at vulnerability by gender, females have a higher percentage of at least a medium risk of vulnerability, with 94% at risk against 86% of males. Looking solely at the high risk category the divide becomes more notable with 57% of females against 38% of men.

In this context vulnerability is described as being at risk of both physical, emotional, sexual and financial exploitation. This vulnerability is also cyclical so even those who are a high risk to others are themselves at a high risk of exploitation. Joe's story, in Section 9, touches upon these issues in more depth .

Issues around vulnerability came though starkly in our research around begging too. In November 2017 FLNG worked alongside Newcastle's Multiple Exclusion Team (MET), who provide city wide support for people who are multiply excluded, to identify and recruit a sample of people with experience of begging for interviews. This research was delivered to support Newcastle City Council's exploration of the experiences of people who beg in the city of Newcastle, to help them understand the causes and impact of begging, to develop a local begging policy in November 2017 and to shape their subsequent publicity campaign.

"I did it to feed a habit. Yeah it was a source of income, somebody does one side somebody does the other side of the street and put the money together, there's also beggars robbing beggars and intimidating them, arguments over spots and all that... a lot of violence and dog eat dog especially when spice came on the scene people were killing each other over it and it became quite chaotic."

"Me partner got his head split open, he got a brick hoyed at him we've had glass bottles, been spat at, had wa tent set on fire, sleeping bag cut..."

We also identified examples around reducing vulnerability when housing and access to drug and alcohol treatment came at the same time. Participants who were not currently begging were on a script or in recovery, and described how they were starting to see that life could be different for them, described being in a 'good place' and on the right footing to access services. There appears to be a link too then between secure housing coming together at the same time as drug and alcohol treatment, at this point participants reported feeling ready to reduce begging activity and the associated lifestyle.

6. Female clients

In seeking to better understand the experiences of women with multiple and complex needs we will give attention in each of our future reports to a specific focus on women. Work in this area has mainly been to explore our female client demographic in relation to trauma. Over 35% of female clients have had children removed from their care. Our data is less reliable around access arrangements because our Navigators did not always know their client's parental history where working with a client whose children are grown up, but we believe that around 40% of clients who have had children removed from their care do not have access arrangements in place to see their children.

FLNG conducted a small scale survey exploring gender specific services in December 2017, and this included exploration of women's experiences of having children removed from their care. This quote from a female client on her experience of accessing support around children's social care highlights the dual experience of domestic violence and going through child protection procedures:

"If I had more support I could have kept my son. I felt a failure and tried to take my life. No one cared how I felt. I tried to put my kids first but was in an abusive relationship. I was in a refuge, it was very supportive. My partner found me and kidnapped me. I just managed to get away. I ended up back with him. I was scared. I feel guilty"

Over 65% of female clients have experienced domestic violence, and 15% are currently in an abusive relationship, as this data is self-reported we suspect that this is a conservative estimate of female client's experiences, as highlighted in Emma's case study.

Emma's Story

Background

- Emma is a 40 year old female client
- Homeless on referral, supported accommodation and reported as missing person twice
- Heroin and alcohol user
- Multiple offences, drug related, theft, fraud, offences against the person
- DV history Referral for Emma was received from Girls are Proud ¹service
- The CRC seconded worker was Emma's navigator
- Emma had a probation worker from Northumbria CRC

Navigation

- Emma is a vulnerable client; often she would not want her navigator to know where she was living, or would not give her full address. Emma has tended to gravitate towards men stating she thinks they will protect her, but with support of her navigator has made progress recognising that these relationships are not always positive.

¹ Girls Are Proud (GAP) is a Changing Lives project providing assertive outreach to vulnerable women who are involved in sex work or at risk of being sexually exploited

- Emma's navigator initially suspected she was experiencing domestic violence, something Emma denied. Instances of Emma presenting with bruising increased, Emma continued being adamant she was not in an abusive relationship. As Emma began to trust her navigator she later opened up, finally disclosing that her partner was being controlling. She later made a further disclosure of a traumatic event from her past which she is being supported with at present.
- Much of the navigation work done with Fulfilling Lives has been about securing flexibility with services for example:
 - Emma breached terms of her licence in 2016; navigator asked whether it would be possible for Emma to attend court the following day and surrender to her arrest warrant. This was allowed, in court the navigator was able to expand on the work she and Emma did together. The warrant was withdrawn, the court advised Emma to thank her navigator advising her to remain in contact with her probation officer and navigator
 - Service navigator accompanied Emma to Newcastle Magistrates Court for appearance for a public order matter. Navigator went to the Probation Office to give a positive update on Emma and proposed a 12 month conditional discharge "*given her progress in the last 6 months since the matter.*" Magistrate agreed to this proposal and Emma was fined £100 costs.
 - Emma had left debt in a previous tenancy and her navigator applied to the Vicar's Relief Fund to help pay it back; with her navigators intervention Emma also received part of a large overpayment back from another housing provider.
 - Emma's navigator successfully rescheduled Emma's appointment with DWP assessment centre stating difficulties with addiction as reason for non-attendance
- Emma has 48 convictions for 98 offences and has been in a constant cycle with prison and probation – she recently spent nearly a year out of CJS.
- The navigator has excellent connections with housing services in Newcastle, securing emergency accommodation for Emma which Fulfilling Lives broker noted as impressive because "*our clients don't generally get accommodated*".
- This accommodation was not long term, Emma was offered a flat Summer 2017, she felt the location of this would hamper her recovery. Emma was given a 28 day notice to leave emergency accommodation, believing she was being evicted Emma stopped paying her rent. Her navigator intervened and a second offer was made, Emma did not turn up to accept the offer which was withdrawn, her navigator intervened again and Emma moved into a flat in July 2017.
- Her navigator reports this next period is crucial for Emma, she has not lived in unsupported accommodation alone before. Emma is currently stable, happy in a new relationship and flat. She was anxious about being allocated a new navigator but is reportedly happy to work with her new worker.
- Emma recently started a new relationship, her navigator views this as one of the most positive relationships Emma has held, they are being treated as a couple for their substance misuse, supporting each other and recently Emma's navigator saw them out cycling together on the way to a picnic.

7. Leaving care

The Hard Edges (2015) indicated that 17% of people with multiple and complex needs were brought up in care, our data mirrors this, it also shows 17% of clients having grown up in the care system, and 17% of clients have had a child removed from their care, though both figures are likely to be a conservative estimate based on data we have for active clients.

Our Experts by Experience peer researchers are exploring the experiences of people with multiple complex needs who grew up in the care system, their report will be available later in 2018.

8. Disability and long-term health

We have fully explored the health profile of our client cohort. Traditionally we have reported that 25% of our client cohort have either a disability or long term health condition; this data was previously taken from referral information. An in depth study of 100 active clients, taking on self-reported health concerns and diagnoses our workers have been made aware of in their client facing work highlighted that 37% of our active client cohort have a physical disability (as defined by the Equality Act 2010), sensory impairment or long term condition.

This is much higher than the proportion for the average Newcastle and Gateshead population which has 10% of the population with a disability, and of this population 78% are over 65 (2011 census). Given that the majority of the Fulfilling Lives client group fall within an 18 – 54 age range this strongly implies that disabled individuals are disproportionately represented within the multiple complex needs group.

The Local Government Association recently published a guide for local authorities aimed at addressing the health needs of those who are homeless. The document states that a recent audit found that 41% of homeless people reported a long-term physical health problem, compared to 28% in the general population¹.

Initial scoping has now been completed to look at the FLNG cohort and their interaction with Adult Social Care across Newcastle and Gateshead. This scoping commenced with an exploration of client's health and care needs.

Self-reported data on client's health is generally collected at referral and we traditionally report that 53% of clients have disability, which often includes mental health needs.

We wanted to understand our client's profile better, so reviewed this data to give a better breakdown of needs. This data shows us that 37% of our active client cohort have a physical or learning disability or a long term condition.

Physical disability²

This data relates to our active clients only, and shows that 24% of active clients have a physical disability as defined in the Equality Act 2010. We've coded these physical disabilities as follows:

Physical disability impacting mobility	13
Epilepsy	5
Sensory impairment	4
Acquired brain injury	2
Alcohol induced cognitive impairment	1
Total	25

1 Leng, G (2017). The Impact on Health of Homelessness. A Guide for Local Authorities. LGA, September 2017.

2 The Equality Act 2010 says you have a disability if you have a physical, sensory (visual loss, hearing loss) or mental impairment that has a **substantial, adverse, and long term effect** on your ability to carry out normal day-to-day activities.

Learning disability

This data relates to our active clients only, and shows that 8% of active clients have a learning disability:

Low IQ / global development delay	4
Autism	1
ADHD	3
<u>Aspergers</u>	1
Total	9

Long term condition

This data relates to our active clients only, and shows that 31% of active clients have a long term condition:

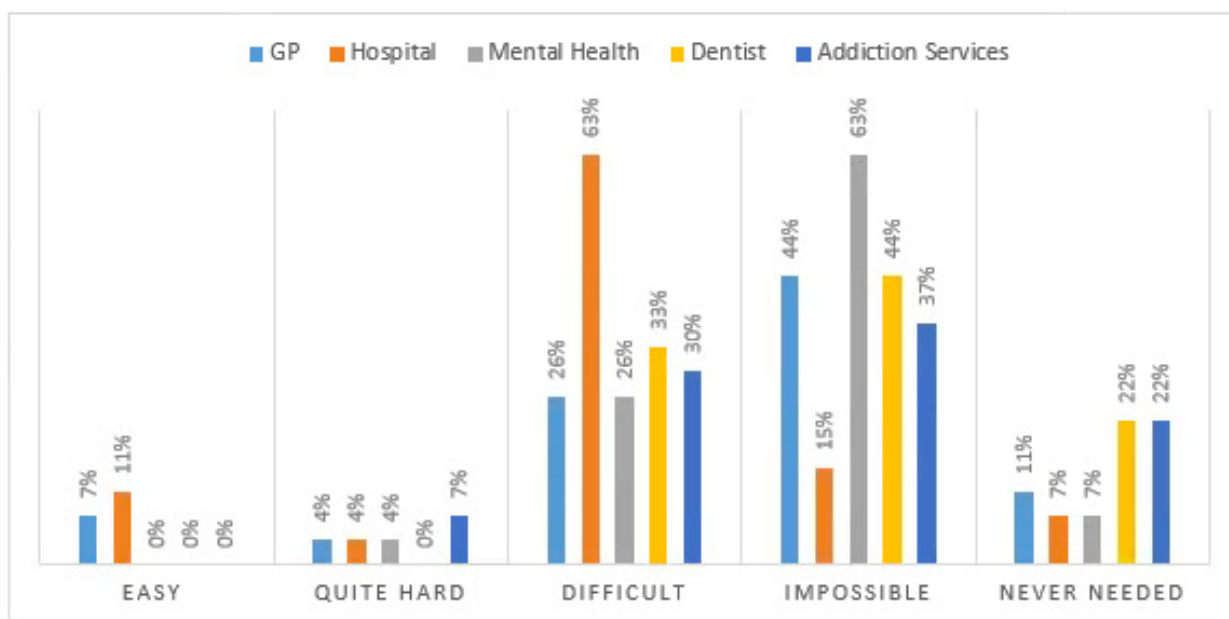
Musculoskeletal condition*	11
Lung condition/COPD	7
Heart condition	5
Diabetes	2
Liver disease	2
Musculoskeletal condition and liver damage	2
Asthma	1
Bowel condition	1
Memory loss	1
Musculoskeletal condition and COPD	1
Osteoporosis and liver disease	1
Total	34

**Musculoskeletal conditions affect the joints, bones and muscles, and also include rarer autoimmune diseases and back pain*

We currently have 27 clients who have had a social care assessment of their care and support needs, generally pre - Care Act, (eight clients have had a Care Act Assessment). Of these clients 21 have a social worker, 11 have a care package for care support, 2 of these clients are in long term residential care which we helped broker, the remaining 9 receive a low level of support; one of our clients has a personal budget for care and support.

Further work is needed to explore our client's interactions with health and social care. This scoping exercise highlighted for example that we have some clients who have assessed mental health needs and a care package paid for by the local health trust. We also have some clients who have a care package whose needs appear very similar to those clients who have been assessed as not having eligible care and support needs. The next phase of our case study work will explore this in detail.

Our work exploring the health needs of the homeless population highlight that people with multiple and complex needs find it incredibly challenging to access healthcare services:



Overwhelmingly respondents stated that they find it difficult or impossible to access health services. That mental health was raised as one of the primary causes of homelessness but 63% of those asked stated that they found it impossible to access these services, rising to 89% when including those who found it difficult or impossible, highlights a primary area of concern in relation to homeless populations accessing needed health services. However 70% of the respondents stated it was difficult or impossible to access a GP, 78% that it was difficult or impossible to access other acute health services, and 77% that it was difficult or impossible to access dental care.

For further exploration is data around medical access in relation to inpatient medical treatment. A disproportionate amount of male clients had an inpatient medical episode in 2017 compared with female clients. Five female clients had an inpatient episode against 18 males. In early 2017 FLNG facilitated a feedback survey across its Operational Reference Group members and other community providers, looking at their operational experiences of mental health services throughout NTW. A wide range of barriers were recorded, those most commonly referenced relate to a need to improve access for those clients misusing substances and timeliness and flexibility of services being offered. Respondents generally report that once a client *has* been able to access secondary services their experience is in general, positive, indicating the issues are more around access.

9. Mental Health

93% of accepted clients have mental health needs at the point of referral, this is self-reported; we needed to understand if self-diagnosis was taking place, rather than clients having a clinically assessed condition. Our current data shows that 67% of our active clients have a diagnosed mental health issue; 24% have depression, or anxiety and depression, 19% have a personality disorder diagnosis, 6% psychosis and 5% a schizoaffective disorder or schizophrenia.

The table below provides a further breakdown of the diagnoses.

Diagnosis	No. (active) clients
Anxiety and depression	19
Depression	5
Bipolar disorder	2
Personality disorder	6
Anti-social personality disorder	2
Emotionally unstable personality disorder, borderline personality disorder	1
Schizophrenia and personality disorder	1
Split personality disorder	2
Emotionally unstable personality disorder	7
Drug induced psychosis	1
Psychosis	5
OCD	1
Paranoid schizophrenia	2
Schizophrenia	4
Schizoaffective disorder	1
Affective schizoid disorder, schizophrenia, OCD	1
PTSD	6
Post traumatic amnesia Horizontal (Category) Axis	1
Total	67

We are especially interested in this client demographic who have a personality disorder diagnosis. We have been following Joe's story over the past 18 months initially exploring his interactions with the criminal justice system and more recently in relation to access to mental health. Joe is a client whose worker frequently describes feeling 'stuck' with, firstly in relation to his cycling through homelessness and prison, and later in relation to access to mental health. We are now linking in locally with personality disorder pathways and Joe's story is already having an influence in testing the system.

Joe's Story

Background

- 54 year old male client referred by Northumbria CRC October 2016
- Poly drug user
- History of violence and intimidation
- History of serious self-harm
- Family estrangement
- Diagnosis of schizophrenia, COPD, personality disorder

Pre custody

- Joe is an older male who presents with chaotic challenging behaviour and complex support needs which services struggle to meet, this results in Joe moving rapidly through short term accommodation stays and hospital admissions.
- Joe was released from prison in February 2017 and bounced between rough sleeping, short term stays in temporary accommodation and hospital inpatient admissions. In June 2017 Joe's hospital admissions increased.
- On release FLNG asked by Probation not to have contact with Joe until an investigation with Police and Probation was completed as they deemed Joe dangerous to work with. Joe was allocated a new probation worker who started working in pairs with Joe, however it became quickly apparent this wasn't necessary as he was engaging with several services without issues. It was decided that further working in pairs with Joe would deter his progress.
- Joe informed he had exhausted all of his accommodation options. His navigator challenged this and Joe was placed in a Hostel. Gateshead Housing Options funded week one and Fulfilling Lives funded week two. Other accommodation options would be looked at as long as Joe upheld his bed. Joe evicted after 11 days due to aggressive behaviour so wasn't offered anywhere else, however after several hospital admissions relating to his COPD and with probation and FLNG's support Joe was offered a hostel place. He was removed owing to behaviour towards residents and threats to staff.
- Joe was offered a bed at a hostel where his behaviour quickly made him a target and a victim. Joe can resort to serious self-harm when things do not go his way or his place at the 'top of the hierarchy', 'is threatened as he enjoys a sense of notoriety about his offences. At the hostel he struggled with this, cutting off his own ears and was moved to a probation approved premises. He was asked to move out due to behaviour towards residents and after one week at another hostel was evicted owing to his behaviour.
- Joe's navigator reflects that he can be draining to work with, repeatedly asking for things and pestering staff. Joe has represented himself in court many times, stating that he is aware if he calls many witnesses his cases will be unmanageable, likely to be thrown out, and this will increase the cost of the case.
- In between and during all these accommodation stays Joe was admitted to hospital numerous times. After the last accommodation in June 2017 he was admitted and discharged 12 times in the space of 7 days so a package was put in place to accommodate Joe at a specialist mental health accommodation after a meeting between Ward 11, Mental Health team, the provider, Gateshead Council, Probation and FL navigator.

Custody

- While accommodated at the specialist mental health provision, Gateshead Council agreed that Joe would be supported to get his own tenancy with floating support if, whilst staying at the specialist MH provider, he took medication to cut his cravings for alcohol refrained from drinking and paid £5 a week off current rent arrears. This 5 week period was the longest Joe had been out of Prison and hadn't been admitted in to Hospital. The specialist MH provider tenancy broke down and was terminated once he consumed alcohol and made threats towards staff, culminating in the theft of a night staff member's purse.
- Joe was remanded in custody on 14/08/17 for burglary at the specialist mental health provider, as well as theft from a motor vehicle. Joe's trial is in December 2017. He is struggling in prison, having been in segregation for threatening officers, other prisoners, smashing up his cell and jumping on to the safety net in the prison.
- Joe recently made a complaint about his navigator, he has a history of making complaints and his navigator hopes Joe will not take this further as he risks isolating himself further.

- All of the services around Joe have expressed informally that Joe needs to be sectioned. Joe has had assessments previously, he is deemed to have capacity and chooses not to be medicated for his schizophrenia, saying he enjoys the stigma of being an un-medicated schizophrenic.
- In November navigator reflects that in December Joe will be released and they “*will be back to square one again*”, the probation officer that Joe engaged with well has moved on, navigator reported that he “*suspects that Joe will do something to get noticed*”.
- Joe was released from prison in December 2017 to no fixed abode and his navigator accompanied him to present to the local authority. Due to his previous behaviour all providers approached refused to make an accommodation offer. His navigator planned to accompany Joe to Shelter but Joe was angry at being “knocked back” by services and became upset. He returned to his last accommodation, the scene of his last offence and where he was last evicted, he was verbally abusive to staff and made threats so was arrested and remanded back in custody as he was in breach of his bail conditions.

Post custody

- Joe was released 16/02/18 to no fixed abode.
- On 19/02/18 Joe’s Navigator spoke with ward staff at QE Hospital, was informed that Joe was admitted with a stab wound after hanging around at the hospital all weekend, he was transferred to RVI, discharged and then attended QE. Joe is reported to have made threats towards a nurse so was no longer allowed on the ward.
- On 19/02/18 Joe’s Navigator received call from Basis@336, Joe was at the drop in and they were concerned for his wellbeing. Joe had a wound which he reported was a result of being stabbed by a friend over money. He was struggling for breath and appeared very weak. He refused to attend A&E stating that he would be refused treatment having had an altercation with security staff at the hospital. His Navigator reassured him that he would not be refused treatment and Basis@336 provided a taxi and Joe and his navigator attended A&E. Tests were conducted and Joe was found to have an infection. Joe and his Navigator expressed that they found security staff to be intimidating towards Joe, preventing him from going for a cigarette when he wanted to.
- Joe’s Navigator was informed by probation worker that Joe’s wound was caused by himself in prison on 01/02/18, when he was admitted to Cramlington Hospital. He was discharged back to prison prior to his release.
- Joe’s Navigator asked about a Mental Health Assessment for Joe at hospital, a referral was put in though the ward nurse stated that it was unlikely to be acknowledged.
- On 26/02/18 Joe was discharged from the QE to no fixed abode, severe weather protocol meant that the local authority provided emergency hotel accommodation up to 5/03/18.
- On 06/03/18 Joe’s Navigator contacted Gateshead Housing and a decision was made that Joe is not priority need, so there is no duty to accommodate. FL accessed personalisation for a two night stay in a local motel, based on Joe’s current level of need and vulnerability. Basis and they have agreed to fund a further two days if needed and Thursday if needed. Joe due to be spoken about at MASH on 07/03/18 awaiting update and FLNG working with Shelter to challenge the GH Company decision. Letters of support from Joe’s GP state that his wound requires attention to change dressings and he needs to be in a safe clean environment, accessible to nursing support to prevent further infection and sepsis, and states that Joe’s mental health needs be considered as this fluctuates “*from the sublime to the ridiculous.*”

- 07/03/18 Joe is offered accommodation in Blyth; Joe and his FL worker do not feel this appropriate due to Joe's difficulty engaging with services, mobility issues due to poor physical health and also mental health presentation at present. His UC claim has just been submitted in Gateshead and his access to food is solely through FL personalisation budget. His FL worker is concerned Joe will end up being evicted due to them struggling with his needs. Shelter have requested that Joe be offered accommodation in Gateshead.
- 08/03/18 Joe and his Navigator are due to meet with a worker from SIB team, Changing Lives.

10. Education

At least 25% of the Fulfilling Lives case load have no qualifications and a further 12% have significant literacy problems. Only 5% have achieved A Level or equivalent qualifications. This lends itself to the Lankelly Chase supposition that multiple complex needs typically presents in those from low socio-economic backgrounds.

The dominance of those from low socio-economic areas also hints that poverty may be a key contributing factor in multiple complex needs. The longevity of the Fulfilling Lives programme allows for us to build the evidence base in order to answer that question.

For further exploration is our data on client employment and volunteering. A relatively recent snapshot of the FLNG dataset exploring clients' employment and volunteering experiences highlighted that of 123 active clients (at July 2017) 11 clients were in education and training, 9 clients were taking part in regular volunteering activities, one client had part time work that they had been in for 13 weeks, and a further two clients had full time work they had been in for over 13 weeks.

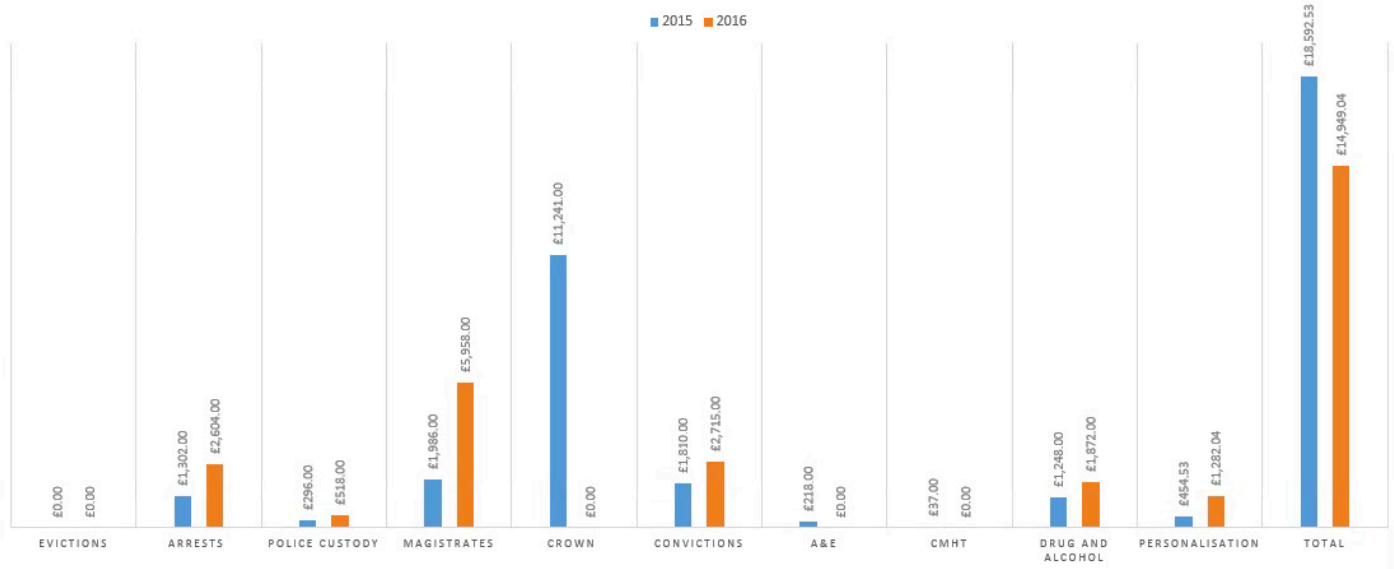
11. Asylum Seekers

Whilst constituting a small number of the overall caseload 8 clients who have been referred, and accepted, into the FLNG programme are non-EEA destitute migrants. Five are Iranian, and there is a more visible population in Newcastle with seven out of the eight referrals coming from Newcastle. These eight clients were referred by local refugee services, or community based organisations working with refugees and migrants.

As a consequence this particular group have a disproportionate cost impact on both the criminal justice system and emergency health care with no resolution until a final decision is made on their immigration or asylum status. This is not a healthy situation for either the individual or for the services providing the safety net.

Whilst recognition must be given to the statutory limitations of supporting this group, acknowledgement must also be made that these individuals do exist within the region, that they are trapped in chaos and are in extremely unsettled and uncertain situations.

This chart shows the breakdown of costs by area of spend for one of these clients, taking account of evictions, arrests, A&E, drug and alcohol support across the two full years we have data for:



This data doesn't account for their engagement with Home office or immigration system, but it shows that these clients don't present with particularly high cost to the system in comparison to an average multiple complex needs client, of the average £16k cost per annum the costs for this particular client are overwhelming ascribed to the criminal justice system. The average cost per year for a FLNG client is £45,000.

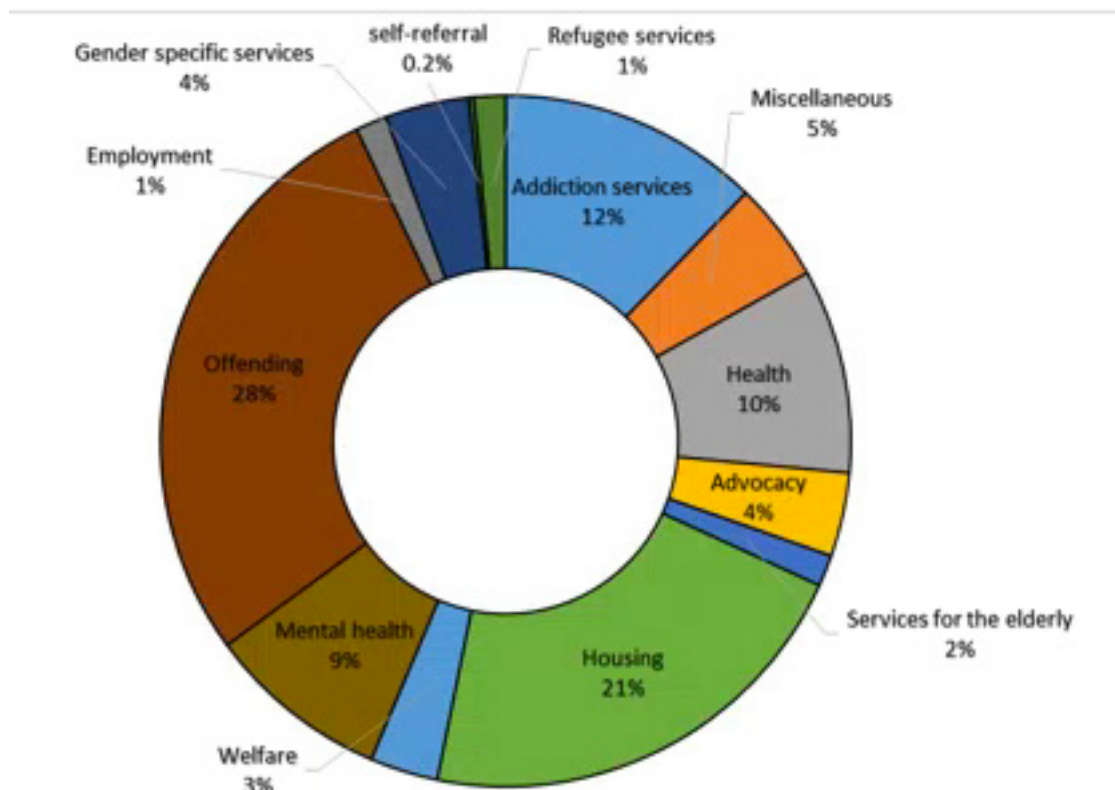
A typical FLNG client has access to the benefit system including housing benefit. Housing benefit, plus the cost of hostels or supported accommodations, and additional benefits including disability benefits can constitute a large proportion of the costs an individual incurs. Without access to stable housing provision it is inevitable that their costs will be lower. This client was rough sleeping at the time of this cost analysis.

This is a group that present as particularly chaotic but also especially vulnerable in no small part due to their ineligibility for housing or benefit support. This traps them in a cycle of rough sleeping or sofa surfing and given they are reliant entirely on a £15 hardship payment per week places them in a very precarious situation in terms of being able to legally provide themselves with food and shelter.

12. Referral sources

A strong indicator of the system that this client group is engaged with or visible to, are the referral sources of clients into the Fulfilling Lives programme. Since May 2017 we have not been accepting new referrals and to date 94 services from across the complex needs system have referred to the programme.

Offending services still constitute the highest number of our referrals, with 28% of referrals received and Northumbria CRC is the single highest referrer by a significant margin, followed by National Probation Service.



13. Interactions with services

In Q3 of 2017 we explored client interactions with services in detail and found that six of the ten most commonly accessed services related to interactions with the criminal justice system; arrests, magistrates court proceedings, police custody, conviction, nights in prison, police caution.

In Q4 of 2017 we reviewed the service use statistics that we gather quarterly. These relate to client interactions with interventions we might define as more positive or proactive, such as accessing psychotherapy, advice and guidance, education, arts and culture etc.

In the table below we see that the seven most popular services accessed have been GP, housing, substance misuse support worker contact, legal and criminal justice support, addictions support, money and debt support and personalised budget use. Interestingly we might expect to see an increase in a client's positive service use over time, yet our data appears relatively static across the eight quarters from Q1 2016 to Q4 2017.

It will be interesting to explore with frontline staff what 'other support' they are navigating to (or perhaps is being self-directed by clients, as this service use is more proactive in nature) as we do see some fluctuations in data here. In 2017 our Navigators had training exploring 'endings' in relation to client facing work; on reflection workers spoke about recognising how resourceful our clients are, they see us for only a few hours a week and despite what we know about sporadic engagement with services there are examples of positive relationships, of strong community links and of positive service use that we can explore further into this next phase of the programme.

Exploring our client's interactions with the system in a more focussed way, hearing their stories in their words and involving them in case study development is paying dividends, as we build a better picture of what they engage with, or do not engage with, and why, as Alan's Story shows (full case study forthcoming):

"I'm not saying I'm an angel, and I miss some appointments...but I'm not saying, like to make anyone feel sorry for us, but the only reason I like didn't engage with appointments was cos I suffer from anxiety and depression and I hadn't been getting me anti-depressants for a long time. I was going to get me prescription for me methadone, then going and lying in bed like festering thinking about me kids, me lifestyle and what am I going to do and thinking I'm 30 years of age like what life have I got, haven't got a house, haven't got me family."

Alan's story also links to our work on what makes a good multiple and complex needs worker (report forthcoming) under our workforce development (WFD) work stream. Our future plans in this area include a MCN system skills audit and evaluation, PIE evaluation in a greater number of services, and further exploration of what makes a good MCN worker through ongoing 25 key skills for MCN worker's audits.

We interviewed Alan about his experience of Universal Credit together with his DWP Work Coach. The case study highlights a very positive relationship between Alan and his Work Coach, they have been working well together building an excellent relationship which shines through and as a result of this collaborative approach, Alan has not received any sanctions during the claim:

Work Coach: *“He came back to me for his commitments so I got him which was nice because I had done his ID...you don’t always see someone again. I always ring my more vulnerable clients, Alan will always answer...”*

Alan: *“I’d rather get on with everybody, you be polite to me and I’ll be polite to you, she had showed us all the ropes and I hadn’t had me methadone, I was sweating! Now she’ll praise us, Alan you’re looking a lot fresher, that boosts me confidence up.”*

Work Coach: *“I can kind of relate to our more complex clients, if Alan hasn’t made the appointment I’ll call, he always answers and I check in, just check he’s OK.”*

As we move into a Critical Time Intervention approach to delivery this understanding of client goals, of their hopes and dreams will be crucial. We are beginning to build a rich picture here, for example one of our clients identified their goal highlights how rich and tangible these are:

“To secure my own tenancy, with a washing line so I can hang out my washing.”

Service use data: % of active clients accessing services in the quarter

	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017
GP	64%	60%	56%	56%	61%	52%	53%	57%
Housing	58%	57%	55%	52%	51%	50%	54%	58%
Subst. misuse support worker	57%	54%	53%	43%	41%	40%	39%	40%
Legal and criminal justice	47%	45%	50%	46%	46%	38%	40%	47%
Addictions	0%*	52%	53%	46%	51%	45%	45%	48%
Money and debt	33%	32%	35%	32%	32%	26%	31%	41%
Personalised budget	19%	38%	40%	29%	31%	31%	34%	34%
Other support	15%	29%	27%	28%	34%	18%	25%	27%
Community mental health support	17%	17%	19%	18%	20%	17%	21%	18%
Outpatient treatment	10%	13%	18%	13%	13%	16%	10%	14%
In-patient treatment	10%	17%	15%	12%	8%	11%	13%	10%
Care and personal support	10%	15%	15%	13%	11%	11%	13%	7%
Sports and fitness	9%	9%	12%	10%	14%	13%	13%	8%
Self-help and support group	11%	8%	11%	11%	11%	11%	6%	7%
Life skills- budgets, cooking	8%	9%	13%	10%	10%	9%	5%	7%
Social work	5%	10%	10%	8%	9%	6%	8%	8%
Arts, culture and libraries	5%	12%	11%	6%	7%	6%	4%	7%
Welfare rights	2%	7%	7%	7%	9%	5%	9%	9%
Counselling	8%	5%	7%	10%	4%	5%	5%	3%
Community nursing	3%	5%	7%	4%	8%	5%	4%	4%
Psychotherapy	6%	4%	8%	6%	4%	3%	2%	5%
Peer mentoring	3%	8%	9%	3%	5%	5%	3%	1%
Worship and faith	5%	4%	6%	7%	4%	2%	4%	3%
Detox	3%	7%	5%	4%	4%	6%	5%	3%
Education course	5%	7%	5%	7%	5%	3%	2%	1%
Anger management. assertiveness	4%	6%	6%	6%	5%	2%	3%	0%
Day centre	4%	6%	5%	4%	6%	1%	0%	5%
Other mentoring	4%	2%	3%	3%	5%	6%	3%	2%
Basic skills- literacy and numeracy	3%	2%	6%	4%	6%	1%	2%	2%
Careers	3%	3%	5%	2%	2%	3%	6%	2%
Immigration	4%	3%	4%	4%	3%	1%	2%	2%
Rehab	3%	2%	2%	3%	3%	2%	3%	2%
Residential or nursing care/home	2%	1%	2%	1%	3%	2%	3%	4%
Befriending	5%	2%	5%	1%	3%	0%	1%	1%
Cognitive Behavioural Therapy	3%	2%	4%	3%	1%	1%	1%	2%
Occupational therapy	2%	3%	2%	2%	1%	2%	1%	0%
Work experience placement	0%	1%	2%	2%	1%	1%	1%	1%

*There is an anomaly in this data reported on InForm, in Q1 2016 no addiction service use was recorded, this data is missing

Until now we have shared our service use data with CFE Research but have not drilled down for a comprehensive analysis of client service use. Doing so helps us better understand the client journey, and also helps navigators see the value of the rich dataset they collect each quarter.

There were 140 clients active during Q3 2017 who gave consent for their data to be used.

Of the ten most commonly accessed services in the quarter drug and alcohol service contact was accessed by almost 40% of clients in this active cohort (52 people accessing).

Interestingly six of the ten most commonly accessed services related to interactions with the criminal justice system; arrests, magistrates court proceedings, police custody, conviction, nights in prison, police caution. This is the first time we've explored this data and we are presenting a snapshot in time. In future analysis we will look at how this service use has changed over time.

	No. of people accessing
Drug and alcohol service contact	52
Arrest	32
Magistrate court proceeding	28
Night spent in police custody	27
Presentation at A & E	26
Community Mental Health Team - face to face contact	22
Conviction	20
Night in prison	15
Hospital inpatient episode	14
Police caution	11

14. Exploring motivation to change

This exploration is in its infancy but we identified the importance of exploring client's motivations to change, particularly positive examples of clients progressing in substance and alcohol reduction. Our outcome star data explored by status breakdown highlights that clients on move-on who appear to be getting ready to move on positively from the programme have seen their outcome star scored increase most significantly in relation to their levels of motivation and their substance misuse; these are the two areas where we see the biggest decreases for those who have disengaged from the programme.

These case studies form the scoping for a piece of peer research work in 2018 exploring experiences of accessing drug and alcohol treatment.

Client A

35 year old female client

Worked with FL since July 2016

Referred by Adult Social Care

Client A has lost significant brain function owing to her alcohol use and before working with FLNG frequently missed appointments at the drug and alcohol service. Client A has a history of making calls to emergency services related to chaotic alcohol consumption, and of not managing to maintain a basic standard of cleanliness at her property. With encouragement and support from her FL Navigator, since August 2017 Client A has been reducing her alcohol intake and has not made further calls to emergency services. Client A often needs encouragement and validation from her Navigator that she is doing well with her gradual alcohol reduction as she feels unsupported by her family in this. Client A's tenancy support is now withdrawing as she is managing her tenancy well and is now keeping her property clean and tidy.

Client B

45 year old male client

Worked with FL since February 2015

Referred by Evolve

Client B is a war veteran with PTSD and bipolar disorder. Client B's referral stated that he needs regular support to maintain contacts with services. Client B was not engaging with his CPN and alcohol use was threatening his tenancy as he was having disputes with his neighbours. Much of the navigation FL has done with Client B has been around dual diagnosis, Client B stated that his drinking is triggered by his mental health. Client B detoxed in hospital in May 2017 after an admission relating to his liver function. Client B has been alcohol free for eight months, is engaging well with community mental health services, and veterans support services and he is consistently taking mental health medication. Client B is now actively looking to find employment.

Client C

32 year old male client

Working with FL since September 2015, closed August 2017

Referred by Northumbria CRC

Client C was referred onto the programme by Northumbria CRC who cited significant alcohol issues and mental health issues as having an impact on accommodation and offending. Much of the navigation with Client C was around criminal justice and his mental health and wellbeing, with Client C having long periods of presenting as withdrawn and with low mood. Client C had periods where he tried to reduce his drinking for up to 15 days, followed by periods of chaotic substance misuse. In July 2016 Client C had a short rehab intervention but his mental health impacted on relationships with other residents and he left the programme. Client C started to explore his options around volunteering, he was interested in woodwork and joinery. In July 2017 Client C went back into rehab and started the 12 steps programme. Client C's mental health presentation improved significantly and he started a new relationship, in August 2017 Client C had reached step 5 of the 12 steps programme and moved out of area but maintained contact with the programme for a short time. Client C now has his own joinery business which successfully won a shop fitting contract for delivery in the South at the end of 2017.

Client D

35 year old male client

Working with FL since September 2016

Referred by Northumbria CRC

Client D's Navigator used personalisation to buy a ticket for Client D to go to a comedy night, in the week prior to the event Client D had been drinking more than usual. Client D wrote a client testimonial about the event and the impact it had on his drinking:

"I knew I had to cut down in order to feel well enough to go and it motivated me to stop drinking before then so I would enjoy the evening. The event was on the 30th of June and that was the first full day I had not had a drink in a long while. As it happens it worked out quite nicely as a little earlier in the month I had the idea of trying to get sober and try to remain that way for the whole of July. The concert had put me in a really good mood and I couldn't wait to tell my Navigator about it. At the time of writing this I haven't had a drink of alcohol since. It will be the longest period of time I had been sober in a number of years and I believe that is very significant indeed."

Client D has since had a couple of relapses, but has generally been reducing his alcohol consumption.

15. Experience of move on

We currently have only two clients on move on, we are exploring what the move on phase of the client journey looks like particularly with a view to comparison with clients moving on from a Critical Time Intervention delivery approach. Generally when clients are on move on we find that something changes for them and we brings them back into the programme for active client work for a time, so this can be a phase which clients move in and out of before they move out of the programme.

As across the FL programme nationally, this links with what we know about client through put, we have a relatively static caseload categorised by client stasis (see Section 18). Workers had training around 'endings' in relation to frontline work late in 2017 and identified that they feel stuck with clients as the system is not ready to work with our clients in the way they had hoped; they report *"not having anywhere to move them on to"*.

Where clients are doing well however we still see challenges in moving clients on; as Max's story shows. It will be interesting to explore the movement between phases in CTI delivery, to explore whether this feels different for clients and for the workforce.

Max's Story

Background

- Max is a 24 year old man, referred into Fulfilling Lives in April 2015.
- On referral Max stated he had an undiagnosed mental health issue, and self-medicated with cannabis
- He also had a history of offending and housing support needs

Navigation

- Much of the navigation work done with Max has been around accessing mental health services. The navigator recognised that Max and his GP had a poor relationship, Max's GP said Max's mental health couldn't be explored unless Max stopped using cannabis. Max was frustrated and was asked to leave the surgery more than once because his frustration presented as anger.
- Max's GP had not been willing to prescribe him Mirtazapine which he had taken before in 2013. The GP had offered Max an alternative medication which he refused. Max was again asked to leave the surgery. Max's navigator helped him to register with a new GP.
- Max took an overdose of amphetamines, reported this to the police, and was admitted to the Tranwell Unit in July 2016. This led to Max being diagnosed with Emotionally Unstable Personality Disorder and being prescribed Mirtazapine.
- Max often stated he felt anxious and depressed and this was heightened when he attended the GP due to poor past experience, but has a better relationship with this second GP. Max's navigator said that this GP showed compassion, patience, and empathy for Max and treated him like a human being. This GP also repeated Max's Mirtazapine prescription which Max was happy with.

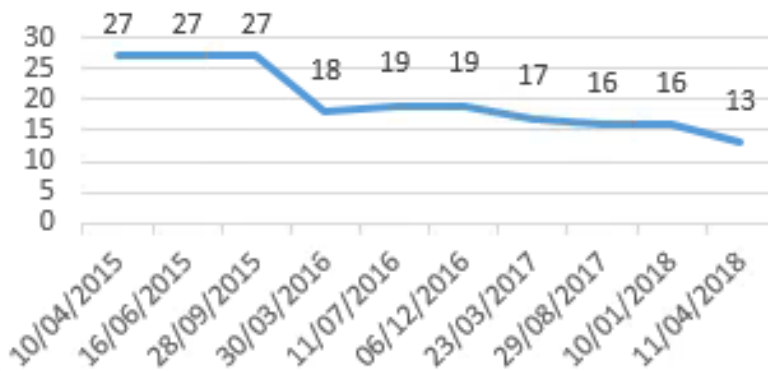
Positive recreational activities

Alongside Max having more access to mental health support and medication, he also began to take part in recreational activities. Max and his Navigator went swimming which Max told his navigator he had previously enjoyed. Max's navigator stated that using the gym and doing boxercise together would help Max to channel his anger and energy; this was well-received and Max has continued these activities.

Reluctance to move on from Fulfilling Lives

- Max's Navigator says Max is stable, this is reflected by his NDTA score over time (Fig. 1).
- 'Stress and Anxiety' has been consistently high, whilst 'Impulse Control' dropped after Max's first three NDTA scores, potentially showing lasting change.
- Max reportedly does not feel ready to move-on from the Fulfilling Lives programme, despite him appearing ready, and has said he will disrupt the move-on process if his navigator tries to change his status and end support.
- Max's Navigator engages with him less regularly but has not changed his status officially

Figure 1. Max's NDTA scores over time



Learning

Before Max took an overdose he was relying on his GP to get access to mental health services; access to mental health for clients with dual diagnosis is a barrier experienced by other Fulfilling Lives clients (see section 7 of this report).

Although he had a poor relationship with his GP Max still engaged with health services with the support of his Fulfilling Lives navigators. This shows Max was flexible and engaged but good engagement is required from both parties, evidenced by the more positive relationship he has with his new GP who showed compassion.

The navigator cited the need for understanding the client and using a holistic approach with Max. Max's navigator felt it was very important to 'ask the client what they want', and this has led to Max and his navigator going swimming, and Max reportedly wanting to do this again. Max does not want to leave the programme despite appearing ready to his navigator. If he later feels ready to move on from the programme, it would be interesting to explore why this is. Max engaged better with his navigator than with services, perhaps due to the navigator's informal and friendly approach. This will be explored further within the programme's new workforce development activity along with exploring Navigator responses to move on and other 'endings' experienced on the programme such as closing cases, disengagement, client deaths, staff handover of clients. Our new Critical Time Intervention (CTI) approach is time limited so 'move on' is essential so any learning will support the implementation of this approach.

16. Client deaths

To date we have had 20 deaths on the programme, this equates to roughly 7% of the client cohort. There is a relatively 50/50 split between male and female and Newcastle and Gateshead based clients (see table below). There is an average age at death of 38 years old, although the age range shown is generally representative of the overall FLNG caseload with the youngest individual being 21 years old, and the eldest 61.

Based on the support needs highlighted at the point of referral it is clear that nearly every person in this group was experiencing both mental health needs and substance misuse or alcohol problems. This is particularly pertinent considering that drug related deaths are the most common cause of death, and with a further three deaths caused by alcohol related illness. The majority of these clients were actively engaged with Fulfilling Lives Newcastle Gateshead at the time of their death. Where recent communication of any kind, including telephone contact, or contact with an agency the client is engaged with has been had with the client then they are considered active on the FLNG caseload. It is somewhat surprising to only see two of these clients were disengaged from the programme at the time of their death; one was disengaged for over six months, the other for around 6 weeks. It is clear from the health information recorded on the client records that almost all had some health conditions recorded.

A number of these individuals were living in independent tenancies as opposed to supported accommodation provision. There should certainly be an exploration around whether these individuals were appropriately housed independently or would have benefited from a more supportive environment.

This health profile suggests a cohort with a range of health and care needs. Data on their engagement with health services is patchy, however it is significant few were accessing mental health support or seeing their GP.

When considering the high mental health needs of this group this is particularly concerning. Overall though that so few services are being accessed is something that must be explored further in looking at what further support could have been offered to these individuals prior to their death. This is particularly relevant for those who died from drug related deaths.

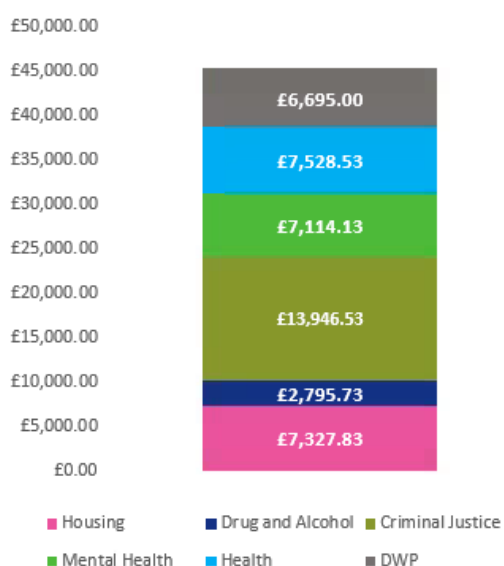
M/F	Age	Ncl/Gd	Homeless?	Mental health needs?	Substance misuse?	Offending behaviour?	Status at time of death	Support start date	Date of death	Accom at time of death	Disability	Health information
M	35	G	No	Yes	Yes	Yes	Disengaged	01/09/14	23/09/15	Supported accom	No	None
F	51	G	No	Yes	Yes	No	Never engaged	24/09/14	17/12/14	Hospital	Yes	Chronic cerebral atrophy
F	40	G	No	Yes	Yes	No	Active	04/02/15	06/04/15	Social Housing	No	Liver complications associated with alcohol consumption at point of referral
M	34	G	Yes	Yes	Yes	Yes	Active	18/02/15	08/12/16	Social Housing	Yes	Mental health – affective schizoid disorder
M	28	G	Yes	Yes	Yes	Yes	Disengaged	18/03/15	04/08/16	Hospital	Yes	Severe damage to hands and arms, chronic liver condition
M	61	G	No	Yes	Yes	Yes	Never engaged	24/03/15	01/04/15	Unknown	Yes	Heart problems recorded at point of referral, suicide attempts, regular A&E attender
F	45	G	No	Yes	Yes	Yes	Active	13/05/15	28/07/15	Social Housing	Yes	Mental health
M	37	G	No	Yes	Yes	Yes	Active	19/04/16	02/08/16	Unknown	Yes	Acquired brain injury
F	42	G	Yes	Yes	Yes	Yes	Active	01/02/2016	20/07/17	Unknown, recently evicted	Yes	Long term depression and anxiety
M	43	G	No	Yes	Yes	Yes	Active	14/12/2015	12/03/18	Family and friends	Yes	Long term depression
F	43	G	No	Yes	Yes	Yes	Active	16/06/2015	30/10/17	Own tenancy private sector	Yes	Mobility issues
F	42	N	Yes	Yes	Yes	Yes	Active	15/10/14	01/08/16	Own tenancy (private sector)	Yes	Mental health, alcoholism
M	58	N	No	No	Yes	Yes	Active	11/11/14	22/11/16	Own tenancy (private sector)	Yes	Mobility/progressive chronic illness, HIV, Hep A,B,C, Neuropathology, Leg ulcers
M	32	N	Yes	Yes	Yes	Yes	Active	17/04/15	28/12/15	Family or friends	No	Sciatica, compacted disc
F	43	N	No	Yes	Yes	Yes	Active	14/10/15	18/04/17	Social Housing	Yes	Mental health, depression
F	35	N	No	Yes	Yes	Yes	Active	22/02/16	07/04/16	Temporary accom	Yes	Mobility, amputee, wheelchair user
M	22	N	Yes	Yes	Yes	Yes	Active	13/09/16	25/02/17	Hospital	Yes	Learning disability, autistic spectrum condition
F	31	N	No	Yes	Yes	Yes	Active	22/08/16	26/02/17	Supported accom	No	Not known
M	21	N	No	Yes	Yes	Yes	Waiting list	-	10/05/17	Temporary accom	Not known	Not known
F	36	N	Yes	Yes	Yes	Yes	Active	06/07/2015	22/11/17	Social housing	Yes	Epilepsy and personality disorder

17. Costs

17.1 Cost to the system

The Hard Edges report estimated the average cost of an individual with Multiple and Complex Needs to be around £19,000 a year (Bramley, G et al. (2015)). Based on the initial findings from the Fulfilling Lives programme in our year one evaluation, and supported by this evaluation, this would appear to be a low estimate as our costings are more in line with those found in the Evaluation of the MEAM Pilots (Battrick et al. (2014)).

The Hard Edges report does provide an estimated benchmark of £4600 per the average adult for the same range of services and this is the comparator used in this report.



The costings utilised in our Year One review (2015) were calculated using the average cost to services from the 32 clients who had been engaged with the programme since September 2014. Due to the limitations of the data available these costings were estimated on the low side. Where service usage was uncertain the conservative estimate was utilised. Using this information it was estimated that an individual with Multiple Needs costs, on average, around £45,000 per year.

Using the benchmark of £4600 our estimate suggests that an individual with multiple complex needs costs nearly 10 times as much as the average adult.

The Hard Edges report estimates that on average each Local Authority has 1,470 cases of multiple complex needs per year. Based on this assessment we can estimate that across Newcastle and Gateshead multiple complex needs is costing the area approximately £133 million per year.

17.2 Case Studies

The following case studies examine the costings of five clients in relation to their engagement with the Fulfilling Lives programme. Three of these clients were included in our Year One evaluation, so here we compare their costings data. Costs presented here are not an exact comparator for Year One data as the time periods compared are different, this costings data is for Jan – Dec 2017 because we had full service use data for all five clients for this one year period. It is our intention to carry out a cost benefit analysis for the full active client cohort by the end of 2018.

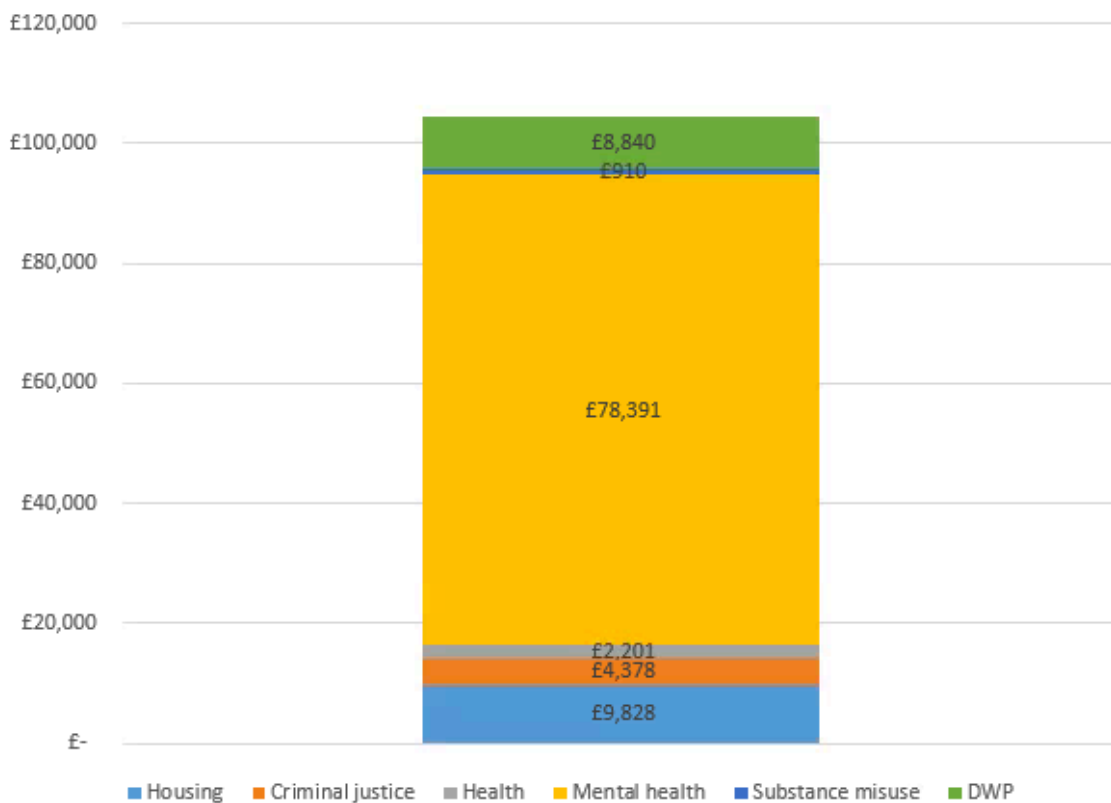
These case studies demonstrate wide variances in change in costings, from Mark's, which have increased considerably as his story shows the system not meeting his needs, to Sarah whose costs have reduced in line with her increasing stability. The narratives for each of their stories highlight complexities around putting in place appropriate support which the client may decline, around the need for critical windows of opportunity for our clients to be met with a timely response, and around increased costs to the system where additional needs, in Steve's case a learning disability assessment, are identified and are met by the system.

Mark

- **24 year old with low capacity for long term planning**
- **Binge drinks and uses legal highs**
- **Self-harms and has attempted suicide on multiple occasions**
- **Has no specific mental health diagnosis despite previous engagement with Early Intervention in Psychosis team**
- **Is regularly evicted due to anti-social behaviour. Cycles through various temporary and supported accommodations and street homelessness**

From January 2017 to December 2017 it is estimated that Mark has cost the system approximately £104,500. From October 2014 – June 2015 when Mark's costs were last explored it was estimated that Mark had cost approximately £47,600, his significant Criminal Justice costs at that time related to a Crown Court case.

Mark began working with Fulfilling Lives in October 2014. Mark cycled through various temporary and supported accommodations and street homelessness. Previously Mark's costs were mainly owing to large criminal justice costs, a crown court case. In this last one year period Mark's costs have increased significantly, mainly due to a lengthy (over 7 months) inpatient mental health episode. Mark was discharged from inpatient mental health services in July 2017. Though his costs show a housing placement, a mental health supported housing placement put in place on his discharge, Mark has not slept at the property other than on a handful of occasions and has been rough sleeping. Mark is disengaged with services and his substance misuse is escalating. His most recent NDTA score was 31 and his risk from others is high. Recently concerns have been raised from FLNG and other agencies in relation to Mark's increased vulnerability and the people he is associated with.



Grace

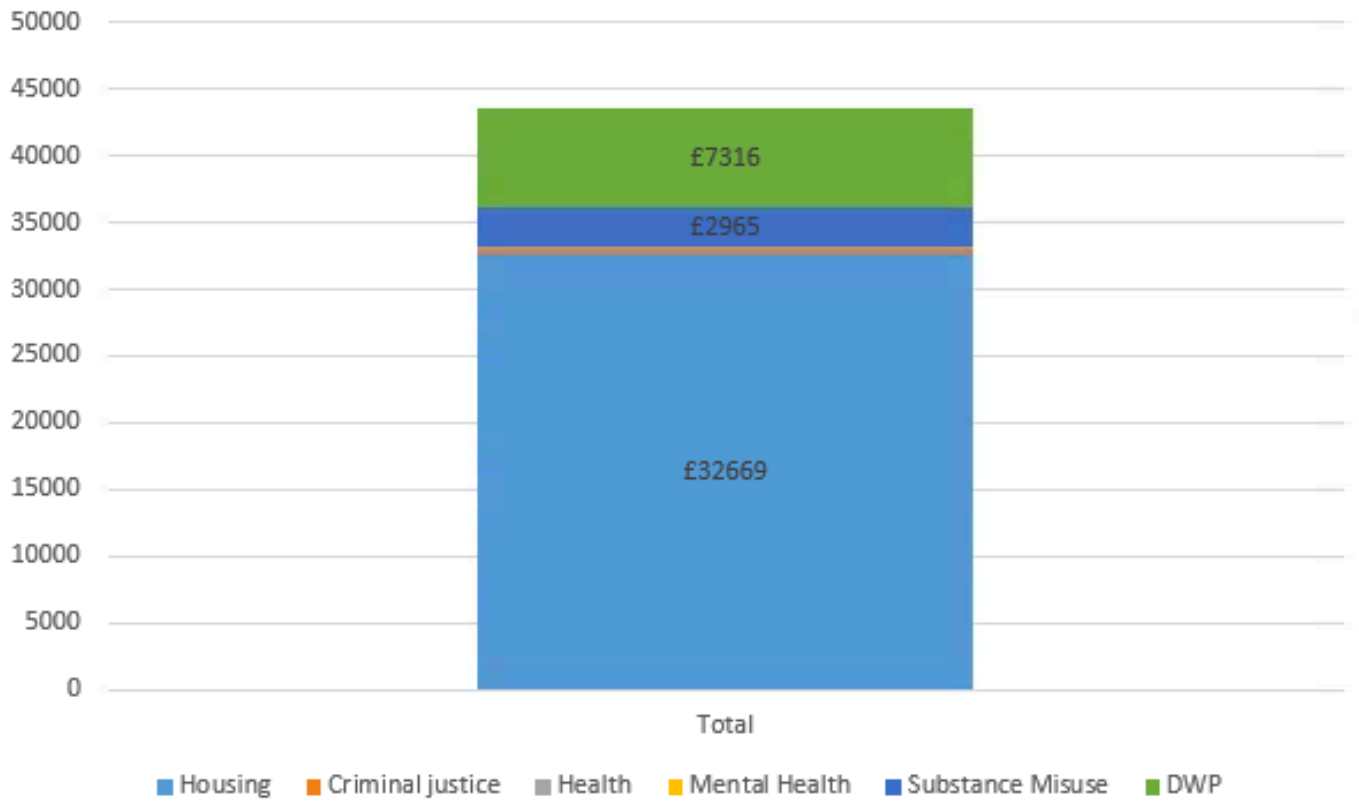
- **27 years old care leaver**
- **Heroin user**
- **Sex working**
- **Self-harming and suicidal**
- **Bouncing between rough sleeping, sofa surfing, temporary accommodation and mental health facilities**

From January 2017 to December 2017 it is estimated that Grace cost approximately £43,000. From July 2014 – June 2015 it was estimated that Grace had cost approximately £55,500, this was largely ascribed to rehab costings.

Grace began working with Fulfilling Lives in August 2014. She presented as extremely chaotic with a particularly high reliance on mental health services. Her housing situation was unstable and she was prone to move regularly between rough sleeping, sofa surfing or staying with friends and temporary accommodation. She had regular stays in mental health facilities due to self-harming and suicidal behaviour. During her engagement with Fulfilling Lives it became apparent that accessing rehab was a key motivator for Grace. Due to previous failed attempts at rehab, paid for by Gateshead Local Authority, Grace was not eligible for funded rehab. Fulfilling Lives, supported by a contribution from Grace's benefits, funded a rehab place in Scotland.

Despite completing six months Grace left the placement two weeks early and returned to Newcastle, she was offered a place in a drug and alcohol resettlement project; she was found to be drinking alcohol and asked to leave. Grace lived on the streets putting herself in risky situations, including sex working for accommodation and money to fund her addiction and was admitted to hospital on several occasions due to overdoses and attempted suicides. Grace had a detox, a referral was made for mental health support when she came out, this looked like a window of opportunity for her however she was told she needed to have 4 weeks clean to access this support, she was quickly back in chaos and the window of opportunity closed.

Grace stayed at a mental health supported accommodation from January 2016; she continued to use heroin; the service was very flexible and she was accommodated for around 18 months owing to their support and flexibility. This placement was at risk several times, due to bringing heroin and illicit methadone on to the premises, verbal aggression to both staff and other residents and eventually she could stay no longer but the provider ensured she had somewhere to go. Grace was since housed in another supported accommodation where she also had flexible support, but due to a serious arson incident this placement has come to an end with Grace now in a further period of homelessness/sofa surfing. There is an ongoing offer of support through Fulfilling Lives and partners in relation to access to detox and private psychotherapy support and at the time of writing Grace was due to take up a fully funded rehab placement with an offer to stay on with the rehab programme as a peer support worker for three months including three months free placement.



Sarah

- **28 year old victim of emotional, physical and sexual abuse**
- **Regular binge drinker**
- **Has a diagnosis of Emotional Unstable Personality Disorder**
- **Self-harming and suicidal**
- **Has been in and out of prison since she was a teenager**
- **Has been a resident in supported accommodation for three years**

From January 2017 to December 2017 it is estimated that Sarah cost approximately £33,000. From October 2014 – June 2015 it was estimated that Sarah cost approximately £40,300.

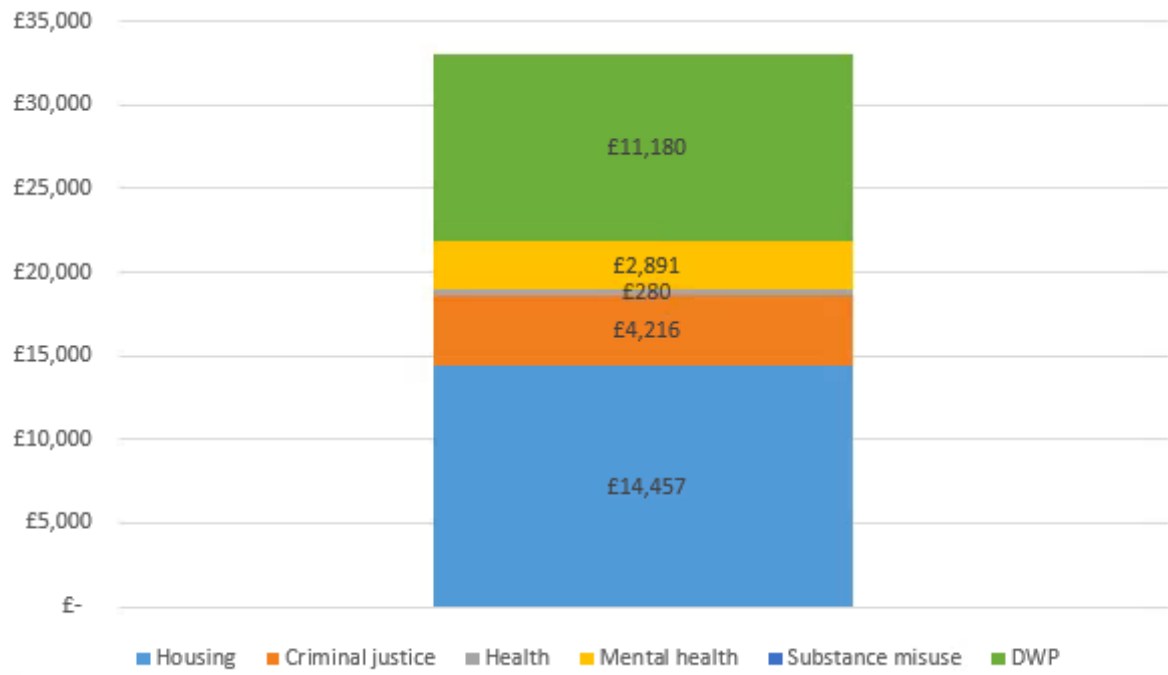
Sarah began working with Fulfilling Lives in September 2014. She is well known to local services and had exceeded the two year maximum stay in her supported accommodation. Despite threats of eviction she did not engage with housing support or change her behaviour within the accommodation. She disengaged from mental health services but was often found in crisis particularly when under the influence. She responded well to regular appointments with her Service Navigator who managed to engage her with a Personality Disorder Hub worker.

Sarah left her supported accommodation in March 2017 and moved into her own tenancy; generally this has been positive for Sarah. At the hostel Sarah was exploited for alcohol and money as residents knew she was desperate for company; this would result in Sarah being arrested for drunk and disorderly offences or for damaging property.

She now has an outreach housing support worker who she has contact with a couple of times a month. Her probationary period has been increased by six months due to some disturbances and Sarah's criminal justice costs relate to several arrests for drunk and disorderly offences, however her offending has reduced because her drinking has reduced and her mental health is more stable.

Sarah goes to a weekly DBT session at the Personality Disorder Hub and has a weekly one to one with her CPN. Her self-harm has reduced significantly and her social anxiety is showing improvement, previously she would vomit before and on to way to appointments, she now takes her dogs for a walk and is open to being referred to community groups to help with boredom and isolation.

Sarah is not registered with a drugs and alcohol service as she feels she doesn't require this, she binge drinks approximately once a week however she does this now only with friends she knows will not cause "*drama and trouble.*"



Greg

- 29 year old male
- Sex working
- Significant safeguarding issues
- Learning difficulties

Greg began working with Fulfilling Lives in March 2015. He had all four needs on referral.

From January 2017 to December 2017 it is estimated that Greg cost approximately £54,000.

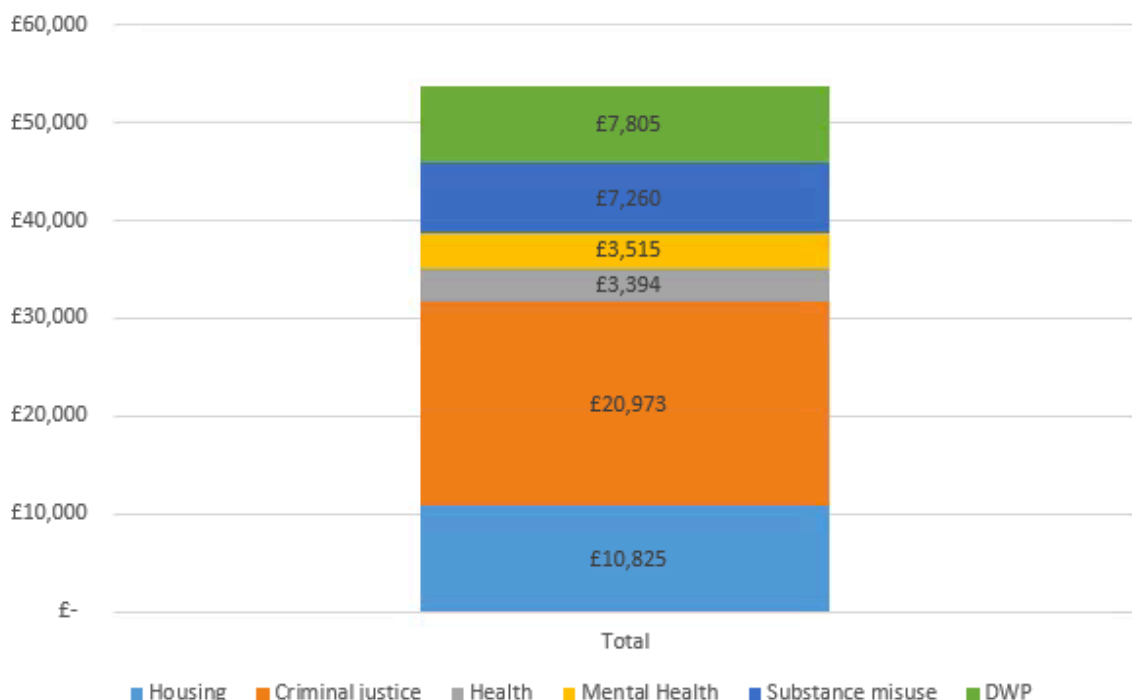
Greg resided in a direct access hostel for half of the reporting period, and was remanded in custody earlier in the year. Greg’s accommodation was not suitable for his needs, and his self-neglect increased.

Greg struggled to manage his day to day tasks and would often present unwashed and without changing his clothes for long periods of time. Greg has a CPN, a social worker, drug worker, harm reduction worker and had a support worker at his hostel. Greg self-harms by inserting needles into his groin and chest cavity; he can also go for long periods of time without eating; he is at risk of exploitation and has been sexually and financially exploited.

Greg is one of FLNGs most chaotic clients, Greg’s costings are very conservative, they do not include multiple out of area A&E presentations where Greg takes a train out of area presenting at A&E, for example in this reporting period he took a train to Edinburgh to present at A&E asking them to section him. This pattern of behaviour became typical during the reporting period, with Greg presenting as homeless in multiple areas, and seeking a section at multiple A&E departments nationally.

Greg presented at A&E locally on over 15 occasions and was arrested 12 times, his out of area presentations are estimated at around 10 occasions however they are likely to number many more.

Greg was remanded in custody earlier in 2018 and was released to a secure mental health rehab placement where he is likely to remain for twelve months, with plans for appropriate mental health supported accommodation to follow. Greg is reportedly settling well.



Steve

- 38 year old male
- Diagnosed with learning disability
- Traumatic family history, PTSD
- Poly drug user

Steve began working with Fulfilling Lives in August 2017. He had all four needs on referral.

From January 2017 to December 2017 it is estimated that Steve cost approximately £32,000.

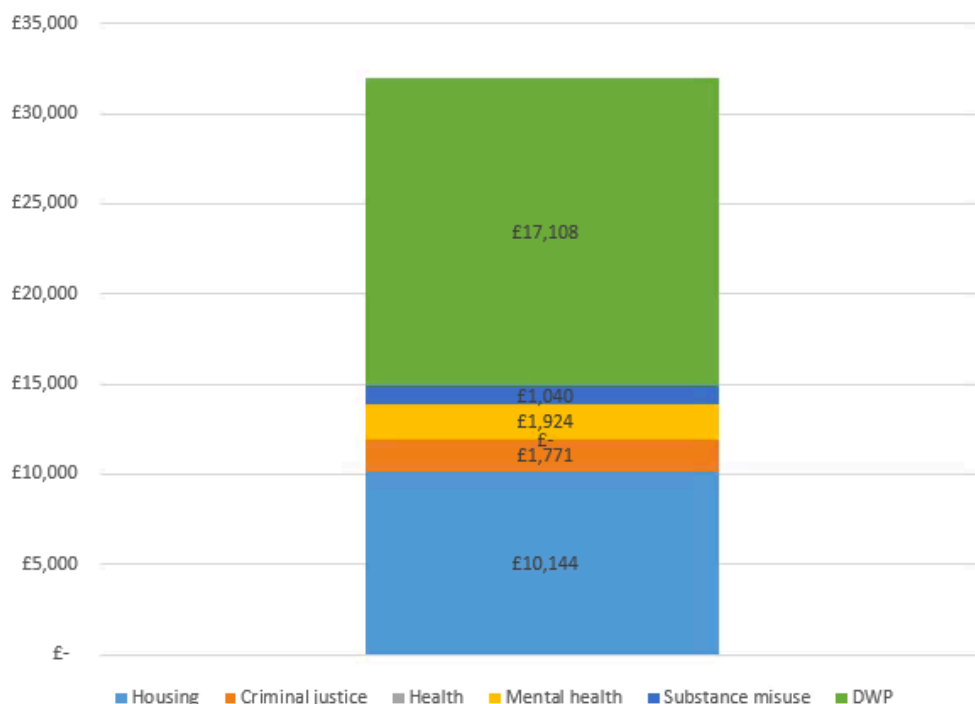
Steve has a history of offending, periods in custody and rough sleeping on release. He doesn't have a good relationship with his family and has witnessed some very traumatic events in his life, including the suicide of his brother in law. Steve was diagnosed with PTSD and his own mental health has worsened over the years. This is partly due to drug use which Steve states he uses to self-medicate and make himself feel better.

Steve told his Navigator that he feels that he does not fit in, diagnosed with ADHD as a child he said he always felt different, and asked for help to explore this. This led to a mental health assessment taking place in the reporting period which concluded that Steve had no underlying mental health issues apart from PTSD. The assessment was queried by his Navigator and Probation Officer and led to the decision that Steve would benefit most from a referral and assessment at the community learning disability team.

It was challenging to motivate Steve to attend the assessment as it involved lots of tests and talking; Steve struggled with this on both levels. Lots of encouragement was needed to coax him to attend and despite these struggles the assessment was carried out over several appointments. The diagnosis that was given was described by Steve as "life changing".

He was diagnosed with a global learning disability, and the realisation that he wasn't imagining things was really positive. Steve has a care package including 8 hours of home care support and his benefits increased.

He is currently in a shared house, he is managing well, engaging with drug and alcohol treatment services sporadically and feels he needs to be in supported accommodation.



18. Client engagement

18.1. About this section

This part of the programme relates primarily to the work that the Service Navigators do in supporting individual clients in engaging, navigating and understanding the system around them and the support they can access. Fulfilling Lives does not provide a service in itself, but links clients with existing support or services that they are currently unable to either engage with or access. When relating this to outcomes this means that any changes relate also to the work of direct services.

18.2 Engaging people with multiple and complex needs

Traditionally we have talked about worker's engagement skills being important, our work exploring what makes a good multiple and complex needs worker has started to broaden our understanding of what it means to be good at engaging this client cohort. The lead Broker working on our Workforce Development (WFD) system change strand highlights five key skills in relation to working with people with multiple and complex needs. These five areas form the basis of our new workforce development offer and we will complete a sector skills audit across these five areas in 2018/19:

Five key skills for working with people with Multiple and Complex Needs

- Accepting (validating, active listening)
- Believing people can get better (building motivation, building hope)
- Collaborating (building problem solving skills)
- Developing trusting relationships (being reliable and consistent)
- Establishing and maintaining roles and boundaries

The Research Team interviewed a Navigator about their engagement with clients, interestingly the notes from this interview highlight these five skills; we propose a similar exploration of these skills with other Navigators to further develop our understanding of client's motivations to change.

Navigator interview notes:

The Navigator sees engagement as a joint effort (Collaborating). The Navigator's perspective of this is that it can be hard to be in charge of your own life but that it is important to allow clients to make their own decisions, even if they are the 'wrong' decision (Accepting).

The Navigator highlighted that they are careful not to judge and allow clients to make their own decisions; explaining to them that it doesn't matter whether they have used alcohol or drugs or not; she is not going to be disappointed (Developing trusted relationships). Whilst the Navigator builds hope and motivation she also acknowledges the entrenched lifestyle and behaviours clients show, and their right to live the life they wish to (Believing people can get better, and Accepting).

The Navigator reports setting consistent rules with clients, and if paperwork is needed explains that it's what they have to do to access services and support (Establishing role and boundaries).

Reviewing our engagement data highlights that 79% of our clients have had sustained and active engagement with the programme in their time with us; 21% have disengaged. Disengaged for Fulfilling Lives constitutes not engaging at all with the programme for three months or more. In the first year of the programme our disengagement rate was 11%; due to the chaotic nature of this client group, and given a lack of engagement is a key criteria for acceptance into the programme this felt like a very low disengagement rate. This 21% is a notably higher proportion of clients disengaging and feels like a more accurate picture given what we know of our client cohort. This will be reviewed regularly in our quarterly reporting as our engagement rate may be linked to staffing changes and sickness on the programme, for example we know that recent programme delivery changes have had an impact on workforce morale and some clients have experienced a change of worker.

18.3 New Directions Team Assessment; Chaos Index

All clients in the Fulfilling Lives programme are assessed using the New Directions Team Assessment (NDTA), or Chaos Index. This is a tool developed by South West London and St George's Mental Health Trust as a way of assessing people with chaotic lives who would be appropriate for their services. The tool requires the individual to be scored on 10 different criteria relating to engagement with services; intentional self-harm; unintentional self-harm; risk to others; risk from others; stress and anxiety; social effectiveness; alcohol/drug abuse; impulse control; and housing. A high score indicates high levels of chaos, with the highest score being 48.

The average overall score of clients at point of referral into the Fulfilling Lives programme is 30.

The average related statement for each of the individual criteria are:

- Non-compliant with routine activities or reasonable requests; does not follow daily routine, though may keep some appointments
- Definite indicators of risk of deliberate self-harm or suicide attempt
- High risk to physical safety as a result of self-neglect, unsafe behaviour or inability to maintain a safe environment
- Risk to physical safety of others as a result of dangerous behaviour or offending/criminal behaviour
- Definite risk of abuse or exploitation from other individuals or society
- Obvious reactiveness; very limited problem solving in response to stress; becomes hostile and aggressive to others
- Uses only minimal social skills, cannot engage in give-and-take of instrumental or social conversations; limited response to social cues; inappropriate
- Recurrent use of alcohol or abuse of drugs which causes significant effect on functioning; aggressive behaviour to others
- Impulsive acts which are fairly often and/or of moderate severity
- Immediate risk of loss of accommodation; living in short-term / temporary accommodation; high housing support needs

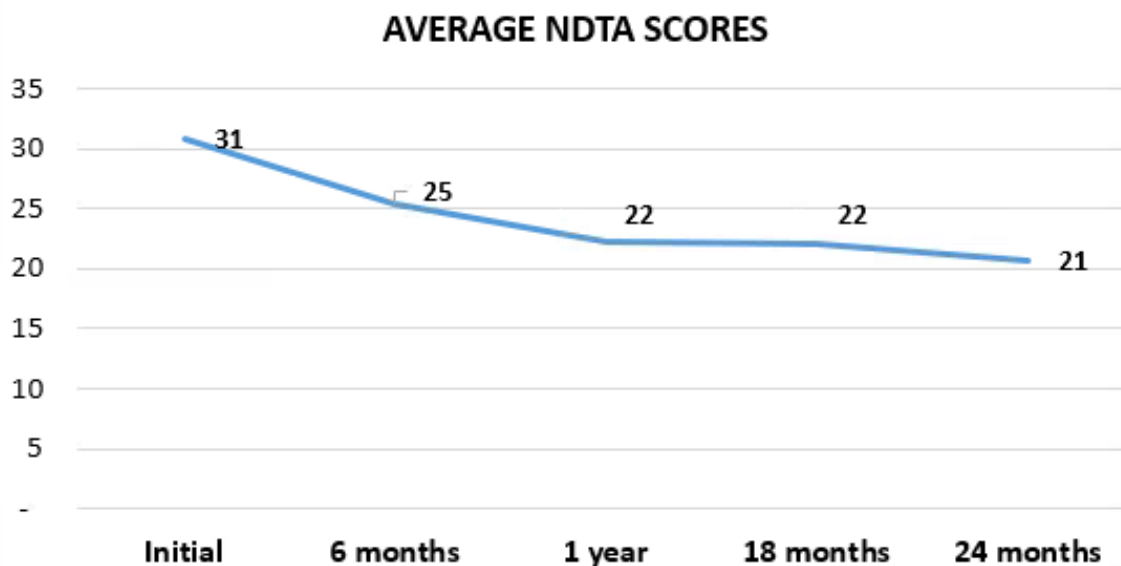
In comparison with the statements listed above, the average related statement for each criterion for the reduced score are:

- Follows through some of the time with daily routines or other activities; usually complies with reasonable requests; is minimally involved in tenancy/treatment
- Minor concerns about risk of deliberate self-harm or suicide attempt
- Definite indicators of unintentional risk to physical safety
- Minor antisocial behaviour

- Minor concerns about risk of abuse or exploitation from other individuals or society
- Moderately reactive to stress; needs support in order to cope
- Marginal social skills, sometimes creates interpersonal friction; sometimes inappropriate
- Some use of alcohol or abuse of drugs with some effect on functioning; sometimes inappropriate to others
- Some temper outbursts/aggressive behaviour; moderate severity; at least one episode of behaviour that is dangerous or threatening
- Living in short-term / temporary accommodation; medium to high housing support needs

For clients who have had at least 24 months involvement with the Fulfilling Lives programme, on average NDTA scores have reduced from 30 at initial assessment, to 21 at the six month point. This is positive as it indicates reducing chaos, however consistently throughout the programme we have seen client's NDTA scores reducing in the first six months of working with us, and then we see this client stasis.

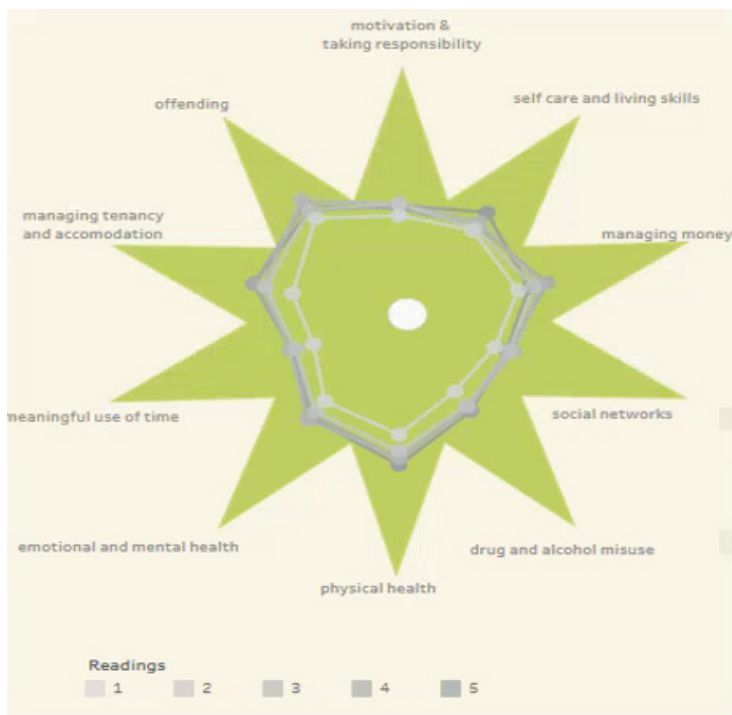
Exploration of individual clients in the cost analysis section above demonstrates clear variations in client journeys which we are seeking to better understand as we gather more data on clients we have worked with for over 24 months.



18.4 Homeless Outcomes Star

The Homeless Outcome Star is a tool for planning, supporting and measuring change when working with people who are homeless, or with multiple and complex needs. It is a self-assessment on a scale of one to ten for ten different issues which include offending, managing money and physical health. An increase in the score indicates progress, so higher scores are positive. The Star is completed within two months of engagement with FLNG and then at six monthly intervals thereafter. Notes are recorded alongside the outcomes star to explore these scores in more detail.

A comparatively smaller, but positive change has been seen across the Homeless Outcomes Star data. It is worth noting that the initial sampling point may show higher scores than expected. This is because Outcomes Stars can be completed up to three months into engagement with the programme and therefore clients are potentially at a slightly more stable point than when they were first referred.



In general, like the NDTA scores we see a sharp increase across many areas of the outcome star between the first and second reading, and then we see relatively sustained scores. Across the whole cohort greater increases in scores are recorded for managing accommodation and tenancy, physical health, drug and alcohol misuse and self-care and living skills. Our outcome star data explored by status breakdown highlights that clients on move-on who appear to be getting ready to move on positively from the programme have seen their outcome star scored increase most significantly in relation to their levels of motivation and their substance misuse; these are the two areas where we see the biggest decreases for those who have disengaged from the programme.

18.5 Personalisation

We've used personal budgets in frontline client work since inception. It was hoped that a small amount of personalised expenditure directed at clients could have a significant impact. We expected 3 main areas PBs could have impact for clients; encouraging engagement, offering support that may not be available or accessible and offering choice and control. Throughout the programme we have reviewed personalisation use. The infographic below shows our most recent finding in numerical format.



Engagement was recorded as the most frequent impact by navigators. Our most recent review of personalisation talked about how some lower value items can have big impacts, taking the example of a cup of coffee:

A *“cup of coffee is way more valuable than people might think”*, showing clients that they can access coffee shops, be part of public spaces, take part in the ‘normality’ of going for coffee, that they *“are worthy”*.

We have a great example from a Navigator who talked about the difference between a £1.70 cup of coffee in McDonalds and a £1.70 coffee at a local art gallery. This really highlighted this issue that even a cup of coffee can be an innovative purchase, building engagement using different social spaces to open different conversations.

In contrast we found fewer examples of personalisation use that really showcased our client’s choice and control, and fewer ‘fun uses’ – something we were actively looking for in our last review.

We found that often the worker identifies the personalisation spend; in response to this we are exploring linking personal budgets to our Critical Time Intervention approach. We are considering a pilot to encourage client-led personalisation, perhaps linked to CTI client goals, and perhaps administered by a panel of Experts by Experience to explore whether this presents any differences in how we use personalisation.

20. Conclusions

In the first four years of Fulfilling Lives Newcastle and Gateshead we have developed a deeper understanding of what it means to live in Newcastle and Gateshead and have multiple complex needs.

Working with 267 clients in total, and now 100 active clients for whom we have a much greater understanding of their demographic, what their community looks like and what their hopes and dreams and goals look like stands us in good stead as we move towards a Critical Time Intervention delivery model.

We will continue to explore client costs in more detail, particularly the nuances that the case studies presented here show; with an increased focus on peer research, and on case studies to ensure we hear the voices of our cohort, speaking about their experiences in their own words.

The stark difference in costs across the five casestudies presented in this report point to costs accruing across all areas of the system, this is indicative of the potential for pooled commissioning for people with multiple and complex needs and presents an exciting opportunity both for our system change offer and the commissioning community of practice we will launch in 2018.

We would like to invite stakeholders to explore these costs further with us, though we have a relatively robust cost framework there are gaps, for example in Greg's case study we did not have a cost heading for sexual health clinical time and in Steve's case we estimated the cost of a learning disability assessment as this cost heading was also difficult to pin down.

Clearly client stasis continues to be an issue, and this was also picked up recently in CFE's whole FL cohort evaluation for 2017. We believe that our new CTI approach will help with this client stasis and look forward to evaluating and sharing our learning from this new approach.

Looking ahead then to future evaluations of the FLNG client journey we will undertake a thorough exploration of client costs for the whole cohort. When we review costs for the whole client cohort we will also in future factor in our hours spent with the client where relevant. We know in the case of one of our clients, our worker spent over 40 hours getting the client's Universal Credit claim up and running. These costs are significant and we can build a better picture of need factoring in our time spent supporting clients.

We will engage staff, clients and Experts by Experience in an exploration of the impact of Critical Time Intervention, both in relation to client outcomes and their experience of being supported in what will be a different way to the navigation model they will be used to.

Linked to this, this evaluation highlights how important it is for workers to invest in building engagement and exploring client's motivations to change. Inherent in this report are links to WFD and our new workforce development work stream will support us to build on the evidence base in relation to our understanding of what makes a good multiple and complex needs worker, with new data from our workforce audits informing future evaluations.

FULFILLING LIVES

Newcastle Gateshead



CHANGING LIVES

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